Appendix D

Algorithm (Decision Tree) for the Prescribing of Psychotropic Medications

Basic Principles:

These *Guidelines* are grounded in the following principles and values:

- **Safety:** Child safety and health are paramount in our work, and children are, first and foremost, protected from abuse and neglect.

- **Permanency:** Children do best when they have strong families, preferably their own. When that is not possible, a stable, long-term placement with a relative, non-related extended family member, tribal family, foster family, or adoptive family who can meet their physical, emotional, and therapeutic needs is preferred.

- **Well-Being:** The State and its counties are committed to offering relevant services to children and families to meet their identified needs, build on their strengths, and promote children's development, education, physical and mental health, and general well-being.
    - Most families have the capacity to change with the support of individualized service responses.
    - Children should be placed in the least restrictive setting at which they can be safely treated. Whenever possible, this setting should be within their own community.

- **Government cannot do the job alone:** Real partnerships with people and agencies involved in a child's life–for example, families, tribes, medical providers, teachers, child care providers, community partners and mentors, including informal and formal mentors, community spiritual and clergy –are essential to ensure child safety, permanency, and well-being, and to build strong families.

- **Child-centered care:** Care should be provided in a manner sensitive to the child's strengths and needs. When developmentally appropriate, children and adolescents should be a part of their health care planning, as described in the Core Practice Model developed in response to the Katie A. lawsuit.

- **Continuity of care for children and youth is important:** Consistent with the Core Practice Model, these *Guidelines* strive to strengthen coordination across systems of care to minimize the number of unnecessary transitions for children and youth and to support transitions that are necessary when coming into care, during care, and transitioning to permanency.
    - These *Guidelines* are consistent with, and support the goals of, Continuum of Care Reform: The treatment needs of children and youth are best met when

services are provided at the lowest level of care at which the client can be safely treated.
  - Critical to the success of these Guidelines and inter-related State initiatives is access to providers who have the capacity and specialized competencies to serve our children and youth, as well as access to these providers within timeframes that meet the needs of children and youth.

- **Quality:** The State and its counties expect our children to receive high quality healthcare, inclusive of physical, emotional/behavioral, and dental health.

- **Integration:** These inclusive health care needs of a child/youth are expected to be integrated into a health care services plan that provides integrated, coordinated services that are individualized and tailored to the strengths and needs of each child and their family.

- **Collaboration:** The State and its counties recognize the importance of collaboration with treatment providers, particularly prescribing providers, to ensure the success of these *Guidelines* and psychotropic medication management reform for children and youth in out of home care served by child welfare and/or probation.

- **Limitations:** Psychotropic medication is never the sole intervention but should be part of an overall treatment strategy (T-May 2010). Medication also carries the risk of adverse (side) effects, so careful monitoring by the prescriber is essential.

Prescribing Algorithm (Decision Tree)

Below is an algorithm (decision tree) designed to assist the prescriber in maintaining compliance with State and county regulations and guidelines pertaining to the prescribing of psychotropic medications for children and youth in foster care.

A. Before prescribing, have the following concerns been considered:

☐ 1. Might the existing treatment be exacerbating the child's behavior?

☐ 2. Weigh the potential benefits and risks of psychotropic medication use against the risks of untreated illness.

☐ 3. Caution is recommended in prescribing psychotropic medications to children and adolescents especially those for which long term consequences are not completely understood.

☐ 4. Are there evidence-supported non-pharmacological treatments appropriate for this child/youth available in the community?

☐ 5. Have non-pharmacological treatments been offered by an appropriately trained provider? If so, was the length of treatment adequate to evaluate treatment effectiveness, as evidenced by written documentation provided by the therapist?

☐ 6. If there are no evidence-supported psychotherapeutic treatments appropriate for this child/youth available in the community, could other mental health interventions could be tried?

☐ 7. Are there environmental factors, e.g., in the placement or school setting, that could or should be addressed first?

☐ 8. A consult with a psychiatric specialist is indicated if there is a question of neurological or medical conditions contributing to the child's symptoms or if medication is a possible component of treatment.

☐ 9. Medication adherence is an important component of the treatment plan. As part of the informed consent process, the prescriber discusses medication adherence with the youth and family, including the physical and behavioral consequences of abrupt withdrawal. Adverse effects should routinely be discussed as part of informed consent.

☐ 10. If there is concurrent substance abuse and prescription of psychotropic medication is being considered, the prescriber considers need for concurrent dual diagnosis (mental health and substance abuse) treatment to ensure concerns in both domains are addressed. Medications should be considered with care during events or situations which may be stressful or traumatic for a youth, such as the initial removal from the home, or a change of placement.

☐ 11. When indicated, psychotropic medications are to be prescribed as part of a documented comprehensive treatment plan and not as the sole intervention. They are not prescribed in lieu of instituting available non-pharmacological treatments that are evidence-supported and that target the individual child's needs.

B. When prescribing, consider the following:

☐ 1. Preference is given to FDA approved medications, or medications clinically indicated for off-label use for a child's age group and diagnosis before other medications are tried.

☐ 2. Is there a generic equivalent of medication available?

☐ 3. Medications that have more data regarding safety and efficacy for children are preferred over newly FDA-approved medications.

☐ 4. Medication dosages should be kept within FDA guidelines for children when these are available. Any deviation from FDA guidelines is to be documented with the underlying rationale in the child's treatment records.

☐ 5. Treatment with a single medication for a single symptom or disorder should be tried before treatment with multiple medications is considered.

☐ 6. The use of two or more medications for the same symptom or disorder requires specific documentation from the prescribing clinician in the child's health record.

☐ 7. In most circumstances, only one medication should be changed at one time.

☐ 8. Medications should be initiated at a low dose and increase gradually only if there is a lack of response to medication. The clinical wisdom, "start low and go slow" is particularly relevant when treating children in order to minimize side effects and to observe for therapeutic effects.

☐ 9. The decision to treat a child with more than one medication from the same class should be supported by written documentation in the child's health record from the prescribing clinician and may warrant a second review by a Child and Adolescent Psychiatrist.

☐ 10. A clinician prescribing more than 3 psychotropic medications to one child must justify and document the rationale for doing so in the child's treatment plan and may warrant a second review by a Child and Adolescent Psychiatrist. Multiple psychotropic medications are indicated only when multiple separate diagnoses have been documented.

C. If this is not the first prescription for psychotropic medication for this child, periodic evaluation of treatment efficacy and tolerability should occur, as described above. At each subsequent appointment for medication management, this evaluation includes review of the following:

☐ 1. Is there amelioration of symptoms of behavioral dyscontrol or emotional distress as assessed by clinical interview, collateral reports, validated assessment instruments (e.g., Beck Youth Inventories, Trauma Symptom Checklist for Children), and improved psychosocial functioning?

☐ 2. Are target symptoms well controlled in at least one of the child's natural environments (excludes group homes and Residential Treatment Centers)?

☐ 3. Are the medication dose and duration adequate?

☐ 4. Has the child/youth (or care environment as a whole) received appropriate evidence-supported psychotherapeutic treatments (if indicated)?

- [ ] 5. Has the child/youth received informal psychosocial supportive interventions that promote development of resilience and learned control?
- [ ] 6. What is the child/youth's perspective regarding the medication? Does the child/youth state that the medication is helpful?
- [ ] 7. Do the observed therapeutic benefits to date outweigh the potential risks?
- [ ] 8. Are there any medication adverse effects that indicate a need for tapering dosage and/or discontinuation?
- [ ] 9. Efforts have been made to adjust medication dose to the minimum at which it remains effective and side effects are minimized. These efforts, or reasons why adjustments could not be considered, are documented in the youth's Treatment Plan and have been discussed with the youth and family.
- [ ] 10. Periodic attempts at taking the child off medication have been tried or were determined to not be appropriate at this time. Efforts to discontinue the medication(s), or the rationale for continuing the medication, are documented in the child's Treatment Plan.
- [ ] 11. The child/adolescent should be monitored for adverse effects, such as movement disorders, extreme weight gain or loss, and documentation should be present in the child's medical/psychiatric record.
- [ ] 12. If adverse effects occur, tapering off the medication may be indicated, and identification of another clinically appropriate intervention is encouraged. These side (adverse) effects and efforts to taper and identify another clinically appropriate intervention are documented in the youth's Treatment Plan.
- [ ] 13. The youth and family are consulted in discussions regarding tapering or discontinuing medication and identification of potential alternatives.
- [ ] 14. Caution and pause should be used before treating side effects with the addition of medication. If used, the rationale is documented in the youth's Treatment Plan. The rationale also has been discussed with the youth and family; this discussion also is documented in the youth's Treatment Plan.