Division of Children and Family Services Protection and Safety Procedure #13-2017	
Regarding:	Health Care Coordination and Psychotropic Medication Guidelines
Rescinds:	#11-2016 Health Care Coordination and Psychotropic Medication Guidelines
Date Effective:	04/11/2017
Contact:	Alyson Goedken at 402-471-8404 or Alyson.goedken@nebraska.gov
Issue by:	Douglas J Weinberg, Director, Division of Children and Family Services

Philosophy:

Children/youth in foster care have a high prevalence of chronic and complex illnesses. Assessing each child/youth's unique needs is critical, as is establishing continuity of care and ensuring a coordinated treatment approach by all professionals involved in the child/youth's care. Children/youth in foster care often have significant emotional and behavioral challenges as a result of maltreatment and trauma, and a high proportion of these children/youth are prescribed psychotropic medication to manage their symptoms. The use of this medication with a vulnerable population must be managed with care. The Division of Children and Family Services (DCFS), as part of the Health Care Coordination and Oversight Plan, has developed this document in order to provide guidance for the appropriate use and oversight of prescription medications, including psychotropic medications for children/youth identified as state wards and for children/youth served without the intervention of the court.

Procedure:

When the Department of Health and Human Services (DHHS) is the legal custodian of a child/youth resulting from court action or voluntary relinquishment, DHHS is legally authorized to make decisions regarding medical treatment while recognizing the importance of parental involvement in decision making (when parental rights are intact).

The Division of Children and Family Services-Protection and Safety has the responsibility to ensure that the medical/physical, dental and behavioral health needs of children/youth are coordinated and the necessary monitoring and management of medication occurs, paying special attention to psychotropic medications.

CFS Specialists have the responsibility to:

1. Provide informed consent or denial to the prescription of psychotropic medications;
2. Coordinate and share information with the medical provider, dental provider, behavioral health provider, the parent(s), and any out-of-home care provider that may be delivering service to children/youth (Reference Program Guidance Memo ~~#18-2015~~, "Medical, Dental, and Vision Exams for State Wards"); and

3. Monitor and routinely review the effectiveness of psychotropic medications.

Youth residing at a Youth Rehabilitative Treatment Center (YRTC):

1. **The YRTC is responsible for providing and documenting the informed consent or denial to the prescription of psychotropic medication;**
2. **The YRTC is responsible to coordinate and share information with all providers participating in the treatment of the youth, including the CFS Specialist.**
3. **The YRTC is responsible for the monitoring and review of the psychotropic medication prescriptions.**

I. Prior to giving consent for psychotropic medication, the CFS Specialist or YRTC will:

A. During normal business hours:

1. Verify that the child/youth had a medical evaluation within the past 12 months.
    a) This documentation will be found in the "Detail Medical Exam" window under the "Program Person;"
2. Verify that the child/youth has a DSM 5 diagnosis.
    a) This documentation will be found in the "Detail Conditions" window under the "Program Person;"
3. Review all medical narratives documented in the "Medical Section" under "Program Person." Is there information in this section that should be shared with the professional requesting consent i.e. allergies, medical conditions, recent behavioral/symptom changes?
4. Ask for the generic name of the medication and review the side effects, overall benefits and risks of the identified psychotropic medication with the prescriber, child/youth and caregiver. The following resource is one of many that can be used: Http://www.appi.org/Dulcan;
5. Collaborate with and seek input from the prescriber, child/youth, the parents and caregiver on the decision to consent to psychotropic medications:
    a) When possible, parents should consent to the use of medically necessary psychotropic medication. Ask about/consider the child/youth and family's cultural beliefs about psychotropic medication; and
6. Encourage the child/youth to participate in their health care decision making process, when possible and when developmentally appropriate.

B. After normal business hours (i.e. holidays, weekends and evenings):

1. Verify that the child/youth had a medical evaluation with the past 12 months.
    a) This documentation will be found in the "Detail Medical Exam" window under the "Program Person;"
2. Verify that the child/youth has a DSM 5 diagnosis.
    a) This documentation will be found in the "Detail Conditions" window under the "Program Person;"
3. Review all medical narratives documented in the "Medical Section" under "Program Person." Is there information in this section that should be shared with the professional requesting consent i.e. allergies, medical conditions, recent behavioral/symptom changes?
4. Review the side effects, overall benefits and risks of the identified psychotropic medication with the prescriber, child/youth and caregiver. The following resource can be used: Http://www.appi.org/Dulcan; the sections "How Can This Medicine Help?" and "What Side Effects Can This Medicine Have?" begin usually on page 3 of this document;
5. Consult with the on-call CFS Supervisor with any concerns after reviewing the information identified in steps 1-4 above; and

6. Document a narrative in the "Program Person" narratives "Medical Section" that identifies the individual requesting consent, the prescribers name and credentials, the name of the medication including dosage and frequency and whether consent was given or denied.

C. Requesting a Second Opinion:

It is always acceptable for CFS Specialist to seek a second opinion about a child/youth's treatment plan, including medication use. There are a number of scenarios that may be indicative of the need for a second opinion. These scenarios include when treatment with medicine has not resulted in improvement within two months of starting the medicine; any time a parent, caregiver guardian or other involved health care provider has concerns with the medications and talking with the prescriber about these concerns has not helped; or when a child/youth is being treated with benzodiazepines or narcotics for more than a month. CFS Specialists are encouraged to discuss their concerns with the primary prescriber first, and request their assistance with obtaining/requesting the second opinion.

II. When providing consent or denial, the CFS Specialist or YRTC will:

A. Complete the Psychotropic Medication Informed Consent Form:
   1. This documentation will be scanned into the document imaging, folder "Mental Health/Substance Abuse – P & S;"
   2. A narrative will be documented in the "Program Person" narratives; "Medical Section" summarizing the results of the above steps; and
   3. Send the assigned CFS Specialist and their supervisor an email notifying them of the request and the outcome of the request, when consent is provided after normal business hours.

B. Contact the Service Area Administrator or their designee, to request a psychotropic medication consultation when assistance is needed with making decisions related to consents for psychotropic medications. Consultation requests should be made to the Field Operations Administrator or the Deputy Director for Protection and Safety, who will coordinate a consultation with a qualified healthcare professional. Requests can be made during normal business hours as well as after hours (i.e. holidays, weekends).

III. Monitoring, Reviewing and Communicating, the CFS Specialist or YRTC will:

A. Ensure communication and sharing of information about prescribed medications is occurring between the prescribing healthcare professional, the child/youth, parents, guardian, foster parents, CFS Specialist, therapist(s), pediatrician and any other relevant members of the child/youth's treatment team.

   All medications have side effects which can sometimes be serious. Some medicines begin working right away while other medicines can take several weeks. To work best, the dose of medicines must be high enough, but without causing side effects that are worse than the benefit that may come from the medicine. Determining the best dose of a medicine requires review by the prescriber in consultation with the child/youth and family and others on the treatment team regarding the benefit and side effects at each dosing level.

B. Conduct monthly visits between the child/youth and the caregiver. The monthly visits provide an excellent opportunity to explore the effectiveness of medications and to share information (Reference Program Guidance Memo ~~#8-2013~~ "Mandatory Monthly Visits with Children").

C. Use the questions below as a guide to obtain critical information:

a) Is the child/youth taking the medications as prescribed?
b) Have any of the medications been changed?
c) Does the medication appear to be managing the intended symptoms?
d) Is the child/youth experiencing side effects i.e. change in appetite, weight gain, irritability, restlessness?
e) Is the child/youth experiencing suicidal thoughts?

D. Continue to coordinate the communication between all involved providers to ensure that each member of the team is informed of child/youth and family dynamics that could impact treatment. Ask for feedback from the child/youth, parents, guardian, foster parents, therapist(s), pediatrician and any other relevant member of the child/youth's treatment team about how the child/youth is reacting to the medication(s).

In the event that the CFS Specialist learns that the child/youth is having suicidal thoughts, behavioral changes of concern or is experiencing a life event that is traumatic for them i.e. loss of a family member or friend (breakup with a boyfriend/girlfriend), or bullying; the CFS Specialist will immediately contact the prescribing health care professional as well as members of the youth's treatment team to communicate this information and to determine the best course of action.

IV. Mandatory supervisory consultations for any child/youth 5 years old or younger prescribed psychotropic medications and for any child/youth who are prescribed more than 3 psychotropic medications, the CFS Specialist or YRTC will:

A. Specify the names of the psychotropic medications and reasons for the prescriptions;
B. Identify any concerning medication effects that resulted from discussions with the child, parent(s); out of home care provider(s); service providers; school personnel or others involved with the child/youth;
C. Review the prescribing healthcare provider's treatment plan for the child/youth, this will identify how the prescribed medications is targeting the identified symptoms as well as the treatment goals; and
D. Identify any follow up steps that need to be taken i.e. phone call to prescribing healthcare professional, scheduling follow up appointment with prescriber.
E. Document the mandatory consultation point under the "CFS/APS Narrative – Consultation Point, Periodic Review".

CFS Administrators will receive data reports for those children/youth who are prescribed more than 3 psychotropic medications and have a responsibility to monitor these children/youth and to provide guidance to CFS Specialists and Supervisors.

Attachments:

- Psychotropic Medication Informed Consent Form
- Quick Reference Guide to Psychotropic Medications

Department of Health & Human Services
DHHS
NEBRASKA

Nebraska Department of Health and Human Services
Division of Children and Family Services

Psychotropic Medication Informed Consent

Youth Name	Date of Birth	Age
Name of Prescribing Physician/Practitioner	Date Consent was Requested	
Credentials of Prescribing Physician/Practioner: ☐ Primary Care Physician ☐ APRN ☐ Psychiatrist		
Name of Health Care Practitioner Informed Consent given to (if different from Prescribing Physician/Practitioner)	Request is being made for the following medications:	
Ask the following questions of the Prescribing Physician/Health Care Practitioner:		
R **Reason:** What is the reason for giving the medication? (Include the target symptom(s) that warrant the use of this medication. What is the DSM-5 diagnosis? Is this medication consistent with the DSM-5 diagnosis?)		
A **Alternatives:** What are the alternatives to this medication? (Include non-medication alternatives or safer medications that could be used instead)		
R **Risks:** What are the risks, or unanticipated adverse events/effects that can happen with this type of medication?		
E **Expectations:** What are the prescriber's expectations (+ and -) including improvements to the target symptoms and common adverse effects that should be monitored?		
Polypharmacy: Polypharmacy is not uncommon in children who are in foster care. The biggest risk for adverse drug events is polypharmacy (more than 1 psychotropic medication).		
Is the youth currently prescribed other medications? ☐ Yes ☐ No If yes, complete the following:		
What other prescription medication is the youth taking? (Remember to share medical information). (List psychotropic and/or non psychiotropic drug name, dosage and frequency)		
According to the prescriber, what are the risks/adverse effects/possible drug interactions that can possibly happen and/ or should be monitored while the youth is taking these medications?		
Informed Consent Granted? ☐ Yes ☐ No If no, describe reasons and what, if any, alternatives will be explored.		
Date of Follow up Appointment (Follow up appointmens should be schedule every 90 days).		
Signature of CFS Specialist	Date	
Signature of CFSS Supervisor	Date	
Signature of CFS Administrator (only required when child/ youth is prescribed more than 3 Psychotropic Medications.	Date	

QUICK REFERENCE TO PSYCHOTROPIC MEDICATIONS®

DEVELOPED BY JOHN PRESTON, PSY.D., ABPP

To the best of our knowledge recommended doses and side effects listed below are accurate. However, this is meant as a general reference only, and should not serve as a guideline for prescribing of medications. Please check the manufacturer's product information sheet or the P.D.R. for any changes in dosage schedule or contraindications. (Brand names are registered trademarks.)

ANTIDEPRESSANTS

NAMES		Usual Daily Dosage			Selective Action On Neurotransmitters[2]		
Generic	Brand	Range	Sedation	ACH[1]	NE	5-HT	DA
imipramine	Tofranil	150-300 mg	mid	mid	++	+++	0
desipramine	Norpramin	150-300 mg	low	low	+++++	0	0
amitriptyline	Elavil	150-300 mg	high	high	++	++++	0
nortriptyline	Aventyl, Pamelor	75-125 mg	mid	mid	+++	++	0
clomipramine	Anafranil	150-250 mg	high	high	0	+++++	0
trazodone	Desyrel, Oleptro	150-400 mg	mid	none	0	++++	0
nefazodone	Generic Only	100-300 mg	mid	none	0	+++	0
fluoxetine	Prozac[4], Sarafem	20-80 mg	low	none	0	+++++	0
bupropion	Wellbutrin[4]	150-400 mg	low	none	++	0	++
sertraline	Zoloft	50-200 mg	low	none	0	+++++	+
paroxetine	Paxil	20-50 mg	low	low	+	+++++	0
venlafaxine	Effexor[4]	75-350 mg	low	none	+++	+++	+
desvenlafaxine	Pristiq	50-400 mg	low	none	+++	+++	+
fluvoxamine	Luvox	50-300 mg	low	low	0	+++++	0
mirtazapine	Remeron	15-45 mg	mid	mid	+++	+++	0
citalopram	Celexa	10-40 mg	low	none	0	+++++	0
escitalopram	Lexapro	5-20 mg	low	none	0	+++++	0
duloxetine	Cymbalta	20-80 mg	low	none	+++	+++	0
vilazodone	Viibryd	10-40 mg	low	low	0	+++++	0
atomoxetine	Strattera	60-120 mg	low	low	+++++	0	0
vortioxetine	Brintellix	10-20 mg	low	none	+	+++++	+
levomilnacipran	Fetzima	40-120 mg	low	none	+++	+++	0
MAO INHIBITORS							
phenelzine	Nardil	30-90 mg	low	none	+++	+++	+++
tranylcypromine	Parnate	20-60 mg	low	none	+++	+++	+++
selegiline	Emsam (patch)	6-12 mg	low	none	+++	+++	+++

[1]ACH: Anticholinergic Side Effects
[2]NE: Norepinephrine, 5-HT: Serotonin, DA: Dopamine (0 = no effect, + = minimal effect, +++ = moderate effect, +++++ = high effect)
[3]Uncertain, but likely effects
[4]Available in standard formulation and time release (XR, XL or CR). Prozac available in 90mg time released/weekly formulation

BIPOLAR DISORDER MEDICATIONS

NAMES		Daily	Serum[1]
Generic	Brand	Dosage Range	Level
lithium carbonate	Eskalith, Lithonate	600-2400	0.6-1.5
olanzapine/ fluoxetine	Symbyax	6/25-12/50mg[4]	2
carbamazepine	Tegretol,Equetro	600-1600	4-10+

NAMES		Daily	Serum[1]
Generic	Brand Dosage	Range	Level
divalproex	Depakote	750-1500	50-100
lamotrigine	Lamictal	50-500	(2)
oxcarbazepine	Trileptal	1200-2400	(2)

[1]Lithium levels are expressed in mEq/l, carbamazepine and valproic acid levels express in mcg/ml.
[2]Serum monitoring may not necessary [3]Not yet established [4]Available in: 6/25, 6/50, 12/25, and 12/50mg formulations

ANTI-OBSESSIONAL

NAMES		
Generic	Brand	Dose Range[1]
clomipramine	Anafranil	150-300 mg
fluoxetine	Prozac[1]	20-80 mg
sertraline	Zoloft[1]	50-200 mg
paroxetine	Paxil[1]	20-60 mg
fluvoxamine	Luvox[1]	50-300 mg
citalopram	Celexa[1]	10-40 mg
escitalopram	Lexapro[1]	5-30 mg
vilazodone	Viibryd[1]	10-40 mg

[1]often higher doses are required to control obsessive-compulsive symptoms than the doses generally used to treat depression.

PSYCHO-STIMULANTS

NAMES		
Generic	Brand	Daily Dosage[1]
methylphenidate	Ritalin	5-50 mg
methylphenidate	Concerta[2]	18-54 mg
methylphenidate	Metadate	5-40 mg
methylphenidate	Methylin	10-60 mg
methylphenidate	Daytrana (patch)	15-30 mg
methylphenidate	Quillivant XR (liquid)[2]	10-60 mg
dexmethylphenidate	Focalin	5-40 mg
dextroamphetamine	Dexedrine	5-40 mg
lisdexamphetamine	Vyvanse	30-70 mg
d- and l-amphetamine	Adderall	5-40 mg
modafinil	Provigil, Sparlon	100-400 mg
armodafanil	Nuvigil	150-250 mg

[1]Note: Adult Doses. [2]Sustained release

ANTIPSYCHOTICS

NAMES Generic	Brand	Dosage Range[1]	Sedation	Ortho[2]	EPS[3]	ACH Effects[4]	Equivalence[5]
LOW POTENCY							
chlorpromazine	Thorazine	50-800 mg	high	high	++	++++	100 mg
thioridazine	Mellaril	150-800 mg	high	high	+	+++++	100 mg
clozapine	Clozaril	300-900 mg	high	high	0	+++++	50 mg
quetiapine	Seroquel	150-600 mg	mid	mid	+/0	+	50 mg
HIGH POTENCY							
perphenazine	Trilafon	8-60 mg	mid	mid	++++	++	10 mg
loxapine	Loxitane	50-250 mg	low	mid	+++	++	10 mg
trifluoperazine	Stelazine	2-40 mg	low	mid	++++	++	5 mg
fluphenazine	Prolixin[5]	3-45 mg	low	mid	+++++	++	2 mg
thiothixene	Navane	10-60 mg	low	mid	++++	++	5 mg
haloperidol	Haldol[5]	2-40 mg	low	low	+++++	+	2 mg
pimozide	Orap	1-10 mg	low	low	+++++	+	1-2 mg
risperidone	Risperdal	4-16 mg	low	mid	+	+	1-2 mg
paliperidone	Invega	3-12 mg	low	mid	+	+	1-2 mg
olanzapine	Zyprexa	5-20 mg	mid	low	+/0	+	1-2 mg
ziprasidone	Geodon	60-160 mg	low	mid	+/0	++	10 mg
iloperidone	Fanapt	12-24 mg	mid	mid	+	++	1-2 mg
asenapine	Saphris	10-20 mg	low	low	+	+	1-2 mg
lurasidone	Latuda	40-80 mg	mid	mid	+	+	10 mg
aripiprazole	Abilify	15-30mg	low	low	+	+	2 mg

[1]Usual daily oral dosage
[2]Orthostatic Hypotension Dizziness and falls
[3]Acute: Parkinson's, dystonias, akathisia. Does not reflect risk for tardive dyskinesia. All neuroleptics may cause tardive dyskinesia, except clozapine.
[4]Anticholinergic Side Effects.
[5]Dose required to achieve efficacy of 100 mg chlorpromazine.
[6]Available in time-release IM format.

ANTI-ANXIETY

NAMES Generic	Brand	Single Dose Dosage Range	Equivalence[1]
BENZODIAZEPINES			
diazepam	Valium	2-10 mg	5 mg
chlordiazepoxide	Librium	10-50 mg	25 mg
clorazepate	Tranxene	3.75-15 mg	10 mg
clonazepam	Klonopin	0.5-2.0 mg	0.25 mg
lorazepam	Ativan	0.5-2.0 mg	1 mg
alprazolam	Xanax, XR	0.25-2.0 mg	0.5 mg
OTHER ANTIANXIETY AGENTS			
buspirone	BuSpar	5-20 mg	
gabapentin	Neurontin	200-600 mg	
hydroxyzine	Atarax, Vistaril	10-50 mg	
propranolol	Inderal	10-80 mg	
atenolol	Tenormin	25-100 mg	
guanfacine	Tenex, Intuniv	0.5-3 mg	
clonidine	Catapres, Kapvay	0.1-0.3 mg	
prazosin[2]	Minipress	5-20 mg	
pregabalin	Lyrica	25-450 mg	

[1]Doses required to achieve efficacy of 5 mg of diazepam
[2]For treatment of nightmares and day time anxiety

HYPNOTICS

NAMES Generic	Brand	Single Dose Dosage Range
temazepam	Restoril	15-30 mg
triazolam	Halcion	0.25-0.5 mg
zolpidem	Ambien	5-10 mg
zolpidem	Intermezzo	1.75 mg
zaleplon	Sonata	5-10 mg
eszopiclone	Lunesta	1-3 mg
ramelteon	Rozerem	4-16 mg
diphenhydramine	Benadryl	25-100 mg
doxepin	Silenor	3-6 mg

OVER THE COUNTER

Name	Daily Dose
St. John's Wort[1, 2]	600-1800 mg
SAM-e[3]	400-1600 mg
Omega-3[4]-EPA	1-2 g
Folic acid[8]	500 mcg
N-acetylcysteine[5]	1200-2400 mg
Chamomile[6]	200-1500 mg
5-HTP[7]	300-600 mg

[1]Treats depression and anxiety
[2]May cause significant drug-drug interactions
[3]Treats depression
[4]Treats depression and bipolar disorder
[5]For trichotillomania
[6]Treats anxiety:equivalent: one cup of chamomile tea
[7]Treats depression
[8]Note: available as Deplin 1-methylfolate (prescription) 7.5-15 mg

REFERENCES and RECOMMENDED BOOKS

Quick Reference • Free Downloads
Website: www.PsyD-fx.com

Handbook of Clinical Psychopharmacology For Therapists (2013) Preston, O'Neal and Talaga

Clinical Psychopharmacology Made Ridiculously Simple 8th Edition (2014) Preston and Johnson

Consumer's Guide to Psychiatric Drugs (2009) Preston, O'Neal, Talaga

Child and Adolescent Psychopharmacology Made Simple (2010) Preston, O'Neal, Talaga