

POLICY # 216	SUBJECT: Psychotropic Medication
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Approved By: Carla Benson-Green, Cabinet Secretary	

DELAWARE CHILDREN’S DEPARTMENT POLICY

I. Policy

Children and youth served by the Department of Services for Children, Youth and their Families (DSCYF) should have access to individualized, culturally and linguistically competent and effective trauma-informed prevention, early intervention and treatment services and supports to promote their overall health and wellbeing. Behavioral health services provided to children in foster care and in state-run or contracted residential programs often include evidence-based psychosocial treatments as well as psychotropic medication services. It is the position of the Department that whenever possible, trauma informed, evidence-based psychosocial treatment should begin before or concurrent with the prescription of psychotropic medication. When psychotropic medication services are provided, they should follow established practice parameters. DSCYF is committed to providing oversight of the use of these medications to ensure children’s health and well-being. Department oversight is accomplished through collaboration with children and their families, providers who deliver psychotropic medication services and other community partners (e.g. Division of Medicaid and Medical Assistance, Medicaid Managed Care Organizations).

II. Purpose

The purpose of this policy is to promote the use of best clinical practices regarding the prescribing of psychotropic medication for children in foster care and for those served in state-run or contracted residential facilities. Children who are in the direct custody of DSCYF and/or served in out of home settings require additional safeguards to ensure active participation of each child and their parent in treatment decisions.

III. Definitions

A. Assent: The process by which the prescriber requests willing participation by a child in taking the recommended medication(s). The assent conversation includes providing the child with a developmentally appropriate understanding of why the medication is being prescribed, medication risks and benefits as well as alternative treatment options. (reference 2012 American Academy of Child and Adolescent Psychiatry Guide for Community Child Serving Agencies on Psychotropic Medication for Children and Adolescents available on their website).

B. Child/children/youth: Individuals under the age of 18.

C. Informed Consent: Informed consent is the process by which the prescriber educates the youth and family regarding the youth’s diagnosis and the proposed treatment and monitoring plan. The

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parent or person legally authorized to make health care decisions must be informed and have a full understanding of the risks and benefits of any medications as well as options for alternative or complementary treatments before they give their consent to the prescriber for a medication trial (ref: American Academy of Child and Adolescent Psychiatry:

http://www.aacap.org/app_themes/aacap/docs/press/guide_for_community_child_serving_agencies_on_psychotropic_medications_for_children_and_adolescents_2012.pdf

D. Polypharmacy: The prescribing of more than one psychotropic medication at the same time.

E. Prescriber: A clinician who is authorized to prescribe psychotropic medications including child and adolescent psychiatrists, general psychiatrists, pediatricians, primary care physicians (PCP), neurologists and nurse practitioners.

F. Psychotropic Medication Class: A group of psychotropic medications that may work in a similar way or be used to treat the same condition (e.g., stimulants or antipsychotics).

IV. Informed Consent

Children who receive psychotropic medication and their parents need to be meaningfully engaged in decisions regarding the initiation, change or discontinuation of medication. Providing thorough information regarding recommended psychotropic medications is essential to informed decision making. To ensure that children, youth and families are actively involved in decisions regarding the use of psychotropic medication, DSCYF promotes the following expectations:

A. When a child under 18 years of age is in DSCYF custody or out of home care, it is expected that the child's parent or legal guardian makes decisions regarding the use of psychotropic medication. Limited exceptions for children in DFS custody are outlined in DFS policy (reference DFS User Manual – Services to Youth in Out of Home Care – Placement- Section D Medical Consent and Health Care).

B. Assent to taking medication should be obtained from children under age 18 in a developmentally appropriate way.

C. Except in the case of an emergency, informed consent should be obtained from the appropriate party(s) before beginning psychotropic medication.

D. Prescribers provide information to children and families regarding the child's diagnosis (es), expected benefits and risks of psychotropic medication treatment including potential adverse effects and/or potential drug interactions, and discussion of laboratory studies that may be needed to monitor for adverse effects of medication. Alternative treatments, the risks associated with no treatment, and the overall potential benefit to risk ratio of treatment should be a component of an informed consent discussion.

E. DSCYF contracted prescribers are required to document informed consent for psychotropic medication. Prescribers are encouraged to use the DSCYF informed consent form (see

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Attachment A). If prescribers elect to use an alternative form, a copy of their informed consent document is submitted to the Contract Manager at the time of annual renewal.

V. General Therapeutic Guidelines

DSCYF supports the use of the American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters for the use of Psychotropic medications (reference: http://dcf.psychiatry.ufl.edu/files/2011/05/JAACAP_-_Psychotropic-Meds_2009.pdf). DSCYF requires contracted prescribers to adhere to the AACAP Practice Parameters including::

A. Assessment-informed medication recommendations

1. Prior to initiation of psychotropic medication, prescribers review the child's medical history and where appropriate conduct or request a comprehensive medical evaluation.
2. Prior to initiation of psychotropic medication, the prescriber conducts a comprehensive psychiatric evaluation to establish diagnosis(es) contained in the current version of the diagnostic and statistical manual.

B. Initiation, monitoring and discontinuation of psychotropic medication

1. Clearly defined target symptoms and treatment goals for the use of psychotropic medication should be identified and documented. Target symptoms and goals are reviewed at each visit. Standardized clinical rating scales or other measures should be used when appropriate to establish diagnosis and/or quantify the response of the child's target symptoms to treatment and progress towards treatment goals.
2. Medications typically should be initiated at the lower end of the recommended dose range and titrated carefully as needed ("start low and go slow").
3. Children receive appropriate baseline and follow-up monitoring of indices such as height, weight, blood pressure and laboratory studies based on their specific prescribed medications.
4. Decisions regarding continued medication treatment are made considering benefits and adverse effects and with input from youth and families. During the prescription of psychotropic medication, the presence or absence of adverse medication effects should be documented in the child's medical record at each visit.
5. The decision to treat a child with more than one medication from the same class (e.g. two anti-psychotic medications) should be supported by written documentation by the prescriber in the child's record.

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6. Prescribers who recommend more than 3 psychotropic medications concurrently to one child must justify and document the rationale for doing so in the child's treatment plan.
7. Only one medication should be changed at a time, unless a clinically appropriate reason to do otherwise is documented in the medical record. (Note: starting a new medication and beginning the dose taper of a current medication is considered one medication change).
8. Prescribers consider titrating youth off medication whenever possible but especially when target symptoms have resolved and the child has been stable for six months or more.
9. The use of prn or as needed prescriptions is discouraged. If they are used, the situation indicating need for the administration of a prn medication should be clearly documented as well as maximum dosage in a 24-hour period. Frequency of administration should be monitored to determine if a regularly scheduled medication can be substituted for prn usage.
10. DSCYF strictly prohibits the use of psychotropic medications by its contracted prescribers as a behavior management tool without regard to any therapeutic goal. Psychotropic medication may never be used as a method of discipline or punishment. Psychotropic medications are not to be used in lieu of or as a substitute for identified psychosocial or behavioral interventions and supports required to meet a child's mental health needs.

VI. Monitoring and Oversight

- A. The Division of Prevention and Behavioral Health (DPBH), the Division of Family Services (DFS) and the Division of Youth Rehabilitative Services (DYRS) collect and record psychotropic medication information for children served in residential and foster care settings. This data is utilized for both case specific review as well as to monitor for trends in prescribing.
- B. DPBH, DFS and DYRS monitors the prescribing of antipsychotic medications provided to children served in foster care and state-run and contracted residential programs for adherence to the HEDIS measures for the use of antipsychotic medication by children. These measures include:
 1. Limiting the use of antipsychotic medication for children under the age of six
 2. Limiting the use of two or more antipsychotics concurrently for children for more than 90 days
 3. Use of metabolic testing for children receiving antipsychotic medication
 4. Use of psychosocial therapy prior to the use of antipsychotic medication

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- C. If the prescribing of antipsychotic medication(s) is not consistent with the HEDIS measures listed above, the active Division(s) will arrange for a consultation with the prescriber to discuss the concerns and where appropriate provide recommendations for modification to the current treatment plan.
- D. DBPH, DFS and DYRS monitor to ensure that informed consent has been obtained from the child's parent or other legally authorized adult.
- E. DSCYF contracts for services which include psychotropic medication will have language promoting the use of the AACAP Practice Parameters and the requirements for informed consent.
- F. Divisions provide an annual report to the DSCYF Cabinet Secretary on the use of psychotropic medications for children in foster care and in state-run and contracted residential services. Data includes the number/percent of children receiving psychotropic medication, number/percent receiving antipsychotic medications and the number of consultations completed.

VII. Education and Training

- A. The Department provides general information on psychotropic medication for children and families on its website.
- B. The Department ensure that case managers working with children and families in residential, hospital and foster care have access to training on psychotropic medication.

VIII. Responsibility for this policy

The Department Psychotropic Medication Workgroup has responsibility for the oversight of this policy.