Guidelines for Psychotropic Medication Use in Children and Adolescents

Psychotropic Medication Advisory Committee
State of Connecticut Department of Children and Families

2021 Guidelines for Psychotropic Medication Use in Children and Adolescents

Department of Children and Families
State of Connecticut

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Foreword

Thank you for your commitment and dedication in caring for youth under the care of the Department of Children and Families (DCF). We understand that you may face special challenges in treating these youth and their families and we look forward to working collaboratively with you in the future.

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Since 2000, the DCF Psychotropic Medication Advisory Committee (PMAC), composed of child psychiatrists, pediatricians, pharmacists, advanced practice registered nurses, and family advocates from both the private sector and the state system, has been reviewing the psychiatric and mental health treatment needs of youth in the DCF system while working to refine and standardize the processes related to the use of psychotropic medications in DCF-committed youth. Using multiple resources, we have formulated guidelines to improve and systematize psychotropic medication treatment. Additionally, these guidelines aid DCF personnel who work diligently to advocate for youth under their care. **While these guidelines are not meant to dictate standards of care in your practice, they provide a consistent consent process for the use of psychotropic medications as well as serve to improve the overall level of care for DCF youth.**

These guidelines are reviewed and revised by PMAC on a regular basis to reflect the latest in state-of-the-art, evidence-based practice. It is the hope of the Department of Children and Families that communication and collaboration between the Department and providers for will result in enhanced continuity of care and positive long-term outcomes for youth in our care.

Chapter One: Introduction

Youth in the care of the Department of Children and Families may offer special challenges to the practitioner. There are approximately 3000 Connecticut youth at any given time whose guardian is the Commissioner of DCF. In addition, there are many other youths who are entering and leaving the system through orders of temporary custody, 96-hour holds, or by turning age 18 and reaching the age of consent. Many of these youth cycle between foster homes, group homes, residential treatment centers and hospitals; often with incomplete medical records and no consistent primary care practitioner overseeing their care. There is now widespread acknowledgement among healthcare professionals that these youth represent a very vulnerable sub-population. Not only may youth in state care present with complex psychiatric diagnostic issues, but reliable and comprehensive medical history on the child may not be available to help clarify complex medical and mental health issues. One study found that nearly 90 percent of young youth entering the foster care system had physical health problems, and 55% have two or more chronic conditions (1). The child may have had multiple caretakers as well as disruptions and trauma within the foster care system itself and may currently be in transition from one home setting to another. In other words, not only the trauma associated with abuse and/or neglect that led to their initial removal from their family, but traumatic experiences within the foster care system, have the potential to create a set of circumstances that may lead to behavioral health problems and the need for psychiatric assessment. Medicaid data demonstrates that youth in foster care represent only 3 percent of youth in Medicaid, but 15 percent of youth using behavioral health services. Furthermore, these youth represent 13 percent of those in Medicaid receiving psychotropic medications and are four times more likely to receive these medications than youth in Medicaid overall (2).

As a result of these findings, many agencies including the Child Welfare League of America (CWLA); American Academy of Pediatrics (AAP), and the American Academy of Child and Adolescent Psychiatrists (AACAP) (3,4,5) have published guidelines for treatment of youth for whom the state is their guardian. These guidelines focus on the importance of a complete diagnostic work-up and the establishment of a “medical home” for overall preventative care.

Alongside the identification of the vulnerabilities of this population is an expanding literature documenting concerning trends in psychotropic medication use in youth overall, particularly those in the foster care system. These trends include a lack of an evidence-base for pediatric psychopharmacology in the treatment of trauma-derived symptoms; increased susceptibility to diabetes, metabolic syndrome and obesity with many commonly prescribed psychiatric medications; the increasing off-label use of antipsychotic medication for the treatment of disruptive behavior; and a dearth of available community based, evidence-informed psychosocial treatment options that may drive increased rates of prescribing. There is a growing consensus calling for caution and prudence in prescription-writing for this population, and in response to federal guidelines, states are now required to develop their own monitoring and oversight systems for the prescribing of psychotropic medications to foster youth. Connecticut was one of the first states ahead of the curve in this regard: in 2005, in response to the

growing concerns already present in the public and academic press, state legislation was passed requiring DCF to set up a state-of-the-art medication management system for children and youth in the care and custody of the Commissioner.

A third major development in understanding the needs of this population has been the acknowledgement of the pervasive effects of trauma (usually the reason for the change in guardianship) in this population, including effects on brain development, attachment, cognitive development, educational readiness, physical health, and last but not least the development of long-term psychological and behavioral difficulties. The overlay of exposure to trauma during critical periods of development in infancy and childhood often leads to long-term, complicated treatment problems that do not respond well to a "quick-fix" approach or to work done by providers working in isolation. Given that many behavioral symptoms within the foster care population may be related to trauma, it is vital when evaluating and treating these youth to consider the ways development can be affected by traumatic experiences (6). Many of the symptoms related to chronic exposure to trauma are not especially medication-responsive, although medication may be necessary to help the child to improve functioning and to participate actively in trauma-informed treatment modalities. Close collaboration between mental health providers, families, DCF case workers, primary care providers, school systems, community-based support systems, and residential/foster home/group home/ hospital staff is a key ingredient to a successful outcome (i.e., a healthier child in the least restrictive setting available, ideally a safe, secure, loving and permanent home).

The following protocols and procedures have been recommended by the Psychotropic Medication Advisory Committee and adopted by DCF. The recommendations are based on clinical evidence, clinical judgment, and research, and represent community standards of practice in the use of psychotropic medications in youth under DCF's care. Their purpose is to support practitioners who work with this complex, ever- changing, ever-moving population and to guide quality treatment of these patients

Chapter Two: Psychiatric Assessment of DCF Children and Adolescents

Assessment

The baseline assessment of a child or adolescent prior to initiating psychopharmacological treatment is complex. It must involve the evaluation of a myriad of biological, psychological, and social variables. The actual purpose of the assessment is multifaceted and includes: 1) the establishment of a therapeutic relationship with the patient and parent/caregiver/guardian; 2) the formulation and establishment of a working diagnosis; 3) the identification of target symptoms; and, 4) the development of a comprehensive treatment plan.

It is important to note that co-morbid medical and psychiatric disorders are often present in youth who require our care**. All youth should have a thorough health evaluation and identification of acute medical problems prior to the consideration of psychotropic medications. In some cases, medical problems mimic and/or occur co-morbidly with psychiatric disorders**. In those cases, the identification of target symptoms is most critical. When pharmacologic intervention is identified as part of the treatment plan, considerations such as diagnostic medical evaluations, drug-drug interactions, polypharmacy, treatment compliance, informed consent, and the safe storage and administration of medications are important.

The administration of psychotropic medication should involve appropriate education of the patient and caretaker, an adequate trial, and careful monitoring by the prescribing practitioner along with other treatment providers. An **adequate trial** refers to an appropriate dose of the medication being given over a reasonable period needed to obtain benefit. **Adequate treatment** must be offered to clearly determine therapeutic efficacy; however, the practitioner must be ever mindful of possible adverse reactions, which might necessitate a careful discontinuation of the medication. Regular and frequent follow-up with the patient and guardian is important in enhancing compliance, providing ongoing psychoeducation about side effects and medical monitoring, and monitoring therapeutic effects of the medication.

The **assessment of a medication trial** is facilitated by the initial identification of target symptoms and the regular evaluation of those target symptoms. The consideration of intercurrent life events, particularly in youth is also essential in assessing benefits of medication. The start of school, a change in living situation, physical illness, parental functioning, issues of loss, a birthday, etc., can all impact functioning and can confound the evaluation of a medication trial. Particularly for youth in foster care, disruptive behaviors secondary to trauma-derived patterns of coping may complicate permanency planning and perpetuate polypharmacy, when parenting, family, psychological or behavioral interventions are more appropriate. Compliance may also need to be investigated through pharmacy or medication administration records to clearly assess efficacy of a medication trial. Once an informed decision is made about a particular medication, changes in the treatment plan may be necessary including changes in medication regimen, adjustment in non-pharmacologic treatment strategies, and re-evaluation of the diagnosis.

In youth, **re-evaluation of the working diagnosis** is useful not only when there is a lack of treatment response but in other situations as well. By nature, youth are developing and changing during their treatment. Longitudinal information may become available revealing temporal patterns of functioning that may alter diagnoses and at times, the successful treatment of one disorder may then expose an underlying co-morbid disorder that also requires treatment. Ultimately, the resolution of a disorder or the ineffectiveness of a medication requires the medically supervised discontinuation of medications. Because withdrawal or discontinuation effects may arise and confound the clinical picture, **close monitoring is vital to sort out the illness from medication effects. Polypharmacy can be avoided or minimized if these issues are considered.**

With respect to the use of multiple psychiatric medications simultaneously, there is growing concern about the general lack of efficacy of polypharmacy regimens for the majority of child and adolescent mental and behavioral disorders. Youth in foster care are prescribed polypharmacy regimens at greater rates than other publicly insured youth (7); these regimens carry their own risks to short and long-term physical health, as well as risks of drug-drug interactions, and greater economic costs.

Safety Guidelines for Psychotropic Medication Treatment

To further safeguard prescribing practices for this vulnerable population, the following safety guidelines are utilized with DCF-involved youth who receive psychotropic medication treatment:

1. Monotherapy regimens for a given disorder or specific target symptoms should be tried before polypharmacy regimens. The dosage should be optimized as tolerated before the medication trial is considered ineffective.

2. One medication change should be made at a time (except for cross-tapers).

3. Polypharmacy (i.e., the use of two or more medications for the same indication or specific mental disorder) is discouraged and requires specific justification (except for different forms of the same medication).

4. Medications reviewed and not approved by the Psychotropic Medication Advisory Committee and thus not listed as approved for use in DCF-involved –youth based on a lack of safety and/or efficacy data -- should be avoided.

5. Medications should only be prescribed in compliance with the PMAC recommended dosing guidelines which are available on the DCF CMCU website.

6. In addition to informed consent by the DCF Centralized Medication Consent Unit and/or DCF Regional Medical Director and assent by patients over the age of 8, psychotropic medications must be prescribed in collaboration with other treatment providers and with the primary care physician.

Chapter Three: Psychotropic Medication Consent Process

DCF Policy 44-5-2.1 Psychotropic Medications: Informed Consent

The Department has a streamlined process for requesting and obtaining consent to treat DCF youth with psychotropic medications. These guidelines will summarize this process, including how the prescribing provider will interface with the Department to obtain required informed consent for the use of psychotropic medications in treatment of youth who are under the care and custody of DCF. These guidelines, along with the attached appendices, are reviewed on a regular basis by the Psychotropic Medication Advisory Committee. Revisions will be available to prescribing providers on an ongoing basis accessible on the DCF website.

The procedure for informed consent is based in DCF policy. Per the policy, the DCF Commissioner and/or designees shall authorize consent to prescribe psychotropic medication in a timely manner to youth who are committed to the agency. To facilitate this process DCF has a **Centralized Medical Consent Unit (CMCU),** comprised of child psychiatrists and advanced practice registered nurses. The CMCU staff is authorized to review all requests by providers for psychotropic medications for DCF-committed youth, and to make the final decision to approve the request, with or without modification, or to deny the request.

This process, which started in 2007, allows providers to interact directly with medical/nursing staff who are trained and certified in psychiatry. It increases the level of expertise in psychopharmacology used in making such decisions and increases the overall efficiency of the decision-making process. A database has been developed that collects information about each child's history of CMCU approvals in a centralized location. This database can be used to provide information to providers and area office workers about medication history, treatment response, and monitoring studies.

Contacting DCF for Psychotropic Medication Consent

The provider who wishes to prescribe psychotropic medications to youth who are under the care and custody of DCF must obtain informed consent from the Agency, who acts as the legal guardian for the child. The first point of contact with DCF to request this consent is with the **Centralized Medication Consent Unit (CMCU).** Providers may contact the CMCU to request psychotropic medication consent either by fax or email.

Medication Consent Process

The Process for Obtaining Medication Consent is as follows:

1. Requests for psychotropic medications are to be submitted to the **CMCU**, using **the DCF-465, Request for Psychotropic Medications Form which can be completed online or faxed to the CMCU**.

Toll free fax: 1-877 323-3784 (1 877 DCF-DRUG) or
Email: getmeds.dcf@ct.gov.

It is important to **complete the information requested on the form in its entirety, including target symptoms; all psychiatric and medical diagnoses and medications with dosages; plans to taper, cross-taper, discontinue other medications as part of the treatment plan; and labs, vital signs, etc. Certain medications require mandatory baseline or ongoing monitoring studies for consideration of approval.** Providing sufficient information about the child's clinical condition and needs on the request form will decrease time delays that could occur if inadequate baseline information is provided.

2. The CMCU receives the DCF Form 465 and verifies the child's demographic information, assigned Area Office, and legal status in the DCF record. Based on the child's legal status, the CMCU will use an algorithm to triage and communicate appropriate information regarding the medication request:

    - If the child is committed to DCF, the CMCU will process the medication request according to CMCU procedures.

    - If the child is on an Order of Temporary Custody (OTC) or 96-hour hold, the CMCU notifies the DCF social worker so that reasonable efforts can be made to locate the parent/guardian and acquire parental/guardian consent. If the parent/guardian is located, the social worker will call the provider to inform him/her of this fact so that they can request consent from the parent/guardian. If the parent/guardian cannot be located, the DCF social worker may seek a juvenile court order for the agency to authorize medical decisions for the youth, in which case the request would be returned for approval by the CMCU. In any case in which DCF is not the legal guardian but a court order exists authorizing the agency to make medical decisions, a copy of the court order should be submitted to the CMCU by the DCF social worker.

    - If the child is not committed to DCF, the CMCU will notify the prescribing provider to inform him/her of this fact so that he/she can request consent from the parent/guardian. The DCF social worker is also informed of the request.

3. CMCU notification is necessary for all STAT medications given in the context of an emergency when prior authorization had not been received. Using the DCF-465 form, the name, doses, and target symptoms of all previously unauthorized STAT medications must be submitted to the CMCU within 12 hours of their use. If the provider has previously requested and received approval for the medication that was used in an emergency, a new DCF-465 does not have to be submitted.

Response Time

The response time for medication requests is often dependent upon the request form being properly completed. The goal is to complete each request within one business day of receipt, however when outdated or incomplete forms are submitted for review, **or when additional clarifying information is needed from either the provider or the area office team to make an informed decision, the processing time may be extended.**

Appeals Process

Any medication decision by the CMCU can be appealed by the provider. Instructions on how to appeal the decision are given on the formal response.

All appeals are reviewed by the DCF Chief of Psychiatry or designee.

The final decision will be recorded in the CMCU database and any modification in the decision will be provided in writing to the prescribing provider and DCF social worker. The decision of the DCF Chief of Psychiatry is final.

Notification of Psychotropic Medication Discontinuation Process

It is important that DCF be kept apprised of any changes in psychotropic medication treatment, including discontinuation of medications and/or changes in dosage/frequency of a medication previously approved with a defined dosage range. The prescribing provider is requested to notify the CMCU of such changes by submission of **Form DCF-465A, Notification of Discontinuation or Dosage Change of a Psychotropic Medication** either by fax or email. Please note consent is not required to discontinue a medication or change the dosage within a previously approved dosage range.

Chapter Four: DCF Psychotropic Medication Protocols and DCF Approved List of Medications

On the CMCU website is the document titled DCF-Approved Medication List and Associated Monitoring Protocols. This document is reviewed regularly by PMAC and revisions are posted to the website at least semi-annually. The document includes a list of the DCF-approved medications, approved dosing ranges, required and suggested baseline and follow up labs, and other monitoring interventions that are based on the latest in evidence-based practice and research literature. Prescribing providers may be asked to provide clinical information and follow-up based on this document.

Requests for medications that are not listed require review by a CMCU child psychiatrist.

Providers should note that this list of approved medications is separate from and unrelated to any formulary that may be published by any insurance company, including the HUSKY/Medicaid managed care organizations. It is the prescribing provider's responsibility to seek authorization from the child's health plan for any medication that is subject to the health plan's prior authorization process.

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