IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

Y.A. through his next friend **Sara Adams**,
in the care of Prince George's County Department of Social Services
425 Brightseat Road
Landover, MD 20785

Y.B. through his next friend **Beverly Schulterbrandt**,
in the care of Baltimore County Department of Social Services
6410 York Road
Baltimore, MD 21212

and

B.F. through his next friend **Janice Falk**,
in the care of Howard County Department of Social Services
7121 Columbia Gateway Drive
Columbia, MD 21046

For themselves and those similarly situated,

Plaintiffs,

v.

Lourdes R. Padilla, in her official capacity as Secretary of the Maryland Department Human Services,
311 West Saratoga Street
Baltimore, MD 21201

and

Denise Conway, in her official capacity as Executive Director of the Maryland Social Services Administration,
311 West Saratoga Street
Baltimore, MD 21201,

Defendants.

Civil Action No.:

CLASS ACTION COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF

I. INTRODUCTION

1. The State of Maryland has assigned to its Department of Human Services ("DHS" or "Department") and Social Services Administration established within DHS ("SSA" or "Administration") (collectively, Defendants) the legal responsibility for administering Maryland's child welfare program, including the operation of its foster care system. When the State, through DHS and SSA, acts to remove children from their family homes, it undertakes an affirmative constitutional duty as custodian of those children to assure their basic safety and well-being. At any given time, DHS and SSA act as the custodian, or temporary "parent," for thousands of children who reside in foster care and depend on the State for their protection and care, including the provision of necessary medical and mental health services.

2. Children in state foster care have suffered significant trauma in their young lives, including being separated from their families and suddenly deprived of the familiar relationships and surroundings on which they depend. Under the best of circumstances, entry into foster care is a turbulent event for a child.

3. Foster care exposes many children to additional trauma. Children are frequently moved from one foster home to another, which disrupts their important relationships with caretakers, siblings, friends, and teachers. Sometimes, children are placed in foster homes or residential facilities far away from their home communities and local support systems, effectively tearing apart their worlds. Foster care's uncertainties and lack of regularity hinder the ability of these children to form consistent, healthy relationships.

4. Given their histories of trauma, children in foster care often display complex behaviors that call for the attention of mental health professionals. In response, they may be prescribed one or more psychotropic medications. Assuring timely and safe professional attention

to children's mental health needs is a foreseeable and vital obligation of DHS and SSA in their role as custodian. Maryland, through DHS and SSA, is failing to meet that duty.

5. Psychotropic medications are powerful drugs that directly affect chemicals in the brain that help to regulate emotions and behavior. They include anti-anxiety agents, antidepressants, mood stabilizers, stimulants, antipsychotics, and alpha agonists. They also include medications from the anticonvulsant and antihypertensive drug classes when the medication is prescribed for a behavioral health indication. Children administered these medications face a greater risk of harmful physical and emotional side effects than adults. Harmful physical and emotional side effects may include but are not limited to seizures, suicidal thinking and behavior, irreversible movement disorders, adverse cardiovascular and respiratory effects, severe liver disease, excessive weight gain, and unexpected death. As research on the pediatric use of psychotropic medications lags behind prescribing trends and prescriptions to children often are made without prior U.S. Food and Drug Administration ("FDA") approval, the full spectrum of short- and long-term side effects is unknown.

6. Foster care's instability exacerbates the risks associated with the use of psychotropic medications. The U.S. Department of Health and Human Services, Office of Inspector General has observed that "[u]p to 80 percent of children in foster care enter State custody with significant mental health needs. . . . [C]hildren in foster care often do not have a consistent interested party to coordinate treatment planning or to provide continuous oversight of their mental health treatment. Further, responsibility for children in foster care is shared among multiple people—foster parents, birth parents, and caseworkers—which creates risk of miscommunication, conflict, and lack of follow-up. Children in foster care may also experience multiple changes in placement and in physicians, which can cause health information about these

children to be incomplete and spread across many sources. Therefore, children in foster care may be at risk for inappropriate prescribing practices (e.g., too many medications, incorrect dosage, incorrect duration, incorrect indications for use, or inappropriate treatment)."

7. For at least a decade, Defendants have recognized the serious risks of harm associated with the administration of psychotropic medications to children in foster care. They have acknowledged their duty to maintain oversight mechanisms to protect against these risks. However, Defendants have not adequately implemented an oversight system.

8. Defendants continue to allow hundreds of children in foster care to be administered one or more potentially dangerous psychotropic drugs without exercising minimally adequate oversight. As a result of Defendants' ongoing oversight failures, the use of psychotropic drugs is rampant in the State's foster care system. As many as 34% of children in Maryland foster care statewide are administered psychotropic drugs, as compared to 8% of Medicaid-eligible children nationally who are not in foster care. Additionally, 53.68% of Maryland foster children who are taking psychotropic drugs are prescribed multiple drugs at the same time, which is a potentially dangerous practice known as polypharmacy.[1]

9. Moreover, recent DHS data shows that at least 72.1% of children in Maryland foster care who are taking psychotropic drugs do not have a documented psychiatric diagnosis. While this could suggest that psychotropic drugs are not administered in response to a diagnosed mental health condition but instead are administered as a form of chemical restraint, at minimum it evidences inadequate medical record-keeping.

10. Defendants' failures in oversight include the following:

[1] All figures quoted in this Complaint regarding Maryland exclude data from Baltimore City unless specified as a statewide figure.

a) **Inadequate Medical Records**: Defendants fail to compile and maintain minimally-comprehensive and up-to-date medical and mental health records for all children in foster care. They likewise fail to provide this information to all foster caregivers upon placement of a child in their care. As a result, and as Defendants admitted in their 2020 Report to the General Assembly Regarding the Factors Affecting Services Provided to Children in Out-of-Home Placements, "[h]ealth care providers and caregivers alike often do not have the information required for decision making around health care needs."

b) **Inadequate Informed Consent**: Defendants fail to maintain and implement an adequate informed consent process in which a designated individual consults with a prescriber regarding the drug's anticipated benefits and risks and provides consent for the prescription of one or more psychotropic drugs. As a result of Defendants' failure, children in Maryland foster care are routinely administered psychotropic medications against their will, children's parents or guardians are often not engaged in the consent process, and when the designated consenter is the State, the informed consent process frequently amounts to nothing more than a rubber stamp. Additionally, children possessing the capacity to understand the risks and benefits of a psychotropic medication under consideration are routinely not given a voice–so-called "informed assent"–in the prescribing process.

c) **Inadequate Secondary Review**: Defendants fail to operate an adequate secondary review system to assure that "outlier" prescriptions of psychotropic medications to children are immediately flagged for purposes of obtaining a second opinion from a child psychiatrist.

11. As a result of the above failures, hundreds of children in Maryland's foster care system are exposed daily to unreasonable risks of harm from the unsafe administration of psychotropic drugs. It is imperative that Defendants rectify these systemic deficiencies with

urgency. Defendants have actual knowledge of the dangers caused by their failure to oversee psychotropic drug use among children in foster care and have effectively ignored those dangers.

12. On behalf of the putative class, Plaintiffs Y.A., Y.B., and B.F., through their respective adult Next Friends (collectively, the "Named Plaintiffs"), bring this action against Lourdes R. Padilla and Denise Conway in their official capacities as Maryland's Secretary of the DHS and Executive Director of the SSA, respectively, pursuant to 42 U.S.C. § 1983, seeking solely declaratory and prospective injunctive relief to address ongoing violations of Plaintiffs' federal substantive and procedural due process rights under the Fourteenth Amendment to the U.S. Constitution and their federal statutory rights pursuant to the Adoption Assistance and Child Welfare Act of 1980.

II. JURISDICTION AND VENUE

13. This action is brought pursuant to 42 U.S.C. § 1983 to redress violations of the U.S. Constitution and federal statutory law. This Court has jurisdiction pursuant to 28 U.S.C. §§ 1331 and 1343(a)(3) and authority to grant declaratory and prospective injunctive relief under 28 U.S.C. §§ 2201 and 2202 and Rules 57 and 65 of the Federal Rules of Civil Procedure.

14. Venue is proper in this District pursuant to 28 U.S.C. § 1391(b) because a substantial part of the events or omissions giving rise to the claims occurred in this District. Y.A., Y.B., and B.F. currently reside in Maryland.

III. PARTIES

A. The Named Plaintiffs

i) Plaintiff Y.A.

15. Y.A. is a sixteen-year-old Black child in the foster care custody of Maryland DHS. Y.A. brings this case through his adult Next Friend, Sara Adams. Y.A. first came into foster care in 2021. His case is based in Prince George's County. Over the two years that Y.A. has been in

Maryland's foster care custody, Defendants have failed in their obligation to provide for his safety and well-being with respect to how psychotropic medications are administered to him. Defendants have allowed Y.A. to be placed on at least four psychotropic drugs at once and failed to provide appropriate oversight mechanisms of Y.A.'s psychotropic medications. As a result, he has been harmed and put at further risk of harm.

16. Y.A. is currently on multiple psychotropic medications, including Zyprexa (an antipsychotic), Thorazine (another antipsychotic), Trileptal (an anticonvulsant), and Vyvanse (a stimulant). He is also taking Benadryl and was previously prescribed Lithium (an antimanic agent). Upon information and belief, he has been treated for Disruptive Mood Dysregulation Disorder ("DMDD") and Attention-Deficit/Hyperactivity Disorder ("ADHD").

17. When Y.A. first entered DHS custody in early 2021, he had just been discharged from a psychiatric facility due to a mental health crisis.

18. Since being placed into foster care, Y.A. has cycled between hospitalizations and temporary motel stays, eventually ending up in a residential treatment facility. There has been little continuity with regard to his placements, and little continuity in the oversight of his psychotropic medications.

19. While placed in a motel, Y.A. overdosed on his medications when left without supervision in the motel room with unlocked medications. He was hospitalized for a week and was placed back in a motel where he again subsequently overdosed and was again hospitalized.

20. Y.A. has suffered severe side effects from his psychotropic medications. For example, he has suffered extreme weight gain, which is a known and common side effect of his medication Zyprexa (antipsychotic). He has experienced difficulty controlling his hands and arms and difficulty walking. Balance and coordination problems are known side effects of his

medication Trileptal (anticonvulsant). In addition, he has suffered from dizziness, fatigue, stomach aches, and headaches, all of which are known side effects of one or more of the psychotropic medications he is taking. Upon information and belief, there has been no secondary review or effective secondary review of his medications.

21. No adult with authority to consent to his medications regularly attends Y.A.'s psychiatric appointments with him. Upon information and belief, Y.A.'s mother is only informed of changes to Y.A.'s psychotropic medications after the fact.

22. In addition, Y.A. himself does not fully understand his psychotropic medications. Instead, Y.A. believes that DHS "doesn't pay attention" to him.

23. Y.A. currently remains in a residential treatment facility and is in the legal custody of DHS.

24. Defendants' actions and inactions, policies, patterns, customs, and/or practices have violated and continue to violate Y.A.'s substantive due process and federal statutory rights. Defendants have failed to protect him from harm and risk of harm while in their care by subjecting him to psychotropic medication regimens without adequate oversight.

25. Y.A. continues to be at risk of injury as a result of Defendants' actions and inactions, policies, patterns, customs, and/or practices.

26. Defendants' actions and inactions, policies, patterns, customs, and/or practices have also violated and continue to violate Y.A.'s procedural due process rights. Defendants have subjected Y.A. to unnecessary administration of psychotropic medication without adequate procedures for ensuring that the medications are appropriately administered and without a sufficient process for informed consent.

ii) Plaintiff Y.B.

27. Y.B. is a sixteen-year-old Black child in the foster care custody of DHS. Y.B.'s case is brought by his adult Next Friend, Beverly Schulterbrandt. Y.B. first came into state custody in 2013 when he was seven years old. His case is based in Baltimore County. Over the decade that Y.B. has been in Maryland's foster care custody, Defendants have failed in their obligation to provide for his safety and well-being with respect to how psychotropic medications are administered to him. Defendants have allowed Y.B. to be placed on at least five psychotropic drugs at once and failed to provide appropriate oversight mechanisms of Y.B.'s psychotropic medications. As a result, he has been harmed and put at further risk of harm.

28. Y.B. is currently prescribed multiple psychotropic medications, including Clonidine (an alpha agonist), Depakote (an anticonvulsant), and Lexapro (antidepressant). He is also prescribed Melatonin. At times he has been prescribed at least five psychotropic medications concurrently. In or around April 2022, he was prescribed Lexapro (an antidepressant), Abilify (an atypical antipsychotic), Clonidine (an alpha agonist), Methylphenidate (a stimulant), and Depakote. He was also prescribed Melatonin.

29. Upon information and belief, Y.B. has been treated for DMDD, Post-Traumatic Stress Disorder ("PTSD"), Oppositional Defiant Disorder ("ODD"), and ADHD. Y.B. has experienced repeated suicidal ideation and self-harm.

30. Y.B. first entered foster care in or around February 2013, when he was admitted to an in-patient psychiatric unit as a result of a mental health crises. Y.B. has been in twelve different placements over his nearly ten years in care. Eight of these placements have been residential facilities, such as residential treatment centers and psychiatric hospitals. As Y.B. moved between

these twelve different placements, he has had little continuity in the oversight of his medications and in his medical providers.

31. While being administered multiple psychotropic medications, Y.B. has experienced behaviors that have resulted in repeated hospitalizations. For example, he has repeatedly engaged in self-harming behaviors, including ingesting laundry detergent and threatening to jump off of a roof. Y.B. has also experienced repeated physical restraints and placement disruptions in response to his behaviors. Significant agitation and mood swings are known side effects of his current medications Clonidine (alpha agonist) and Depakote (anticonvulsant) and previous medication Abilify (atypical antipsychotic).

32. In addition, since being put on these psychotropic medications Y.B. has experienced significant weight gain. Between May 2021 and April 2022, Y.B. gained over 50 pounds. During this time, he was taking Lexapro (antidepressant) and Abilify (atypical antipsychotic), both medications known to cause weight gain. His blood tests have indicated he has elevated triglycerides and high blood pressure. Y.B.'s Court-Appointed Special Advocate ("CASA") has expressed concern that Y.B. is over-medicated. Upon information and belief, there has been no secondary review or effective secondary review of his medications.

33. Y.B. currently remains in a residential treatment facility and is in the legal custody of DHS.

34. Defendants' actions and inactions, policies, patterns, customs, and/or practices have violated and continue to violate Y.B.'s substantive due process and federal statutory rights. Defendants have failed to protect him from harm and risk of harm while in their care by subjecting him to psychotropic medication regimens without adequate oversight.

35. Y.B. continues to be at risk of injury as a result of Defendants' actions and inactions, policies, patterns, customs, and/or practices.

36. Defendants' actions and inactions, policies, patterns, customs, and/or practices have also violated and continue to violate Y.B.'s procedural due process rights. Defendants have subjected Y.B. to unnecessary administration of psychotropic medication without adequate procedures for ensuring that the medications are appropriately administered and without a sufficient process for informed consent.

iii) <u>Plaintiff B.F.</u>

37. B.F. is a fourteen-year-old white child in the foster care custody of DHS. B.F.'s case is brought by his adult Next Friend, Janice Falk. B.F. first came into state custody in 2018. His case is based in Howard County. Over the four years that B.F. has been in Maryland's foster care custody, DHS has failed in its obligation to provide for his safety and well-being with respect to how psychotropic medications are administered to him. DHS has allowed B.F. to be placed on up to six psychotropic drugs at once and failed to provide appropriate oversight mechanisms of B.F.'s psychotropic medications. As a result, he has been harmed and put at further risk of harm.

38. B.F. is currently taking multiple psychotropic medications, including Trazodone (an antidepressant), Methylphenidate (a stimulant), Lithium (an antimanic agent), and Abilify (an atypical antipsychotic). Upon information and belief, B.F. has been treated for ODD, Disruptive Behavior Deregulation, ADHD, and anxiety with panic attacks.

39. B.F. first entered foster care in May 2018. B.F. has moved numerous times during his more than four years in foster care. As he bounced between multiple placements, including multiple foster homes and a residential treatment facility, his treating physician repeatedly changed. In addition, the medical records, or "medical passport," DHS has provided to new placements to update them

on B.F.'s medical history has been insufficient and at times inaccurate. As a result, B.F. has had little continuity in the oversight of his medications.

40. In or around May 2018, when B.F. first entered foster care, he was taking three psychotropic medications: Buspar (an anti-anxiety agent), Clonidine (an alpha agonist), and Focalin (a stimulant). A year later, by around March 2020, B.F. was on six psychotropic medications. His Focalin (stimulant) had been increased and, along with continuing Clonidine (alpha agonist) and Buspar (anti-anxiety agent), three new psychotropic medications had been added: Xanax (a benzodiazepine), Trazodone (an antidepressant), and Zoloft (another antidepressant). While on these medications, B.F. experienced escalating behavioral issues that led to his removal from his foster home. Upon information and belief, there was no secondary review or effective secondary review of these concurrent medications.

41. In July 2020, B.F. returned to his mother for a trial placement. B.F. remained on these psychotropic drugs, his behavior continued to escalate, and by June 2021 he was placed in a residential treatment center.

42. At the residential treatment facility, B.F.'s medication regimen was changed again and he was administered seven psychotropic drugs. He, at various times, was prescribed a combination of Lithium (an antimanic agent), Abilify (an atypical antipsychotic), Depakote (an anticonvulsant), Ritalin (a stimulant), Methylphenidate (another stimulant), Zoloft (an antidepressant), and Trazodone (another antidepressant).

43. While he was on this cocktail of psychotropic medications, B.F. experienced increasingly emotional outbursts and aggression. Significant agitation and mood swings are known side effects of his medications Abilify (atypical antipsychotic) and Depakote (anticonvulsant). B.F.

also experienced side effects from the medication including stomach issues and dry mouth, which are known symptoms of several of his medications.

44. While placed at the residential treatment center, by information and belief, B.F. again never received a secondary review or effective secondary review of his medications.

45. B.F. attended his psychiatry appointments at the residential treatment center alone; no adult with authority to consent to his medications attended these appointments with him to review medication options.

46. In mid-October 2022, B.F. was discharged from the residential treatment facility to a trial placement with his birth mother. Because of this, B.F. once again had to switch to a new psychiatrist, again disrupting oversight of his psychotropic medications.

47. B.F.'s mother has not been provided adequate information about B.F.'s psychotropic medications. While B.F. was at the residential treatment facility, B.F.'s mother would only be advised of medications changes after the fact. B.F.'s new psychiatrist did not receive records of B.F.'s current medications. As a result, at one appointment the physician sought to piece together B.F.'s prescription history based on available pill bottles. Upon information and belief, B.F. has not himself had adequate conversations with his treating physicians explaining his medications and seeking his assent.

48. B.F. is currently placed at home with his mother on a trial placement. He remains in the legal custody of DHS.

49. Defendants' actions and inactions, policies, patterns, customs, and/or practices have violated and continue to violate B.F.'s substantive due process and federal statutory rights. Defendants have failed to protect him from harm and risk of harm while in their care by subjecting him to psychotropic medication regimens without adequate oversight.

50. B.F. continues to be at risk of injury as a result of Defendants' actions and inactions, policies, patterns, customs, and/or practices.

51. Defendants' actions and inactions, policies, patterns, customs, and/or practices have also violated and continue to violate B.F.'s procedural due process rights. Defendants have subjected B.F. to unnecessary administration of psychotropic medication without adequate procedures for ensuring that the medications are appropriately administered and without a sufficient process for informed consent.

B. <u>The Next Friends</u>

52. Pursuant to Fed. R. Civ. P. 17(c)(2), Plaintiff Y.A. appears through his Next Friend, Sara Adams. Ms. Adams is an associate at Tully Rinckey PLLC. Prior to this position, she spent eight years advocating for children in foster care, including nearly five years serving as an attorney at Maryland Legal Aid and nearly four years as a CASA. Because Y.A. is in state custody, has experienced frequent placement moves, and lacks consistent significant relationships with adults able to represent him, the appointment of Ms. Adams as his Next Friend is necessary.

53. Ms. Adams is familiar with Y.A.'s case and has knowledge of the Department's failure to provide adequate oversight of Y.A.'s mental health care, including the administration of psychotropic medications. She understands her role as a Next Friend in this case, is willing and able to represent Y.A., is dedicated to his best interests, and has no conflict that would preclude such representation.

54. Pursuant to Fed. R. Civ. P. 17(c)(2), Plaintiff Y.B. appears through his Next Friend, Beverly Schulterbrandt. Ms. Schulterbrandt is a senior attorney at the American Bar Association. She previously worked at the Maryland Office of the Public Defender where she was a supervising attorney working on child welfare cases. Ms. Schulterbrandt has over two decades of experience working on dependency and delinquency cases. Because Y.B. is in state custody, has experienced

frequent placement moves, and lacks consistent significant relationships with adults able to represent him, the appointment of Ms. Schulterbrandt as his Next Friend is necessary.

55. Ms. Schulterbrandt is familiar with Y.B.'s case and has knowledge of the Department's failure to provide adequate oversight of Y.B.'s mental health care, including the administration of psychotropic medications. Ms. Schulterbrandt understands her role as a Next Friend in this case, is willing and able to represent Y.B., is dedicated to his best interests, and has no conflict that would preclude such representation.

56. Pursuant to Fed. R. Civ. P. 17(c)(2), Plaintiff B.F. appears through his Next Friend, Janice Falk. Ms. Falk has worked with the CASA program since 2002. She holds a degree in elementary education and has worked and volunteered with children with mental health needs for decades. Ms. Falk has been a coach for Maryland Special Olympics, Howard County, since 2000, and is a member of National Alliance on Mental Illness. Ms. Falk has served as B.F.'s CASA since February 2022. She is closely familiar with B.F.'s situation, regularly meets with him and his family, and advocates for his care.

57. As B.F.'s CASA, Ms. Falk has personally observed the Department's failure to provide adequate oversight of B.F.'s mental health care, including the administration of psychotropic medications. Ms. Falk understands her role as a Next Friend in this case, is willing and able to represent B.F., is dedicated to his best interests, and has no conflict that would preclude such representation.

C. <u>Defendants</u>

58. Lourdes R. Padilla, Maryland's Secretary of DHS, is sued in her official capacity only. Defendant Padilla maintains her principal office at the Maryland Department of Human Services, 311 West Saratoga Street, Baltimore, Maryland 21201. Defendant Padilla is vested under state law with serving as the "head of the Department," advising the Governor on "all matters

assigned to the Department" and "carrying out the Governor's policies on those matters." MD Code, Hum. Serv. § 2-202(a), (c). As Secretary, Defendant Padilla is "responsible for the operation of the Department." *Id.* § 2-203(a). Padilla is also responsible for the budget of the office of the Secretary and of each unit in the Department and for planning activities of the Department. *See id.* §§ 2-210, 2-211.

59. Denise Conway, Executive Director of SSA, is sued in her official capacity only. Defendant Conway also maintains her principal office at the Maryland Department of Human Services, Social Services Administration, 311 West Saratoga Street, Baltimore, Maryland 21201. The Administration is a unit within DHS. *See id.* § 2-301. It serves as the "central coordinating and directing agency of all social service activities in the State, including[] child welfare services." *See id.* § 4-205(a)(1)(i). The Administration is responsible for supervising, directing, and controlling "the activities of the local departments that it finances wholly or partly." *See id.* § 4-205(b). The Administration is further responsible for supervising "all public and private institutions that have care, custody, or control of abused, abandoned, dependent, or neglected children." *See id.* §4-205(c). The Executive Director serves as the administrative head of the Administration and is responsible for administering and organizing the Administration, supervising the social service activities of the local departments, and supervising other agencies and institutions under the supervision of the Administration. *See id.* § 4-204. The Executive Director is appointed by the Secretary of DHS and "serves at the pleasure of the Secretary." *See id.* § 4-203.

IV. CLASS ACTION ALLEGATIONS

60. Plaintiffs Y.A., Y.B., and B.F. bring this action pursuant to Rules 23(a) and 23(b)(2) of the Federal Rules of Civil Procedure on behalf of themselves and a class of similarly situated

children. The Named Plaintiffs, on behalf of themselves and the putative class, seek solely systemic injunctive relief in this action and no individualized money damages.

61. The putative class (the "Class") is defined as all children under 18 years old who are or will be prescribed or administered one or more psychotropic medications while in Maryland foster care custody statewide, except for children in foster care custody in Baltimore City.[2]

62. The Class is sufficiently numerous to make joinder impracticable. As of October 2022, an estimated 2,581 children were in the legal custody of DHS/SSA in Maryland. Upon information and belief, at least hundreds of children in state foster care presently receive or in the future will receive psychotropic medications. Joinder of hundreds of children would be unduly burdensome and impractical in these circumstances.

63. The Named Plaintiffs will fairly and adequately represent and protect the interests of the Class.

64. The violations of law and resulting harms averred by the Named Plaintiffs are typical of the legal violations and harms suffered by all Class members.

65. Each Named Plaintiff appears by a Next Friend who is undertaking that role pursuant to Fed. R. Civ. P. 17(c)(2). Each Next Friend has sufficient knowledge and familiarity with the facts of their respective Named Plaintiff as well as the systemic common deficiencies underlying this complaint. The Next Friends are dedicated to fairly and adequately representing the best interests of their respective Named Plaintiff, as well as the best interests of the Class.

66. Named Plaintiffs and the putative Class are represented by individual attorneys employed by: (i) Children's Rights, a non-profit organization whose attorneys have substantial

[2] The foster care system in Baltimore City is subject to a federal consent decree, which includes within its scope the provision of mental health services to children in foster care in Baltimore City. *See L.J. v. Massinga*, Modified Consent Decree, Doc. No. 586, Case No. 1:84-cv-4409 (D. Md.).

experience and expertise in child welfare institutional reform class actions; (ii) Morgan Lewis & Bockius LLP, a private law firm with extensive experience in complex civil and public interest litigation, including class action litigation; (iii) Disability Rights Maryland, a non-profit organization and Maryland's designated Protection & Advocacy agency working to advance the civil rights of people with disabilities; and (iv) ACLU of Maryland, a non-profit organization that empowers Marylanders to exercise their rights so that the law values and uplifts their humanity. Both Disability Rights Maryland and the ACLU of Maryland have extensive knowledge of the needs of Maryland's population and expertise in litigating in Maryland.

67. The above attorneys (collectively, "Plaintiffs' Counsel") have thoroughly investigated all claims brought in this Complaint and have committed sufficient resources to represent the putative Class throughout the litigation.

68. Plaintiffs' Counsel knows of no conflicts among Class members.

69. Defendants have acted or failed to act on grounds generally applicable to the Class, necessitating declaratory and injunctive relief for the Class.

70. The questions of fact and law raised by this Complaint are common among the Named Plaintiffs and the members of the putative Class of children they seek to represent. Each child in the Class relies on Defendants' actions to ensure their safety and well-being, including their physical and mental health. The longstanding and well-known systemic deficiencies plaguing Defendants' oversight of psychotropic drug utilization place the Class at a common and ongoing risk of harm.

71. Questions of fact common to the Class include:

i. Whether Defendants, through their actions and inactions, have demonstrated a policy, pattern, custom, and/or practice of inadequately

monitoring and overseeing the administration of psychotropic drugs to children in the custody of DHS by failing to: (a) maintain complete, current, and reasonably accessible medical records, including medication history for children in foster care, and provide these records to foster caregivers and health care providers to facilitate the effective delivery of services; (b) ensure that informed consent is obtained prior to and throughout the time that children in foster care are administered psychotropic drugs; and (c) operate a statewide secondary review system capable of promptly identifying and addressing outlier prescribing practices to assure the safe administration of drugs to children in foster care; and

ii. Whether these systemic failures expose children administered psychotropic drugs while in DHS custody to harm or the risk of harm.

72. Questions of law common to the Class include:

i. Whether Defendants' actions and inactions, policies, patterns, customs, and/or practices violate the Class's substantive due process right to (a) personal safety and security; (b) be free from harm or substantial risk of serious harm; (c) necessary treatment, care, and services to protect Class members from deteriorating or being harmed physically, psychologically, developmentally, emotionally, or otherwise; and (d) adequate supervision and monitoring of Class members' health and safety, as guaranteed by the Fourteenth Amendment to the United States Constitution;

ii. Whether Defendants' actions and inactions, policies, patterns, customs, and/or practices violate the Class's procedural due process right to be free

from the unwarranted deprivation by the State of their liberty interest in bodily integrity, as guaranteed by the Fourteenth Amendment to the United States Constitution;

iii. Whether Defendants' actions and inactions, policies, patterns, customs, and/or practices violate the Class's rights under the Adoption Assistance and Child Welfare Act of 1980 to have their medical records kept up-to-date and delivered to their foster caretakers in a timely manner upon placement in their home; and

iv. Whether the Class members are entitled to declaratory and prospective injunctive relief to vindicate the rights they have been denied.

V. FACTUAL ALLEGATIONS

A. Children Administered Psychotropic Drugs Are in Danger of Emotional, Psychological, and Physical Harm

73. Children administered psychotropic drugs are at a heightened risk of serious short- and long-term adverse effects. As the International Association for Child and Adolescent Psychiatry and Allied Professions has recognized, "[p]harmacological treatment during human development [such as childhood and adolescence] may result in toxicities that are not seen in adults . . . and result in unwanted long-lasting changes."

74. Research supports that children administered psychotropic drugs face a risk of experiencing seizures, irreversible movement disorders, suicidal thinking and behavior, mood disruption, irritability and restlessness, weight gain, diabetes and metabolic abnormalities, nausea and vomiting, blurred vision, excessive fatigue, somnolence, tremors, anorexia, severe liver disease, adverse cardiovascular and respiratory effects, and unexpected death, among other life-threatening conditions.

75. Antipsychotics can be particularly harmful to children's developing brains and bodies. Studies have found that children taking antipsychotics are at least three times more likely than children taking other psychotropic medications to suffer from diabetes and that higher doses of antipsychotics in children are associated with a significantly increased risk of unexpected death.

76. Further, the short- and long-term impact of psychotropic drugs on children are not yet fully understood. In a 2012 memorandum issued to all state agencies administering a Title IV-E foster care program ("2012 ACF Information Memorandum"), the Administration of Children and Families ("ACF")—the office in the U.S. Department of Health and Human Services tasked with administering the Title IV-E foster care program—cautioned that "research on the safe and appropriate pediatric use of psychotropic medications lags behind prescribing trends. . . . In the absence of such research, it is not possible to know all of the short- and long-term effects, both positive and negative, of psychotropic medications on young minds and bodies."

77. As a result, most psychotropic drugs have not been proven safe or effective in children and have therefore not been approved by the FDA for use in children. Yet, these drugs are regularly prescribed to children "off-label," a term the FDA defines as the "[u]napproved use of an approved drug." At least one study has found that more than 75% of psychotropic drug use in children and adolescents is off-label.

78. The risks of psychotropic medication administration are compounded for children in foster care. In addition to having psychotropic medications prescribed at rates higher than Medicaid-eligible peers, children in the foster care system in Maryland face an increased risk of being exposed to dangerous prescribing practices that in turn place them at an increased risk of harm.

79. The American Academy of Child and Adolescent Psychiatry ("AACAP"), a leading medical guidance body, has deemed prescribing too many psychotropic medications, or prescribing psychotropic medications at too high a dose or at too young an age, as inappropriate. These practices are commonly referred to as "too many," "too much," and "too young." The federal government similarly cautioned in its 2012 ACF Information Memorandum that those outlier practices may signal that factors other than clinical need are impacting the prescription of psychotropic medications.

80. **Too many.** As the 2012 ACF Information Memorandum makes clear, there is scant evidence that polypharmacy is effective for children. No research supports the use of three or more psychotropic drugs concomitantly in children.

81. Polypharmacy is considered a dangerous practice for a number of reasons. The likelihood of adverse effects of medication increases with the number of medications. One study found that children taking two drugs reported 17% more adverse effects than children taking one, and children taking three or more medications report 38% more adverse effects.

82. The likelihood that certain side effects will be severe significantly increases with three or more medications. For instance, increased appetite is four times as likely to be reported as moderate or severe among children taking three or more medications than children taking one medication. Sleepiness/fatigue is approximately three times as likely to be rated as moderate or severe. The risk of suicidality and self-harm also increases with the number of medications.

83. With multiple atypical, or second generation, antipsychotic medications in particular, children are five times more likely to become obese when compared with children taking no atypical antipsychotics. The risk of developing diabetes is significantly greater for children who are prescribed an antidepressant in combination with an antipsychotic.

84. As a result, and as stated in the 2012 ACF Information Memorandum, the federal government considers the use of three or more medications simultaneously, the use of two or more medications in the same class for more than 30 days, and the use of multiple psychotropic medications before testing the effectiveness of a single medication to constitute concerning prescribing practices.

85. Polypharmacy is widespread in Maryland's foster care system. According to Defendant DHS's Child Welfare System Report, as of June 30, 2021, 53.68% of all children in foster care in Maryland who were prescribed a psychotropic drug were taking multiple drugs.

86. According to a study published in 2018 titled "Patterns of Early Mental Health Diagnosis and Medication Treatment in a Medicaid-Insured Birth Cohort," which was conducted by the University of Maryland, the concurrent use of three or more psychotropic medications was three to four times more common among children in foster care than income-eligible children.

87. **Too much.** Dosage guidelines are typically established by FDA prescription labels. But because most pediatric psychotropic use is off-label and few psychotropic medications have been tested on children, research-based guidelines for medication dosages are not available for many of the psychotropic medications prescribed to children.

88. Leading medical guidance bodies, including the Substance Abuse and Mental Health Services Administration and AACAP, have stressed the importance of appropriate dosing strategies, emphasizing that dosing should start low and should increase over time only if needed.

89. As the federal government flagged in its 2012 ACF Information Memorandum, "until all drugs are properly studied in the populations for which they are being used, the lack of specific evidence-based [dosing] recommendations reinforces the need for close supervision and monitoring for patients receiving psychotropic medication for off-label uses."

90. Moreover, research shows that prescribing doses at higher than the maximum levels recommended increases the risk of adverse side effects and generally does not significantly increase the efficacy of the drug.

91. Youth in foster care are prescribed psychotropic medication at dosages that exceed recommended maximum levels much more frequently than non-foster youth despite the increased risk of side effects and absence of evidence indicating increased efficacy. With respect to antipsychotics in particular, a study of children on Medicaid from ten states, which was published in 2018 and is titled “Differences in Medicaid Antipsychotic Medication Measures Among Children with SSI, Foster Care, and Income-Based Aid,” found that children in foster care, when compared to those enrolled in Medicaid who were not in foster care, are twice as likely to receive higher than recommended doses of antipsychotics.

92. **Too young.** Young children are especially vulnerable to serious adverse effects from psychotropic medications. In its 2012 ACF Information Memorandum, the federal government deemed the use of medications in children under the age of six to constitute a potentially inappropriate psychotropic medication use.

93. According to the aforementioned 2018 study conducted by the University of Maryland, nearly one out of three children in foster care received a psychotropic medication by age eight.

94. That same study also found that children in foster care had 153 additional days of psychotropic medication exposure from ages three through seven as compared to income-eligible children who were not in foster care.

95. Another University of Maryland study published in 2014 of young children in foster care, which was sponsored by the Maryland Department of Health and Mental Hygiene, now the

Department of Health, highlighted the risks associated with early, chronic exposure to antipsychotic medications in particular, noting that such exposure impacts brain development and carries potential metabolic side effects, including an increased risk of incident diabetes. The study, titled "Age-Related Trends in Psychotropic Medication Use Among Very Young Children in Foster Care," found that nearly one-quarter of children aged five and six who had been in foster care for over a year had received a psychotropic medication. The study further found that "[c]oncomitant use of three or more psychotropic classes began among children as young as four." Children in the study who were prescribed antipsychotic and ADHD medications before the age of six continued to receive them for longer periods of time.

96. Defendant DHS reported that, in all of Maryland, nearly one out of three children in foster care between ages five and eleven who were taking a psychotropic medication were taking multiple such medications as of June 30, 2021.

97. **Lack of mental health diagnoses**. Although a mental health diagnosis is a prerequisite for appropriately prescribing psychotropic drugs, only 27.9% of children in foster care in Maryland who were prescribed a psychotropic drug had a documented psychiatric diagnosis.

98. **Lack of metabolic monitoring.** Despite the importance of quality metabolic screening and monitoring for individuals taking antipsychotic drugs, monitoring schedules are rarely followed. The aforementioned 2018 study of Medicaid data from ten states revealed that only 8% of children in foster care who were prescribed antipsychotics received baseline metabolic screening and only 25.1% received annual metabolic laboratory monitoring. In light of the serious potential adverse effects associated with psychotropic drugs, the failure to monitor their use in children could be life-threatening.

99. **Impact on Black children.** Black children are overrepresented in the foster care system, accounting for 23% of the foster care population nationwide even though they represent 14% of the general child population. The disparity is even starker in Maryland, where Black children account for roughly 43.25% of Maryland's foster care population even though they comprise 29.21% of the general child population.

100. Black youth in Maryland foster care are prescribed psychotropic medications at disproportionately high rates in many counties. In Anne Arundel County, for instance, Black youth make up 43.36% of the foster care population but represent 68.75% of youth in foster care prescribed psychotropic medications.[3] In Baltimore County, Black youth comprise 44.31% of the foster care population but represent 58.43% of youth in foster care prescribed psychotropic medications.

B. In Recognition of these Risks, Federal Law and Professional Standards Require That States Have in Place a System to Oversee the Administration of Psychotropic Medications to Children in Foster Care

101. The vital need for rigorous and effective oversight of psychotropic medication use among foster children is well established. Under federal law, Defendants must develop "a plan for the ongoing oversight and coordination of health care services for any child in a foster care placement," which must include "an outline of . . . the oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications." *See* 42 U.S.C. §§ 622(b)(15)(A), 622(b)(15)(A)(v).

102. In its 2012 ACF Information Memorandum, the federal government declared that "[s]trengthened oversight of psychotropic medication use is necessary in order to responsibly and effectively attend to the clinical needs of children who have experienced maltreatment" and

[3] This and the following figure include youth in foster care over the age of 18.

recommended "close supervision and monitoring . . . [and] careful management and oversight" of the use of psychotropic medications for children.

103. The federal government requires that states provide information in their Annual Progress and Services Report submissions on:

> [T]he protocols used to monitor the appropriate use of psychotropic medications for children and youth in the foster care system. States must support their choice of protocols and provide additional information on how the child welfare workforce and providers are trained on the appropriate use of psychotropic medications. The State's protocol must address:
>
> - Comprehensive and coordinated screening, assessment, and treatment planning mechanisms to identify children's mental health and trauma-treatment needs (including a psychiatric evaluation, as necessary, to identify needs for psychotropic medication);
> - Informed and shared decision-making (consent and assent) and methods for ongoing communication between the prescriber, the child, his/her caregivers, other healthcare providers, the child welfare worker, and other key stakeholders;
> - Effective medication monitoring at both the client and agency level;
> - Availability of mental health expertise and consultation regarding both consent and monitoring issues by a board-certified or board-eligible Child and Adolescent Psychiatrist (at both the agency and individual case level); and
> - Mechanisms for sharing accurate and up-to-date information related to psychotropics to clinicians, child welfare staff, and consumers. This should include both data sharing mechanisms (e.g., integrated information systems) and methods for sharing educational materials.

104. Additionally, AACAP recommends that child welfare agencies implement "a clearly delineated process for medication monitoring and oversight" given the "concerning trends in the prescription of psychotropic medication." AACAP further recommends that monitoring methods "entail a combination of approaches that include review of aggregate data on prescribing patterns, chart audits, and tracking of specific red flag markers" and that systemic oversight be pursued in a manner "that promotes the use of evidence-informed practice."

105. In 2019, the publicly-funded Patient-Centered Outcomes Research Institute recommended that states implement the following policies and practices concerning the administration of psychotropic drugs to youth in foster care based on current research:

- Implement a robust informed consent and informed assent policy that ensures consenters and youth have the information they need and access to consult with a child and adolescent psychiatrist to make a truly informed decision;
- Create a centralized, up-to-date, accessible medical records system;
- Implement monitoring and oversight systems that will flag dangerous outlier prescribing practices for peer review both prospectively and retrospectively, and will seek to curb such practices moving forward;
- Promote safe prescribing practices, including by ensuring the availability of concurrent psychosocial services and closely tracking required bloodwork monitoring;
- Provide ready access to pertinent information for clinicians, foster parents, and other caregivers; [and]
- Collect, track, and analyze relevant data to evaluate the efficacy of various initiatives implemented.

C. Defendants Have Long Known About the Dangers Associated With the Improper Administration and Inadequate Oversight of Psychotropic Medications to Children and Effectively Ignored Those Dangers

106. For at least a decade, Defendants have been aware of the prevalence of psychotropic medication use among children in Maryland foster care. In 2012, the Maryland Department of Health responded to a request from the Maryland General Assembly to report on the prevalence of psychotropic medication usage, including in the state foster care system. The Department of Health's report found that the "[f]requency of use of psychotropic medications was three times greater among foster children than among other children in Medicaid [in Maryland] from 2008 to 2010."[4] The report elaborated that the rate of psychotropic medication use among children in

[4] This report is a matter of public record, and the Department of Health has collaborated closely with Defendants to provide mental health services to children in foster care and in particular, to monitor psychotropic medication use among children in foster care.

Medicaid in Maryland, on average, was 8.89% whereas the rate for children in foster care, on average, was 30.29%.

107. The 2012 report further noted that "[c]hildren in foster care were 7 times more likely to receive an antipsychotic medication than other children enrolled in Medicaid [in Maryland] in 2008 through 2010." Where the utilization rate among other children in Medicaid was, on average, 1.97%, the rate for children in foster care was 13.9%.

108. According to the Maryland Citizen's Review Board for Children, which is comprised of DHS staff, as many as 34% of children in Maryland foster care statewide were taking psychotropic drugs from 2020 through 2021.

109. As Defendants themselves have observed, "[s]everal studies have shown that use [of psychotropic medications] is much higher, singly and concomitantly (with one or more other class of medications), among youth in foster care, relative to other Medicaid-insured or privately insured youth."

110. Defendants have also long recognized the dangers posed by psychotropic medication use among children in the foster care system. In its 2014 Annual Progress and Services Report ("2014 APSR"), DHS noted that a recent Government Accountability Office ("GAO") Report "identified specific concerns" related to psychotropic medication treatment for youth in foster care, including concerns about "high dosing, polypharmacy, treatment of young children (including psychotropic medication treatment of youth <1 year old), and inadequate oversight."

111. The 2014 APSR further stated that there had been a large increase in the use of antipsychotic medications in the last decade and that they are "associated with serious cardiovascular, neurologic, and metabolic side effects that can impact current and possibly future health risks."

112. In the above-mentioned 2012 legislative report, the Maryland Department of Health acknowledged the need to ensure that children in foster care receive "the appropriate psychotropic medications." The report noted that children in foster care have "complex medical needs, both in terms of behavioral health and physical health," and require "increased surveillance" as well as "access to quality somatic and behavioral health care."

113. In the 2014 APSR, Defendants acknowledged several challenges of administering psychotropic medications to youth in foster care, including that providers may not have access to prior treatment history, that medication consent may be provided by someone other than the parent, and that youth may experience disruptions in placement that lead to changes in treatment teams. Defendants acknowledged that GAO had recommended that medication monitoring programs follow AACAP guidelines for consent, consultation, information, and oversight.

114. The 2014 APSR additionally noted that "[t]he use of psychotropic medication among foster youth has been a topic of national concern given inadequate oversight for safety or effectiveness."

115. In 2014, Defendant SSA published Policy SSA-CW# 15-8 regarding the oversight and monitoring of psychotropic medications to children in foster care. In that policy, SSA acknowledged that as a part of the Child and Family Services Improvement and Innovations Act of 2011, "[s]tates are required to amend their Title IV-B state plan to identify appropriate use and monitoring of psychotropic medications, as part of the state's current oversight of prescription medications." SSA further acknowledged AACAP's recommendations on "basic principles" regarding the psychiatric and pharmacologic treatment of children in foster care.

116. Defendants' Policy SSA-CW# 15-8 provides that "[t]he administration of psychotropic medications to youth is not an arbitrary decision and documented oversight is

required to protect youth's health and well-being." Moreover, "[p]sychotropic medication ***must not*** be used as a method of discipline or control for any youth. Psychotropic medications are not to be used in lieu of or as a substitute for identified psychosocial or behavioral interventions and supports required to meet a youth's mental health needs."

117. Nonetheless, Defendants presently permit hundreds of children in Maryland foster care to be administered one or more powerful psychotropic drugs without supplying sufficient oversight mechanisms to assure child safety, thereby knowingly exposing children in their care to serious risk of harm. Maryland's oversight failures include the following: (1) its failure to maintain complete and current medical records and provide critical health information promptly to caregivers; (2) its failure to assure a meaningful informed consent process; and (3) its failure to operate a monitoring and oversight system that promptly flags outlier prescriptions and subjects them to secondary review.

D. Defendants Fail to Maintain Complete and Current Health Records for the Class and Fail to Supply These Records to Caregivers

118. The case plan and case review system requirements of the Adoption Assistance and Child Welfare Act of 1980, under Title IV-E of the Social Security Act, require child welfare agencies to maintain and share up-to-date health records as part of a written case plan for every child in custody. 42 U.S.C. §§ 675(1)(C), (5)(D).

119. The case plan is a written "plan for assuring that the child receives safe and proper care and that services are provided to the parents, child, and foster parents in order to . . . address the needs of the child while in foster care." 42 U.S.C. § 675(1)(B). That plan must contain "the health . . . records of the child, including the most recent information available regarding . . . the names and addresses of the child's health . . . providers, . . . the child's known medical problems, the child's medications, and any other relevant health . . . information." 42 U.S.C. § 675(1)(C).

120. Child welfare agencies must also have a case review system and procedure to ensure that each "child's health record . . . is reviewed and updated" and that "a copy of the record is supplied to the foster parent or foster provider with whom the child is placed, at the time of each placement of the child in foster care." 42 U.S.C. § 675(1)(D).

121. The Child Welfare League of America ("CWLA") has issued standards that instruct child welfare agencies to develop "an abbreviated health record, such as a medical passport, that accompanies the child throughout the child's stay in out-of-home care." This record should include: "[t]he child's health history prior to placement[;] . . . health status immediately before entering care[;] . . . [a]ny medical, dental, mental health, or developmental problems[;] . . . [c]urrent medications[;] . . . [and a]llergies[,]" as well as "any medication allergies."

122. CWLA's standards further instruct agencies to update this record "in a timely manner, entering information about the child's health status, services, and needs as soon as [the information] becomes available."

123. AACAP likewise recommends that child welfare agencies "maintain an ongoing record of diagnoses, height and weight, allergies, medical history, ongoing medical problem list, psychotropic medications, and adverse medication reactions that are easily available to treating clinicians 24 hours a day."

124. Since 2014, Defendants' policy has required a "Health Passport" be delivered to a foster caregiver or other placement provider at the time of a child's placement in their care. The Health Passport must contain historical and current medical information and should be accessible by the caretaker, physicians, and Local Department of Social Services ("LDSS") in order to identify and meet the child's health needs. For children in foster care who have been prescribed psychotropic medication, the Health Passport must specifically include the following information:

- Mental Health Diagnosis;
- Name of prescribed psychotropic medications, dosage, and prescribing clinician's name and medical specialty;
- Routine medication monitoring appointments with prescribing physician;
- If applicable, ongoing testing/lab work specific for the prescribed medication;
- Any potential side-effects; and
- All non-pharmacological treatment services (i.e. therapy, behavioral supports/monitoring, and other interventions).

125. The foregoing must also be incorporated into the case service plan, along with the following information:

- The youth's physical reaction to the medication;
- The youth's comments and/or concerns regarding the medication;
- The caregiver's observations and comments regarding the effects of the medication;
- Feedback regarding the medication's effect on the child from birth parent(s), therapist, daycare providers, teachers, and/or other persons as applicable; and
- All feedback (oral and written) from the prescribing clinician.

126. Additionally, state policy has long required that the health record for children in out-of-home placements be maintained in the State's system of record. The purpose of this requirement is to allow caseworkers and their supervisors to monitor and track the health care needs of children in foster care.

127. Notwithstanding federal law and policy directives, as well as Maryland's own policy directives, Defendants fail to maintain comprehensive and current health records for children placed in their custody. They further fail to provide caregivers with complete and up-to-date health information at the time a child is placed in their foster home or in another placement in a routine and consistent manner.

128. Significantly, in Maryland's 2020 Annual Progress and Services Report, Defendants acknowledged that one of the barriers negatively impacting the well-being of youth in

foster care was the "lack of access to necessary health information and medical records," as well as "insufficient health data for the children being served."

129. In Maryland's 2022 Annual Progress and Services Report ("2022 APSR"), Defendants admitted again that "the agency has struggled to accurately capture data to reflect the overall mental health needs of children and youth in care in the electronic data system."

130. DHS's 2020 Report to the General Assembly Regarding Factors Affecting Services Provided to Children in Out-of-Home Placements likewise concedes that "health care providers and caregivers alike do not have information required for decision making around health care needs." It notes that children often visit health care providers "with case workers or resource families who cannot always provide any medical or developmental history, both of which are essential for care planning." The report continues that the Health Passport, DHS's mechanism for providing health information to foster families and health care professionals, has "poor readability and poor completion rates."

131. An audit of Defendant SSA dated November 20, 2017 conducted by the Office of Legislative Audits of the Maryland General Assembly found that SSA's system of record "did not accurately reflect [medical] services provided to children in foster care, which hampered the ability of SSA to monitor service delivery." The Office of Legislative Audits made the same finding again in 2021.

132. According to a December 2022 report released by the Maryland Citizen's Review Board for Children, only 41% of a sample of children in Maryland foster care had completed medical records in their case files.

133. As Maryland has recognized, the collection, maintenance, and provision of adequate health care information is in need of overhaul in order to assure child safety. The

Maryland State Council on Child Abuse & Neglect Annual Report for 2021 plainly recommends that the State "[c]reate an electronic health passport to replace the current paper passport," explaining that "[t]his electronic passport is vital to ensure that foster youth, foster care workers, foster parents, biological parents, and health care providers have access to critical health information." Such an electronic passport has yet to be implemented.

134. The failure to collect, maintain, and provide foster caretakers with complete and accurate health records places children who have been prescribed psychotropic medications at an unreasonable risk of serious harm. Often, foster caretakers are given little idea why a child placed in their care has been prescribed psychotropic medications or what side effects to look out for. Additionally, foster caregivers frequently receive minimal or no documentation about children's mental health history, prior medications and observed side effects, or current mental health diagnoses.

135. Without a system to ensure that foster caregivers are consistently provided this critical health information, caretakers are often left to conduct their own research, with little guidance as to when and how to administer the medications, potential risks and adverse effects, and how to respond when a child experiences adverse side effects.

E. <u>Defendants Fail to Assure an Adequate Informed Consent Process</u>

136. The State of Maryland requires informed consent prior to the provision of medical and mental health treatments to a child, including the administration of psychotropic medications. When a child is living at home with their family, the child's biological parent or legal guardian is authorized to consent to treatment on behalf of the child. When a child enters foster care, the State must, among other things, establish a policy that designates an individual with the authority to

provide informed consent for the child in state custody and a process for assuring that meaningful consent occurs.

137. In its 2012 ACF Information Memorandum, the federal government identified the "need for written policies" with provisions for "[i]nformed and shared decision-making (consent and assent) and methods for on-going communication between the prescriber, the child, his/her caregivers, other healthcare workers, [and] the child welfare worker."

138. AACAP standards further provide that:

> [a]lthough particularly important at the time of psychotropic medication initiation, informed consent and assent are ongoing processes. Informed consent involves discussion of target symptoms, likely benefits of a potential treatment, potential risks of treatment, and risks of *not* pursuing the treatment in question. Documentation of the discussion is essential, to provide clear evidence of what occurred.

139. Defendant SSA has acknowledged the importance of an informed consent process in assuring appropriate administration of psychotropic medications to children. Policy SSA-CW# 15-8 states "[t]he Local Department of Social Services (LDSS) must have an informed consent for each psychotropic medication prescribed to a foster child. An informed consent is consent for treatment provided after an explanation [of] the proposed treatment, expected outcomes, side effects and risk is provided by the prescribing clinician."

140. Policy SSA-CW# 15-8, however, is constitutionally deficient on its face in at least the following ways:

(a) Failure to assure that an adequate process is undertaken to meaningfully engage biological parents/legal guardians in informed consent decision-making in relation to the administration of psychotropic medications to children, including the absence of adequate definition in state policy regarding the circumstances in which a parent or guardian is considered "unavailable" or "unwilling" to provide consent;

(b) Failure to require that children and youth possessing adequate mental capacity to make psychotropic medication treatment decisions are engaged in the informed consent process, including the absence of policy language addressing the capacity of children

below the age of 16 to form an informed decision whether to assent to a psychotropic medication and the process to be undertaken to determine the child's capacity;

(c) Failure to require that an independent, secondary review by a child psychiatrist occurs in relation to the prescription and administration of higher risk psychotropic medications and combinations of psychotropic medications to children, including the absence of policy language providing for an independent review process and identifying those outlier or clinically suspect prescriptions that trigger the need for a mandatory secondary review;

(d) Failure to require that the person designated by the State to undertake the informed consent role on behalf of a child is sufficiently knowledgeable regarding the child's medical and mental health history, including the absence of policy language requiring the person assigned informed consent authority (the LDSS Director or Assistant Director) to review pertinent medical and mental health records and to interview knowledgeable individuals (such as the child's caseworker, the supervisor, and the child's assigned foster parent(s)) in preparation for making the informed consent decision;

(e) Failure to require that informed consent for the administration of psychotropic medications to children is valid only for a set duration; and

(f) Failure to assure that informed consent for the administration of psychotropic medications to children is conditioned on the timely completion of laboratory testing and follow-up medical care.

141. Despite the critical importance of assuring proper informed consent, Defendants do not have a system to track whether informed consent is obtained across all children in foster care, violating the widely recognized principle that one cannot manage what one cannot measure. Defendants have no system for tracking whether (a) the child's biological parents or legal guardian are engaged in medical decision-making when available, (b) youth are given the opportunity for informed assent before going on a psychotropic medication regimen, (c) LDSS personnel exercising informed consent authority only do so when possessing the minimally necessary information to make informed decisions, and (d) informed consent is valid subject to requisite follow-up care and only for a finite duration. Absent this tracking mechanism, Defendants are

unable to identify and promptly correct deficient informed consent processes, leaving children like the Named Plaintiffs and the Class at risk.

142. Defendants' failure to institute constitutionally adequate informed consent policies, as well as their failure to ensure existing policies are being complied with, results in children being administered psychotropic drugs without proper informed consent, which places children at an unreasonable risk of harm.

143. Upon information and belief, biological parents are often not engaged in the significant decision about whether their child should be administered psychotropic drugs. Parents are sometimes not even aware that their child is taking psychotropic medications. Significantly, Maryland's current policy allows this to occur even when the child's permanency goal is reunification.

144. In practice, there is no formal process for youth to raise concerns with prescribed medications.

145. In Maryland's 2022 APSR, Defendants acknowledged that "youth involvement, as well as bio-parent input, in [psychotropic] medication decision-making is not consistent."

146. Defendants also admitted in the 2022 APSR that "[p]sychiatric treatment providers additionally may change medications without LDSS or the parent's consent."

147. Moreover, according to Defendant DHS, at most 25.26% of children in foster care in Maryland who were taking psychotropic drugs had received a mental health examination between June 2020 and July 2021.

148. In addition, there has been a longstanding shortage of mental health providers in Maryland, which limits or depresses Defendants' capacity to deliver therapy to children along with or before prescribing psychotropic medications.

149. The lack of comprehensive and up-to-date health records for all children in foster care materially impedes the informed consent process. Consent may be provided without the benefit of knowing a child's health history, which could include medication allergies, documented adverse side effects to medications, or failed previous attempts with respect to the very same drug.

150. Recognizing this dangerous gap, the Maryland State Council on Child Abuse & Neglect Annual Report for 2021 recommends that the State consider instituting statutory reforms to address "the issue of informed consent for psychotropic medications."

F. Defendants Fail to Operate an Oversight System That Adequately Flags Outlier Prescriptions and Subjects Them to Secondary Review

151. Professional standards call for child welfare agencies, like Defendants, to implement a secondary review system to detect and assess outlier or otherwise concerning prescriptions of psychotropic medications to children in state custody. A minimally adequate secondary review system employs independent child psychiatrists to conduct second opinion evaluations of the therapeutic recommendations made by initial prescribers when specific triggering circumstances occur, including but not limited to "too many," "too much," and "too young" prescribing practices.

152. In 2005, AACAP publicly recommended the implementation of a secondary review system designed for child and adolescent psychiatrists to identify and assess potential outlier practices to reduce the risk that children are placed on unsafe psychotropic drug regimens.

153. In 2015, AACAP again recommended in a publicly-available document titled "Recommendations about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems" the development of systemic capacity to identify "red flag criteria triggering external reviews" as well as "[m]andatory consultations with an identified child and adolescent [psychiatrist] reviewer" in response to identified red flags.

154. In that same document, AACAP highlighted various "red flag markers" used by states as indicators of possibly concerning prescribing practices. Those red flags "included, but were not limited to, psychotropic medication use in young children, polypharmacy before monopharmacy, multiple medications simultaneously (various cutoffs), multiple medications within the same class for longer than 30 days, doses exceeding maximum recommendations, and no documentation of discussion of risk and benefits of medication."

155. Defendants have long recognized that for children prescribed psychotropic medication in Maryland, certain criteria should trigger further review of the child's clinical status.

156. Indeed, in response to concerns about unsafe and inappropriate psychotropic medication administration to children in foster care and inadequate oversight, Defendant DHS in 2014 published draft psychotropic medication guidelines to improve the safe and appropriate treatment of children in foster care. In the draft guidelines, DHS identified clinical factors warranting "further review" of a child's clinical status upon the prescription of a psychotropic medication. Those factors relate to the child's age and body mass index, provider specialty, the absence of an evaluation, whether the medication prescribed is inconsistent with national practice guidelines and/or expert consensus criteria, polypharmacy, multiple medications from the same class, abnormal laboratory results, and abnormal electrocardiogram.

157. Defendants fail to operate a monitoring and oversight system that adequately flags for secondary review outlier prescriptions of psychotropic medications for children in their care. The limited "Peer Review Program for Mental Health Medications" that does exist in Maryland in fact only reviews a subset of psychotropic medications, specifically antipsychotic medications. The program provides no oversight of wider classes of psychotropic medications, including antidepressants, stimulants, alpha agonists, anxiolytics (anti-anxiety)/hypnotics, or mood

stabilizers. DHS itself acknowledged in their 2015-2019 Child and Family Services Plan that the Peer Review Program should include all classes of psychotropic medications, but still has not done so.

158. Moreover, the review criteria under this limited program are so lenient that even antipsychotic medications go largely unreviewed. The current review criteria allow for immediate approval of multiple forms of off-label prescribing practices, including the use of antipsychotics for diagnoses that are typically not prescribed antipsychotics, such as PTSD, ODD, intellectual disability/developmental disability, and DMDD. As the State describes in their "frequently asked questions" document regarding the Peer Review Program, denial of even antipsychotic medication by the program is "rare" under current criteria.

V. CAUSES OF ACTION

A. FIRST CAUSE OF ACTION: VIOLATION OF PLAINTIFFS' SUBSTANTIVE DUE PROCESS RIGHTS UNDER THE U.S. CONSTITUTION

(Asserted on behalf of all Named Plaintiffs and the Putative Class and against all Defendants)

159. The foregoing paragraphs of this Complaint are repeated and re-alleged as if fully set forth herein.

160. A state assumes an affirmative duty under the Fourteenth Amendment to the United States Constitution to protect a child's safety and well-being when it removes that child from their home and places them into foster care custody.

161. The foregoing policies and practices of Defendants, in their official capacities, constitute a failure to meet their affirmative duty to protect the safety and well-being of the Named Plaintiffs and the Class. These failures are a substantial factor leading to, and a proximate cause of, the ongoing violation of the Named Plaintiffs' and Class members' constitutionally-protected

fundamental liberty interests conferred upon them by substantive due process rights under the Fourteenth Amendment to the United States Constitution.

162. The foregoing actions and inactions of Defendants, in their official capacities, constitute policies, patterns, practices, and/or customs that are contrary to law and are substantial departures from any accepted professional judgment such that they are outside of that judgment. Defendants' actions and inactions are also in deliberate indifference to their awareness of facts from which a reasonable inference exists that harm or substantial risk of serious harm exists for the Named Plaintiffs and the Class. As a result of Defendants' actions and inactions, the Named Plaintiffs and the Class have been harmed or are at substantial risk of serious harm, and have been deprived of their substantive due process rights guaranteed by the Fourteenth Amendment to the United States Constitution.

163. These substantive due process rights include, but are not limited to: the right to personal safety and security; the right to be free from harm or substantial risk of serious harm while in state foster care custody; the right to necessary treatment, care, and services to protect the Named Plaintiffs and Class members from deteriorating or being harmed physically, psychologically, developmentally, emotionally, or otherwise while in state foster care; and the right to adequate supervision and monitoring of the Named Plaintiffs' and Class members' health and safety.

B. SECOND CAUSE OF ACTION: VIOLATION OF PLAINTIFFS' PROCEDURAL DUE PROCESS RIGHTS UNDER THE U.S. CONSTITUTION

(Asserted on behalf of all Named Plaintiffs and the Putative Class and against all Defendants)

164. The foregoing paragraphs of this Complaint are repeated and re-alleged as if fully set forth herein.

165. The Due Process Clause of the Fourteenth Amendment to the United States Constitution prohibits Defendants from depriving any person of life, liberty, or property without due process of law.

166. Children in foster care have a substantial liberty interest, protected by the Due Process Clause, in being free from the unnecessary administration of medical treatment, including the unnecessary administration of psychotropic medication.

167. Defendants have a compelling interest in the protection of minor children.

168. The foregoing actions and inactions of Defendants, in their official capacities, constitute policies, patterns, practices, and/or customs that deprive the Named Plaintiffs and Class members of this liberty interest without due process of law.

169. Defendants' actions and inactions have interfered with the Named Plaintiffs and Class members' liberty interest.

170. Defendants' actions and inactions subject the Named Plaintiffs and Class members to the unnecessary administration of psychotropic medication without having sufficient procedures for ensuring that these medications are appropriately administered to the Named Plaintiffs and the Class.

171. Defendants' actions and inactions fail to provide the Named Plaintiffs and the Class with a sufficient process for informed consent prior to and throughout the time that children in foster care are administered any psychotropic medication.

C. THIRD CAUSE OF ACTION: VIOLATION OF PLAINTIFFS' RIGHTS UNDER THE FEDERAL ADOPTION ASSISTANCE AND CHILD WELFARE ACT, 42 U.S.C. §§ 621 *et seq.*, 670 *et seq.*

(Asserted on behalf of all Named Plaintiffs and the Putative Class and against all Defendants)

172. The foregoing paragraphs of this Complaint are repeated and re-alleged as if fully set forth herein.

173. The foregoing actions and inactions of Defendants, in their official capacities, constitute policies, patterns, practices, and/or customs that violate the statutory rights of the Named Plaintiffs and Class members under the Adoption Assistance and Child Welfare Act of 1980 ("AACWA"), as amended by the Adoption and Safe Families Act of 1997, 42 U.S.C. §§ 621 *et seq*., 670 *et seq*., and the regulations promulgated under the Act, 45 C.F.R. Parts 1355-1357.

174. These rights include, but are not limited to, the rights of the Named Plaintiffs and Class members to: (a) have their own individualized "written" case plan "for assuring that the child receives safe and proper care and that services are provided to the parents, child, and foster parents in order to . . . address the needs of the child while in foster care" that contain, *inter alia*, the child's health records, which must "includ[e] the most recent information available regarding" the names and addresses of the child's health providers, a record of the child's immunizations, the child's known medical problems, the child's medications, and any other relevant health information concerning the child determined to be appropriate by the State agency; and (b) have their health records reviewed, updated, and supplied to the foster parent or foster care providers with whom the child is placed at the time of placement. 42 U.S.C. §§ 671(a)(16), 675(1), 675(5).

175. These rights created by AACWA are clearly and expressly intended to benefit the Named Plaintiffs and Class members; the rights are specific and concrete requirements that are

neither vague nor amorphous such to strain judicial competence; and the statutory provisions noted above impose a mandatory, binding obligation on Maryland to fulfill these requirements.

VI. PRAYER FOR RELIEF

176. WHEREFORE, the Named Plaintiffs, on behalf of the putative Class they represent, respectfully request that this Court exercise its legal and equitable powers and award Class-wide relief as follows:

a. Assert subject matter jurisdiction over this action;

b. Order that this action be maintained as a class action pursuant to Federal Rules of Civil Procedure 23(a) and 23(b)(2);

c. Declare pursuant to Federal Rule of Civil Procedure 57 that:

    i. Defendants' failure to maintain a minimally adequate oversight system in relation to the administration of psychotropic medications to the Class violates the Class members' substantive due process rights under the Due Process Clause of the Fourteenth Amendment to the United States Constitution, while in state foster care, to personal safety and security, to be free from harm or substantial risk of serious harm, and to adequate supervision and monitoring of the Class members' health and safety;

    ii. Defendants' failure to institute procedures to ensure that psychotropic medications are being appropriately given to the Class members violates their procedural due process rights under the Due Process Clause of the Fourteenth Amendment to the United States Constitution to be free from the unnecessary and inappropriate administration of psychotropic medication; and

iii. Defendants' failure to (1) maintain complete and updated medical records, including, but not limited to, medication history and any history of adverse reactions and side effects, in the case plans of each Class member and (2) deliver such medical records to Class members' foster caretakers upon placement violates the Class members' statutory rights under the Adoption Assistance and Child Welfare Act to have: (a) a written case plan that contains, *inter alia*, the child's health records, including the child's most recent health information available regarding the names and addresses of the child's health providers, a record of the child's immunizations, the child's known medical problems, the child's medications, and any other relevant health information concerning the child determined to be appropriate by the State agency; and (b) the child's health records reviewed, updated, and supplied to foster care providers with whom the child is placed at the time of placement;

d. Permanently enjoin Defendants from subjecting the Class members to policies and practices that violate the Class members' constitutional and statutory rights as set forth in subparagraph (c) above as follows:

i. Medical Records: Order Defendants to: (1) implement and maintain a comprehensive and updated electronic healthcare record for the Class and (2) deliver to each Class member's foster caretaker upon placement of the child in the caretaker's home or licensed facility a complete medical history for the child including, but not limited to, the child's prescription medication history and any history of adverse reactions and side effects;

ii. Informed Consent Policy: Order Defendants to: (1) promulgate a clear, unambiguous and effective informed consent policy that extends to all psychotropic medications that remedies the deficiencies alleged above; (2) develop, maintain, and review a system of records that facilitates the tracking of aggregate compliance with the above informed consent policy; and (3) develop and implement a mandatory training program for all social workers and foster caretakers regarding the safe administration of psychotropic medications to children and compliance with Defendants' policy in relation to these medications;

iii. Secondary Review System: Order Defendants to develop and implement a secondary review system that (1) establishes and tracks "red flag" criteria designating outlier or elevated risk prescribing practices in relation to the administration of one or more psychotropic medications to the Class; and (2) requires secondary review by a child psychiatrist of all "red flag" prescription regimens to Class members and a feedback mechanism to the prescribing doctor and the individual authorized to provide informed consent on behalf of the child regarding the findings of the secondary review and any need for revision of the prescription;

e. Award to the Named Plaintiffs the reasonable costs and expenses incurred in the prosecution of this action, including reasonable attorneys' fees pursuant to 28 U.S.C. § 1920 and 42 U.S.C. § 1988 and Federal Rules of Civil Procedure 23(e) and 23(h); and

f. Grant such further equitable relief as the Court deems just, necessary, and proper to abate the ongoing risk of harm and protect the Class from further harm while in Defendants' custody and care.

DATED: January 17, 2023

Respectfully Submitted,

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