California Guidelines for the Use of Psychotropic Medications with Children & Youth in Foster Care: Revised 2017

Education & Training Module

First draft September 14, 2016
Second draft October 6, 2016
Third Draft October 19, 2016
Fourth Draft February 7, 2016
Final draft June 13, 2017

Quality Improvement Project Clinical Workgroup
Education & Learning Objectives

• This education and training module was developed as a result of a consensus among the QIP Clinical Workgroup members.

• The module provides a “road map” to assist busy readers with navigating through the contents and sections of the guidelines. However, the module is not meant to be an interpretation of the guidelines.

• Please note that commentaries and after thoughts are deliberately excluded.
Guidelines Developers

• Department of Health Care Services (DHCS)
• California Department of Social Services (CDSS)
  • Clinical Workgroup, Quality Improvement Project
Purpose and Use

• Purpose and Use:
  – Use in conjunction with related California State Regulations and other initiatives:
    • Community Care Licensing (CCL)
    • Licensing standards and written directives related to foster homes, resource family homes, group homes, short-term residential therapeutic program and residential treatment centers
    • Core Practice Manual (Katie A)
    • Medi-Cal Performance Outcome System
    • Continuum of Care
Who should read the Guidelines?

• The guidelines are statements of best practice for the treatment of children and youth in out of home care.
• Everyone involved in the care of these children and youth is encouraged to read, share, disseminate, reflect upon and apply these best practices grounded in the guidelines’ principles and values.
What’s in the Guidelines?

• The Guidelines:
  – Basic principles and values
  – Expectations in developing treatment plans, addressing the principles for:
    • emotional and behavioral health care, psychosocial services, and non-medication treatments
    • informed consent to medications
    • medication safety
What’s in the Guidelines?

• The Guidelines (continued)
  – First comprehensive effort at state level to address psychotropic medication use
  – Incorporates work products of:
    • American Academy of Child & Adolescent Psychiatry (AACAP)
    • American Academy of Pediatrics (AAP)
    • California County Child Welfare & Behavioral Health Polices and Practices
    • Other states practices
  – Updated annually, to include:
    • Research
    • Best practices
    • Feedback from youth, families, prescribers, and other providers
Guidelines Table of Contents

• Statement of Best Practice
  – Trauma and Resilience (p.1)
  – Principles & Values (p.4)
  – CFT Treatment Plan or Comparable Mental Health Treatment Plans & JV 220 requirements (p.5-8)
  – Psychiatric Evaluations & Diagnosis (p.9-11)
  – Informed Consent and Assent (p.12)
  – Prescribing psychotropic medications (p.12-16)
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  – References (p.16-19)

• Appendix A: Prescribing Standards by Age Groups
• Appendix B: Parameters
• Appendix C: Addressing Complex Cases
• Appendix D: Prescribing Decision Tree
SAMHSA’s Definition of Trauma

• Explains that trauma can result from a “set of circumstances” and does not require exposure to a specific event, or series of events.

• The definition acknowledges that circumstances, such as exposure to neglect, can result in trauma, and:

• Neglect is the most frequent reason that children and youth are removed from their homes.
SAMHSA’s Definition of Trauma (2)

• Because adverse *circumstances* can result in trauma, the SAMHSA definition clarifies that youth may exhibit trauma reactions due to *neglect*, and

• Posttraumatic stress disorder (PTSD) is a very restricted way of assessing trauma reactions because that diagnosis requires exposure to a *specific* event, or *series of events* (per the DSM), *which may not apply to many foster youth who exhibit trauma symptoms who have histories of neglect*. 
SAMHSA’s Definition of Trauma (3)

• The SAMHSA definition reflects research clearly demonstrating that a response to an event, series of events, or set of circumstances is a deeply personal and individualized response that must be assessed carefully.
SAMHSA’s Definition of Trauma (4)

• The SAMHSA definition reflects the reality that there are many different ways and degrees to which different people experience the same event(s) or circumstances. These “individual differences” are based on each individual’s past experiences such as past social support and ability to control one’s environment, and intrapersonal characteristics such as temperament and intellectual functioning. These experiences and intrapersonal characteristics interact and impact neurophysiological functioning, thus affecting and emotion and cognitive regulation.
What Is Resilience?

“What protective factors that reduce poor outcomes under conditions of adversity and risk”

Three interactive components:
(a) individual differences in temperament and cognitive abilities;
(b) quality of social relationships (e.g., the relationship with the primary caregiver or another supportive other); and
(c) quality of the broader environment, such as school and neighborhood (Greenberg, 2006)
Why Is This Definition of Resilience Important?

• It includes factors *within* the child or youth, and

• Factors within the youth’s environment:
  – Immediate social relationships
  – Broader social environment: School, neighborhood

• These intra-personal and inter-personal factors interact to alter neurophysiological functioning, impacting psychosocial functioning in positive or negative ways

• Focusing on enhancing adaptive factors within the immediate and broader environment can lead to improvement in emotion and cognitive regulation and psychosocial functioning
Building Resilience

• CA Guidelines emphasize the importance of a careful assessment, including review of:
  – collateral interviews
  – assessment of support resources currently in the youth’s life
  – explore other resources potentially could be leveraged to promote resilience
Guideline Principles & Values

- Safety
- Permanency
- Well-Being
- Least restrictive placement
- Government cannot do the job alone
- Child-Centered Care
  - accessible, integrated, comprehensive, continuous
- Continuity of Care
- Quality
- Integration
- Collaboration
- Limitations (of psychotropic medication use)
CFT Treatment Plan or Comparable Mental Health Treatment Plan

• Guided by the principle that interventions should be:
  – Strength based
  – Child focused
  – Family centered

• Interventions chosen are based on:
  – Child’s emotional, cognitive and/or behavioral dysregulation,
  – Strength and needs of the child and family
  – Resources available in the community
CFT Treatment Plan or Comparable Mental Health Treatment Plan (2)

• What is an appropriate treatment plan?
  – Addresses root cause of child’s emotional, cognitive and/or behavioral dysregulation
  – Treatment not limited to symptom relief
  – Intervention is evidence based (proven effective)
  – If psychotropic medications are prescribed, to include close monitoring of side effects
  – Comprehensive, see components of treatment plan
CFT Treatment Plan or Comparable Mental Health Treatment Plan (3)

• What else should be included in a treatment plan?
  – Documentation of ongoing communication between clinicians (psychiatrists, primary care physicians), specialists with the network of Child & Family Team (CFT)
  – Judicial approval (JV 220, 2016) is mandated by California law prior to the administration of psychotropic medications to children and youth in foster care.
CFT Treatment Plan or Comparable Mental Health Treatment Plan (4)

• (Continued)
  – Up to date JV 220 documentation must include a medication plan consists of:
    • Dosages
    • Medication start date and re-assessment dates
    • Medication trial’s targeted goals
    • Supportive collaterals
  – To the extent possible, the plan is developed in collaboration with CFT
CFT Treatment Plan or Comparable Mental Health Treatment Plan (5)

• What is *inappropriate*?

  – To use psychotropic medication for the purpose of discipline or chemical restraint
  – Youth to be coerced into taking medication as a condition of placement
  – Biased risk and benefits evaluation (more significantly associated with antipsychotics) resulting in more potential risk; due to prescriber’s lack of current knowledge and/or slow adoption of best practice and standards
New JV 220 (2016) Requirements

• Effective July 1, 2016
• Incorporates the guidelines’ principles and values; strengthens the continuity, quality, integration and coordination of care
  – Continuity: sharing treatment history
  – Quality: enhanced monitoring when specific medication therapy is used
  – Integration & coordination: social workers and public health nurse have greater and easier access to needed information to facilitate delivery of quality of care
Components of CFT Treatment Plan or Comparable Mental Health Treatment Plan

• The development, implementation and execution of a treatment plan includes the CFT

• Components include:
  – Child’s diagnosis
  – Child’s baseline strengths and needs
  – Target symptoms; stated in practical and everyday language as agreed by the CFT
  – Client driven short and long term goals
  – Evidence-supported treatment interventions
  – Assessment and regular reassessments periods
  – Evidence of judicial approval (JV220, 2016) for psychotropic medication use
Psychotropic Medication

• Definition

Welfare & Institution Code 369.5(d)

“Medications prescribed to affect the central nervous system to treat psychiatric disorders or illnesses. They may include, but not limited to, anxiolytic agents, antidepressants, mood stabilizers, antipsychotic medications, anti-Parkinson agents, hypnotics, medications for dementia, and psychostimulants.”
Psychotropic Medication (2)

• Prescribing requirements
  – Be prescribed only as part of a comprehensive treatment plan, except under emergency conditions
  – Authorized prescribers are prescribers licensed to prescribe
  – Recommended prescribers include:
    • Board certified or board eligible specialists in one of the following expertise: psychiatry, neuro-developmental pediatrics, pediatric neurology, pediatric or family practice specialized in training in utero exposure to illicit drugs or alcohol and/or high risk children
Psychiatric Evaluation & Diagnosis

• Evaluation Components include:
  – Review of collateral documents provided by child welfare services (CWS), when available
  – Reminder: CWS Social Worker or probation officer may need to obtain court authorization in order to provide copies of documents from confidential juvenile files.
  – A thorough physical and mental status exam
  – Complete review of current emotional and behavioral symptoms
  – Assessment for potential psychosocial precipitants
Psychiatric Evaluation & Diagnosis (2)

• (Continued)
  – Review of Collateral Documents:
    • Detention Hearing Report
    • Jurisdiction/Disposition Report
    • Significant additional court reports such as documents of major changes in the family situation
    • Prior psychological evaluations
    • Prior treatment plan
    • Psychiatrist’s prior hospitalization documents, including history and physical (H&P), admission and discharge summaries
- (Review of Collateral Documents, continued)

- Court order authorizing health assessment, routine health care, release of information
- History of Child Placement report
- Current Health & Education Passport (HEP)
- Individualized Education Plan (IEP) and IEP Triennial evaluation (Psychoeducational Assessment Report)
- Medication log as attached to JV 220
Psychiatric Evaluation & Diagnosis (4)

– Physical Examination
  • Review past examination conducted within the year
  • Order baseline laboratory tests
  • Order pregnancy test, when appropriate
  • Order baseline screen for substance use, when needed
    – Review probation records
  • Review and assess above tests
  • Conduct verbal screen and discuss substance use history with child/youth
Psychiatric Evaluation & Diagnosis (5)

– Mental Health Examination
  • Sensitive to the age and developmental stage
  • Case conceptualization and appropriate trauma-informed diagnosis often requires multiple sessions
  • Ideally, the child is interviewed both with and without parents or care giver present
Psychiatric Evaluation & Diagnosis (6)

– Diagnosis

• Develop a case conceptualization and trauma informed diagnosis
• If the diagnosis of the prescriber is inconsistent with the diagnosis of the current treating professionals (i.e. therapists), there is a reconciliation process
• All treating professionals, prescribers and therapists to work on same diagnosis and case conceptualization
Goals and Target Symptoms

• Often are manifestations of the child’s emotional and/or cognitive dysregulation
• To refrain from solely focusing on these behavioral manifestations; rather to focus on underlying emotional distress
• Reassess often, and include review of meaningful measures of psychosocial functioning (i.e. improved grades, improved peer relationship at school and at child’s natural environment)
• If medication is used, reassessment includes evaluating medication’s effectiveness
Psychiatric Evaluation & Diagnosis (8)

– Use of Medication
  • Prescribed only as part of comprehensive treatment strategy

– Informed Consent
  • Children are included in the consent and assent, to the extent feasible and appropriate for the developmental age
  • Prescribers explain the proposed treatment using terms that are understandable to the CFT
  • Prescribers to include phone numbers to reach in case CFT has questions
  • Prescribers to consult social workers or probation officer on who can provide legal consent, and who can release HIPAA information
Guidelines for Prescribing Psychotropic Medications

• *Before* prescribing:
  • Are the potential risks of use of psychotropic medication greater than its benefits?
  • Is long term use of psychotropic medication largely unknown or well established?
  • Are there age-appropriate, evidence-supported psychotherapeutic treatment in the community accessible to the child or youth?
  • Are there environmental factors (school, home) to address first?
  • Is a psychiatric specialist consult necessary?
  • How likely will the child or youth adhere to therapy?
  • Is there a need for dual treatment of mental health and substance use?
Guidelines for Prescribing Psychotropic Medications (2)

• When prescribing:
  – Preference is given to FDA approved medications for a child’s age group and diagnosis
  – Use the brand/generic specified in the Medi-Cal contract drug list
  – Medication dosage is within FDA guidelines, is child and age appropriate, and consistent with professional organizations’ guidelines
  – Treatment with a single medication for a single condition should be tried first, before adding more medications
Guidelines for Prescribing Psychotropic Medications (3)

• (continued)
  – Only one medication should be changed at one time
  – Start low and go slow
  – Seek consultation with a psychiatrist specialist when considering treatment using more than one psychotropic medication from the same class
  – Seek consultation with a psychiatrist specialist when considering use of three psychotropic medications concurrently
Guidelines for Prescribing Psychotropic Medications (4)

• (Continued)
  – Monitoring and evaluation of medication therapy should include:
    • Objective evaluation of improved functioning, i.e., using Beck Youth Inventories, Trauma Symptoms Checklist for Children
    • Are target symptoms well controlled in the child’s national environment?
    • Is medication dose and duration adequate?
    • Has child/youth received age appropriate evidence-supported psychotherapeutic treatments?
Guidelines for Prescribing Psychotropic Medications (5)

• (continued)
  – Has the child/youth received informal psychosocial support such as resilience and learned control?
  – Do the observed therapeutic benefits continue to outweigh the risks?
  – Are there medication side effects requiring discontinuation or dose reduction?
  – Overtime, there is a plan to attempt dose reduction safely, in order to identify the lowest optimal dose
  – When serious side effects occur, discontinue medication safely
Guidelines for Prescribing Psychotropic Medications (6)

• (Continued)
  – Always consult CFT when discussing tapering or discontinuing medications, or identifying an alternative medication or treatment
  – Exercise caution and pause before adding a medication to treat side effects
References

• The reference section is kept up to date by including current literature and writings relevant to the guidelines
• Newly identified references are reviewed at clinical workgroup or other meetings
• At guidelines annual review, references are included in the new edition of guidelines
CA Guidelines: Appendix A

Prescribing Standards of Psychototropic Medication Use by Age Group
Prescribing Standards

• The following prescribing standards are for use in reviewing a JV-220(A) application for the court. The standards are:
  – Based on American Academy of Child & Adolescent Psychiatry Practice Parameters
  – Current best practice
  – Evidence-based
  – Not intended to stifle independent treatment or care by a provider
  – To provide guidance to prescribe minimum number of medications necessary, with the lowest therapeutic dose and for the appropriate age
Summary of allowable psychotropic medication by age group:

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Number of psychotropic medications allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>&lt;2 (allows 1)</td>
</tr>
<tr>
<td>6-11</td>
<td>&lt;3 (allows no more than 2)</td>
</tr>
<tr>
<td>12-17</td>
<td>&lt;4 (allows no more than 3)</td>
</tr>
</tbody>
</table>
## Prescribing Standards (3)

<table>
<thead>
<tr>
<th>Age in years</th>
<th>&lt;4 psychotropic medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. &lt;2 antipsychotics (any combination of atypical and typical)</td>
</tr>
<tr>
<td></td>
<td>b. &lt;2 mood stabilizers (anti-psychotics not included)</td>
</tr>
<tr>
<td></td>
<td>c. &lt;2 antidepressants (trazodone as hypnotic excepted)</td>
</tr>
<tr>
<td></td>
<td>d. &lt;2 stimulants (this does not include a long-activating</td>
</tr>
<tr>
<td></td>
<td>stimulant and immediate-release stimulate tat is the same</td>
</tr>
<tr>
<td></td>
<td>chemical entity (e.g.;, methylphenidate-OROS and methylphenidate)</td>
</tr>
<tr>
<td></td>
<td>e. &lt;2 hypnotics (including trazodone, diphenhydramine,</td>
</tr>
<tr>
<td></td>
<td>zolpidem and melatonin, benzodiazepines, not including</td>
</tr>
<tr>
<td></td>
<td>clonidine, guanfacine, and prazosin)</td>
</tr>
<tr>
<td></td>
<td>f. Medication dose(s) within the usual recommended dose(s)</td>
</tr>
<tr>
<td></td>
<td>as defined in the most recent version of the State parameters</td>
</tr>
<tr>
<td></td>
<td>(adaptation of the Los Angeles County Department of Mental</td>
</tr>
<tr>
<td></td>
<td>Health’s Parameters 3.8 For Use of Psychotropic Medicine</td>
</tr>
<tr>
<td></td>
<td>For Children and Adolescents, which can be accessed at:</td>
</tr>
<tr>
<td>6-11</td>
<td>&lt;3 psychotropic medications</td>
</tr>
<tr>
<td></td>
<td>a. All other restrictions from above.</td>
</tr>
<tr>
<td>0-5</td>
<td>&lt;2 psychotropic medications</td>
</tr>
<tr>
<td></td>
<td>a. All other restrictions from above.</td>
</tr>
<tr>
<td></td>
<td>b. Allows stimulant, atomoxetine, guanfacine, clonidine, or</td>
</tr>
<tr>
<td></td>
<td>risperidone (for Autistic Spectrum Disorders and associated</td>
</tr>
<tr>
<td></td>
<td>aggression) only.</td>
</tr>
</tbody>
</table>
CA Guidelines: Appendix B

Parameters for the Use of Psychotropic Medication for Children & Adolescents
Parameters

• The Los Angeles County Department of Mental Health (LACDMH), in December 2014, granted approval to DHCS and CDSS the use of LACDMH Parameters 3.8 for Use of Psychotropic Medication for Children & Adolescents

• Parameters 3.8 update occurs quarterly

• The parameters are included in the CA Guidelines as Appendix B
Parameters

• To access LACDMH link to parameters 3.8:
  – A “two-step” process
    • First, access the clinical tool-clinical practice page clinical tools
    • Second, click on the link to 3.8 parameters Using a saved link is not recommended, because the link changes every time the document is updated
  – Use of the “two-step” to ensure getting the most updated information
Clinical Practice

DMH PRACTICE PARAMETERS/GUIDELINES/SUGGESTED BEST PRACTICE INFORMATION

The Los Angeles County Department of Mental Health establishes Practice Parameters and Guidelines and provides clinical information to assist mental health professionals in their clinical practice. The following sections by category of information are:

1. DMH Practice Parameters which identify critical factors to be considered in the provision of care
2. Suggested Best Practices and Standards
3. LANTRM/FETRIS-HORTY (L/F/H) Information, e.g., regarding authorization, denouncement and/or designation
4. Clinical Risk Management
5. Psychiatric MH Nurse Practitioner Standardized Procedures and Practice Information
6. Clinical Information
   - Improving access to services
   - Integrating Treatment
   - Provision of Services to the Medically Indigent

1. DMH PRACTICE PARAMETERS

LAC DMH Introduction to Practice Parameters

1.0 Introduction to the Use of DMH Practice Parameters / Revised June 2014

LAC DMH Parameters for Clinical Assessment

- 2.1 Assessment/Management of Clients at Risk for Suicide / Revised 11/2002
- 2.2 Initial Psychiatric Assessment of Older Adults / Revised 11/2002
- 2.3 LAC-UHM Psychiatric Services in Emergency Settings / Revised March 2014
- 2.4 The Use of Telepsychiatry / Revised March 2014
- 2.5 LAC UHM Parameters for Older Adults / Revised July 2014
- 2.6 Discharge Planning For Older Adults / Revised February 2014
- 2.7 Co-Occurring Cognitive Impairment Assessment Parameters / Revised 6/2011
- 2.8 Co-Occurring Cognitive Impairment Treatment / Revised 4/2011
- 2.9 Access to NM Services Post Discharge / 1/2011
- 2.10 Psychiatric Consultation 06/2011

LAC DMH Parameters for Medication Use

- 3.1 DMH Policy 100.01 Standards for Prescribing and Managing Medications / Revised February 2011
- 3.2 Use of Antipsychotic Medications / Revised October 2014
- 3.3 Use of Antidepressant Medications / Revised May 2015
- 3.4 Use of Antiepileptic Medications / Revised November 2013
- 3.5 Use of Mood Stabilizing Medications / Revised October 2014
- 3.6 Use of Antipsychotic Medications in Dual Diagnostic Clients / Revised January 2014
- 3.7 Parameters for General Health Monitoring / Revised December 2015
- 3.8 Use of Psychopharmacological Medications in Older Adults / Revised June 2014
- 3.9 JCMH’s PMPAR Policy / Revised May 2010
- 3.10 Use of Medication Assisted Treatment (MAT) in Individuals with Co-occurring Substance Use Disorders. / Revised April 2015

LAC DMH Parameters for Clinical Programs

- 4.1 LAC DMH Outpatient and Clinic Environment
- 4.2 Staff Rights to Initiate Inpatient Interventions
- 4.3 Treatment Non-Compliance in IP Settings
- 4.4 The Use of Psychosocial Rehabilitation Interventions
- 4.5 Treatment of Co-occurring Substance Abuse. / January 2002
- 4.6 Psychotropic Treatment of Individuals in IOMs
- 4.7 Clinical Supervision / Revised 12/12/02
- 4.8 Delivery of Culturally Competent Clin. Serv. / 12/12/02
- 4.9 Parameters for Referrals to 24-Hr Referral Groups / Appendix-revised 11-00
- 4.10 Parameters for Wellness Centers / 1/26-06
- 4.11 Parameters for Healthy Living Programs / Revised January 2008
- 4.12 Service Relationships in a Recovery-Based Mental Health / Services / 07/26-06
- 4.13 Parameters for DMH Peer Advocates / 11-07-06
- 4.14 Parameters on QIB behavior 2015-07-27
- 4.15 Parameters for Spiritual Support / Revised 2012-05-24
- 4.16 Parameters for Family Inclusion
- 4.17 Parameters for the Determination of Involuntary Client Engagement of Adults at Risk for Suicide
- 4.18 Parameters for Assessment and Treatment of Co-occurring Intellectual Disabilities
CA Guidelines: Appendix C

Challenges in Diagnosis and Prescribing of Psychotropic Medications
Common Challenges & Recommendations

• This appendix describes common challenges that occur in psychiatric diagnosis and prescribing psychotropic medications for foster care

• Addresses four categories of common challenges and offers recommendations:
  – Diagnostic clarity
  – New medication trials
  – Polypharmacy
  – Indications for the prescriptions
CA Guidelines: Appendix D

Algorithm (Decision Tree) for the Prescribing of Psychotropic Medications
Prescribing Algorithms (Decision Tree)

• Designed to assist the prescriber in maintaining compliance with State and county regulations and guidelines pertaining to the prescribing of psychotropic medications for children and youth in foster care
  – Before prescribing
  – When prescribing
Your Action Plan

• In a few sentences, describe:
  a. One thing you have learned as a result of reading the guidelines
  b. How will this change the way you do your work?
  c. When do you plan to start making this change?
  d. What results/outcome do you wish to see? and
  e. Who do you want to share your new commitment for change?

• We encourage you to share your “action plan” with the QIP by emailing to:
  – Pauline.chan@dhcs.ca.gov
  – Lori.Fuller@dss.ca.gov
Further Reference: ACIN I-36-15

CDSS’s ACIN I-36-15 provides a framework for response by child welfare and probation agencies to the need of youth who have been prescribed psychotropic medications.

The notice states:

“The existence of any of the high risk circumstance does not always mean that the prescription or administration of that medication is an inappropriate treatment. However, these circumstances warrant additional precautions and increased monitoring of the child or youth. Case managers that are aware of any of these circumstances can also consult with their county PHN(s), or other medical professionals for additional information and support.”
Further Reference: ACIN I-36-15

ACIN I-36-15 informs readers that:

“More information regarding all high risk circumstances is available in the California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care (Guidelines) issued by DHCS and CDSS. Further medication-specific information can be found in the Department of Mental Health Parameters 3.8 For Use of Psychotropic Medication In Children and Adolescents which is included as Appendix B to the Guidelines.”
Questions?

Email contacts