MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Psychotropic Medication Guidelines - Children and Adolescents

Title: Psychotropic Medication Use in Children and Adolescents

Goal: To establish and maintain a process that promotes clinical best practices regarding the safe and effective use of psychotropic medications for children and adolescents.

Target Population: Children and adolescents treated by MCCMH who are prescribed psychotropic medications.

Background: The use of psychotropic medications for children and adolescents must appropriately incorporate the following 12 Principles. These principles are:

- Collaboration with the child and family,
- Consideration of functional outcomes,
- Collaboration with others,
- Accessibility,
- Utilization of best practice approaches,
- Consideration for the most appropriate setting,
- Adherence to timeliness,
- Services tailored to the child and family,
- Promote stability,
- Respect for the child and family's unique cultural heritage,
- Foster independence, and
- Connection to natural supports.

Black Box Warnings have been issued for numerous psychotropic medications, this has raised public concern about the potential risks and overuse of these medications in children, adolescents, and young adults. The American Academy of Child and Adolescent Psychiatry (AACP) has previously issued a policy statement regarding prescribing anti-depressants and attention-deficit disorder medications. In addition, the AACP has released a policy statement on “Off-Label Prescribing” (March, 2018).

> "Off-label medication use is part of the standard of care in the treatment of psychiatric disorders when: 1) there is a solid evidence base for the medication; 2) an off-label medication has better efficacy and/or safety evidence than an on-label one; 3) a child has symptoms that are not controlled by, or experiences unacceptable side effects due to, an on-label medication; 4) a child has a disorder or comorbid conditions for which there is no FDA-approved treatment; 5) adjunct medication is necessary for control of side effects of another medication; and/or 6) a child is below the age for which an FDA approved treatment is available."

Clinicians must be fully aware of the wide variety of covered behavioral health services available to effectively provide comprehensive, individualized care. In some instances, psychotropic medications may not be the best choice to address the presenting concerns most effectively.

Procedures – Psychiatric Evaluations:

A comprehensive psychiatric evaluation of a child/youth should include a synthesis of the following, at a minimum:

1. Biological, psychological, social, environmental, spiritual, and personal factors influencing diagnosis and treatment;
2. Birth and developmental history;
3. Estimated intelligence and cognitive functioning;
4. Social and interpersonal skills;
5. Medical history and results of any physical examinations, laboratory, radiology, allergies, or other tests, if available; Include all current medications including those prescribed, over the counters (OTC), and/or herbal preparations;
6. Psychiatric history (including the prior use of psychiatric medications and the effects of those medications);
7. Education and special needs;
8. Safety in the community;
9. Family circumstances and social history;
10. Substance use;
11. Legal issues;
12. Mental status examination; and
13. Strengths

Safe Prescribing Practices:

The use of psychotropic medication in children/youth must be monitored carefully to ensure safe and effective use of medications. The following practices should be considered:

1) Identify specific target symptoms to be addressed with the medication and how these target symptoms will be monitored objectively.

2) Start with a low dose and increase slowly.

3) Use the lowest effective dose to adequately treat the identified target symptoms.

4) Identify desired outcomes and track progress toward achieving outcomes, using the Functional Outcomes Measures and reporting format.

5) Clearly document the clinical rationale whenever intra-class and/or inter-class prescribing is utilized.

6) Taper ineffective medications slowly unless adverse effects have been noted and more rapid discontinuation is indicated.

7) Make only one medication adjustment/change at a time whenever possible to better track the effect of the medication change.

8) Do not be too quick to add/increase medications when requests are made by staff or caregivers. Gather information to make a rational, objective decision. Again, if changes are made, make only one change at a time, identify target symptoms, and outline how the target symptoms will be monitored objectively.

9) Consider if a truly adequate trial has been attempted (adequate dose for an adequate time) before determining that a medication is ineffective. Ensure that treatment non-response is not attributable to other factors such as nonadherence or co-occurring substance abuse.

a. Once it is determined that a medication is not adequately effective, it should be discontinued to avoid polypharmacy concerns.

b. Follow-up must be arranged following the decision to discontinue a medication. This may consist of telephone contact or a follow-up face-to-face appointment, depending on the circumstance. The follow-up plan must be documented and implemented.

10) Do not prescribe a medication simply because a specific medication is being requested. Television marketing and word-of-mouth can be extremely influential.

Medications must always be prescribed in a thoughtful manner after considering necessary clinical information.

11) Medications known to have abuse potential, involve significant risks, or are associated with significant undesirable side effects must be carefully monitored and findings documented.

12) Before initiating the use of anti-psychotic medication, the absence or presence of movement disorders must be assessed, documented, and then monitored on a regular basis.

13) Medications that have been shown to adversely affect hepatic, renal, endocrine, cardiac function, other bodily functions, or require serum level monitoring must be assessed via appropriate laboratory studies.

14) Consult with a knowledgeable and qualified Child and Adolescent Psychiatrist for a second opinion, if necessary. At a minimum, if the prescribing clinician is not a Child and Adolescent Psychiatrist or if the clinician who started the medications was not a Child and Adolescent Psychiatrist, a licensed Child and Adolescent Psychiatrist should review the following situations:

a. Children under the age of three on psychotropic medications for more than 2 months: complete a chart review,

b. Children less than the age of 12 years prescribed >3 (i.e., 4 or more) psychotropic medications for more than 3 months: complete a chart review, and

c. Children less than the age of 12 years prescribed >4 (i.e., 5 or more) psychotropic medications for more than 3 months: complete a face-to face assessment.

15) Health parameters such as weight, height, and blood pressure must be collected as a part of a baseline assessment and, as appropriate, periodically monitored and recorded in the member's medical record.

16) Potential drug-drug interactions (including over the counter, herbal preparations, homeopathic remedies, etc.) and food-drug interactions should be considered.

17) Consider the impact of environment/psychosocial influences on current clinical presentation. Abusive, chaotic, unstable environments Call greatly impact the observed impact of prescribed medications. Modifications to the environment and addressing current stressors may be the most appropriate interventions.