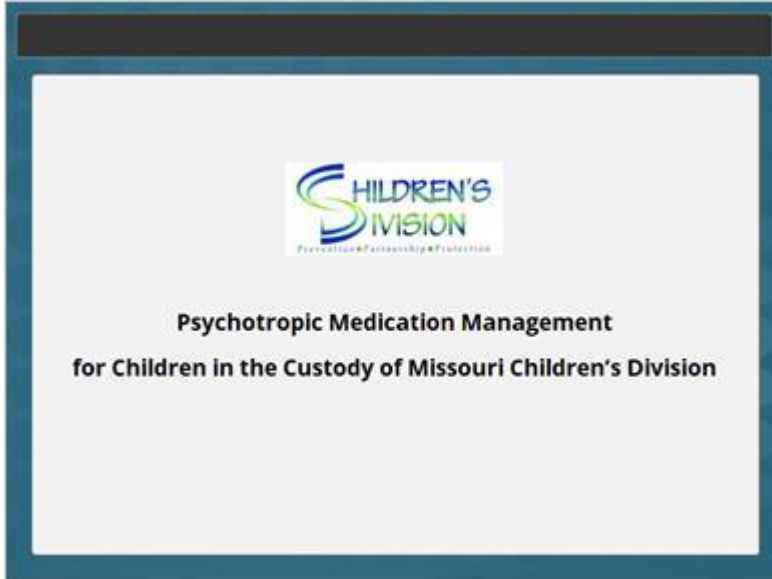


# Psychotropic Medication Management

## 1. Introduction

### 1.1 Title



## 1.2 Training for :

### Page 2

Training for : Page 2



- **Children's Division Staff**
- **Foster Care Case Management Staff**
- **Resource Providers, including relative caregivers, foster parents and residential providers**

## 1.3 Disclaimers

### Page 3

Disclaimers Page 3

This training explains the State's expectations for the safe and effective use of psychotropic medications for children in the custody of the Missouri Children's Division.

This is a training created in October 2019.

Please be aware that medications and treatment recommendations are always evolving and may change.

Always discuss specific questions about the medications with the child's doctor.




## 1.4 Purpose

### Page 4

Purpose Page 4

The purpose of this eLearning is to educate CD staff and Foster Care Case Management staff, foster parents, relatives (kinship), and residential providers about psychotropic medications, help them make informed decisions, and monitor children in CD custody who are prescribed these medications.



## 1.5 Goals & Objectives

### Page 5

Goals & Objectives Page 5

1. Understand that other interventions must be explored and utilized before psychotropic medications are administered.
2. Understand the need for a complete psychiatric evaluation (including physical examination) before making a decision about psychotropic medications and treatments.
3. Understand the responsibility of the case manager medical consentor to decide whether or not to give informed consent for each psychotropic medication prescribed for a child.
4. Understand how psychotropic medications are used.
5. Understand how to monitor a child for possible side effects or to see if the psychotropic medication is working.
6. Know what to do if you have concerns about the psychotropic medications prescribed to children in your care.
7. Be aware of how various classes of psychotropic medications work, their side effects, and examples of medications in each class.


## 1.6 What is a psychotropic medication?

Page

6

What is a psychotropic medication? Page 6

Psychotropic medications are prescribed to address emotional, behavioral or psychological symptoms and that are used to exercise an effect on the central nervous system to influence and modify behavior, cognition, or affective state.




**The term refers to the following pharmaceutical drug and these types of drugs:**

- Lithium
- Antipsychotics
- Antidepressants
- Stimulants
- Alpha-adrenergic agonists
- Anxiolytics/hypnotics
- Anticonvulsants/mood stabilizers

## 1.7 Module 1: Decisions About Consenting & Psychiatric Evaluation

Module 1: Decisions About Consenting & Psychiatric Evaluation

Module 1:  
Decisions About Consenting & Psychiatric Evaluation



## 2. Module 1: Decisions About Consenting & Psychiatric Evaluation

### 2.1 Policy Requirements for Medical Consent Training

Page 8

Policy Requirements for Medical Consent Training Page 8

Medical Consenters are required by Missouri Children's Division to receive training on:

- Informed consent for psychotropic medication and
- Non-pharmacological (non-medication) interventions

This information is covered in both this training and the Children's Division's Informed Consent training.

### 2.2 Who is a Medical Consenter?

Page 9


Who is a Medical Consenter? Page 9

A person who has been given legal authority by CD or the court to make health care decisions for a child in the custody of CD.

There are two types of medical consenters:

1. The person deciding whether or not to consent to routine medical, dental or eye care for children in CD custody - this is typically the resource provider but may also be the case manager.
2. The person deciding whether or not to consent to behavioral health (mental health) care for children in CD custody including decisions about psychotropic medications - this must be the case manager or an alternative person given legal authority by the court.

Note: For children placed in residential facilities with shift staff, the case manager will be the **primary** medical consenter.



## 2.3 Use of Psychotropic Medications

Page

10

**Use of Psychotropic Medications** Page 10

Most children in CD custody never need psychotropic medications.

Children who are traumatized by abuse, neglect or separation may show negative behaviors or signs of emotional stress that are a normal reaction to what they have been through. Also, all children act out at different stages of their lives. For example, two-year olds commonly have temper tantrums and teenagers often rebel.

Support from caregivers knowledgeable of trauma-informed care can help a child heal.

But some children need medication to cope with the trauma of abuse, neglect or separation. Other children need medication to treat behavioral health disorders that they inherited or developed, such as Attention Deficit Hyperactivity Disorder (ADHD), severe depression, or psychosis.

Psychotropic medications may help children function at home, in school, and in their daily lives. They may need these medications temporarily to treat emotional stress or long-term to treat life-long behavioral health disorders.

## 2.4 The Importance of an Appropriate Environment

Page 11

**The Importance of an Appropriate Environment** Page 11

Most children will heal with stability, consistency, nurturing and support of caregivers knowledgeable of trauma-informed care.

This means that the child does not change placements and the caregiver:

- Is patient, understanding, kind, loving, and gentle.
- Gives clear instructions about expectations and house rules.
- Provides consistent feedback to reinforce expectations and establish framework for child to be held accountable when acting unsafely.
- Teaches the child coping skills and how to manage their behavior and emotions in an age appropriate way.
- Praises the child for positive behaviors.

Children may act out as they adjust to a new home and learn new rules. Caregivers should expect that adjustment takes time and give appropriate support and acceptance. If given safe, positive, nurturing, consistent trauma-informed care, most children will learn to trust, feel safe, and learn to control their emotions and behavior in way that is appropriate for their age.

## 2.5 Non-pharmacological Interventions

Page 12

Non-pharmacological Interventions Page 12

Psychosocial therapies, behavior strategies, and other non-pharmacological (non-medication) interventions are to be attempted by the medical consenter before psychotropic medications.

- Non-pharmacological interventions are specific methods a caregiver can use to help a child manage behavior.
- This may include therapy and specific behavior strategies.
- Each child is different, so the strategies should be specific to the child's needs and discussed with the child's therapist or medical provider.



## 2.6 Non-pharmacological Interventions

Page 13

Non-pharmacological Interventions Page 13

Just as non-pharmacological interventions should be attempted for any condition, pharmaceutical intervention for mental health issues should never be the first nor sole intervention for children in Children's Division's custody.

A case manager shall not consent to the use of psychotropic medications without first having sought alternative interventions to aid the child, resource provider or parents. Those may include, but are not limited to, mental health assessment, therapy, skills building, parenting assistance or family therapy. A mental health professional must make a recommendation for a child to be assessed by a qualified prescriber to determine if psychotropic medications would be of benefit for the child prior to the case manager pursuing this type of intervention.

A resource provider can get help by:

- Talking to the child's case manager about how to help the child manage behaviors or deal with emotional stress.
- Talking to the child's case manager about seeking behavior health therapy. This is professional counseling that may be individual therapy (child only); family therapy; and/or group therapy
- Working with the child's therapist, the school, and others to find interventions that work and make sure everyone is using the same interventions. Consistent interventions and consequences help the child learn to manage his or her behavior and emotions.

## 2.7 Seek Medical Help

Page

14

Seek Medical Help Page 14

If a child has serious symptoms which are not improving with non-pharmacological interventions, the caregiver or medical consentor should talk to a mental health provider to see if the provider recommends a mental health assessment to determine the need for psychotropic medication.

Anytime a child is a danger to himself/herself or others, the caregiver or medical consentor should immediately contact the doctor. Examples include suicidal or violent thoughts or actions.

A primary care provider may be able to conduct a mental health assessment and treat some behavioral health disorders including prescribing psychotropic medications.

For more complex problems, or if you would like a further assessment of the child you may request an appointment with a psychiatrist. The child and adolescent psychiatrist will do a complete psychiatric evaluation and make a recommendation about treatment. Ask the child's primary care provider if you are not sure if the child needs to see a psychiatrist.



## 2.8 What to Expect From a Psychiatrist or Psychiatric Evaluation

Page

15

What to Expect From a Psychiatrist or Psychiatric Evaluation Page 15

Based on best practices, a mental health provider should:


- Talk to the child
- Talk to the caregivers and medical consentor
- Review medical history
- If needed, get laboratory studies such as blood tests or electrocardiograms (EKGs).  
If needed, get special assessments such as:
  - A psychological evaluation which is a mental examination and testing by a psychologist
  - Educational assessments which help find out the child's ability to learn material at an appropriate age and grade level and the best way for the child to learn
  - Speech and language evaluation to assess the child's ability to understand language, express him or herself, and speak clearly
- Give a diagnosis
- Recommend the best way to treat the child



Complete Psychiatric Evaluation Page 16

What the psychiatrist will need to know:

- Description of child's problems and symptoms
- Information about health, illness and treatment (both physical and mental) including current medications
- Parent and family health and psychiatric histories
- Information about the child's abuse and neglect history
- Information about the child's development
- Information about school and friends
- Information about family relationships in the child's birth family and home or living arrangement




It is important for a child's caregiver or medical consentor to find out as much of this information as possible before taking the child to the psychiatrist. The psychiatrist needs to know how the child is doing in all areas of his or her life.

Diagnoses of Mental Health Disorders Page 17

Before prescribing psychotropic medications for a child, the prescriber will give the child a diagnosis using the Diagnostic and Statistical Manual of Mental Disorders V (DSM).

The DSM is used to diagnose and classify mental disorders, the criteria are concise and explicit, intended to facilitate an objective assessment of symptom presentations in a variety of clinical settings—inpatient, outpatient, partial hospital, consultation-liaison, clinical, private practice, and primary care.

If the caregiver or medical consentor needs help understanding the diagnosis, they should talk with the prescriber.



## 2.11 Psychiatrist's Recommendations

Page

18

Psychiatrist's Recommendations Page 18

The psychiatrist will make a recommendation for treatment, such as therapy or psychotropic medication, after completing the psychiatric evaluation and making a diagnosis.

The medical consenter should be diligent while working with the medical provider to:

- Get answers to questions about medication and therapy
- Find treatments that help the child get better
- Determine what treatment is in the best interest of the child




## 2.12 Making Decisions about Psychotropic Medications

Page

19

Making Decisions about Psychotropic Medications Page 19



The psychiatrist should obtain "informed consent" from the child's medical consenter before prescribing a psychotropic medication.

This means the doctor must give the medical consenter enough information to decide whether or not to consent for the child to have the medication. The doctor must also allow the medical consenter to ask questions. The process of understanding the risks and benefits of giving the medication to the child is a vital part of informed consent.

There are circumstances where the psychiatrist may prescribe the psychotropic medication but filling that prescription and administering the medication to the child will not occur until the informed consent has been given by the case manager.

## 2.13 What does “undue influence” mean to me?


Page

20

What does “undue influence” mean to me? Page 20

Making an informed decision about behavioral health treatment or medications without “undue influence” means that the medical consenter is deciding based on what is best for the child, not because of pressure to consent to the medication or treatment.

For example, a decision should not be based on the child’s school insisting the child be put on medications before they can return to school.



## 2.14 Informed Consent Before Administering Psychotropic Medications

Page 21

Informed Consent Before Administering Psychotropic Medications Page 21

Your consent to giving a psychotropic medication is valid only if:

- It is given voluntarily and without undue influence; and
- The consenter receives information, from the prescriber, describing:
  - the specific condition to be treated;
  - the beneficial effects on that condition expected from the medication;
  - the probable health and mental health consequences of not consenting to the medication;
  - the probable clinically significant side effects and risks associated with the medication; and
  - the generally accepted alternative medications and non-pharmacological (non-medication) interventions to the medication, if any, and the reasons for the proposed course of treatment

## 2.15 Improving Disparate Health Treatment

Page

22

Improving Disparate Health Treatment Page 22

It is important for medical consenters to be aware of research about healthcare and disparities in treatment and ensure that decisions about services are made with the best interest of each individual child or youth in mind.

- Children and youth (in the child welfare system) living with relatives have been found to have lower rates of mental health and behavioral problems than do children in foster care and group care, although they have higher rates of these problems than the general population does and of those in non-child welfare related (informal) kinship placements.  
  
Source: Gleason, J.P. (2007). Kinship Care Research and Literature: Lessons Learned and Directions for Future Research. Kinship Report. Child Welfare League of America, 1(2), 1, 8-11.
- Parents should be expected and encouraged to participate in all school, medical and therapeutic appointments.  
  
Technical Assistance Bulletin, Right from the Start: The CCC Preliminary Protective Hearing Benchcard, A Tool for Judicial Decision-Making, published by the National Council of Juvenile and Family Court Judges, Reno, Nevada. © 2010, National Council of Juvenile and Family Court Judges. All Rights Reserved. [http://www.ncjfcj.org/sites/default/files/Right%20from%20the%20Start\\_1.pdf](http://www.ncjfcj.org/sites/default/files/Right%20from%20the%20Start_1.pdf)

## 2.16 Improving Disparate Health Treatment (cont.)

Page

23

Improving Disparate Health Treatment (cont.) Page 23

- Case managers and caregivers should encourage participation, of parents, when in the child's best interest, taking safety into account.
- Recent research has found that African Americans are diagnosed with schizophrenia at a disproportionately high rate compared to non-Latino whites, which researchers say can lead to inappropriate treatment, including excessive use of antipsychotics, excessive dosing, and under-prescribing of mood stabilizers.  
  
Arch Gen Psychiatry. 2012;69(6):593-600. Published online February 6, 2012. doi:10.1001/archgenpsychiatry.2011.2040
- A medical conserter should be aware that stereotypes and biases about race and ethnicity may impact clinical assessment in mental health care, and should discuss with the doctor whether the child's assessment, diagnosis or recommended treatment has been influenced by factors related to race or ethnicity.

## 2.17 Consenting to Psychotropic Medications

Page

24

Consenting to Psychotropic Medications Page 24

Informed consent must be obtained from the case manager for:

- Each new psychotropic medication administered
- If a dosage change exceeds guidelines
- If a child enters care who is currently taking a psychotropic medication previously prescribed
- Annual review and re-authorization of informed consent

If a prescriber recommends a dose increase or decrease for a medication (within guidelines) that has already been approved by the case manager, no additional consent is needed and the resource provider can fill the prescription and administer the medication. The resource provider must let the case manager know about any dose changes as soon as possible and can document this information on the CD-265 Monthly Medical Log.

Although a case manager can withdraw consent, children should never stop taking a medication without first consulting with the prescriber or another health care provider. The case manager must always document the informed consent decision. For psychotropic medication, the case manager shall complete the CD-275 Informed Consent for Psychotropic Medication.

## 2.18 Monitoring Use of Psychotropic Medications Every Three Months

Page 25

Monitoring Use of Psychotropic Medications Every Three Months Page 25

The case manager for a child in foster care should ensure that a child prescribed a psychotropic drug has a review of the informed consent decision, in consultation with their supervisor, at least every three months to determine whether continuation of the treatment or medication is in the youth's best interest. The case manager may withdraw consent to treatment with a psychotropic medication at any time after consulting with the supervisor, the prescribing provider and the statewide clinical consultant.



## 2.19 What Does Informed Consent Involve?

Page 26

What Does Informed Consent Involve? Page 26

Here are some things the medical consentor should discuss with the doctor:

- What are the child's diagnosis and symptoms?
- How will the psychotropic medication help the child?
- What are the potential side effects or adverse reactions?
- Are there alternatives such as interventions that do not require the child to take a psychotropic medication?


## 2.20 Potential Questions to Ask the Doctor

Page

27

Potential Questions to Ask the Doctor Page 27

There may be other questions that you have for the doctor. Think about these factors, as it relates, to the child and their situation.



- What is the name of the medication? Is it known by other names?
- How effective has it been for other children who have a similar condition to the child?
- How will the medication help the child? How long before I see improvement?
- Is this medication approved by the Federal Food and Drug Administration (FDA) for the child's condition? If not, (i.e., it is being prescribed "off-label"), why is this medicine being recommended?
- What are the side effects that occur with this medication and how will I know if the child is experiencing any of these effects?
- What is the recommended dosage? How often will the medication be taken?
- Does the child need laboratory tests (e.g. electrocardiograms, blood tests, etc.) before taking the medication? Does the child need any tests while taking the medication?
- Will a child and adolescent psychiatrist monitor the child's response to the medication and change the dose if necessary? Who will check the child's progress and how often?
- Does the child need to avoid other medications or foods while taking this medication?
- Does this medication interact with other medications (prescription and/or over-the-counter) the child is taking?

## 2.21 Discuss Psychotropic Medications with Children

Page

28

Discuss Psychotropic Medications with Children Page 28

It is important to talk with the child about taking psychotropic medications. You should:

- Talk to the child in a way that the child can understand.
- Make sure the child understands why he or she is taking these medications.
- Tell the child what he or she can expect from any tests or treatment.

**Assent** is described as an interactive and ongoing process between a child and the health care provider wherein developmentally relevant information is disclosed about a particular intervention. During the assent process, the child is engaged and his or her input is sought allowing them to voice their preferences and concerns.

## 2.22 Why talk with a child about psychotropic medications?

Page


29

Why talk with a child about psychotropic medications? Page 29

Involving the child:

- Helps children feel more in control and builds trust.
- May help make the treatment more successful.
- Helps children learn to make medical decisions as adults.

Children should have more input into decisions about taking psychotropic medications as they get older. However, the medical consentor should always make the final decision based on what is best for the child.



## 2.23 Informed Assent ( with children under age 18)

Page

30

**Informed Assent ( with children under age 18)** Page 30

**Obtain Assent:** Before providing informed consent for a psychotropic medication, the case manager or supervisor (in coordination with the alternative consentor, if applicable) must seek to obtain informed assent from the youth, consistent with the following:

- In partnership with the child's treating healthcare provider, ensure that the child is informed, in an age and developmentally appropriate manner, of the recommendation for prescribed medication(s) as part of the child's treatment plan.
- In partnership with the child's treating healthcare provider, ensure the child is provided an opportunity to voice his or her reactions or concerns regarding prescribed medication(s).
- Ensure that the child (if over age 12) and the child's attorney/GAL is provided notice in writing of Children's Rights, along with:
  - the right to file a service delivery grievance or to file a motion with the juvenile court;
  - the right to speak privately with the healthcare provider;
  - the right to seek a second opinion from a different healthcare provider;
  - the right for children age 12-17 to request that their refusal to assent to the administration of a psychotropic medication be reviewed by the Statewide Clinical Consultant.
- Give the child the opportunity to sign the CD -275 and ensure that the signed form is placed in the child's case record.

## 2.24 Older Youth Transition Planning

Page

31

**Older Youth Transition Planning** Page 31

Case managers must ensure that a youth's transition plan includes provisions to assist the youth in safely managing medication usage after exiting foster care, including information that educates the youth about:

- the use of the medication
- resources available to assist the youth in safely managing the medication
- informed consent and the right of the youth to be his or her own medical consentor





## 2.25 Youth 18 Years and Older

Page 32

Youth 18 Years and Older Page 32

Once a youth has reached 18 years of age, the ability to give consent or refuse treatment shall transfer from the case manager to the youth.


The case manager should be available to answer questions and assist the youth in making an informed decision.

The only exception to this is if a court order has been obtained that such a transfer would not be in the youth's best interest due to incapacity or disability. In that event, the case manager should continue as the consenter but involve the youth in the decision-making process to the greatest extent possible.

## 2.26 Module 2: Giving Psychotropic Medications, Monitoring, and Follow Up

Module 2: Giving Psychotropic Medications, Monitoring, and Follow Up

**Module 2:**  
Giving Psychotropic Medications, Monitoring, and Follow Up



## 3. Module 2: Giving Psychotropic Medications, Monitoring, and Follow Up

### 3.1 Giving Psychotropic Medications to Children

Page

34

Giving Psychotropic Medications to Children Page 34

- Remember that psychotropic medications are only one strategy to help the child. The resource provider must continue to provide a stable environment and consistent behavior intervention and explore non-pharmacological (non-medication) interventions with healthcare providers. The child may also need behavior health therapy.
- Always read and keep the insert from the pharmacy that comes with each medication. The insert tells you important information on how to give the medication and on possible side effects to watch for.
- Store the medication in the original container that came from the pharmacy.



### 3.2 Court Review – Summary of Care

Page

35

Court Review – Summary of Care Page 35

RsMO 210.720(2) In such permanency hearing the court shall consider all relevant factors including: (3) The mental and physical health of all individuals involved, including any history of abuse of any individuals involved.

The case manager shall provide a comprehensive summary regarding the child's health in regular court reports and shall include any current diagnoses and medications, if any.



A summary of the child's medical care that is presented to the court at each hearing where medical care is reviewed should include:

- a description of the psychosocial therapies, behavior strategies, or other non-pharmacological (non-medication) interventions that have been provided to the child; and
- the dates of any office visits the child has had with the prescribing medical provider since the previous hearing.


### 3.3 Notifications about psychotropic medications

Page

36

Notifications about psychotropic medications Page 36

- The child's resource provider should give information to the case manager as soon as possible about any *dosage changes* of an approved psychotropic medications.
- The resource provider may provide this information to the case manager verbally and these changes should be tracked in writing on the Monthly Medical Log (CD-265).
- The case manager should regularly attempt to involve the parent in the child's treatment by offering invitations to appointments and providing updates about the child's health status.
- The case manager must make a least two attempts, on different days, to contact the parent if the healthcare provider recommends mental health treatment or other non-routine medical care. If after two attempts, and two different forms of contact initiated, and neither parent is reachable, then the case manager may provide consent or refusal to the recommended treatment and documentation of the decision must be completed in FACES.



### 3.4 More About Giving Psychotropic Medications

Page 37

More About Giving Psychotropic Medications Page 37

- Give the medication exactly as prescribed and never more or less unless directed by the doctor.
- Never quit giving the medication to the child unless the doctor tells you to quit. Some psychotropic medications require weaning off gradually. Always follow the doctor's instructions when stopping medications.
- Follow the doctor's direction for giving the medication. For example, the doctor may tell you to give the medication at a certain time of day or to make sure the child does not eat certain foods.
- Watch to make sure the child takes the medication.
- Never give a child a medication that is prescribed for someone else.
- Keep a medication log for each child. Write down the date, time, and who gave the medication to the child.
- Coordinate with the doctor to make sure you get refills on time.

### 3.5 What Are Side Effects?

Page

38

What Are Side Effects? Page 38

- These are uncomfortable effects such as stomach aches, drowsiness, dizziness, sleep problems, tremors, and weight gain that may occur when starting a new medication, increasing the dose, or stopping the medication.
- These may get better with healthy diet, rest, and exercise.
- These may make the child feel very uncomfortable or the side effect may interfere with functioning, and the medical consentor should call the child's doctor and seek advice if this happens.



### 3.6 Adverse Reactions

Page

39

Adverse Reactions Page 39



Adverse reactions:

- Are uncommon and unexpected.
- May be an allergic reaction.
- Are likely harmful if the child keeps taking the medication.
- May be life threatening.

Immediately talk to the child's doctor and follow his or her directions if there is an adverse reaction or seek emergency medical treatment if doctor is not available.


### 3.7 Side Effects and Adverse Reactions

Page

40

Side Effects and Adverse Reactions Page 40

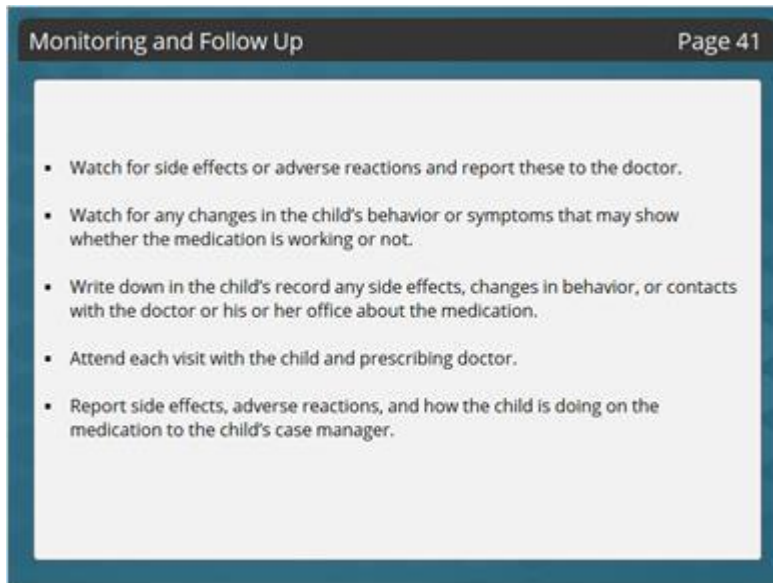
- Always talk to the child's doctor anytime you have a concern about how a medication is affecting a child.
- Always report adverse reactions to the doctor right away.
- Call 911 or immediately take the child to the emergency room if the child is having an adverse reaction that is life threatening.
- Remember to report this information to the Children's Division case manager or contracted case management staff.



### **3.8 Monitoring and Follow Up**

**Page**

**41**



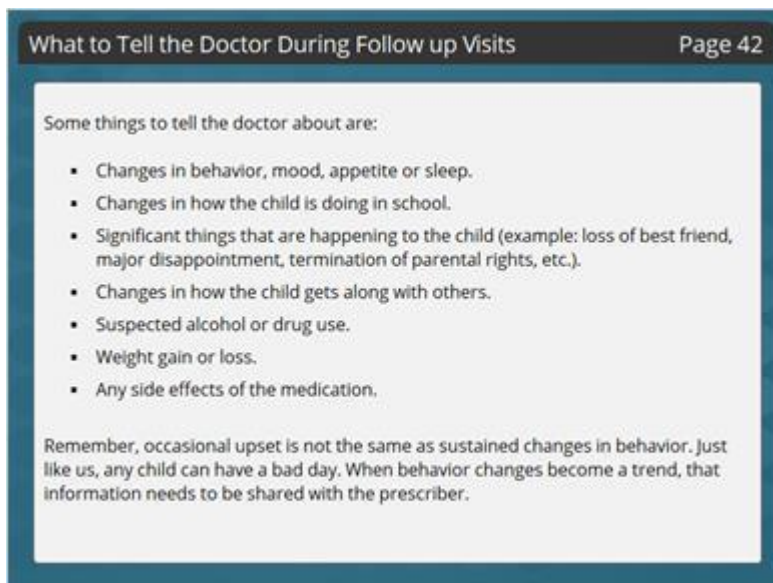
Monitoring and Follow Up Page 41

- Watch for side effects or adverse reactions and report these to the doctor.
- Watch for any changes in the child's behavior or symptoms that may show whether the medication is working or not.
- Write down in the child's record any side effects, changes in behavior, or contacts with the doctor or his or her office about the medication.
- Attend each visit with the child and prescribing doctor.
- Report side effects, adverse reactions, and how the child is doing on the medication to the child's case manager.

### **3.9 What to Tell the Doctor During Follow up Visits**

**Page**

**42**



What to Tell the Doctor During Follow up Visits Page 42

Some things to tell the doctor about are:


- Changes in behavior, mood, appetite or sleep.
- Changes in how the child is doing in school.
- Significant things that are happening to the child (example: loss of best friend, major disappointment, termination of parental rights, etc.).
- Changes in how the child gets along with others.
- Suspected alcohol or drug use.
- Weight gain or loss.
- Any side effects of the medication.

Remember, occasional upset is not the same as sustained changes in behavior. Just like us, any child can have a bad day. When behavior changes become a trend, that information needs to be shared with the prescriber.

### **3.10 Is it Okay for A Child to Take a Medication that Does Not Have FDA Approval?      Page 43**

Is it Okay for A Child to Take a Medication that Does Not Have FDA Approval?      Page 43

- Many medications used in children's behavioral health are safe and effective.
- Many psychotropic medications, however, do not have Federal Food and Drug Administration (FDA) approved labeling for use in children and adolescents due to the majority of medication being approved by the FDA based on research in adults.
- Over time, clinical studies and research may support the use of the medication for an "off-label" use in children and/or adolescents.
- However, many medications have not been studied or approved for use with children. Researchers are not sure how these medications affect a child's growing body.



### **3.11 Module 3: Overview of Psychotropic Medications**

Module 3: Overview of Psychotropic Medications

Module 3:  
Overview of Psychotropic Medications



## 4. Module 3: Overview of Psychotropic Medications

### 4.1 How Do Psychotropic Medications Work?

Page

45

How Do Psychotropic Medications Work? Page 45



Psychotropic medications act on the brain and central nervous system. They change the way chemicals in the brain called "neurotransmitters" send messages between brain cells through a synapse or crossing. Each psychotropic medication is used to treat certain "target" symptoms.

### 4.2 Overlapping Target Symptoms (Behaviors)

Page 46

Overlapping Target Symptoms (Behaviors) Page 46

	Anger/ Depression	Impulsive	Withdrawn Sad	Destructive Defiant	Anxious	Difficulty w/ Focus	Manipulative
ADHD	X	X		X		X	
Conduct Disorder	X			X			X
Oppositional Defiant Disorder	X	X		X			X
Anxiety Disorder	X	X	X		X	X	
Bipolar Disorder	X	X	X	X		X	X
Obsessive Compulsive Disorder		X			X		
PTSD	X		X		X	X	



## 4.3 Classes Of Psychotropic Medications

Page

47

Classes Of Psychotropic Medications Page 47

Common types of psychotropic medications are:

- Stimulants
- Antidepressants
- Antipsychotics
- Anticonvulsants/ mood stabilizers, including Lithium
- Antianxiety agents
- Alpha agonists
- Anxiolytics/hypnotics (anti-anxiety agents & sedatives)



We will now discuss the different classes of psychotropic medications used in children, and examples of medications in each class and their side effects. The medication your child is taking may not be mentioned since new medications come out all the time. It is important to read the pharmacy insert and talk with the doctor to learn about each medication.

## 4.4 Stimulants

Page

48

Stimulants Page 48

Stimulants are commonly used to treat Attention-Deficit Hyperactivity Disorder (ADHD). Symptoms of ADHD interfere with functioning at school and in daily living and may include:

- Short attention span.
- Inability to stay still.
- Being impulsive.

Stimulants may be short acting or long acting. Short acting means that they act right away but do not last a long time. Long acting means that they take longer to act but last longer. Some children need to take a short acting and a long acting stimulant to get coverage throughout the day. Taking a short acting and a long acting stimulant together counts as only one stimulant and is not outside the parameters of recommended treatment.

## 4.5 Stimulants


Stimulants Page 49

Examples of short acting stimulants:	Examples of long acting stimulants:
<ul style="list-style-type: none"><li><input type="checkbox"/> Amphetamine (Adderall)</li><li><input type="checkbox"/> Dexmethylphenidate (Focalin)</li><li><input type="checkbox"/> Methylphenidate (Ritalin, Metadate, Methylin)</li><li><input type="checkbox"/> Dextroamphetamine (Dexedrine, Dextrostat)</li></ul>	<ul style="list-style-type: none"><li><input type="checkbox"/> Amphetamine (Adderall XR)</li><li><input type="checkbox"/> Dexmethylphenidate (Focalin XR)</li><li><input type="checkbox"/> Methylphenidate (Concerta)</li><li><input type="checkbox"/> Lisdexamfetamine (Vyvance)</li></ul>

## 4.6 Possible Side Effects and Adverse Reactions of Stimulants

Possible Side Effects and Adverse Reactions of Stimulants Page 50

Side Effects:	Adverse Reactions:
<ul style="list-style-type: none"><li><input type="checkbox"/> Decreased appetite</li><li><input type="checkbox"/> Weight loss</li><li><input type="checkbox"/> Headaches</li><li><input type="checkbox"/> Stomachaches</li><li><input type="checkbox"/> Trouble getting to sleep</li><li><input type="checkbox"/> Jitteriness</li><li><input type="checkbox"/> Social withdrawal</li><li><input type="checkbox"/> Tics, sudden repetitive movements or sounds</li><li><input type="checkbox"/> Aggressive behavior or hostility</li><li><input type="checkbox"/> Psychotic or manic symptoms</li></ul>	<ul style="list-style-type: none"><li><input type="checkbox"/> Sudden death in children with pre-existing serious heart problems</li><li><input type="checkbox"/> High blood pressure</li><li><input type="checkbox"/> Problems with growing, such as a slower growth rate</li></ul>



## 4.7 Other ADHD Treatments

Other ADHD Treatments Page 51

Sometimes medications that are not stimulants are used to treat ADHD. These medications come from different classes. You will need to read the pharmacy insert to learn about side effects and adverse reactions to these medications. A child in your care may be prescribed one of these medications.

**Examples are:**

- ❑ **Clonidine (Catapres, Kapvay)**—used to treat high blood pressure in adults but causes sedation in children in small doses
- ❑ **Guanfacine (Tenex, Intuniv)**—used to treat high blood pressure in adults but causes sedation in children in small doses
- ❑ **Atomoxetine (Strattera)**—newer antidepressant, in rare cases causes suicidal thought risk
- ❑ **Bupropion (Wellbutrin, Wellbutrin SR, Wellbutrin XL)**—newer antidepressant
- ❑ **Imipramine (Tofranil)**—older antidepressant, usually used to treat bed wetting, but may be used to treat ADHD

## 4.8 More About Treating ADHD

More About Treating ADHD Page 52

- ❑ Stimulants are usually the first medication tried for ADHD.
- ❑ Sometimes antidepressants are given for ADHD if 2 to 3 stimulants are tried and do not work.
- ❑ Your child's doctor should start the stimulant at the lowest dose and only increase the dose as needed.
- ❑ A short acting stimulant should last for about 4 hours and a long acting stimulant for about 8-12 hours.

## 4.9 Antidepressants

Antidepressants

Page 53

Antidepressants are used in children to treat symptoms of depression and other conditions.

**Symptoms of depression may include:**

- Feelings of hopelessness or helplessness
- Loss of energy
- Changes in appetite
- Weight gain or weight loss
- Not being able to enjoy activities the child used to enjoy
- Thoughts of suicide

**Antidepressants may help with other conditions:**

- School phobias
- Panic attacks
- Eating disorders
- Autism
- ADHD
- Bedwetting
- Anxiety disorders
- Obsessive-compulsive disorder (OCD)
- Post-traumatic stress disorders (PTSD)
- Personality disorders
- Sleeping problems

## 4.10 Antidepressants: SSRIs

Antidepressants: SSRIs

Page 54

Selective Serotonin Reuptake Inhibitors (SSRIs) are one of the newer groups of antidepressants. SSRIs are often used to treat depression and other disorders in children. SSRIs are often used because they are safer than some of the older antidepressants if overdose occurs.

**Examples are:**

- Citalopram (Celexa)
- Escitalopram (Lexapro)
- Fluoxetine (Prozac)
- Fluvoxamine (Luvox)
- Sertraline (Zoloft)
- Paroxetine (Paxil)

## 4.11 Possible Side Effects and Adverse Reactions of SSRI Antidepressants

Possible Side Effects and Adverse Reactions of SSRI Antidepressants Page 55

<b>Flu-like symptoms:</b>	<b>Other side effects:</b>
<input type="checkbox"/> Headaches	<input type="checkbox"/> Trouble sleeping
<input type="checkbox"/> Nausea	<input type="checkbox"/> Irritability
<input type="checkbox"/> Stomach upset	<input type="checkbox"/> Weight changes
<input type="checkbox"/> Dry mouth	
<input type="checkbox"/> Extreme sweating	

**Warning**

The caregivers of children taking SSRIs should monitor them for depression that is getting worse and thoughts about suicide. The resource provider or medical consenter should immediately talk to the doctor if this happens.

## 4.12 Antidepressants: SNRIs

Antidepressants: SNRIs Page 56

Serotonin Norepinephrine Reuptake Inhibitors (SNRIs) are usually prescribed when SSRIs have not worked. SNRIs are not usually prescribed to children. However, they may be helpful in some cases.

**Examples are:**

- Venlafaxine (Extended Release Effexor XR)
- Duloxetine (Cymbalta)
- Desvenlafaxine (Pristiq)

### 4.13 Possible Side Effects and Adverse Reactions to SNRI Antidepressants


Possible Side Effects and Adverse Reactions to SNRI Antidepressants Page 57

**Side Effects:**

- Abnormal dreams
- Nervousness
- Body weakness
- Chills
- Cough
- Dizziness
- Headache
- High blood pressure
- Increased sweating
- Loss of appetite or weight
- Stomach or colon problems

**Adverse Reactions:**

- Thoughts of suicide
- Panic attacks
- Hallucinations




### 4.14 Atypical Antidepressants

Atypical Antidepressants Page 58

Children who have been traumatized may have problems with sleep. Atypical antidepressants are more often used to help children with sleep problems than to treat depression. These medications are usually safer for children than standard prescription sleep medications (such as Ambien, Halcion, Lunestra, Rozerem, and Sonata).

**Examples are:**

- Bupropion (Wellbutrin)
- Mirtazapine (Remeron)
- Trazadone (Desyrel)



## 4.15 Possible Side Effects and Adverse Reactions of Atypical Antidepressants

Possible Side Effects and Adverse Reactions of Atypical Antidepressants Page 59

Side Effects:	Adverse Reactions:
<input type="checkbox"/> Sleepiness	<input type="checkbox"/> Male erection that is unwanted, painful and lasts a long time (Trazadone)
<input type="checkbox"/> Headache	<input type="checkbox"/> Seizures (Wellbutrin)
<input type="checkbox"/> Constipation	<input type="checkbox"/> Low white blood cell count (Remeron)
<input type="checkbox"/> Dry mouth	
<input type="checkbox"/> Agitation	
<input type="checkbox"/> Nervousness	
<input type="checkbox"/> Weight changes	
<input type="checkbox"/> Flushing	
<input type="checkbox"/> Sweating	
<input type="checkbox"/> Tremors	
<input type="checkbox"/> Changes in blood pressure	

## 4.16 Other Information About Antidepressants

Other Information About Antidepressants Page 60

- These medications may take a couple of weeks to work.
- A two-week break may be needed after finishing one medication and starting another one.
- A child should never stop taking antidepressants suddenly. Your child's doctor will help you wean the child off of the medication slowly. This will help prevent dizziness and other side effects.

## 4.17 Antipsychotics

Antipsychotics

Page 61

Antipsychotics may be used to treat a number of conditions in children:

- Psychosis
- Bipolar disorder
- Schizophrenia
- Autism
- Tourette's syndrome
- Severe aggression

Antipsychotics are divided into two groups:

- Atypical** (or second generation) antipsychotics, were first developed in 1994.
- Typical** (or first generation) antipsychotics were first developed in 1950.

## 4.18 Atypical (Second Generation) Antipsychotics

Atypical (Second Generation) Antipsychotics

Page 62

Atypical antipsychotics are the most common antipsychotics used in children. These antipsychotics are less likely to cause movement disorders (shuffling walk, tongue sticking out of mouth, drooling, etc.) than the typical antipsychotics.

Examples are:

- Aripiprazole (Abilify)\*
- Quetiapine (Seroquel)\*
- Olanzapine (Zyprexa)
- Risperidone (Risperdal)
- Clozapine (Clozaril, Fazaclo)\*
- Ziprasidone (Geodon)
- Paliperidone (Invega)
- Iloperidone (Fanapt)
- Asenapine (Saphris)
- Lurasidone (Latuda)

\*The Physician Desk Reference has a black box warning for Abilify, Seroquel and Clozapine.



#### 4.19 Black Box Warning for

Black Box Warning for Abilify and Seroquel Page 63

The Physician Desk Reference documents the black box warning for Abilify and Seroquel:

- ❑ "Not approved for depression in under age 18. Increased the risk of suicidal thinking and behavior in short-term studies in children and adolescents with major depressive disorder and other psychiatric disorders"

#### 4.20 Black Box Warning for Clozapine

Black Box Warning for Clozapine Page 64

The Physician Desk Reference documents the black box warning for Clozapine:

- ❑ Risk of life threatening agranulocytosis
- ❑ Seizures
- ❑ Myocarditis
- ❑ Other adverse cardiovascular and respiratory effects

## 4.21 Possible Side Effects of Atypical Antipsychotics

Possible Side Effects of Atypical Antipsychotics Page 65

Common Side Effects:	Less Common Side Effects:
<ul style="list-style-type: none"><li><input type="checkbox"/> Sleepiness or tiredness</li><li><input type="checkbox"/> Dizziness</li><li><input type="checkbox"/> Constipation</li><li><input type="checkbox"/> Dry mouth</li><li><input type="checkbox"/> Blurred vision</li><li><input type="checkbox"/> Difficulty urinating</li><li><input type="checkbox"/> Sensitivity to lights</li><li><input type="checkbox"/> Weight gain</li><li><input type="checkbox"/> Change in menstrual cycle</li></ul>	<ul style="list-style-type: none"><li><input type="checkbox"/> Dystonia: muscle spasms; stiff neck; tongue sticking out of mouth; trouble swallowing</li><li><input type="checkbox"/> Akathisia: restlessness, unable to sit still</li><li><input type="checkbox"/> Akinesia: rigid muscles; shuffling walk; drooling; tremor</li></ul>

## 4.22 Possible Adverse Reactions of Atypical Antipsychotics

Possible Adverse Reactions of Atypical Antipsychotics Page 66

- Tardive dyskinesia (permanent involuntary movements of tongue, mouth, face, trunk, arms and legs that are more common with typical antipsychotics than with atypical)
- Overheating or heatstroke (prevent by drinking water and staying out of heat)
- Metabolic Syndrome (excess weight gain, increased blood pressure, high blood sugar and triglyceride levels)
- Type II Diabetes, Heart Disease, and Stroke
- Neuroleptic malignant syndrome (extreme muscle stiffness, high fever, sweating, tremors, confusion, unstable blood pressure and heart rate). **This is a medical emergency.**

**Clozaril:**

- Can cause a dangerous drop in white blood cells
- Requires weekly blood work for 6 months, every 2 weeks for the next 6 months and then every 4 weeks thereafter
- Usually used only when other treatments fail

### 4.23 Typical (First Generation) Antipsychotics

Typical (First Generation) Antipsychotics Page 67

Typical antipsychotics are used less often in children.

**Examples are:**

- Chlorpromazine (Thorazine)
- Haloperidol (Haldol)
- Perphenazine (Trilafon)
- Pimozide (Orap)

### 4.24 Other Information About Antipsychotics

Other Information About Antipsychotics Page 68

- Each child is different, so a child may need to try different medications in order to find the one that works best.
- You should start seeing positive changes in 2-3 weeks, but it may take 6-8 weeks.
- A child should never stop taking an antipsychotic suddenly. This may cause fast changes in mood, agitation, aggression, nausea, sweating or tremors. The child's doctor will help you wean the child off the medication slowly.
- The child's weight, glucose levels and lipid levels should be monitored regularly by a doctor while taking antipsychotic medication.

## 4.25 Mood Stabilizers

Mood Stabilizers Page 69

Mood stabilizers are used to treat children with mood disorders, such as bipolar disorder. Children with bipolar disorder have extreme mood swings (manic or depressed states).

- When children are in the “manic” state, they may be very active, talk too much, have a lot of energy, and sleep very little. They may also be angry, irritable, or feel overly self-important.
- Children in the “depressed” state may:
  - Feel hopeless or helpless.
  - Have a loss of energy.
  - Have changes in appetite.
  - Gain or lose weight.
  - Not enjoy activities the child used to enjoy.
  - Have thoughts of suicide.

## 4.26 Mood Stabilizers

Mood Stabilizers Page 70

Some medications used to treat mood disorders are also used to treat seizure disorders. If it is used to treat seizures, it is not considered a psychotropic medication.

<p><b>Medications that may be used to treat mood or seizures:</b></p> <ul style="list-style-type: none"><li>□ Lamotrigine (Lamictal)</li><li>□ Divalproex (Depakote)</li><li>□ Carbamazepine (Carbatrol, Tegretol, Tegretol XR)</li></ul>	<p><b>Medications that are only used as mood stabilizers:</b></p> <ul style="list-style-type: none"><li>□ Lithium (Eskalith, Eskalith CR, Lithobid)</li></ul>
---	---

#### 4.27 Possible Side Effects and Adverse Reactions of Lamotrigine (Lamictal)

Possible Side Effects and Adverse Reactions of Lamotrigine (Lamictal) Page 71

<b>Side Effects:</b>	<b>Adverse Reactions:</b>
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Serious rashes
<input type="checkbox"/> Problems sleeping	<input type="checkbox"/> Stevens Johnson Syndrome*
<input type="checkbox"/> Drowsiness	
<input type="checkbox"/> Blurred vision	
<input type="checkbox"/> Vomiting	
<input type="checkbox"/> Constipation	
<input type="checkbox"/> Stomach aches	

\* Stevens Johnson Syndrome is a rare, but serious condition affecting the skin and mucous membranes. It is a medical emergency that requires hospitalization. It begins with swelling of the face and tongue, skin pain, blisters, hives, shedding of skin; the child may also have fever, sore throat, burning eyes, cough. **Immediately contact the doctor if your child develops a rash while taking this medication.**

#### 4.28 Possible Side Effects and Adverse Reactions of Divalproex (Depakote)

Possible Side Effects and Adverse Reactions of Divalproex (Depakote) Page 72

<b>Side Effects:</b>	<b>Adverse Reactions:</b>
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Liver toxicity and liver failure (very rare but very serious)
<input type="checkbox"/> Nausea/vomiting	
<input type="checkbox"/> Drowsiness	
<input type="checkbox"/> Hair loss	
<input type="checkbox"/> Weight changes	
<input type="checkbox"/> Changes in menstrual cycles	
<input type="checkbox"/> Constipation	

**Children taking Depakote should have regular blood work to check for liver problems and make sure the dose is safe and effective.**

## 4.29 Possible Side Effects and Adverse Reactions of Carbamazine (Tegretol)

Possible Side Effects and Adverse Reactions of Carbamazine (Tegretol) Page 73

Side Effects:	Adverse Reactions:
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Reduction of blood cell production in the bone marrow
<input type="checkbox"/> Drowsiness	<input type="checkbox"/> Decreased red blood cells, white blood cells, and platelets
<input type="checkbox"/> Nausea	<input type="checkbox"/> Stevens Johnson Syndrome*
<input type="checkbox"/> Unsteadiness	
<input type="checkbox"/> Vomiting	

Children should have regular blood work to rule out decreased blood cells. Contact the doctor right way if the child has tiredness, weakness, easy bruising or unusual bleeding.

\*See previous slide on Lamictal regarding Stevens Johnson Syndrome

## 4.30 Possible Side Effects and Adverse Reactions of Lithium

Possible Side Effects and Adverse Reactions of Lithium Page 74

Side Effects:	Adverse Reactions:
<input type="checkbox"/> Fatigue	These are signs of Lithium toxicity:
<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Repeated vomiting/diarrhea
<input type="checkbox"/> Nausea	<input type="checkbox"/> Severe tremors
<input type="checkbox"/> Stomach cramps	<input type="checkbox"/> Difficulty walking/unable to walk
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Poor coordination
<input type="checkbox"/> Urinating more often	<input type="checkbox"/> Extreme sleepiness
<input type="checkbox"/> Slight hand tremor	<input type="checkbox"/> Slurred speech/difficulty sleeping
<input type="checkbox"/> More thirsty	<input type="checkbox"/> Blurred vision/ringing in ears
<input type="checkbox"/> Low blood sugar	<input type="checkbox"/> Unable to control eyes going in circles
<input type="checkbox"/> Lower thyroid function	<input type="checkbox"/> Muscle twitching
<input type="checkbox"/> Hair loss	<input type="checkbox"/> Seizures

Children taking Lithium should have regular blood work to determine if the blood level of Lithium is in the safe and effective range.

### 4.31 Other Information About Mood Stabilizers

Other Information About Mood Stabilizers Page 75

- Mood stabilizers may effect the metabolism, liver, kidneys, and thyroid.
- Children taking Tegretol, Depakote or Lithium should have routine blood work. Levels are usually checked in the morning before the medication is given to the child.

### 4.32 Antianxiety agents (Tranquilizers)

Page 76

Antianxiety agents (Tranquilizers) Page 76

Anxiolytics/hypnotics may also be referred to as tranquilizers, anti-anxiety agents, and sedatives. These drugs are used to treat people with severe anxiety that interferes with their daily activities. The Benzodiazepines are potentially addictive and are more commonly used in the hospital. However, they may be used to treat neurological problems in children, such as muscle spasms.

**Examples are:**

Benzodiazepines:	Other (not addictive)
<input type="checkbox"/> Clonazepam (Klonopin)	<input type="checkbox"/> Buspirone (Buspar)
<input type="checkbox"/> Lorazepam (Ativan)	
<input type="checkbox"/> Alprazolam (Xanax)	

## 4.33 Alpha 2 Agonists

Page 77

Alpha 2 Agonists Page 77

Extended release products (off-label treatments for ADHD):

- Clonidine
- Guanfacine

These medicines are a second line treatment:

- Less effective than stimulants
- May take up to 2 weeks for full response

Special considerations in using this class:

- Comorbid tic disorder
- Concurrent substance abuse
- Intolerable stimulant side effects
- May not be as effective for inattentive only symptoms

Side Effects for Clonidine & Guanfacine, include:

- Dose dependent side effects
  - Sedation
- Dizziness
- Withdrawal and rebound hypertension
- Do not take ER formulations with high-fat meals due to increased exposure
- Hypotension and/or tachycardia

## 4.34 Module 4: Medical Records

Module 4: Medical Records

**Module 4:**  
Medical Records





## 5. Medical Records

### 5.1 Medical Records

#### Page 79

Medical Records Page 79

Diligent and Reasonable - staff shall collect all available medical records for each child in CD custody. Staff must exercise reasonable and diligent efforts to locate and obtain the records. Those efforts **must be documented in the case record and should include, at minimum,** discussion with parent(s) and requesting parental assistance in completing the CW-103, accessing Medicaid claims data to determine information about prescriptions or providers and requesting information from those providers, contacting the child's health insurer, reviewing any records available from prior contact or custody with CD, and requesting information from other sources who may have been involved in the child's healthcare, including guardians, family members, or school and community resources. Remember, this requirement is for all children in CD custody, not just those who may be on a psychotropic medication.

### 5.2 Medical Records

#### Page 80

Medical Records Page 80

Prescriber Notes

- When medical records are requested you need to specify needing "prescriber notes"
- Prescriber notes are the "Why" each medication is being prescribed
- The Center for Excellence asks for a psychiatric evaluation if a recent one is available, but what is necessary in for a quality review and consultation are the prescriber notes (whether they are from a Primary Care Physician or a Psychiatrist).

## 5.3 Medical Records

Page 81

Medical Records Page 81

Records shall include but not limited to the following:

- Medical and surgical history
- Dental history
- Psychosocial history
- Past mental health and psychiatric history, including medication history and documented benefits and adverse effects
- Past hospitalization or residential treatment history
- Allergies
- Immunizations
- Current and past medications, including current dosage and directions for administration
- Family health history
- Treatment and/or service plans
- Results of any clinically indicated lab work
- The names and contact information for all of the Child's current and past mental health, dental, and medical providers
- Signed consent forms, including but not limited to those for Psychotropic Medications

## 5.4 Documentation of Medical Records

Page

82

Documentation of Medical Records Page 82

All CD staff, FCCM, and Residential Contractors must maintain any and all records related to the potential or actual treatment of any foster child with psychotropic medications. This includes but is not limited to e-mails, handwritten notes and phone messages. These records must be maintained in the child's case file.

To assist resource providers in caring for children, CD and contracted case managers are to provide necessary health information to the resource provider (CD 264 and prior 265). The resource provider is to maintain a medical file for the child during placement and update it regularly, documenting all information on the CD-265, which the worker is to review monthly. If the child transitions to a subsequent placement, that medical file should move with the child.

## 5.5 Documentation of Medical Records (Cont.)

Page 83

Documentation of Medical Records (Cont.) Page 83

Upon initial placement, the assigned *Case Manager* will ensure that placement providers have the Health Care Information Summary (CD-264) and the Child/Family Health and Developmental Assessment (CW-103) within 72 hours, whenever possible. Remember that the CD-264 is a tool designed to help the resource providers with immediate information they would need to know to take care of a child right away: allergies, medications, pending appointments, and other pertinent items. The CW-103 is ideally completed with assistance from the parent(s) or guardian and is a more in-depth review of the child's history. If the forms cannot be provided within 72 hours, they must be provided within thirty days.

If a placement change is required, because the documentation should already exist, the CD-264, the CW-103, and the medical record file from the previous resource parent must be provided to the subsequent placement provider within 72 hours.

## 5.6 Medical Records Uploaded to OnBase

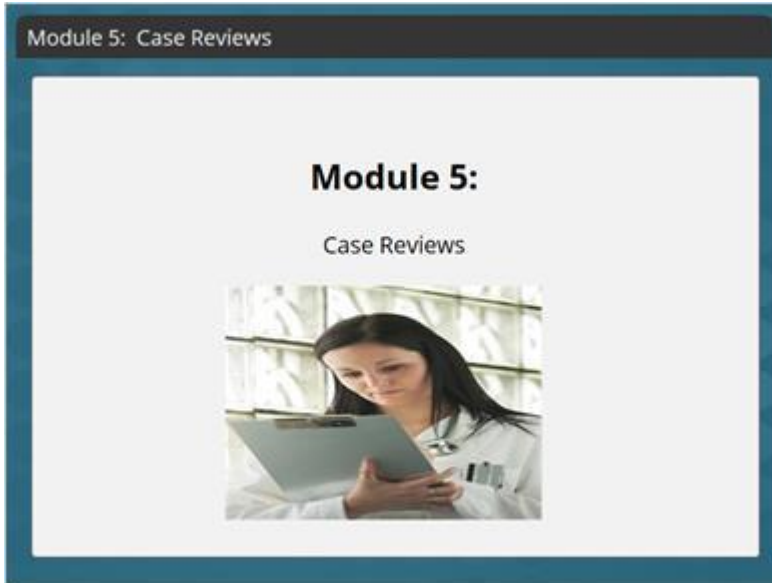
Page

84

Medical Records Uploaded to OnBase Page 84

The documentation should be reflected in FACES where appropriate and in quarterly summaries. Case Managers will ensure there is a completed Monthly Medical Log (CD-265), uploaded to Onbase and placed in the child's file. Any informed consent for psychotropic medications should be documented on the CD-275 and a completed copy of the CD-275 should be retained both in Onbase and the child's file.

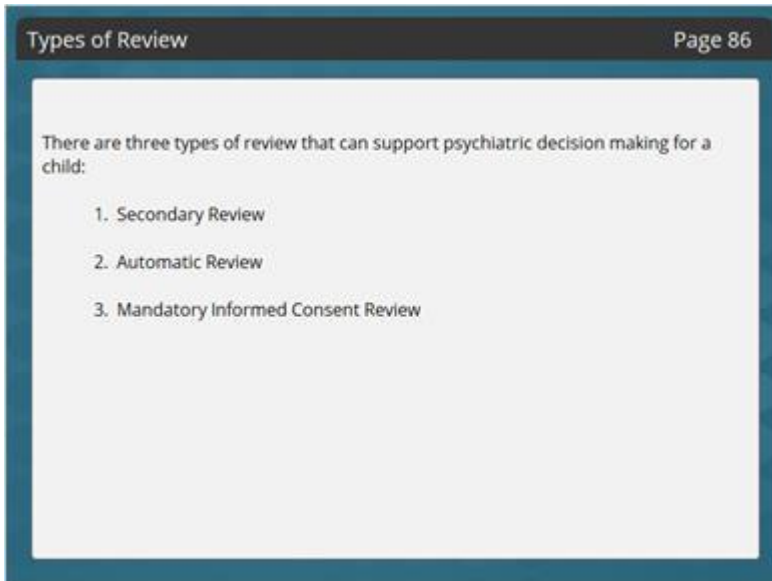
## 5.7 Module 5: Case Reviews



## 6. Explanation of Different Reviews

### 6.1 Types of Review

**Page 86**

A presentation slide titled "Types of Review" with "Page 86" in the top right corner. The slide has a dark blue header with the text "Types of Review" in white on the left and "Page 86" in white on the right. Below the header, the text "There are three types of review that can support psychiatric decision making for a child:" is centered. Below this text is a numbered list with three items: "1. Secondary Review", "2. Automatic Review", and "3. Mandatory Informed Consent Review".

## 6.2 Secondary Review

Page 87

Secondary Review Page 87

Secondary Reviews (Psychiatric Medication Reviews) -

These can include questions related to:

- a child being placed on psychotropic medication for the first time, or
- a change in psychotropic medication, or
- parent(s) not consenting to recommended medication, or
- the youth does not agree with the recommended medication or has questions, or
- if other members of the FST asks for a review to be completed, or
- a general overview of all of the child's medications, if there is a concern

## 6.3 Automatic Reviews

Page 88

Automatic Reviews Page 88

Automatic Reviews - The Center for Excellence must complete quarterly review for children who are identified as triggering certain Quality Indicators (QI) benchmarks. Specifically for these listed:

- Use of an antipsychotic in children 4 and under
- Use of 5 or more psychotropic for 90 or more days
- Use of two or more antipsychotics for 90 or more days
- Multiple prescribers of psychotropic medications for 90 or more days

When a review is indicated the Center will email the case worker, their supervisor and the assigned Health Information Specialist letting them know the child has been pulled for an Automatic Review and what steps the case worker will need to take. Important things to remember:

- Case worker will receive a child specific link where they will submit requested documentation
- Workers only have 10 business days to submit the information
- Prescriber notes, current medication list, current diagnosis and lab results are required
- The Center will provide written recommendations from psychiatrist within five days of the submission of records
- Case manager will review and discuss the Center for Excellence recommendations with prescriber and team members.

## 6.4 Mandatory Informed Consent Reviews

Page 89

Mandatory Informed Consent Reviews Page 89

*Mandatory Informed Consent Reviews* - Case Managers must submit a referral to the Center for Excellence for children who are identified as triggering certain Quality Indicators (QI) benchmarks.

**NOTE - The Center for Excellence WILL NOT be sending reminders for these reviews. Case Managers must know the triggers listed below and make the necessary referrals:**

- Before a child who is three years old or younger begins a psychotropic medication
- When a child who is four years or older has been on:
  - third psychotropic medication for 60 days
  - second antipsychotic medication for 60 days
  - before a psychotropic medication is started by a second physician

## 6.5 Things to Remember in a Reviews

Page 90

Things to Remember in a Reviews Page 90

Important things to remember:

- Case Managers will make a referral to the Center for Excellence on the 60<sup>th</sup> day of the above triggers to allow for the review process to be completed
- Case Manager will submit prescriber notes, current medication list, current diagnosis and lab results with referral
- The Center for Excellence will provide written recommendations from psychiatrist within five days of the submission of records for outpatient children and three business days for inpatient children.
- Case manger will review and discuss the Center for Excellence recommendations with prescriber and team members.

## 6.6 Documentation of Reviews

### Page 91

Documentation of Reviews Page 91

For all reviews (Secondary, Automatic and Mandatory) recommendations must be shared with the following:

- Child's parent (note exceptions in the non-disclosure section) or legal guardian
- Child's case manager
- Child's resource provider

Case manager should share the recommendations with the following:

- Child's GAL
- Child's CASA
- Other members of the Family Support Team
- Child's medical care providers

Documentation of the requests and recommendations shall be included in the child's case.

## 6.7 Non-Disclosure Letter

### Page 92

Non-Disclosure Letter Page 92

CD may decline to share the findings and recommendations in the following circumstances and will send you a written notice, if:

- The court has entered an order limiting your access to certain information about the child.
- Sharing the information is not in the best interest of the child or could endanger the health, safety, and welfare of the child or another person.
- Sharing the information may interfere with a child abuse, child neglect, or a criminal investigation.
- Providing information is contrary to law.

Those denied access have the right to seek an administrative review of the decision through a service delivery grievance (CS-131) or seek review of the decision by the juvenile court. A link to the service delivery grievance policy can be found in the "Resource" tab in the upper right hand corner.

## 6.8 Module 6: Health Information Specialists

Module 6: Health Information Specialists

**Module 6:**  
Health Information Specialists



## 7. Health Information Specialist

### 7.1 Health Information Specialist (HIS) Team Role

Page 94

**Health Information Specialist (HIS) Team Role** Page 94

The HIS Team Members are located throughout the state in each region. Under the direction of Health Information Specialist Coordinator, Stacie Frueh.

Team members are responsible to ensure all elements of the settlement are monitored, documented, and Children's Division is in compliance.

- Members of the HIS Team are acting on behalf of Jennifer Tidball, DSS Acting Director, and David Kurt, Children's Division Director, and shall have convening authority to call meetings with any Children's Division, Division of Legal Services (DLS) and Permanency Attorney Initiative (PAI) staff up to and including the CD Director for the purposes of communicating or recommunicating agreement specifics and to address any challenges in implementation.
- Additionally, the HIS Team has convening authority to communicate, elevate any matter, or request assistance from CD Director, CD Deputy Directors, CD Regional Directors, CD Circuit Managers, CD Supervisors, DLS and PAI Counsel, and/or DSS Director/Designee (Michele Renkemeyer); all parties are expected to provide immediate response and assistance.

The responsibility for this lies with each and every one of us. The Health Information Specialists are available to assist with training, medical records collection, and implementation.



## 7.2 Summary

Summary Page 95

- ❑ The vast majority of children in Children's Division custody do not need psychotropic medications.
- ❑ Some children need psychotropic medications to get temporary relief from symptoms of trauma from abuse, neglect or separation to treat behavioral health disorders.
- ❑ The medical consentor must decide whether or not to give consent before a doctor can start a child on psychotropic medications.
- ❑ Psychotropic medications alone are not the best treatment. They should always be used with non-pharmacological interventions, such as behavior interventions and behavioral health therapy, for long-lasting effects.
- ❑ The caregiver/medical consentor has a responsibility to monitor the child to make sure the medication is helping, watch the child for side effects and adverse reactions, and let the doctor and case manager know how the child is doing.

## 7.3 Let's See What You've Learned

Let's See What You've Learned

Post-Test to Check For Comprehension

**7.4 1: Most children in Children's Division custody need psychotropic medications to help relieve emotional stress caused from the trauma of abuse, neglect and separation.**

*(True/False, 10 points, 1 attempt permitted)*

1: Most children in Children's Division custody need psychotropic medications to help relieve emotional stress caused from the trauma of abuse, neglect and separation.

True

False

**7.5 2: Non-pharmacological interventions should be tried before talking to a doctor about prescribing psychotropic medications to a child. These interventions may include:**

*(Multiple Choice, 10 points, 1 attempt permitted)*

**2: Non-pharmacological interventions should be tried before talking to a doctor about prescribing psychotropic medications to a child. These interventions may include:**

- Providing a consistent, caring, stable environment
- Teaching the child coping skills and how to manage his or her behavior
- Behavioral interventions provided by a therapist to help the child manage his or her behavior and emotions
- Psychosocial therapy or counseling for the child
- All of the above
- None of the above

***7.6 3: Always talk to the prescriber if the child has serious symptoms that are not getting better with other interventions or the child is a danger to himself or others.***

*(True/False, 10 points, 1 attempt permitted)*

**3: Always talk to the prescriber if the child has serious symptoms that are not getting better with other interventions or the child is a danger to himself or others.**

- True
- False

**7.7 4: The child's medical consenter must provide informed consent before the child can be given a psychotropic medication.**

*(True/False, 10 points, 1 attempt permitted)*

A screenshot of a quiz question interface. The question text is "4: The child's medical consenter must provide informed consent before the child can be given a psychotropic medication." Below the question are two radio button options: "True" and "False". The "True" option is selected, indicated by a blue circle around the radio button. The "False" option is unselected, indicated by a white circle around the radio button. The background of the interface is a dark teal color with a pattern of lighter teal circles.

**7.8 5: Informed consent involves a discussion with the physician, physician assistant or advanced practice nurse about which of the following issues:**

*(Multiple Choice, 10 points, 1 attempt permitted)*

5: Informed consent involves a discussion with the physician, physician assistant or advanced practice nurse about which of the following issues:

- The child's diagnoses and symptoms
- How the psychotropic medication will help the child
- What side effects are associated with the medication
- Whether there are any other alternatives, such as non-pharmacological interventions that do not require the child to take a psychotropic medication
- All of the above
- None of the above

***7.9 6: Psychotropic medications alone are not the best treatment. A non-pharmacological intervention should always be tried first, such as behavior strategies, psychosocial therapy, and safe, positive, nurturing, consistent care; and should be a continued course of treatment, even when medication is prescribed, for long lasting effects.***

*(True/False, 10 points, 1 attempt permitted)*

6: Psychotropic medications alone are not the best treatment. A non-pharmacological intervention should always be tried first, such as behavior strategies, psychosocial therapy, and safe, positive, nurturing, consistent care; and should be a continued course of treatment, even when medication is prescribed, for long lasting effects.

- True
- False

***7.10 7: If the child is having undesirable side effects from a psychotropic medication, the first thing to do is:***

*(Multiple Choice, 10 points, 1 attempt permitted)*

7: If the child is having undesirable side effects from a psychotropic medication, the first thing to do is:

- Stop giving the medication to the child
- Reduce the dosage
- Talk to the prescribing physician, physician assistant or advanced practice nurse and follow his or her instructions
- Do nothing

**7.11 8: Stimulants are commonly used to treat which behavioral health condition:**

*(Multiple Choice, 10 points, 1 attempt permitted)*

**8: Stimulants are commonly used to treat which behavioral health condition:**

- Depression
- Attention Deficit Hyperactivity Disorder (ADHD)
- Anxiety
- Psychosis

**7.12 9: Antipsychotics may be used to treat which of the following conditions in children:**

*(Multiple Choice, 10 points, 1 attempt permitted)*

**9: Antipsychotics may be used to treat which of the following conditions in children:**

- Psychosis, bipolar disorder, schizophrenia, autism, Tourette's syndrome, severe aggression
- ADHD, mild depression and anxiety
- Antipsychotics should not be used in children
- All of the above
- None of the above

**7.13 10: Which of the following classes of medications should not be stopped suddenly and require gradual weaning by the doctor:**

*(Multiple Choice, 10 points, 1 attempt permitted)*

**10: Which of the following classes of medications should not be stopped suddenly and require gradual weaning by the doctor:**

- Antipsychotics and antidepressants
- Stimulants and antidepressants
- Mood stabilizers and stimulants
- All psychotropic medications can be stopped suddenly

**7.14 11: Children taking most mood stabilizers need regular drug levels and other lab work to be able to monitor effectiveness.**

*(True/False, 10 points, 1 attempt permitted)*



11: Children taking most mood stabilizers need regular drug levels and other lab work to be able to monitor effectiveness.

- True
- False

**7.15 12: The Secondary Review, also known as a psychiatric medication review, can include these questions related to:**

*(Multiple Choice, 10 points, 1 attempt permitted)*

12: The Secondary Review, also known as a psychiatric medication review, can include these questions related to:

- Parent(s) not consenting to recommended administration of psychotropic medication to their child
- A sibling needing medication for allergies
- A change in psychotropic medication
- Both - parent(s) not consenting to recommended administration of psychotropic medication to their child &/or a change in psychotropic medication

**Feedback when correct:**

---

**7.16 13: There are three types of case reviews for children using psychotropic medication: Secondary Reviews, Automatic Reviews and Mandatory Informed Consent Reviews.**

*(True/False, 10 points, 1 attempt permitted)*

A screenshot of a True/False question interface. The question text is: "13: There are three types of case reviews for children using psychotropic medication: Secondary Reviews, Automatic Reviews and Mandatory Informed Consent Reviews." Below the question, there are two radio button options: "True" (which is selected) and "False". The interface has a dark blue background with a pattern of lighter blue circles.

**7.17 14: Please identify and match the proper form that captures the child's psychotropic medication use and dosage to the correct user of who is responsible for the documentation.**

*(Matching Drag-and-Drop, 10 points, 1 attempt permitted)*

14: Please identify and match the proper form that captures the child's psychotropic medication use and dosage to the correct user of who is responsible for the documentation.

CD-275

Case Manager

CD-265

Resource Provider

***7.18 15: Case managers should always try to discuss medications with children, as age and developmentally appropriate, to support their understanding and obtain their assent. Case managers are required to provide notice of their rights about assent in writing to children age 8 or older.***

*(True/False, 10 points, 1 attempt permitted)*


15: Case managers should always try to discuss medications with children, as age and developmentally appropriate, to support their understanding and obtain their assent. Case managers are required to provide notice of their rights about assent in writing to children age 8 or older.

True

False

## 7.20 Results Slide

*(Results Slide, 0 points, 1 attempt permitted)*



Thank You!

✓ Thank you for completing this training.

If you have any further questions or comments  
you may send those to

[CD.PsyMedSettle@dss.mo.gov](mailto:CD.PsyMedSettle@dss.mo.gov)

Exit