Psychotropic Medication Toolkit for Public Children Services Agencies

PCSAO Behavioral Health Leadership Group

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Introduction

The Fostering Connections to Success and Increasing Adoptions Act of 2008 required that state child welfare agencies develop plans for oversight and coordination of health care services, including use of prescription medications, for children in foster care. This work was to be completed in consultation with the state Medicaid agency, health care experts, child welfare experts, and recipients of child welfare services. On September 30, 2011, the Child and Family Services Improvement and Innovation Act enhanced these requirements by mandating that each state's health care plan also delineate "protocols for the appropriate use and monitoring of psychotropic medications."

Due to having histories of maltreatment and trauma, children in foster care frequently demonstrate symptoms of behavioral health conditions for which psychotropic medications are commonly prescribed. While such medications are often necessary, national and statewide data show a high rate of poly-psychopharmacology prescriptions among children and youth in the custody of the child welfare system:

- **23 percent** of children age 17 and younger who have experienced maltreatment have behavior problems requiring clinical intervention. Clinical-level behavior problems are **almost three times** as common among this population as among the general population.

- **35 percent** of children age 17 and younger who have experienced maltreatment demonstrate clinical-level problems with social skills. This rate is **more than twice** that of the general population.[1]

- Children in foster care are more likely to have a mental health diagnosis than other children. In a study of foster youth between the ages of 14 and 17, **63 percent** met the criteria for at least one mental health diagnosis at some point in their lives. The most common diagnoses were Oppositional Defiant Disorder/Conduct Disorder, Major Depressive Disorder/Major Depressive Episode, Attention Deficit/Hyperactivity Disorder, and Post-Traumatic Stress Disorder.

- According to one study, by the time youth in foster care reach age 17, **62 percent** will exhibit both the symptoms of a mental health disorder and the symptoms of trauma.[2]

- Although they make up **only 3 percent** of the Medicaid population under age 18, children in foster care **account for 32 percent** of the recipients of behavioral health services in this age group. [3]

1. White, CR; Havalchak, A; Jackson, L; O'Brien, K; & Pecora, PJ. (2007). Mental Health, Ethnicity, and Spirituality among Youth in Foster Care: Findings from The Casey Field Office Mental Health Study. Casey Family Programs.

2. Griffin, G; McClelland, Holzberg, M; Stolbach, B; Maj, N; & Kisiel, C (In Press). Addressing the impact of trauma before diagnosing mental illness in child welfare. Child Welfare.

3. Center for Health Care Strategies, Inc. (Forthcoming). Analysis of Medicaid Claims Data for 2005.

- Children in foster care receive antipsychotic medications at a rate of **almost nine times** that of other Medicaid-eligible children, though they represent only 3 percent of that population.[4]
- Of children in foster care taking psychotropic medication,
  - **21.3 percent** take one class of medication;
  - **41.3 percent** take three or more;
  - **15.4 percent** take four or more; and
  - **2.1 percent** take five or more.[5]

When used appropriately, psychotropic medications are often an essential treatment component and necessary to effectively address the multiple needs of children in care. Given the complexity of pharmacological interventions, consistent oversight and monitoring of medication use are critical. As the custodians for children in care, public children services agencies (PCSAs) have a profound responsibility to focus not only on safety and permanency, but also on improving the well-being of children in care. Ultimately, PCSAs are required to authorize use of medication if birth or adoptive parents are unavailable to consent. This responsibility requires knowledge of specific medications, effective interventions, best practices, policies, procedures, and practice guidelines.

To better address this issue, the Public Children Services Association of Ohio (PCSAO) established the Behavioral Health Leadership Group (BHLG) in February 2012. BHLG membership included state and local child welfare entities, as well as public and private providers. Representatives included 15 PCSAs, including both rural and urban jurisdictions; the Ohio Association of County Behavioral Health Authorities; the Ohio Association of Child Caring Agencies; the Ohio Council of Behavioral Health and Family Service Providers; and the Ohio Departments of: Job and Family Services, Mental Health and Addiction Services, Youth Services, Education, Health, and Developmental Disabilities. Technical assistance was provided by Vorys Health Care Advisors.

The BHLG developed this toolkit to guide PCSAs' oversight of psychotropic medication use by children and youth in the custody of Ohio's child welfare system. The recommendations put forth were selected following review of other published works, including Guidelines on Managing Psychotropic Medications from the American Academy of Child and Adolescent Psychiatrists, other state plans (i.e., Connecticut and Texas) and local Ohio child welfare agencies' policies (i.e., those used in Lucas and Summit counties). In 2021, the Toolkit was revised to include updated information about frequently prescribed medications, diagnostic tools, and safe use thresholds by age.

4. Crystal, S; Olfson, M; Huang, C; Pincus, H; & Gerhard, T. (2009). Broadened use of atypical antipsychotics: Safety, effectiveness, and policy challenges. Health Affairs, 28(5):770.

5. Zito, JM; et al., (2008). Psychotropic medication patterns among youth in foster care. Pediatrics. 121(1): e157.

About the Toolkit

This toolkit is comprised of six sections:

- Policy Development
- Practice: Guidelines and Definitions
- Procedures
- Orientation and Training
- Ongoing Monitoring and Evaluation
- Information Sharing

In recognition that community needs and available resources vary, three levels of recommendation are offered under each section, where applicable. Basic recommendations serve as the foundation for practice; enhanced and ideal categories illustrate additional options for consideration.

Throughout this document, the following definitions are used:

- **Psychotropic medication** – medications used to treat mental health conditions; medications that affect the mind, emotions, and behavior.

- **Antipsychotic medications** – a class of psychotropic medications used to treat serious mental disorders (for example, psychosis, schizophrenia, and other disorders that may lead to psychosis, including bipolar disorder).

- **Polypharmacy** – the use of multiple medications at the same time.

A list of reference documents concerning frequently prescribed medications and dosage thresholds are found at the end of the toolkit recommendations.

Sections

I. Policy Development

A. Involving stakeholders to define the issue and generate practical suggestions for implementing informed consent/approval process. Stakeholders include the following:

1. Foster parents or other substitute caregivers **(Basic)**

2. Caseworkers, supervisors, and administrators **(Basic)**

3. Main provider agencies **(Basic)**

4. Inpatient units and psychiatrists **(Basic)**

5. Biological parents of children in agency custody **(Enhanced)**

6. Children **(Enhanced)**

7. Other physicians and nurses **(Enhanced)**

8. Judges and attorneys **(Ideal)**

9. School personnel **(Ideal)**

B. Determining ultimate authority, designees, and medical consultations: *
   * Obtain legal consultation for parameters of authority.

1. Authority for final informed consent for medication:

   a. Executive director or designee **(Basic)**

   b. PCSA case worker or supervisor (provides informed consent for continuation of maintenance level-of-medication or dose adjustment when dose remains within accepted prescribing timelines) **(Basic)**

   c. Executive director or designee with medical background **(Enhanced)**

   d. Executive director with psychiatric consultation **(Ideal)**

2. After hours/emergency approval:

   a. "On-call" child welfare staff give preliminary approval within prescribing guidelines **(Basic)**

   b. "On-call" child welfare supervisor gives approval within prescribing guidelines **(Enhanced)**

   c. Executive director or designee with medical background gives approval following psychiatric consultation **(Ideal)**

3. Parental consent:

   a. Notification given, consent not required when medications are within prescribing guidelines **(Basic)**

   b. Consent requested when prescribed medications are not within guidelines **(Basic)**

   c. Consent required for changes in type of medication **(Enhanced)**

   d. Consent required for any medication change **(Ideal)**

4. Assent from youth:

   a. Risks benefits explained, no assent requested or required **(Basic)**

   b. Assent from children age 15 or older when not clinically contraindicated **(Enhanced)**

   c. Assent from any school-age child when not clinically contraindicated **(Ideal)**

5. Consultation from medical or psychiatric authority:

   a. Required prior to finalizing policy **(Basic)**
   b. Required when medications do not fall within prescribing guidelines **(Enhanced)**
   c. All of the above, with periodic random review of psychotropic database **(Ideal)**

C. **Use of a "Preferred Provider" list:**

   1. Consider **(Basic)**
   2. Develop **(Enhanced)**
   3. Consistently implement **(Ideal)**

II. Psychotropic Medication Practices and Guidelines

A. **Definition of covered medications:**

   1. Non-psychiatric medications used for symptoms related to a behavioral health diagnosis **(Basic)**

   2. All over-the-counter medications used to treat behavioral health symptoms/conditions **(Basic)**

   3. All known substances used by the youth, including alcohol, tobacco, and other drugs **(Basic)**

   4. Items one through four, plus nutritional supplements used on a regular basis **(Enhanced)**

   5. Items one through five, plus over-the-counter medications used on an as-needed basis **(Ideal)**

B. Prescriber criteria:

1. Approved prescribers:

   a. Any clinician licensed to prescribe medication **(Basic)**

   b. Any clinician licensed to prescribe medication who is specially trained **(Enhanced)**

   c. Board-certified or -eligible child/adolescent psychiatrists and developmental behavioral pediatricians **(Ideal)**

2. Medication management for a stable child on maintenance doses of medications:

   a. Any clinician licensed to prescribe medication **(Basic)**

   b. Any clinician licensed to prescribe medication, with major changes overseen by clinicians who are specially trained **(Enhanced)**

   c. Child/adolescent psychiatrists **(Ideal)**

C. Informed consent parameters and medical consultation:

1. Informed consent procedure:

   a. Initial informed consent by executive director or designee for a medication; continued informed consent for changes in same medication by child welfare manager or supervisor when changes are within prescribing parameters **(Basic)**

   b. Initial and continued informed consent always the responsibility of executive director or designee **(Enhanced)**

2. Approval timeline for informed consent:

   a. Within one business day **(Basic)**

   b. On the same business day **(Enhanced)**

   c. Executive director or designee with approving authority is present at the medical appointment, either in person or via conference call, and participates in the informed consent discussion **(Ideal)**

3. Informed consent in psychiatric emergencies:

   a. Covered by the consent for treatment form **(Basic)**

   b. "On-call" child welfare staff give approval if request is within prescribing parameters **(Enhanced)**

   c. Executive director or designee with medical background gives approval following psychiatric consultation **(Ideal)**

4. Medical expert consulted if prescribing is not within prescribing parameters **(Enhanced)**

   a. When medication doesn't "match" diagnosis

   b. When dosages are not within recommended prescribing parameters

   c. When polypharmacy is used without a pretrial of monopharmacy

   d. When four or more psychotropics are used concurrently

   e. For two or more concurrent antidepressants

   f. For two or more concurrent antipsychotics

   g. For two or more concurrent stimulants

   h. For three or more concurrent mood stabilizers

   i. For all children under 6 years of age

   j. For children with three or more mental health hospital admissions during any one-month period

   k. When executive director or designee is not satisfied by the prescriber's justification for medication use.

III. Procedures

A. Approvals for youth on medication prior to policy/procedure implementation

1. Identify information needed immediately at the time of screening (See Appendix 2) and document the checklist data in the psychotropic medication file for each child,. This includes:

   a. Name, age, height, and weight of child **(Basic)**

   b. Name of provider **(Basic)**

   c. Psychotropic medications, dosage, route, and times **(Basic)**

   d. Diagnostic assessment with Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) diagnosis, if available **(Enhanced)**

   e. Individualized service plan, if available **(Ideal)**

   f. Medication history (may be part of diagnostic assessment) **(Ideal)**

   g. Most recent progress note from a medical doctor **(Ideal)**

B. Documentation

1. Consistent filing of information in the Statewide Automated Child Welfare Information System (SACWIS) record **(Basic)**

2. Create and maintain a Psychotropic Medication Information Checklist and spreadsheet for each child for easy access to current information (see Appendix 2); checklist/spreadsheet should include the following: **(Enhanced)**

a. Child name, age, height, and weight

b. Provider name and credentials

c. DSM-V diagnosis

d. Symptoms addressed by prescribed medication

e. Risks and benefits of medication

f. Other interventions ordered (for example, therapies and behavioral interventions)

g. Accept provider's informed consent form (when above data elements are included).

C. Procedure for youth on psychotropics when taken into custody: **(Basic)**

1. Consider "preliminary approval" status if current medications "match" DSM-V diagnosis and are within recommended dosage parameters.

2. <u>Establish timelines for medication review and approval process with the following steps</u>:

   a. PCSA caseworker obtains Psychotropic Medication Information Checklist data and documents it in the Psychotropic Medication File and SACWIS.

   b. PCSA caseworker notifies the behavioral health provider of agency approval process (if not on "Active Provider" list).

   c. PCSA caseworker ensures that the prescriber provides information contained in the Medication Authorization Form.

   d. PCSA caseworker reviews agency policy/procedure with the out–of-home care provider and obtains/documents provider's input about the use of specified psychotropic medications.

   e. Process for executive director or designee to have questions answered by the provider.

   f. PCSA caseworker or PCSA nurse, as assigned by the executive director, communicates informed consent for the psychotropic medications by doing the following:

      1. Notifies the caregiver to continue medication without interruption.

      2. Consults with medical advisers if there are questions or concerns about the psychotropic medication, or whenever the prescribed medication is not within recommended medication parameters.

      3. Submits the request for executive director's or designee's authorization after all information is obtained and reviewed and notifies the substitute caregiver and the physician if informed consent is not granted.

      4. Documents all the information in SACWIS and the Psychotropic Medication Information Checklist.

      5. Regularly monitors medication adherence and child's and caregiver's roles in adherence.

D. Procedure for youth identified as possibly benefitting from psychotropics after being taken into custody: (Basic)

1. <u>Establish timelines for each of the following steps, to be conducted by a PCSA caseworker unless otherwise noted</u>:

   a. Conducting a screening to identify possible behavioral health concerns, especially trauma.

   b. Securing diagnostic, psychological and/or psychiatric assessments, or any referral to behavioral health providers as deemed appropriate by the child's team.

   c. Informing the substitute caregiver or nurse that an assessment is requested.

   d. Making an appointment with a behavioral health provider and communicate appointment date and time to the substitute caregiver.

   e. Informing the behavioral health provider of agency policies on psychotropic medications before or during the appointment.

   f. Attending the initial appointment, and any other appointments during which a psychotropic medication may be prescribed. For youth placed out of county, the caseworker must attend psychiatric appointments at least quarterly.

   g. Documenting diagnosis, symptoms to be addressed with medications, potential risks, expected benefits, medication name, route, dose, and time(s) to be administered (PCSA caseworker or PCSA nurse as assigned by the executive director).

   h. Communicating the name, benefits, and risks of the medication to the child (as developmentally appropriate) and to the caregiver; obtaining and documenting the child's and caregiver's inputs.

   i. Communicating the child's response to the medication to the behavioral health provider, PCSA nurse and substitute caregiver; documenting the child's response to the medication in the record.

   j. Ensuring that the prescriber provides information as contained on the Medication Authorization Form and emails it to the executive director or designee.

   k. Reviewing information and providing informed consent for the psychotropic medications; communicating the decision to the PCSA caseworker (executive director or designee).

      1. If the executive director or designee cannot provide informed consent, the provider must be contacted to share concerns.

      2. If the executive director or designee still is not able to provide informed consent following discussion with provider, he or she shall contact the agency's medical expert.

      3. The caseworker communicates the final decision to the behavioral health provider, out-of-home care provider, child and/or nurse.

l. Filling and administering the medication after approval is received (out-of-home care provider).

m. Contacting the pharmacy if the prescription was electronic and the informed consent was not given (PCSA caseworker or PCSA nurse as assigned by the executive director).

n. Documenting all the information in SACWIS and on the Psychotropic Medication Information Checklist (PCSA caseworker or PCSA nurse as assigned by the executive director).

E. Emergency procedures:

1. Agencies must:

   a. Define "psychiatric emergency." For example, a psychiatric emergency exists when a person needs to be treated by emergency healthcare providers for conditions, symptoms or behaviors that are causing or might cause a danger to self or others, and are or might be related to a diagnosable behavioral health condition.

   b. Determine whether general phone consent for emergency treatment includes a blanket authorization for use of psychotropic medications as determined by an emergency room physician during the course of emergency treatment.

   c. Determine whether the consent for psychotropics administered during the course of emergency psychiatric care extend to any prescriptions written by the emergency room physician for administration until the child can be seen by an outpatient behavioral health provider.

2. The PCSA caseworker must obtain a list of all psychotropic medications used during the course of emergency psychiatric treatment, document them in SACWIS and on the Psychotropic Medication Information Checklist and forward it to the executive director or designee.

F. Inpatient psychiatric episodes:

1. Agencies must determine:

   a. Whether a blanket emergency consent (if in agency's policy) extends through the first 24 hours of hospitalization if the child in care is admitted for inpatient psychiatric treatment.

   b. Whether executive director or designee approval will be required prior to administration of psychotropic medication in hospital settings.

   c. How recommended medications change requirements will be handled at night and on weekends.

   d. Whether "pro re nata" (as necessary) medications can be approved for administration at the discretion of a registered nurse.

IV. Orientation and Training

A. Determine which of the following stakeholders need to be trained:

1. Substitute care caseworkers, out-of-home or foster care providers and behavioral health prescribers **(Basic)**

2. All PCSA caseworkers, child welfare supervisors and administrators, all behavioral health providers (including non-prescribers and administrators) **(Enhanced)**

3. Foster parents or other substitute caregivers; PCSA caseworkers, supervisors, and administrators; provider agencies; biological parents; judges and attorneys; school personnel; children; behavioral health providers (including psychiatrists and inpatient staff); and other physicians and nurses **(Ideal)**

B. Determine training content:

1. Policy procedures and use of specific forms **(Basic)**

2. Procedure implementation, description of national and local issues, and related data analyses **(Enhanced)**

3. Procedure implementation; description of national and local issues; related data analyses; overview of commonly used psychotropics, including their intended uses, risks, benefits, and side effects; and an overview of common psychiatric diagnoses in children and adolescents **(Ideal)**

V. Ongoing Monitoring and Evaluation

A. Data to be collected, aggregated, and analyzed:

1. Approved prescriptions that exceed parameters, listed by medication, the reason why it's being administered, and the name of the behavioral health provider **(Basic)**

2. Instances when consent is not granted and the reason **(Basic)**

3. Adverse medication reactions, including the name of the medication, dose, description of the reaction, and the name of the behavioral health provider **(Basic)**

4. Approved prescriptions that exceed parameters, listed by medication, the reason why it's being administered, and the name of the behavioral health provider; instances when consent is not granted and the reason; adverse medication reactions, including the name of the medication, dose, description of the reaction, and the name of the behavioral health provider; and policy/procedure feedback from providers, caseworkers, out-of-home care providers and youth **(Enhanced)**

5. Approved prescriptions that exceed parameters, listed by medication, the reason why it's being administered, and the name of the behavioral health provider; instances when consent is not granted and the reason; adverse medication reactions, including the name of the medication, dose, description of the reaction, and the name of the behavioral health provider; policy/procedure

feedback from providers, caseworkers, out-of-home care providers and youth; behavioral health treatment outcomes, listed by child, behavioral health provider and service combination; data identical to that collected by the Ohio Psychotropic Medication Quality Improvement Collaborative; and quarterly state- and county-level reports regarding the rates and types of psychotropic medication used by children in care **(Ideal)**

VI. Information-Sharing Mechanisms

A. Releases of information specific to the behavioral health provider **(Basic)**

B. Memoranda of understanding among providers working with the youth and family **(Enhanced)**

C. Sharing of electronic health-related information among providers working with the youth and family **(Ideal)**

D. Establishment and maintenance of a website that provides ready access to pertinent policies and procedures governing psychotropic medication management by clinicians, foster parents, and other caregivers. The website should include psycho- educational materials, consent forms, adverse effect rating forms and reports on prescription patterns for psychotropic medications **(Ideal)**

PCSAO Reference Table for Psychotropic Medication Dosage Thresholds in Children

This reference chart is to be used a guide to inform consumers about the most common drugs used by providers to treat mental health disorders in children and adolescents.

Important considerations:

- These medications are **NOT** recommended for children under 6 years old.

- Doctors usually **start at the lowest dose**, **then increase the dose if needed**. Maximum dose may not be necessary for your child to feel better.

- It is important that children do not self-medicate. The medication is to be taken **as prescribed by the provider.** Always talk to the provider or pharmacist if there are questions regarding the prescription.

Consider talking with your provider and/or pharmacist when:

- The dosage is greater those listed in tables A through F, and/or

- When the patient is prescribed:
    - Four or more psychotropics (Tables A through E)
    - Two or more antidepressants (Table C)
    - Two or more stimulants (Tables A, B)
    - Two or more mood stabilizers (Table E)
    - Two or more antipsychotics (Table D)

This reference chart lists name-brand and generic drug names. Some drugs are available in extended release formulations, allowing for once-a-day dosing, and are not listed individually.

TABLE A

Stimulants for the treatment of Attention deficit Hyperactivity Disorder (ADHD)			
Generic name	Brand name	Maximum Dose (mg) Children 6-12 years	Maximum Dose (mg) Adolescents 13-17 years
Amphetamine	Evekeo	40	40
Amphetamine XR	Adzenys ER, Adzenys XR-ODT	18.8	12.5
Amphetamine and Dextroamphetamine	Adderall	60	60
Amphetamine and Dextroamphetamine XR	Adderall XR	60	60
Amphetamine and dextroamphetamine XR	Mydayis	Not approved	25
Dexmethylphenidate	Focalin	20	20
Dexmethylphenidate XR	Focalin XR	30	30
Dextroamphetamine	Dexedrine, Procentra, Zenzedi	40	40
Dextroamphetamine XR	Dexedrine XR	60	60
Lisdexamfetamine	Vyvanse	70	70
Methylphenidate	Ritalin, Methylin	60	60
Methylphenidate Patch	Daytrana TD	30	30
Methylphenidate XR	Adhansia XR, Aptensio XR	85	85
Methylphenidate XR	Concerta	54	72
Methylphenidate XR	Jornay PM	100	100
Methylphenidate XR	Metadate CD, QuilliChew ER, Quillivant XR, Ritalin LA	60	60
Methylphenidate SR	Metadate ER, Ritalin SR	60	60

TABLE B

Other (non-stimulant) ADHD treatments			
Generic name	Brand name	Maximum Dose (mg) Children 6-12 years	Maximum Dose (mg) Adolescents 13-17 years
Atomoxetine	Stattera	100	100
Bupropion	Wellbutrin, Aplenzin, Forvivo	450	450
Clonidine	Catapres	0.4	0.4
Clonidine XR	Kapvay	0.4	0.4
Guanfacine	Tenex	4	4
Guanfacine XR	Intuniv	4	7
Imipramine	Tofranil	200	200
Nortriptyline	Aventyl, Pamelor	100	100

TABLE C

	Antidepressants		
Generic Name	**Brand Name**	**Maximum Dose (mg) children 6-12 years**	**Maximum dose (mg) Adolescents 13-17 years**
Citalopram	Celexa	40	40
Escitalopram	Lexapro	Not enough information	20
Fluoxetine	Prozac	20	20
Paroxetine	Paxil	Not enough information	Not enough information
Sertraline	Zoloft	200	200
Desvenlafaxine	Pristiq	Not enough information	Not enough information
Duloxetine	Cymbalta	120	120
Bupropion	Wellbutrin, Aplenzin	400	400
Bupropion XL	Wellbutrin XL, Forfivo XL	400	400
Venlafaxine	Effexor	Not enough information	Not enough information
Venlafaxine ER	Effexor XR	Not enough information	Not enough information

TABLE D

	Antipsychotics (Note: Some can be given as an injection at the provider's office)		
Generic name	**Brand name**	**Maximum dose (mg) Children 6-12 years**	**Maximum dose (mg) adolescents 13-17 years**
Chlorpromazine	Thorazine	75	800
Haloperidol	Haldol	Not enough information	15
Perphenazine	Trilafon	Not enough information	64
Aripiprazole	Abilify	15	30
Asenapine	Saphris	Not enough information	20
Clozapine	Clozaril, Fazaclo	400	400
Olanzapine	Zyprexa	20	20
Quetiapine	Seroquel	600	800
Risperidone	Risperdal	3	3
Ziprasidone	Geodon	160	160
Lurasidone	Latuda	Not enough information	80

TABLE E

Mood Stabilizers and Medications for Behavioral Disorders			
Generic name	**Brand name**	**Maximum dose (mg) Children 6-12 years**	**Maximum dose (mg) adolescents 13-17 years**
*Carbamazepine	Carbatrol, Tegretol	1000	1200
*Divalproex (sodium)	Depakote	Not recommended	1000
*Lamotrigine	Lamictal	300	300
Lithium	Eskalith	Blood level	Blood level
Lithium	Lithobid	Blood level	Blood level

*Can be used as anticonvulsant/anti-seizure
medication

Appendix 1: Toolkit Chart

Psychotropic Medication Policy Guidelines for Children in the Care of PCSAs

POLICY DEVELOPMENT			
COMPONENT	**BASIC**	**ENHANCED (Basic, Plus)**	**IDEAL (Enhanced, Plus)**
Stakeholder Involvement	Foster parents or other substitute caregivers Caseworkers, supervisors and administrators Main provider agencies Inpatient units and psychiatrists	Biological parents of children in agency custody Children Other physicians and nurses	Judges and attorneys School personnel
Authority to Provide Informed Consent *(Obtain legal consultation for parameters of authority.)*	Executive director or designee Caseworker or supervisor for continuation of medication or dose adjustment when it remains within accepted prescribing parameters.	Executive director or designee who has a medical or behavioral health background	Executive director in conjunction with psychiatric consultation
After-Hours/ Emergency Approvals	"On-call" child welfare staff give preliminary approval within prescribing guidelines	"On-call" child welfare supervisor gives approval within prescribing guidelines	Executive director or designee with behavioral health or medical background in conjunction with psychiatric consultation
Parental Consent	Notification given, consent not required if prescribed medications are within prescribing guidelines Requested if prescribed medications are not within prescribing guidelines	Required for changes in type of medication	Required for any medication change
Assent from Youth	Risks and benefits explained, no assent requested or required	Assent from age 15 or older when not clinically contraindicated	Assent from any school-age child when not clinically contraindicated
Consultation from Medical/Psychiatric Authority	Prior to finalizing policy	When medications do not fall within prescribing guidelines	Periodic random reviews of psychotropic database
Preferred Provider List	Is considered	Is developed	Is consistently implemented

PSYCHOTROPIC MEDICATION PRACTICE: GUIDELINES AND DEFINITIONS

COMPONENT	BASIC	ENHANCED (Basic, Plus)	IDEAL (Enhanced, Plus)
Definition of Covered Medications	Psychotropic medications used for symptoms related to a behavioral health diagnosis Non-psychiatric medications used for symptoms related to a behavioral health diagnosis All over-the-counter medications used on a regular basis All known substances used by the youth, including alcohol, tobacco, and other drugs	Nutritional supplements used on a regular basis	Over-the-counter medications used on an as-needed basis
Approved Prescriber Criteria	Any clinician licensed to prescribe medications	Any clinician with prescriptive authority who is specially trained	Board--certified or -eligible child/adolescent psychiatrists; developmental pediatricians
Medication Management *(For a stable child on maintenance doses)*	Any clinician licensed to prescribe medication	Any clinician licensed to prescribe medication with major changes handled by clinician with prescriptive authority who is specially trained	Child/adolescent psychiatrists
Informed Consent *(Parameters and Medical Consultation)*	Initial informed consent by executive director or designee for a medication Continued informed consent for changes in same medication at manager or supervisor level if changes are within prescribing parameters	Informed consent is always the responsibility of executive director or designee	
Informed Consent *(Timelines)*	Within one business day	Within the same business day	Executive director or designee participates in the informed consent discussion (in person or via conference call)
Informed Consent *(Psychiatric Emergencies)*	Covered by the consent for treatment form	Emergency/ "n-call" child welfare staff approve if within prescribing parameters Executive director or designee approves when outside of prescribing parameters	Authority as defined in previous column is contacted in all psychiatric emergencies

PSYCHOTROPIC MEDICATION PRACTICE: GUIDELINES AND DEFINITIONS, Continued			
COMPONENT	**BASIC**	**ENHANCED (Basic, Plus)**	**IDEAL (Enhanced, Plus)**
Consultation with Medical Expert **When Prescription Is Not Within Prescribing Parameters**		When medication doesn't "match" diagnosis When dosages are not within recommended prescribing parameters When polypharmacy is used without a pretrial of monopharmacy When four or more psychotropics are used concurrently When two or more antidepressants are used concurrently When two or more antipsychotics are used concurrently When two or more stimulants are used concurrently When three or more mood stabilizers are used concurrently For all children under 6 years old When child has had three or more mental health hospitalizations during any one-month period. When executive director or designee is not satisfied with the prescriber's justification for medication use	

	PROCEDURES		
COMPONENT	BASIC	ENHANCED (Basic, Plus)	IDEAL (Enhanced, Plus)
Approvals for youth on medication Prior to Policy/Procedure Implementation *Identify information needed immediately at the time of screening and document the checklist data in the psychotropic medication file for each child (see Appendix 2 - Psychotropic Medication Information Checklist)*	Name, age, height, and weight of child Name of behavioral health provider Psychotropic medications, dosage, route and times	Obtain diagnostic assessment with DSM-V diagnosis (if available)	Obtain individualized service plan if available Obtain medication history (may be part of diagnostic assessment) Obtain most recent medical doctor progress note
Documentation	Consistent filing of information in SACWIS record Create and maintain a psychotropic medication file and spreadsheet for each child for easy access to current information	Create a Psychotropic Medication Information Checklist* that includes the following: Child name, age, height, and weight Provider name and credentials DSM-IV Diagnosis Symptoms addressed by prescribed medication Risks and benefits of medication Other interventions ordered (for example, therapy and behavioral interventions) *Accept provider's Informed consent form if above is included.	

PROCEDURES	
COMPONENT	**BASIC**
Timelines for Medication Review and Approval Processes	• PCSA caseworker obtains Psychotropic Medication Information Checklist data and documents it in the system. * • PCSA caseworker notifies the prescriber of agency approval process if not on "Active Provider" list (when applicable). • PCSA caseworker ensures that the prescriber completes the Medication Authorization Form, if information is not contained within behavioral health care documents. • PCSA caseworker reviews Agency Policy/Procedure with the out-of-home care provider; obtains and documents care provider's input regarding use of specified psychotropic medications. • Executive director or designee establishes a process to have questions answered by the provider. *All information is to be documented in SACWIS and on the Psychotropic Medication Information Checklist*
Procedure for Youth on Psychotropics when Taken into Custody	Consider "preliminary approval" status if current medications "match" DSM-V diagnosis and are within recommended dosage parameters. **COMMUNICATION OF INFORMED CONSENT**: • As assigned by the executive director, the PCSA caseworker or PCSA nurse (where available) notifies the caregiver to continue medication without interruption. • The PCSA caseworker or PCSA nurse consults medical experts if there are questions or concerns about the psychotropic medication, or whenever the prescribed medication is not within recommended medication parameters. • The PCSA caseworker or PCSA nurse submits request for executive director's or designee's authorization after all information is obtained and reviewed. • Once initial informed consent for a medication is given by executive director or designee, the PCSA caseworker or PCSA nurse communicates the decision with the caregiver and child. • The executive director or designee provides informed consent; the executive director or designee may choose to delegate authorization of adjustments to the caseworker or child welfare supervisor when within prescribing parameters. • PCSA caseworker or PCSA nurse regularly monitors medication compliance and role of child and caregiver in adherence. **IF CONSENT IS <u>NOT</u> GRANTED:** The PCSA caseworker or PCSA nurse, as assigned by the executive director, notifies the substitute caregiver and physician of this decision. *All information is to be documented in SACWIS and on the Psychotropic Medication Information Checklist.*

PROCEDURES	
COMPONENT	**BASIC**
Procedures for Youth Identified as Possibly Benefitting from Psychotropic Medication After Being Taken into Custody	**COMMUNICATION OF INFORMED CONSENT**: • The caseworker ensures that the prescriber provides information identified on the Medication Authorization Form and forwards (emails) it to the executive director or designee. • Executive director or designee reviews medication recommendation and provides informed consent for the psychotropic medications to the prescriber/behavioral health provider. • Executive director or designee communicates the decision to the PCSA caseworker. • The PCSA caseworker communicates the final decision to the out-of-home care provider and the child. • Out-of-home care provider fills prescription and administers medication after approval is received. • PCSA caseworker documents the child's response to the psychotropic medications and communicates his/her response to the behavioral health provider, nurse (where available) and substitute caregiver. * **IF CONSENT IS <u>NOT</u> GRANTED:** • Executive director or designee contacts provider to share concerns. • If still unable to provide informed consent following discussion with provider, executive director, or designee contacts agency's medical expert. • PCSA caseworker or PCSA nurse contacts the pharmacy if the prescription was filed electronically and informs them that consent is not given. ***All required information is to be documented in SACWIS and on the Psychotropic Medication Information Checklist.*** Each agency must decide whether subsequent adjustments to already approved medications require the same level of approval if within acceptable parameters.

PROCEDURES	
COMPONENT	**BASIC**
Emergency Procedures	**EACH CHILD WELFARE AGENCY MUST:** • Define "psychiatric emergency." (For example, a psychiatric emergency exists when a person needs to be treated by emergency healthcare providers for conditions, symptoms or behaviors that are causing or might cause a danger to self or others and/or might be related to a diagnosable behavioral health condition.) • Determine whether general phone consent for emergency treatment includes blanket consent for use of psychotropic medications as determined by an emergency room physician during the course of emergency treatment. • Determine whether the consent for psychotropics administered during the course of emergency psychiatric care extends to any prescriptions written by the emergency room physician, and if such medications are to be administered until the child is seen by behavioral health provider on an outpatient basis. **The caseworker must obtain a list of <u>all</u> psychotropic medications used during the course of emergency psychiatric treatment, document them in SACWIS and on the Psychotropic Medication Information Checklist and forward it to the executive director or designee.**
Inpatient Psychiatric Episodes **Hospital Settings**	**EACH CHILD WELFARE AGENCY MUST DETERMINE:** • Whether a blanket emergency consent (if in policy) extends through the first 24 hours of hospitalization when a child in care is admitted for inpatient psychiatric treatment. • Whether executive director or designee approval will be required prior to administration of psychotropic medication in hospital settings. • How recommended medication change requests be handled at night and on weekends. • Whether PRN medications can be approved for administration at the discretion of a registered nurse.

ORIENTATION AND TRAINING

COMPONENT	BASIC	ENHANCED (Basic, Plus)	IDEAL (Enhanced, Plus)
Who?	Substitute care child welfare caseworkers Care providers Behavioral health prescribers	All caseworkers Child welfare supervisors and administrators All behavioral health providers (including non-prescribers and agency administrators)	Foster parents or other substitute caregivers Caseworkers, supervisors, and administrators Main provider agencies Biological parents of children in agency custody Judges and attorneys School personnel Children Behavioral health providers, including psychiatrists and inpatient staff Other physicians and nurses
What?	Policy implementation procedures and use of specific forms	Description of national and local issues and results of related data analyses	Overview of commonly used psychotropics, including their intended uses, risks and benefits, and side effects, with an overview of common psychiatric diagnoses in children and adolescents.

ONGOING MONITORING AND EVALUATION			
COMPONENT	**BASIC**	**ENHANCED (Basic, Plus)**	**IDEAL (Enhanced, Plus)**
Data to be collected, aggregated, and analyzed	Approved prescriptions that exceed parameters, listed by medication, the reason why they're approved and the name of the behavioral health provider When consent is not granted and the reason Adverse medication reactions, including the name of the medication, dose, description of reaction and the name of the behavioral health provider	Policy/procedure feedback from providers, caseworkers, out-of-home care providers and youth	Behavioral health treatment outcomes, listed by child, behavioral health provider and service combination; this may be obtained from some providers certified by the Ohio Department of Mental Health and Addiction Services. Data identical to that collected by the Ohio Psychotropic Medication Quality Improvement Collaborative. Quarterly state- and county-level reports regarding the rates and types of psychotropic medication used by children in care

INFORMATION SHARING			
COMPONENT	**BASIC**	**ENHANCED**	**IDEAL**
Information Dissemination	Releases of information specific to behavioral health provider	Memoranda of understanding among behavioral health providers working with the youth and family	Sharing of electronic health-related information among behavioral health providers working with the youth and family

Establishment and maintenance of a website that provides ready access to pertinent policies and procedures governing psychotropic medication management by clinicians, foster parents, and other caregivers

Website includes psycho-educational materials, consent forms, adverse effect rating forms and reports on patterns of psychotropic medication use patterns |

Appendix 2: Medication Documentation
Psychotropic Medication Checklist for Youth in Care

Name of Child		**Caseworker**	
Date of Birth		**Date of Custody**	
Height		**Weight**	

Medication	Dose	Route	Times

Diagnoses:

Provider:	**Clinician**	
Phone #:	**Email:**	

	YES	NO	Not Available
Diagnostic Assessment Obtained?	YES	NO	Not Available
Individualized Service Plan Obtained?	YES	NO	Not Available
Medication History Obtained?	YES	NO	Not Available
Most Recent Provider Progress Note Obtained?	YES	NO	Not Available

Completed by: _____   Date: _____

Last Name	First Name	DOB	Height	Weight	Medication	Dosage	Route/Times	Start Date	Stop Date	Provider	Informed Consent Y/N	PCSA Caseworker

Appendix 3: Committee Membership
PCSAO Behavioral Health Leadership Group*

Crystal Ward Allen
PCSAO

Mary Applegate, MD
Ohio Department of Medicaid

Audrey Beasley
Cuyahoga County Department of Child and Family Services

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Ohio | **Department of**
Job and Family Services