

Guidelines for Psychotropic Medication Prescribing in Primary Care for Children and Adolescents in Foster Care

Primary care physicians have an important role in addressing the mental health needs of children and adolescents. The following guidelines can assist in the prescribing of psychotropic medications for children and adolescents in foster care.

When psychotropic medication is being considered:

- Prior to initiating psychotropic medication, a mental health assessment is completed, which identifies strengths, symptoms and behaviors of concern, current child functioning, past mental health history, current and past mental health interventions, and a DSM-V or ICD 10 diagnosis.
- Information is obtained regarding the child's family and community, including relevant psychosocial adversities that might be related to the child's symptoms and maladaptation.
- The mental health history of the child's biological family and the response to use psychotropic medication are obtained, whenever possible.
- The child's caregivers are interviewed, not just the child.
- Specific target symptoms are identified, to be subject to monitoring.
- Non-pharmacological, psychosocial interventions are considered before beginning psychotropic medication, except in urgent situations.
- The primary care physician and medical home are familiar with the array of community-based mental health services – both office-based and in-home – available in the local community.
- When psychosocial treatment is not occurring, there is consideration of whether to defer use of psychotropic medication until mental health treatment is implemented.
- Collateral information is obtained from others involved with the child, whenever possible.
- The primary care physician is familiar with the basic classes of psychotropic medication and with common medications within each class used with children and adolescents – including expected therapeutic effects, possible side effects, and potential differences in impact based on the child's diagnosis and developmental level.
- Informed consent is obtained from the appropriate caregiver and the youth age 14 or older (informed assent, if under age 14), involving expected benefits and potential risks of psychotropic medication, alternative treatment approaches, and likely outcomes with and without the medication.
- The primary care physician determines whether to manage the mental health needs of the child in question or to request technical assistance by contacting the Psychiatric Consultation Team serving that practice's region.

When psychotropic medication is being prescribed:

- A clear rationale is provided and documented for the psychotropic medication that is prescribed.
- One psychotropic medication is prescribed at a time.
- Whenever possible, monotherapy is pursued. The goal is always to use as few psychotropic medications as clinically feasible.
- Preferential medication to be prescribed by the primary care physician is one with an existing evidence base or expert consensus for the disorder being treated, and one with limited side effects.
- The medication dose is within commonly accepted limits.
- As part of medication monitoring, the adequacy of dose and the duration of treatment are assessed prior to consideration of a second medication.
- Medication monitoring by the primary care physician includes attention to short-term and long-term benefits, and also to short-term and long-term side effects.
- Metabolic monitoring guidelines for the primary care physician (2004 ADA/APA Consensus Guidelines) related to the use of atypical psychotic medication involve the following:
 - Fasting plasma glucose – baseline, 12 weeks, and then annually
 - Fasting lipid profile – baseline, 12 weeks, and then annually
 - Weight (BMI) – baseline, 4, 8, and 12 weeks, quarterly, and then annually
 - Waist circumference – baseline, 12 weeks, and then annually
 - Blood pressure – baseline, 12 weeks, and then annually
 - Personal/family history – baseline and then annually
- Use of medication combinations (polypharmacy) is based on a clear rationale – e.g., more than a single mental health diagnosis in need of different medications, or clear need for augmentation of treatment for a single treatment-resistant disorder.
- When polypharmacy regimens are needed, medications are prescribed in a systematic, orderly manner, accompanied by ongoing monitoring, evaluation, and documentation.
- Given the significant side effects of atypical antipsychotics, caution is used in prescribing this class of medication, and alternative classes of medication are considered, when clinically appropriate.
- Atypical antipsychotic medication is prescribed in low doses with slow progression, with the goal of using the lowest effective dose.
- Abrupt stopping and switching of psychotropic medication is avoided.
- Gradual medication tapering and discontinuation are considered in response to progress, consistent with current practices.
- In the absence of a positive response to a medication trial of adequate dose and duration, the following are reassessed: medication adherence, the diagnosis, possible co-morbid conditions, and the impact of psychosocial stressors.
- For complex cases, primary care physicians utilize the existing Psychiatric Consultation Team available in their region, to obtain technical assistance in the management of specific children and psychotropic prescribing.

Additional guidelines developed by DHS and endorsed by managed care organizations.

The following prescribing practices may be subject to further review by reviewers of the responsible physical health managed care organization or the Office of Medical Assistance, as applicable:

- Absence of a thorough assessment for the DSM-V or ICD 10 diagnosis in the child's medical record.
- The prescribed medication is not consistent with appropriate care for the patient's diagnosed mental health disorder or with target symptoms usually associated with a therapeutic response to the medication prescribed.
- Two or more medications are prescribed before utilizing psychotropic monotherapy.
- Psychotropic medication dose exceeds the usual recommended doses.
- Concurrent prescribing of the following:
 - Two or more antidepressants for more than 30 days, while switching medications.
 - Two or more antipsychotics for more than 30 days.
 - Three or more mood stabilizers.
 - Two or more stimulants (possible exception: use of long- and short-acting psychostimulant medication).
 - Two or more alpha agonists.
- Concomitant use of psychotropic medication in very young children:
 - Three or more psychotropic medications for children ages three or younger.
 - Four or more psychotropic medications for children four and older.
- Use of psychotropic medication in very young children:
 - Stimulants: less than three years old.
 - Antipsychotics: less than four years old.
 - Antidepressants: less than four years old.
 - Mood stabilizers: less than four years old.
 - Alpha agonists: less than four years old.
- Use of atypical antipsychotic medication in the absence of:
 - Appropriate monitoring of BMI, glucose, lipids, and blood pressure, consistent with ADA/APA Consensus Guidelines (2004).
 - Monitoring for extrapyramidal symptoms (EPS) using the AIMS or other tool at baseline, at three months, and then annually.
- Prescribing by a primary care provider who has not documented previous specialty training, for a diagnosis other than the following (unless recommended by a psychiatric consultant):
 - ADHD
 - Uncomplicated anxiety disorders
 - Uncomplicated depression