General Principles Regarding the Use of Psychotropic medications in Children

- A DSM-IV psychiatric diagnosis (based on the child’s symptoms and a complete mental health evaluation that includes health, behavioral, developmental, medication, psychosocial, trauma, and family history), should be made before the prescribing of psychotropic medications. This may be more challenging the younger the child is.
- The child’s should have clearly defined target symptoms that the PTM will treat.
- Treatment goals for the use of psychotropic medications should be identified and documented in the medical record at the time of or before beginning treatment with a psychotropic medication.
- Target symptoms and treatment goals should be assessed at each clinic visit with the child and caregiver. Whenever possible, recognized clinical rating scales (clinician, patient, or caregiver filled out, as appropriate) or other measures should be used to quantify the response of the child’s target symptoms to treatment and the progress made toward treatment goals.
- Non-medication treatments should be considered and implemented prior to the use of medication. For example, meditation, exercise, yoga, a healthy diet, routines in the home, positive parenting strategies, behavior modification techniques etc., alone or in combination, may be helpful for many children.
- In making a decision regarding whether to prescribe a psychotropic medication for a specific child, the clinician should carefully consider age, potential side effects (both common and uncommon, including those that potentially severe), existing health problems, interactions with other medications or supplements, and evaluate the overall benefit: risk ratio of pharmacotherapy.
- Except in the case of emergency, informed consent should be obtained from the appropriate party(s) before beginning psychotropic medication. Informed consent to treatment with psychotropic medication entails ensuring that the legal guardian/patient understands the:
  - diagnosis,
  - expected benefits and risks of treatment (including common and uncommon side effects and potentially severe adverse side effects) versus no treatment or non-medication interventions,
  - non-medication interventions that might be useful
  - the results of laboratory findings, and
  - the goals of the treatment plan and how progress will be monitored.
- During the prescription of psychotropic medication, the presence or absence of medication side effects should be documented in the child’s medical record at each visit.
- Appropriate monitoring of indices such as height, weight, blood pressure, and laboratory findings should be documented.
- Mono-therapy (single drug) regimens for a given disorder or specific target symptoms should be tried before poly-pharmacy (more than one drug) regimens.
- Doses should be started at the low end of the range for child’s weight, and titrated upward carefully, and with monitoring, until improvement in target symptoms occurs or side effects develop.
• 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 while tapering the dose of a current medication is considered one medication change).
• The frequency of clinician follow-up with the patient should be appropriate for the severity of the child’s symptoms/condition, and adequate to monitor response to treatment, including: symptoms, behavior, function, and potential medication side effects.
• In depressed children and adolescents, the potential for emergent suicidal symptoms should be carefully evaluated and monitored and caregivers should be advised what to look for and call about.
• If the prescribing clinician is not a child psychiatrist, referral to or consultation with a psychiatrist should occur if the child’s clinical status does not show meaningful improvement within a reasonable time-frame. If the child worsens in any way, urgent consultation is advised.
• Before adding additional psychotropic medications, the child should be re-assessed for
  o adequate medication adherence,
  o accuracy of the diagnosis,
  o the occurrence of comorbid disorders (including substance abuse and general medical disorders), and,
  o the influence of psychosocial stressors.
• If a medication is being used in a child for a primary target symptom of aggression associated with a DSM-IV non-psychotic diagnosis (e.g., conduct disorder, oppositional defiant disorder, intermittent explosive disorder), and the behavioral disturbance has been in remission for six months, serious consideration should be given to slow tapering and discontinuation of the medication. If the medication is continued in this situation, the necessity for continued treatment should be evaluated at a minimum of every three months.
• The clinician should clearly document care provided in the child’s medical record, including history, mental status assessment, physical findings (when relevant), impressions, adequate laboratory monitoring specific to the drug(s) prescribed at appropriate intervals, known risks, medication response, presence or absence of side effects, modifications to the treatment plan, and the use of prescribed medications.

Criteria Indicating Need for Further Review of a Child’s Clinical Status

The following situations do not necessarily indicate that treatment is inappropriate, but they do indicate a need for further review.

For a child being prescribed a psychotropic medication, any of the following suggests the need for additional review of a patient’s clinical status:

• Absence of a DSM-IV diagnosis appropriate to the in the child’s medical record.
• Five (5) or more psychotropic medications prescribed concomitantly. (Three?)
• Prescribing of two or more medications from same class such as two or more concomitant antidepressants, antipsychotics, stimulants or mood stabilizers.
- Initiation of treatment with more than one medication at a time.
- The psychotropic medication dose exceeds usually recommended doses.\(^{(2)}\)
- Prescribing by a primary care provider for a diagnosis other than the following (unless recommended by a psychiatric consultant):
  - Attention Deficit Hyperactive Disorder (ADHD)
  - Uncomplicated anxiety disorders
  - Uncomplicated depression

- Psychotropic medications prescribed for children of very young age, including children receiving the following medications with an age of:
  - Antidepressants: Less than four (4) years of age
  - Antipsychotics: Less than four (4) years of age
  - Psychostimulants: Less than three (3) years of age

Note: The prescription of a long-acting stimulant and a short-acting stimulant of the same chemical entity (e.g., methylphenidate) does not constitute concomitant prescribing.