# California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care

## Introduction

Children have the right to safety, respect, justice, education, health and well-being. As a society we have the obligation to protect these values for all of our children. When children and youth have been removed from their primary homes due to abuse and/or neglect, the State of California and its counties assume the primary responsibility to safeguard these rights for the children in their care. The state also assumes the responsibility of addressing the trauma (defined below) as experienced by the child who is removed from the home and placed into care.

The California Department of Health Care Services (DHCS) and Department of Social Services (CDSS) have the shared responsibility for the oversight of mental health services provided to children and youth involved with county child welfare and probation agencies. The *California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care* is specific to those children and youth who are: (a) involved with child welfare services and/or probation services, and (b) are placed in foster care. Foster care is defined as 24-hour substitute care for children placed away from their parents or guardians and for whom the State and/or county agency has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and pre-adoptive homes. Consistent with research over the past twenty years that has described the effects of abuse and neglect (Brown et al 1990, Lansford 2002)[1] the State is committed to utilizing formal and informal mental health services to ameliorate the negative effects of abuse and/or neglect and the potential negative effects and consequences following removal from the primary home. Together, these negative effects and potential consequences are defined as *trauma*, defined by the Substance Abuse and Mental Health Services Administration (SAMHSA 2014) [2]as "The Three E's": The Event, The Experience, and The Effect:

> *"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being."*

Additionally, the State recognizes that the potential for trauma can be mitigated via child and youth *resilience:* protective factors that reduce poor outcomes under conditions of adversity and risk (Greenberg, 2006)[3]. Resilience is comprised of three interactive influences: *(a)* individual differences in temperament and cognitive abilities;

(b) quality of social relationships (e.g., the relationship with the primary caregiver or another supportive other); and (c) quality of the broader environment, such as school and neighborhood (Greenberg, 2006) Understanding that social relationships and the social environment can promote resilience means that the provision of informal services and access to resources that are resilience-building mitigate the effects of potential trauma (i.e., they are trauma-informed interventions) and promote optimal psychosocial functioning. Thus, the State and counties provide these resilience-building environments and activities as part of a broader array of informal mental health services for children and youth placed in out of home care. *Informal mental health services* are activities deliberately introduced to provide the child or youth opportunities for learning self-discipline, appropriate peer interactions, tolerance for frustration, enhanced self-esteem (self-affirmation), and mastery (learned control). These activities include coached team sports such as basketball, football, soccer, and baseball; art, gardening, dance, and caring for animals. Special attention should be paid to opportunities for children and youth to participate in formal training in singing (choirs, vocal groups,) and learning to play a musical instrument because data suggest these particular activities may enhance executive functioning (Kraus 2009)[4]. Additionally, coaches and teachers involved in these activities are potential sources of social support and mentoring in the child's natural environment. Thus, they are potential members of the child or youth's support network or Child and Family Team (as indicated).

Children and youth with emotional, cognitive, and/or behavioral dysregulation secondary to abuse and/or neglect are vulnerable to developing emotional patterns and behaviors that meet criteria for mental disorders as per the current *Diagnostic and Statistical Manual* (DSM –V)[5] published by the American Psychiatric Association (APA 2014) or with mental and behavioral disorders as per the current International Classification of Diseases (ICD) published by the World Health Organization[6]. These California State Guidelines reflect the understanding that these diagnostic criteria are not always consistent with current research related to the psychosocial presentations of, and best practices related to, children and youth for whom these Guidelines were developed. For this reason, these Guidelines do not always reference specific diagnoses when making treatment recommendations.

Children and youth with emotional, cognitive, and/or behavioral dysregulation have the same right to treatment as children and youth with any other health care need. Respect for the dignity of the child and the family is a prerequisite for treatment. Recognition that the child or youth with emotional, cognitive, or behavioral dysregulation may encounter social stigma and/or sub-optimal treatment is a historical concern of importance to the CDSS and DHCS. One goal of these *Guidelines* is to increase the visibility of the strengths and needs of these children and youth to promote careful and respectful attention to individualized, optimal care. Educational efforts directed toward child welfare social workers, probation officers, family members, caregivers, attorneys, court appointed special advocates (CASAs), and health providers also are designed to address and eliminate social stigma while promoting best practices in the provision of formal and informal mental health services.

The *California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care,* jointly released by the CDSS and DHCS, is a statement of best practice for the treatment of children and youth in out of home care. These children and youth may require psychotropic medications. Depending on the nature, severity and persistence of their symptoms, medication may be indicated as part of an initial treatment plan (as with ADHD, major depression, psychosis and disabling anxiety); may be considered only after appropriate psychosocial interventions are employed (as with moderate anxiety/depression); or may not be indicated at all (as with learned defiance and "predatory" aggression). When psychotropic medication is indicated, it should be used in conjunction with psychosocial interventions. The exception is when psychosocial interventions have been effective and are therefore terminated but continued use of medication is necessary to prevent the recurrence of symptoms.

These *Guidelines* outline:

- Basic principles and values;
- Expectations regarding the development and monitoring of treatment plans; Principles for emotional and behavioral health care, psychosocial services, and non-pharmacological treatments;
- Principles for informed consent to medications; and
- Principles governing medication safety.

These *Guidelines* are to be used in conjunction with California State regulations related to the provision of Medi-Cal funded mental health services and community care licensing (CCL) regulations related to foster homes, group homes, and residential treatment centers (CA Code of Regulations 2014)[7]. These Guidelines are intended to be consistent with, and promote, the values and goals of other State initiatives including the Core Practice Manual CDHCS/CDDS (2014)[8] adopted in response to the Katie A. lawsuit (CA Gov 2014)[9], the Medi-Cal Performance Outcomes System CA DHCS 2013)[10], and the Continuum of Care Reform initiative CDHCS 2014b[11].

These *Guidelines* represent the first comprehensive effort at the State level to address the use of psychotropic medication children and youth in out of home care being served by the child welfare and/or probation system. It is expected that the *Guidelines* will evolve over time in response to updated research and the evolution of best practices, and in response to feedback from youth, families, prescribers, other providers, and additional community stakeholders. For these reasons, these guidelines will be reviewed annually. In developing these G*uidelines*, the CDSS and DHCS reviewed the work of the American Academy of Child and Adolescent Psychiatry (AACAP 2008)[12], the American Academy of Pediatrics (AAP 2008)[13], California county child welfare and behavioral health policies and practices[14], and the policies of child welfare and mental health agencies in other states (NJ office of Child Health Policy 2011, MMDLN & Rutgers 2010. Crystal, Ofson, Huange et al 2009.[15]. The work products of these organizations have been incorporated throughout this document. The CDSS and DHCS acknowledge the efforts of these organizations.

## Basic Principles

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

- **Safety**[16]: 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 ([17]T-May 2010). Medication also carries the risk of adverse (side) effects, so careful monitoring by the prescriber is essential.

## Treatment Plan

Children who have emotional, cognitive, and/or behavioral dysregulation require a variety of interventions to alleviate their symptoms and to promote optimal psychosocial functioning and development[18]. If the child or youth meets Katie A. class or sub-class criteria, then the Treatment Plan[19] is a product of the Child and Family Team (Katie A Manual)[20]. The CFT is a required component of the Core Practice Model developed in response to the Katie A. lawsuit. The CFT ensures that the child and family voices always are included in treatment and placement decisions. Whether or not a CFT is a required element of the child or youth's case plan, development of the Treatment Plan should include the child and family unless their participation is contra-indicated due to age, developmental status, or protective issues in the case. Treatment Plan elements include identified socio-emotional and behavioral concerns, immediate and longer term treatment goals, and interventions that are realistic for the child and family. It represents an agreement to work together toward a mutually agreed upon set of goals. The Treatment Plan should be reviewed and re-assessed by the treatment team, child, family, and supportive collaterals (as described below) as needed or as indicated by Katie A. status to ensure it remains current and appropriate based on the child and family's progress in services.

The Treatment Plan is developed in collaboration with the child and family. The child or youth who is the focus of treatment is expected to be an active partner in the treatment planning process as developmentally appropriate. The unique abilities, strengths, and needs of the child and the family are considered in developing a plan that will work. Consideration also must be given to the range of settings within which the child is involved–home, school, work, sports and clubs–to ensure that all potential

supports and interventions are maximized to create a treatment plan that is individualized, flexible, and robust.

The Treatment Plan is guided by the principle that interventions should be strength-based, child focused, and family centered. The interventions that are selected are chosen based on the child's emotional, cognitive, and/or behavioral dysregulation, the strengths and needs of the child and family, and the resources of the community.

A Treatment Plan includes appropriate treatments and interventions to address root causes contributing to the child's emotional, cognitive, and/or behavioral dysregulation, as well as how (and by whom) symptoms and psychosocial functioning will be monitored to evaluate treatment and intervention effectiveness. If psychotropic medication is prescribed, medication effectiveness and side-effects should be closely monitored according to the monitoring guidelines provided in these *Guidelines* (LAC DMH )[21]. It is expected that there will be ongoing communication between the prescriber and the child, parents, child's caregiver, therapists, social worker, pediatrician, public health nurse, probation officer, care coordinator, school staff, case manager, CASA, attorney, and other members of the child and family's support network, as indicated. This network constitutes the Child and Family Team, if the Team is a required component for the child or youth.

Prior to prescribing, a thoughtful benefit/risk analysis [22]is necessary, comparing the risks and expected benefits of an overall treatment plan that does *not* include medication with the risks and expected benefits of a treatment plan that does include medication (AACAP 2009, AACAP 2001)[23]. Among other considerations, one must consider the likely benefit of psychosocial interventions and of medication, the risk of adverse (side) effects from medication, and the risk of continued symptoms impacting the youth's psychosocial development and placement if medication is withheld.

Judicial approval (JV220 2008)[24] is mandated by California law Rules of Court 2014)[25] prior to the administration of psychotropic medications to children and youth in foster care. The Psychotropic Medication Protocol, also referred to as the JV220 process, initiates the court authorization of psychotropic medications for dependents of the court. The JV220 documentation specifies the dosage and medication plan, ideally including targeted goals. This is undertaken, to the extent possible, in collaboration with the child, family, caregiver, and other supportive collaterals. The prescriber should discuss the JV220 with the child, family, and caregiver. Additional supportive collaterals also are included in this discussion if requested by the family or as indicated by State requirement (e.g., Child and Family Teams for Katie A. class and sub-class members).

Psychotropic medications should not be used for the purpose of discipline or chemical restraint, except as acutely necessary in true psychiatric emergencies (Title 22, CCR, Section 22 51056)[26]. Youth are not to be coerced into taking medication as a condition of placement.

## Components of a Treatment Plan

The development, implementation, and execution of a Treatment Plan includes, but is not limited to, the following individuals: the child; the child's parents (when appropriate), the child's caregiver, the prescriber, care coordinator, therapist, school staff, CWS social worker, pediatrician, attorney, public health nurse, probation officer, case manager, CASA, and other members of the child's support network or CFT (as indicated).

A best practice (Malone Localio, Huang et al 2012, Radley Finkelstein & Stafford 2006)[27], treatment plan includes the following:

a. The child's diagnosis (if indicated) and a conceptualization of the child's emotional, cognitive, and/or behavioral dysregulation based on the child's history of abuse, neglect, and/or removal from the home.

b. The child's baseline strengths and needs.

c. Target symptoms: stated in practical and everyday language as agreed to by the child, family, and their support network or CFT.

d. Client-driven short and long term treatment goals: stated in ways that can be observed and measured on a regular basis by specified means.

e. Treatment interventions: evidence-supported treatments; additional psychosocial interventions such as substance abuse prevention or treatment, case management, informal mental health services, educational or behavioral services, and/or extra-curricular and recreational activities. All identified treatments and interventions should have start dates. Psychotropic medications (if part of the Treatment Plan) also should include a re-assessment date. If medications are utilized, the dosage and medication monitoring schedule must be specified.

f. Treatment and intervention periodic review and reassessment: formal treatments, e.g. (HHS 1996) evidence-supported psychotherapeutic treatments as well as psychotropic medications, are periodically reviewed by the child, family, and additional supportive collaterals (e.g., the Child and Family Team) as indicated.

g. Updated medication treatment plans must be communicated as an attachment to the JV220, as well as shared with the child/youth, family, caregiver, and child welfare social worker and/or probation officer for distribution to all necessary parties in accordance with HIPAA (HHS 1996)[28].

## Psychotropic Medication

For the purposes of this document, "psychotropic medication" is defined[29], per Welfare & Institutions Code, Section 369.5(d), as "those medications prescribed to

affect the central nervous system to treat psychiatric disorders or illnesses. They may include, but are not limited to, anxiolytic agents, antidepressants, mood stabilizers, antipsychotic medications, anti-Parkinson agents, hypnotics, medications for dementia, and psychostimulants."

Psychotropic medication should only be prescribed to the children and youth in California's care as part of a comprehensive Treatment Plan, except under emergent conditions or as described above in this *Plan.* Such a comprehensive Treatment Plan includes evidence-based or best practice non-pharmacological interventions that are linguistically, culturally, and developmentally appropriate for the child or youth's needs and symptoms.

Authorized Prescribers of Psychotropic Medication[30]: Because of the complex medical and psychiatric needs of children in out of home placements (which include foster, kinship, NREFM care; group homes; and the juvenile justice systems), it is recommended that psychotropic medications for children be prescribed by board certified or board eligible specialists in one of the following areas of expertise:

- Psychiatry (specialization in child and adolescent psychiatry recommended),
- Neuro-developmental pediatrics
- Developmental-Behavioral pediatrics
- Pediatric neurology
- Pediatrics or family practice with specialized training in children who are at high risk or who had in utero exposure to illicit drugs or alcohol

However, if a California dependent is placed out of state, the prescriber must meet credentialing criteria for the state in which they are licensed.

## Psychiatric Evaluation and Diagnosis

**Evaluation Components:** The psychiatric evaluation includes a thorough mental status exam, complete review of current emotional and behavioral symptoms, and the assessment for potential psychosocial precipitants for the current presentation[31]. It also should include the review of collateral documents[32] provided by CWS, when available, as described below. These records provide critical history and context for appropriate case formulation. A physical examination also is conducted or a recent physical examination is documented, as indicated. Consultation with other professionals who are treating the child, including therapists, primary care physicians, or medical specialists, is an important component to complete this information.

**A. Review of Collateral Documents:** The prescriber's access to available historical information is critical for the provision of optimal care. The following documents represent optimal psychosocial history to share with the prescriber when available. Prior to the child's appointment, the prescriber is expected to review the collateral documentation when provided by the CWS social worker. Reports should ideally be

received at least 5 business days prior to the appointment to allow ample time for review. These documents should include:

1. The Detention Hearing Report which describes what happened to the child and why the child was removed from the home. These conditions typically are the 'root cause' of the child or youth's emotional, cognitive, and/or behavioral dysregulation.

2. The Jurisdiction/Disposition Report which includes additional information regarding the abuse and/or neglect experienced by the child in the current referral, history of prior referrals and cases (if applicable) which provides context for the current case, and provides more details regarding why out of home care was necessary.

3. Copies of significant additional court reports, i.e., those that document major changes in the family's situation.

4. Copies of all prior psychological evaluations and Initial Treatment Plans/Updates for the client.

5. All prior mental health, physical health, and developmental records.

6. Copies of psychiatrist's Admission and Discharge summaries and the medical H & P (History and Physical) report from all psychiatric hospitalizations for the client.

7. Order Authorizing Health Assessments, Routine Health Care, And Release Of Information (Blanket Court Order) or case-specific forms signed by the Court, as per county process).

8. History of Child Placement report.

9. Current Health and Education Passport (HEP).

10. Individualized Education Plan (IEP) and IEP Triennial evaluation (Psychoeducational Assessment Report conducted by school staff once every three years as a condition of initiating and continuing an IEP), if applicable.

11. Medication log to be attached to JV 220, if available.

**B. Physical Examination:** As part of the decision to initiate a medication trial, the results of the most recent physical examination, conducted within the past year, are reviewed. If no documentation is available or an examination was not completed, a brief physical examination is indicated. Including at minimum, weight, body mass index, and vital signs. When indicated by history, physical examination or psychiatric

evaluation, the child may require medical specialty consultation and testing. Cardiac, endocrinological, neurological or other consultations might be indicated.

1. Baseline laboratory assessment may be advisable both to rule out medical conditions which may be contributing to or causing the symptoms, and is indicated to establish a baseline for monitoring possible medication side-effects. Refer to tables in Appendix B.

2. Consider a pregnancy test, depending on case-specific circumstances, before initiating medication for a female of child-bearing age.

3. Consider a baseline screen for other substance use by the child and youth as indicated. Review of records from child welfare or probation services also can alert the prescriber to the need for substance use screening. The prescriber also may conduct a verbal screen and discuss substance use history with the child/youth.

**C. Mental Status Examination:** The mental status evaluation of a child must be sensitive to the age, developmental stage, and current status of the individual child. Case conceptualization and appropriate trauma-informed diagnosis often requires multiple sessions to gain the trust of the child and to allow for a clear picture of the youngster's mental status. When indicated, the child is interviewed both with and without parents or caregivers present.

**D. Diagnosis:** In developing a case conceptualization/formulation and trauma-informed diagnosis[33], the prescriber considers the child's complete presentation (strengths and challenges), developmental history, medical history, family history, past history of abuse, neglect, and/or removals, current functioning in all settings, and current mental status. If the prescriber's diagnosis is inconsistent with the diagnosis of other current treating professionals (i.e. therapists), the prescriber will discuss and reconcile these diagnostic issues with the other treating professionals to ensure that all members of the treatment team are working from the same diagnoses and case conceptualization/formulation. The diagnosis is supported by sufficient documentation to ensure that other likely potential diagnoses have been ruled out[34]. Additionally, the psychiatric evaluation addresses why the child's presentation no longer meets diagnostic criteria for prior diagnoses of record, if applicable.

**E. Goals and Target Symptoms:** Specific symptoms to be targeted by the medication, based on the child's presentation and the case conceptualization/formulation, are identified. These should be documented and shared with the child, family, caregiver, and the child and family's support network (e.g., the Child and Family Team, as indicated). The prescriber documents in the record why that particular medication is the most appropriate medication at that time; estimates how soon the child, family, and other members of their support network should observe improved emotional and cognitive regulation and other signs of medication effectiveness; and estimated length of time the child will be maintained on the medication.

1. The targeted symptoms often are the behavioral manifestations of the child's emotional and/or cognitive dysregulation. Caution is urged to refrain from focusing on these behavioral manifestations as the sole focus of treatment, rather than treating the underlying emotional distress as the primary target of treatment.

2. Regular assessment and re-assessment of medication effectiveness and side effects is expected. This is conducted via child/youth self-report in interview, collateral (e.g., teacher, coach, caregiver, social worker) reports, and (ideally) by completion of validated brief symptom screening instruments. Re-assessment also is expected to include review of meaningful measures of psychosocial functioning (e.g., improved grades, improved peer relationships at school) in the child/youth's natural environment.

**F. Choice of Medication:** The prescriber considers the underlying dysregulation and/or additional mental health concerns in addition to the more obvious behavioral manifestations of the child's presentation when considering the most appropriate psychotropic medication for the child at that particular time. 'Root cause' issues, as described in the Detention and Jurisdiction/Disposition Court reports as the basis for removal from the home, and possible subsequent adverse events experienced after coming into the dependency and/or delinquency systems, are critical considerations when conceptualizing targets of treatment. Thus, medication decisions are driven by case conceptualization, diagnosis, potential target symptoms, research, likely effectiveness, potential side effects, the youth's medication history, insurance formularies and available forms of medication (liquid, long-acting formulations, etc.) When there is more than one clinically sound option, the prescriber should explain the pros and cons to the youth and family and they should make the decision together. Medication is prescribed as part of a comprehensive treatment strategy that includes other non-pharmacological interventions, and is not prescribed in lieu of instituting non-pharmacological treatments that the individual child needs.

**G. Informed Consent:** Respect for the independence and autonomy of the child and family is implicit in the requirement for informed consent and assent. Children are included in the consent and assent process to the extent feasible and appropriate based on their developmental stage. This means that the prescriber informs the child, family, and caregiver of the risks and benefits of the proposed treatment and the risks and benefits of alternative treatments, including absence of treatment. The prescriber explains the proposed treatment in terms that are understandable and adequate for that child, family, and additional support persons (as indicated) so that they are able to make an informed choice about whether to consent to medication. This includes information about the anticipated benefits of the medication, possible risks and side effects, the range of doses, initial effects to anticipate, and what would constitute a reasonable trial. This information also should be supplied in written form when available and in the primary language of the family. Information about serious adverse effects to watch for and when and how to contact the prescriber is discussed and provided in written form. Children, families, and caregivers should be

provided ample time for questions and discussion before consent and assent are requested.

1. The prescriber is expected to provide a telephone number at which the child, family, and/or caregiver can reach the prescriber or prescriber's designee if they have questions or concerns about the medications. The prescriber or designee is expected to return telephone calls within twenty-four (24) hours.

2. The prescriber obtains appropriate consent to treat and authorization for the release of records by consulting with the referring child welfare social worker or probation officer to determine who can provide legal consent to treat (the biological parent or the Court) and who holds the privilege for authorizing release of protected health information (PHI)–the biological parent or the Court.

The *California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care* will be reviewed annually.

## Challenges in Diagnosis and Prescribing of Psychotropic Medication

To address common challenges that occur in psychiatric diagnosis and prescribing, the guidelines provide additional recommendations that are categorized into three main topics: a) diagnosis clarity and substantiation, b) medication starts, and c) concurrent use of multiple medications (polypharmacy). Information can be found in Appendix C.

## Guidelines for Prescribers of Psychotropic Medications[35],[36]

The following questions and concerns may be helpful for prescribers to review before a decision to prescribe psychotropic medication is reached. Appendix D is a checklist for prescribers to facilitate such review.

**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.

☐ 2. "Off-label"[37] use of medications lack FDA scrutiny regarding their efficacy and safety. Widespread use in practice does not mean that "off-label" uses of medications are effective and safe.

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

☐ 4. Where ever possible prescribing decisions should be based on benefits that have been substantiated in high quality clinical studies.

☐ 5. Different classes of psychotropic medications differ in their risk versus benefit profiles. Those classes with the greatest chance of adverse effects, particularly antipsychotic medications, should be used cautiously and reserved for clinical situations where there is a high level of confidence, based on published evidence, that potential benefits outweigh potential harms.

☐ 6. 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.

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

☐ 8. 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.

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

☐ 10. 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.

☐ 11. 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.

☐ 12. A clinician prescribing more than one psychotropic medication to one child should refer to Appendix A[38] for guidance.

**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.

**D. Prescribing in Emergency Situations**

In emergency situations a child should be stabilized before a long-term medication plan is considered. During emergency situations to stabilize a child, consider the following:

- [ ] 1. Careful consideration should be placed on medication selection even during a psychiatric emergency.
- [ ] 2. One time or short term medication orders should state “no refills” as a safeguard and to prompt a re-evaluation before continuation occurs.
- [ ] 3. Before medications are started, a specific plan for tapering or consolidating the regimen should be developed. This plan should be clearly communicated to the follow-up provider or outpatient team.
- [ ] 4. In residential settings, the medication log should clearly indicate the medications used during the emergency with the doses, frequencies, and start/stop dates.

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