

# **Practice Protocol**

## **PSYCHOTROPIC MEDICATION USE IN CHILDREN, ADOLESCENTS, AND YOUNG ADULTS**



**Developed by the  
Arizona Department of Health Services  
Division of Behavioral Health Services**

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**NOTE:**  
**This Clinical Practice Protocol has required implementation elements. Providers are required to implement the identified Service Expectations, as clearly identified in this document.**

**Title**

Psychotropic Medication Use in Children, Adolescents, and Young Adults

**Goal (What Do We Want to Achieve Through the Use of This Protocol?)**

To establish and maintain a process that promotes clinical best practices regarding the safe and effective use of psychotropic medications for children, adolescents, and young adults (up to age 21).

**Target Population(s)**

Children, adolescents, and young adults enrolled in the Tribal and Regional Behavioral Health Authority (T/RBHA) systems who are prescribed psychotropic medications.

**Definitions**

**Child and Family Team**

The Child and Family Team (CFT) is a defined group of people that includes, at a minimum, the child and his/her family, a behavioral health representative, and any individuals important in the child's life and who are identified and invited to participate by the child and family. This may include, for example, teachers, extended family members, friends, family support partners, healthcare providers, coaches, community resource providers, representatives from churches, synagogues, or mosques, agent from other service systems like Child Protective Services (CPS) or Division of Developmental Disability etc. The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by which individuals are needed to develop an effective service plan, and can therefore expand and contract as necessary to be successful on behalf of the child.

**Intra-class polypharmacy**

Defined as more than two medications prescribed at the same time within the same class, other than for cross-tapering purposes. The person's medical record must contain documentation specifically describing the rationale and justification for the combined use.

**Inter-class polypharmacy**

Defined as more than three medications prescribed at the same time from different classes of medications for the overall treatment of behavioral health disorders. The medical record must contain documentation specifically describing the rationale and justification for the combined use.

Medical behavioral health practitioners (MBHP)

Prescribing clinicians, including psychiatrists, nurse practitioners, and physician assistants

### **Background**

The use of psychotropic medications for children, adolescents, and young adults (up to age 21) must appropriately incorporate the key elements of the Arizona Vision and the Arizona 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.

Recent additions of Black Box Warnings to prescribing information for numerous psychotropic medications have raised public concern about the potential risks and overuse of these medications in children, adolescents, and young adults. Specifically, medications used to treat depression and attention-deficit hyperactivity disorder in children have been the focus of negative attention in the press. The American Academy of Child and Adolescent Psychiatry (AACAP) has issued the following policy statement (September 20, 2001): "Anecdotally the prescribing of multiple psychoactive medications...in the pediatric population seems on the increase. Little data exists to support advantageous efficacy for drug combinations...keeping such use to clearly justifiable [clinical] circumstances." These acknowledgements and public concerns must be recognized and used to guide clinical practice in Arizona.

Clinicians must be fully aware of the wide variety of covered behavioral health services available in order to effectively provide comprehensive, individualized care. In some instances, psychotropic medications may not be the best choice to most effectively address the presenting concerns. Child and Family Teams should consider the potential benefits of family support, peer support, personal care services, respite, and therapy when developing the treatment plan. Behavior specialists can provide expertise by conducting a functional analysis of behavior, developing positive behavior support plans, and assisting families in responding to problematic behaviors. There are certain situations in which these types of interventions are much more effective than the use of

medications, such as when addressing substance exposure in-utero and the resulting impulsivity, irritability, and aggression.

In order to provide for the safe and effective use of psychotropic medications for children, adolescents, and young adults, medical behavioral health practitioners require sufficient time and resources to perform comprehensive psychiatric evaluations and ongoing follow-up assessments. This allows for development of well-defined diagnostic hypotheses, identification of carefully defined target symptoms, and for evaluation of medication response and adverse effects.

## **Procedures**

### **Psychiatric Evaluations**

Providers should conduct assessments for all members in a timely manner as prescribed in [Provider Manual Section 3.2 Appointment Standards and Timeliness of Service](#) and [3.9 Intake, Assessment and Service Planning](#). Providers are encouraged to take up to 45 days to complete the full assessment and should not feel rushed to complete the entire assessment in one meeting.

Psychiatric evaluations should be performed before any psychiatric medications are prescribed whenever possible and at regular intervals thereafter as clinically indicated. If a prescribing practitioner prescribes a medication before a psychiatric evaluation can be completed, a detailed rationale for this decision must be documented in the member's medical record.

The psychiatric evaluation should be developed by considering all available sources of information (i.e., initial assessments, clinicians' progress notes, staffing notes, input from parents/guardians and teachers, direct assessment of the child/youth).

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.

**Service Expectations: Medical behavioral health practitioners must complete a thorough psychiatric evaluation prior to prescribing psychiatric medications except when continuing an existing prescribed medication(s) until a scheduled appointment. If medications are prescribed prior to completion of the psychiatric evaluation, a detailed rationale must be documented.**

### **Coordination with Family Members and the Child and Family Team**

The use of Child and Family Teams is the practice used in Arizona to ensure children/youth and their families receive behavioral health care in accordance with the 12 Principles. Child and Family Teams allow for a single point of contact, family-centered assessment and treatment planning, and collaboration.

Medication use is a collaborative process, and input from the Child and Family Team must be included to effectively evaluate, monitor, and make clinical recommendations for improvement in the medication regimen. Children/youth and their families should play an active role in all decisions relating to the management of their care.

Medical behavioral health practitioners must coordinate care with the Child and Family Team using one or more of the following methods: direct participation in the Child and Family Team meeting, direct communication with the Clinical Liaison, or direct communication with the family. Concerns discussed at the Child and Family Team must be shared with the prescribing practitioner.

**Service Expectations: Medical behavioral health practitioners must coordinate care with the Child and Family Team using one or more of the following methods: direct participation in the Child and Family Team meeting, direct communication with the Clinical Liaison, or direct communication with the family.**

### **Coordination of Care with Inpatient Medical behavioral health practitioners**

Prior to all referrals to inpatient facilities, or immediately upon becoming aware of an inpatient admission, the prescribing practitioner or designee must contact the inpatient prescribing clinician to review the following information at a minimum:

- 1) The reason for admission,
- 2) The anticipated therapeutic goals of the inpatient stay and desired medication changes, or requests not to change medications, if appropriate,
- 3) Current and past medication history and response to medication trials,

- 4) The name of the Child and Family Team facilitator, so the Child and Family Team can be actively involved during the admission and can assist with discharge planning, and
- 5) Any other relevant data.

The inpatient prescribing practitioner must inform the outpatient prescribing practitioner of all medication changes prior to, or at the time of discharge, and make available to the outpatient clinician an up-to-date list of the member's discharge medications, dosages, and clinical indications. Pertinent laboratory findings (such as medication levels) should also be transmitted to the outpatient prescriber at this time. The inpatient prescribing practitioner must ensure that there is a post-discharge appointment with an outpatient prescribing practitioner within seven (7) days and that there is not a lapse in medications prior to that appointment.

**Service Expectations: The outpatient prescribing practitioner must coordinate care with the inpatient prescribing practitioner when a child/youth has been hospitalized. Direct practitioner-to-practitioner communication is optimal. The inpatient prescribing practitioner must ensure that there is a post-discharge appointment with an outpatient prescribing practitioner within seven (7) days and that there is not a lapse in medications prior to that appointment.**

### **Coordination of Care with Other Care Providers**

**Primary Care Providers:** Each child/youth's care must be coordinated with his/her primary care physician (PCP) as outlined in [Provider Manual Section 4.3 Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers](#).

In addition, the behavioral health prescribing practitioner must actively coordinate with the PCP, or other known medical behavioral health practitioners, if there is evidence of the following:

- Member is receiving psychotropic medications for the same condition by both medical behavioral health practitioners, or
- Member is receiving medications from the same therapeutic class for different conditions simultaneously by both medical behavioral health practitioners,
- There is a potential for medication misuse or treatment non-adherence (such as substance abuse) that would interfere with coordination of treatment.

As outlined in the Psychotropic Medication Initiative, an AHCCCS Health Plan PCP may elect to treat select behavioral health disorders within their scope of practice and comfort level. The select behavioral health disorders that AHCCCS Health Plan PCPs can treat are: Attention-Deficit/Hyperactivity Disorder, Depressive disorders, and Anxiety disorders. Children/youth diagnosed with any of these conditions and currently being treated by the T/RBHA or subcontracted prescribing practitioner may be referred back

to the PCP for ongoing care following: consultation with and acceptance by the child/youth's PCP and health plan and with the approval of the child's caregiver.

**Providers in Detention/Correctional Facilities:** The outpatient behavioral health prescribing practitioner must actively coordinate care with medical behavioral health practitioners who are evaluating and treating children/youth who are temporarily placed in detention and correctional facilities.

**Other Care Providers:** Medical behavioral health practitioners must share their expectations for ongoing information sharing between other actively involved parties, including:

- clinicians,
- therapists,
- case managers, clinical liaisons, and other behavioral health care providers,
- group home/day program staff,
- foster families,
- other agency staff (CPS Case Workers, DDD Support Coordinators),
- family members, and
- any other parties involved in the care of the child/youth.

Medical behavioral health practitioners are dependent upon caregivers and staff to provide detailed, accurate information in order to determine the safety and effectiveness of prescribed medications.

**Service Expectations: Medical behavioral health practitioners must coordinate care with the member's Primary Care Physician as well as other providers/caregivers involved in his or her care, such as therapists, foster families, and detention facility staff in order to guide overall treatment.**

## **Informed Consent**

In order to be actively involved in making treatment decisions and to provide adequate informed consent for treatment, children/youth and families must be provided with complete and accurate information in a manner that they can understand. Information should include realistic expectations pertaining to the proposed treatment. The prescribing practitioner is there to educate and advise rather than to dictate treatment.

As per [Provider Manual Section 3.11 General and Informed Consent for Treatment](#), [Provider Manual Section 3.15 Psychotropic Medication: Prescribing and Monitoring](#), and [Provider Manual Form 3.15.1 Informed Consent for Psychotropic Medication Treatment](#), medical behavioral health practitioners must furnish the following information, at a minimum, to parents/guardians through a combination of verbal exchanges and written

handouts. Whenever possible and clinically appropriate, the child/youth should be included when furnishing the following information:

- 1) Information about the diagnosis and the proposed treatment, including the intended outcome, nature, and all available procedures involved in the proposed treatment;
- 2) The risks, including any potential side effects, of the proposed treatment, as well as the risks of not proceeding;
- 3) The alternatives to the proposed treatment, particularly alternatives offering less risk or other adverse effects;
- 4) That any consent given may be withheld or withdrawn in writing or verbally at any time. When this occurs, the provider must document the person's choice in the medical record;
- 5) The potential consequences of revoking the informed consent to treatment; and
- 6) A description of any clinical indications that might require suspension or termination of the proposed treatment.

Written and verbal information should be offered in terminology understood by the guardian and member. If necessary to effectively communicate with the child/youth and/or guardian, written and verbal information should be translated or provided by an interpreter.

Prior to prescribing psychotropic medications, written informed consent should be obtained from the legal guardian that clearly indicates that all required information referenced above has been reviewed. In situations where written consent cannot be immediately obtained, and withholding medication would create undue risk, verbal consent that is clearly documented in the member's medical record will suffice until written consent is received.

No medication changes or discontinuations should be implemented until reasonable attempts to reach guardians and elicit their input have been exhausted by the prescribing practitioner and/or designated staff. Reasonable attempts include, at a minimum, efforts to reach the guardian via telephone calls and the delivery of certified mail to the guardian's last known address. If clinical necessity warrants an immediate response, medication changes or discontinuations can be implemented; however, an attempt to reach the guardian should be made and recorded in the child/youth's medical record.

Special requirements for informed consent for children, as outlined in [Provider Manual Section 3.11 General and Informed Consent to Treatment](#), sub-section 3.11.7-D, must be followed for emergency and non-emergency situations.

Medication should be discontinued promptly if consent for treatment is withdrawn by the child/youth's guardian. If abrupt, discontinuation could potentially result in adverse

effects, the guardian should be so advised and medication withdrawn in a timely manner as clinically appropriate.

Parents/guardians should be informed of directions for administration of the medication, what signs/symptoms to monitor and to report to the prescribing practitioner, when it is appropriate or inappropriate to discontinue, steps to take in the event of an emergency, and how to reach the prescribing practitioner or designee to ask questions.

When clinically and developmentally appropriate, children/youth should be involved in all discussions relating to medication use and informed consent.

**Service Expectations: Medical behavioral health practitioners must obtain informed consent for all new medications prescribed and children, adolescents, and young adults should be involved in all discussions relating to medication use and informed consent when clinically and developmentally appropriate. Directions for administration of the medication and how to monitor/report adverse reactions must be discussed.**

### **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 pharmacy is utilized. (See [Clinical Practice Protocol: Polypharmacy Use: Assessment of Appropriateness and Importance of Documentation.](#))
- 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 in order 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 non-adherence or co-occurring substance abuse.

- a. Once it is determined that a medication is not adequately effective, it should be discontinued in order 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 particular 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, an Arizona-licensed Child and Adolescent Psychiatrist or the T/RBHA's Children's Medical Director 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.<sup>1</sup>
  - 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.

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<sup>1</sup> The use of telemedicine is acceptable.

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

T/RBHAs must develop and implement drug utilization reviews to identify and address potentially unsafe or clinically unsound prescribing practices. Both isolated cases and general prescribing patterns must be tracked and addressed as needed with individual medical behavioral health practitioners. Findings derived from utilization data, prescribing patterns, peer reviews, and other sources should be regularly disseminated to appropriate T/RBHA and subcontractor staff (i.e., committee meeting minutes, memorandums, direct communication via the medical director or designee).

T/RBHAs must have mechanisms in place requiring that adverse drug reactions and medication errors be reported immediately to the prescribing practitioner and recorded in the member's medical record. In addition, T/RBHAs must ensure that all medication errors and adverse medication reactions are reported per [Provider Manual Section 7.4 Reporting of Incidents, Accidents and Deaths](#).

**Service Expectations: Medical behavioral health practitioners must utilize safe prescribing practices in order to decrease the risk of side effects, drug-drug interactions, and other adverse effects. Medical behavioral health practitioners must clearly document target symptoms, how target symptoms will be monitored, and the rationale for medication choices. T/RBHAs must have mechanisms in place to ensure that medication errors and adverse drug reactions are appropriately reported and addressed.**

### **Training and Supervision Expectations**

This Practice Protocol applies to all medical behavioral health practitioners. Formal training on this protocol is not required.

Each T/RBHA shall establish their own process for ensuring all medical behavioral health practitioners have read and understand the expectations of this Protocol. Each T/RBHA is required to maintain documentation of medical behavioral health practitioner training and make this documentation available to ADHS/DBHS upon request.

Whenever the Protocol is updated or revised, T/RBHAs are required to ensure all medical behavioral health practitioners have read and understand the expectations of the revised Protocol.

Supervision regarding implementation of this Protocol is to be incorporated into other supervision processes the T/RBHA has in place for medical behavioral health practitioners.

### **Anticipated outcomes and how they will be measured**

Anticipated outcomes include:

- Thorough, comprehensive assessments,
- Enhanced coordination of care between medical behavioral health practitioners and family members and other involved providers,
- Consistent completion of and documentation of informed consent, and
- Increased use of safe and effective prescribing practices.

Outcomes will be measured through the use of one or more of the following:

- Random audits completed by ADHS/DBHS
  - Independent Case Review (chart reviews)
  - Administrative Reviews (chart reviews)
  - Monitoring and Oversight Department audits (chart reviews)
- Behavioral Pharmacy Management assessments of polypharmacy
- Incident/accident reports

### **How will fidelity be monitored?**

Fidelity will be monitored by:

- ADHS/DBHS:
  - Monitoring and Oversight Department audits (chart reviews)
  - Review of T/RBHA documentation that medical behavioral health practitioners have read and understand the expectations of this Protocol
- T/RBHAs: Monitoring of referrals/second opinion reviews in the following situations (when the medical behavioral health practitioner is not a Child and Adolescent Psychiatrist):
  - Children under the age of three on psychotropic medications: chart review
  - Children prescribed >3 (i.e., 4 or more) psychotropic medications: chart review
  - Children prescribed >4 (i.e., 5 or more) psychotropic medications: face-to-face assessment

# Psychotropic Medication Use in Children, Adolescents, and Young Adults Desktop Guide

## Service Expectations:

- **Medical behavioral health practitioners (MBHP) must complete a thorough psychiatric evaluation prior to prescribing psychiatric medications except when continuing an existing prescribed medication(s) until a scheduled appointment. If medications are prescribed prior to completion of the psychiatric evaluation, a detailed rationale must be documented.**
  - **MBHPs must coordinate care with the Child and Family Team using one or more of the following methods: direct participation in the Child and Family Team meeting, direct communication with the Clinical Liaison, or direct communication with the family.**
  - **The outpatient prescribing practitioner must coordinate care with the inpatient prescribing practitioner when a child/youth has been hospitalized. Direct practitioner-to-practitioner communication is optimal. The inpatient prescribing practitioner must ensure that there is a post-discharge appointment with an outpatient prescribing practitioner within seven (7) days and that there is not a lapse in medications prior to that appointment.**
  - **MBHPs must coordinate care with the member's Primary Care Physician as well as other providers/ caregivers involved in their care, such as therapists, foster families, and detention facility staff in order to guide overall treatment.**
  - **MBHPs must obtain informed consent for all new medications prescribed and children, adolescents, and young adults should be involved in all discussions relating to medication use and informed consent when clinically and developmentally appropriate. Service Expectations: MBHPs must obtain informed consent for all new medications prescribed and children, adolescents, and young adults should be involved in all discussions relating to medication use and informed consent when clinically and developmentally appropriate. Directions for administration of the medication and how to monitor/report adverse reactions must be discussed.**
  - **MBHPs must utilize safe prescribing practices in order to decrease the risk of side effects, drug-drug interactions, and other adverse effects. MBHPs must clearly document target symptoms, how target symptoms will be monitored, and the rationale for medication choices.**
  - **T/RBHAs must have mechanisms in place to ensure that medication errors and adverse drug reactions are appropriately reported.**
- ❖ Key elements to remember about this best practice:
- Consider non-medication covered services which may be beneficial, such as family support, respite, and behavior analysis; and refer for those services if indicated
  - Consider the impact of environmental/psychosocial influences on current clinical presentation
  - Intra-class Polypharmacy: the use of more than 2 medications in same class at the same time, other than when cross-tapering
  - Inter-class Polypharmacy: the use of more than 3 medications from different classes at the same time
  - Ask yourself: "Is this treatment safe, effective, and efficient?"
  - Track target symptoms and functional outcomes
- ❖ Benefits of using this best practice:
- Consistent with the Arizona 12 Principles
  - New MBHPs know why you made the treatment decisions you made
  - Better child/youth/family understanding of medication, expected benefits, and potential risks
  - Potential for increased use of other interventions as alternatives to and to augment medication
  - Decreased medication side effects and drug-drug interactions
  - Potential financial benefit due to decreased medication use
  - Strong documentation reduces potential legal liability concerns