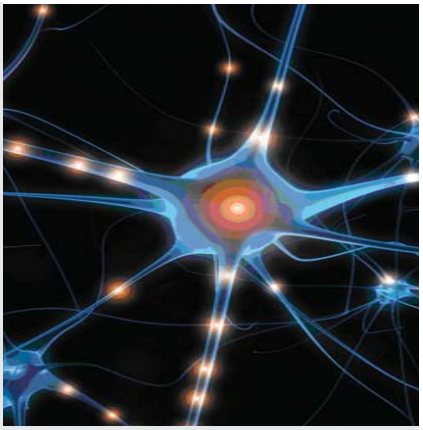
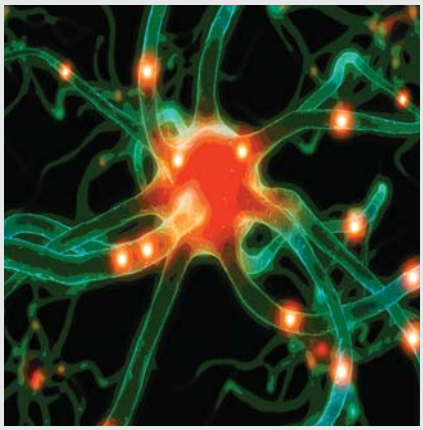
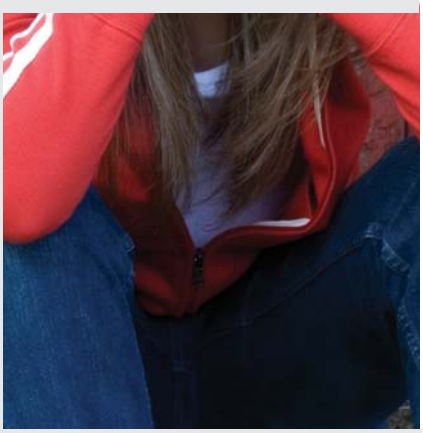
DIVISION OF CHILDREN YOUTH AND FAMILIES

Psychotropic Medication:

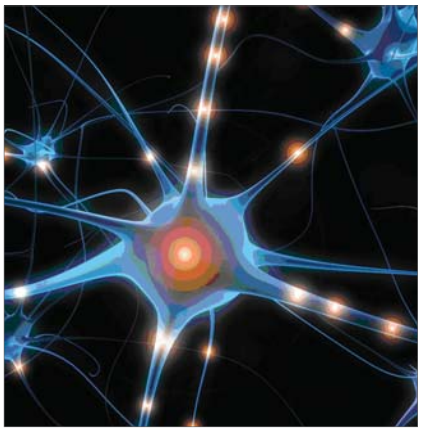


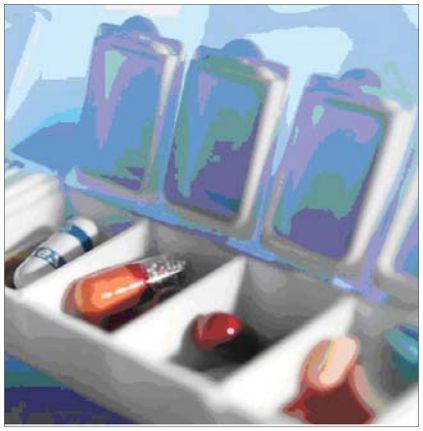




A Guide for CPS Specialists and Licensed Caregivers

Contents





INTRODUCTION

This guide is intended for use by Arizona Child Protective Servicies (CPS) Specialists, licensed resource parents and The Department of Economic Security, Division of Children, Youth and Families (DES/DCYF) group home staff. DES/DCYF in collaboration with the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) and the Comprehensive Medical and Dental Program (CMDP) have developed this guide to provide licensed caregivers and CPS Specialists with information and tools to help improve their awareness of the use of psychotropic medication. Due to variations in procedures and information specific to licensed caregivers and CPS Specialists, this document is not intended for use by unlicensed relative or kinship caregivers. A separate tool is available for these caregivers as well as licensed caregivers.

Children and youth who enter the child welfare system bring with them a unique set of behaviors, problems and issues that can arise from abuse, neglect and/or removal from their home. According to a national study by the Urban Institute, foster children had higher levels of emotional and behavior problems, more often had physical, learning, or mental health conditions that limited their psychosocial functioning, and were less engaged in school and more likely to have been expelled than children living with in parent care (Kortenkamp & Macomber, 2002)[1].

It is known that children entering foster care are often in poor health. Compared with children from the same socioeconomic background, they have much higher rates of serious emotional and behavioral problems, chronic physical disabilities, birth defects, developmental delays, and poor school achievement.[2] The need for youth in foster care to have sufficient and comprehensive assessments and evaluations for behavioral health services and psychotropic medication remains an issue regularly faced by out-of-home caregivers and CPS Specialists. “Any child or adolescent for whom medication is a consideration requires an evaluation of the psychiatric disorder, including the symptoms, co-morbid conditions, any other medical conditions, family and psychosocial assessment and school record.” [3] (AACAP Policy Statement, 2001)

Medication may be prescribed for psychiatric symptoms and disorders, including, but not limited to:

Anxiety – Includes: school refusal, phobias, separation or social fears, generalized anxiety, obsessive-compulsive disorder, or posttraumatic stress disorders. If it keeps the youngster from normal daily activities. The evaluation and management for anxiety may be done by the child's PCP, if the child has no other complicating behavioral disorders.

Attention deficit hyperactivity disorder (ADHD) – marked by a short attention span, trouble concentrating, restlessness, is easily upset and frustrated, and often has problems getting along with family and friends, and usually has trouble in school. The evaluation and management for ADHD may be done by the child's PCP, if the child has no other complicating behavioral disorders.

Autism – Includes other pervasive developmental disorders, such as Asperger's Syndrome – characterized by severe deficits in social interactions, language, and unusual repetitive behaviors. This disorder is usually diagnosed in early childhood.

Bedwetting – If it persists regularly after age 5 and causes serious problems in self-esteem and social interaction. An effective treatment is use of a bed-wetting alarm and behavioral management. This can be managed by the child's PCP. The evaluation and management for this problem may be done by the child's PCP, if the child has no other complicating behavioral disorders.

Licensed caregivers and CPS Specialists must work to support and advocate that medication be integrated as part of a comprehensive treatment plan that may include:

- behavioral health services and support;
- monitoring symptoms and behaviors;
- behavior management;
- communication and collaboration with the:
  - Child and Family Team (CFT);
  - Prescribing practitioner;
  - Caregivers;
  - CPS Specialists;
  - Therapists;
  - Primary Care Physician (PCP) and;
  - Youth and family members.

This guide is intended to provide licensed resource parents, DES group home staff, and CPS Specialists with information necessary to support positive outcomes for a child who may require psychotropic medication. This document is to inform CPS Specialists and caregivers about:

- the identification of a child's behavioral or mental health need;
- assessing and evaluating a child for medication;
- informed consent;
- the policies and procedures guiding the prescribing and use of medication in Arizona;
- oversight and monitoring.

WHAT SHOULD I DO IF I HAVE CONCERNS ABOUT A CHILD'S MENTAL, BEHAVIORAL OR EMOTIONAL SYMPTOMS?

Common Childhood Symptoms and Condtitions

Youth in foster care experience a variety of emotional and behavioral problems. About 30% of children in foster care have severe emotional, behavioral, or developmental problems [4] (AACAP, 2005). Foster children experience problems with aggression, depression, anxiety, and substance abuse. Even children who may not exhibit emotional or behavioral problems when they enter foster care may have emotional and behavioral needs that emerge later.

It is important that ongoing assessments and evaluations continue beyond the initial behavioral health assessment to identify any new issues that develop. Care should be taken not to place too much importance on obtaining a diagnosis. It is equally important to identify

services and supports that can help relieve the child's behavioral or emotional symptoms. Some symptoms may be severe enough to require medication.

DETERMINING WHEN A CHILD'S BEHAVIORS WARRANT INTERVENTION

Every child is different and normal development varies from child to child. All children experience problems with behaviors as a normal part of development so caregivers and CPS Specialists must be observant of how a child's behaviors or emotional difficulties impair his/her ability to function in daily activities.

Some children may only require a minimal amount of supports to address problems while others may require more intensive services and supports. Caregivers and CPS Specialists should consult the child's PCP, therapist, CFT and other professionals involved with the youth. It is important that caregivers and Specialists gather information from teachers, daycare workers, family and professionals about the child's behaviors, especially how those behaviors affects the child's ability to function in daily activities.

Urgent Response

Children in Arizona, who are placed in out-of-home care by CPS, are referred to the behavioral system through the "Urgent/Rapid Response" system upon removal. The CPS worker calls the local Regional Behavioral Health Authority (RBHA) and requests a comprehensive behavioral health assessment. The RBHA will schedule an assessment within 24 hours according to individual RBHA procedures. The CPS Specialist will contact the behavioral health service provider to coordinate services for youth already enrolled in the behavioral health system according to district operating procedure.

Some children may exhibit behavior problems as a reaction to being removed from their homes and attempting to adjust to a new and strange environment. The goals of the behavioral health assessment include, but are not limited to:

- Identifying any immediate needs of the child;
- Determining if any immediate action is needed to mitigate the effects of the removal;
- Providing supports and services to caregivers to meet the child's needs; and
- Providing recommendations related to the behavioral health needs of the child to CPS for the Preliminary Protective Hearing.

Medication may be prescribed for psychiatric symptoms and disorders *(continued)*

Bipolar disorder – periods of depression alternating with manic periods (may include irritability, "high" or happy mood, excessive energy, behavior problems, staying up late at night, and grand plans).

Depression – Lasting feelings of sadness, helplessness, hopelessness, unworthiness and guilt, inability to feel pleasure, a decline in school work and changes in sleeping and eating habits. The evaluation and management for uncomplicated depression may be done by the child's PCP, if the child has no other complicating behavioral disorders.

Eating disorder – self-starvation (anorexia nervosa) and/or binge eating and vomiting (bulimia).

Obsessive-compulsive disorder (OCD) – Recurring obsessions and/or compulsions, such as hand washing, and checking to see if doors are locked) which are often seen as senseless and interfere with a child's daily functioning.

Psychosis symptoms – Includes irrational beliefs, paranoia, hallucinations, social withdrawal, clinging, strange behavior, extreme stubbornness, persistent rituals, and deterioration of personal habits. May be seen in developmental disorders, severe depression, schizoaffective disorder, schizophrenia, and some forms of substance abuse.

Severe aggression – Which may include assaultiveness, excessive property damage, or prolonged self-abuse, such as head-banging or cutting.

Sleep problems – Can include insomnia, night terrors, sleep walking, fear of separation, and anxiety.

American Academy of Child and Adolescent Psychiatry provides a series of questions to help get a better understaninding of psychotropic medications:

1. What is the name of the medication? Is it known by other names?
2. What is known about its helpfulness with other children who have a similar condition to my child?
3. How will the medication help my child? How long before I see improvement? When will it work?
4. What are the side effects which commonly occur with this medication?
5. Is this medication addictive? Can it be abused?
6. What is the recommended dosage? How often will the medication be taken?
7. Are there any laboratory tests (e.g. heart tests, blood test, etc.) which need to be done before my child begins taking the medication? Will any tests need to be done while my child is taking the medication?

DETERMINING WHEN A CHILD NEEDS MEDICATION

Consultation

Any decision to have a child evaluated for medication should be in consultation with the CFT, PCP, CPS Specialist, caregiver(s), therapist, and/or in CPS clinical supervision.

"Medication use is a collaborative process, and input from the Child and Family Team (CFT) must be included to effectively evaluate, monitor, and make clinical recommendations for improvement in the medication regimen. Children/youth and their families should play an active role in all decisions relating to the management of their care.

Medical behavioral health practitioners must coordinate care with the Child and Family Team using one or more of the following methods: direct participation in the Child and Family Team meeting…or direct communication with the family. Concerns discussed at the Child and Family Team must be shared with the prescribing practitioner." [5] (DBHS Practice Protocol)

The use of medication is a serious decision and should not be the only consideration for intervention. A.A.C. R9-21-207 states that all clients have a right to be free from unnecessary or excessive medication. It also states that medication shall not be used as punishment, for the convenience of the staff, or as a substitute for other behavioral health services.

According to the American Academy of Child & Adolescent Psychiatry (AACAP), psychiatric medication should not be used alone. The use of medication should be based on a comprehensive psychiatric evaluation and be one part of a comprehensive treatment plan. [6] (AACAP, 2004)

If it is determined that psychotropic medication may be warranted after consulting with these team members then a psychiatric evaluation will be required.

Referrals and Timelines

CPS Specialists and caregivers should make a referral for a psychiatric evaluation through the CFT, the child's service provider or directly through the RBHA.

According to DBHS policy, "Referrals for psychotropic medication through a RBHA contracted provider should occur within a time frame that is clinically indicated based on need but no later than 30 days from the initial request." [7] Additionally, when a child is admitted to an inpatient setting, the inpatient prescribing practitioner must ensure that there is a post-discharge appointment with an outpatient prescribing practitioner within seven (7) days and that there is not a lapse in medications prior to that appointment. [8]

According to A.R.S. § 8-527, CPS Specialists shall make every reasonable effort to not remove a child who is placed in out-of-home care from school during regular school hours for appointments, visitations or activities not related to school. When scheduling appointments, the caregiver or CPS Specialist should always ask a provider for appointments after school if available.

Preparing for the Evaluation

The CPS Specialists and/or caregivers will attend the psychiatric evaluation to provide the provider with information about the child's history. Specialists and caregivers should bring or have sound knowledge of the child's history to assist in making the most appropriate decision.

Tips for caregivers and CPS Specialists to prepare for the evaluation:

- Maintain a folder for the child that includes medical history;
- Write a list of the behaviors which concern you or keep a journal that describes the child's behaviors;
- Be prepared to describe the behaviors in detail. This includes the duration, intensity and frequency of behaviors and how this impairs their ability to function in daily activities;
- Write down questions you may want to ask the prescribing practitioner;
- Bring or be prepared to discuss school reports, evaluations or testing;
- Bring or be able to discuss information from previous psychological, psychiatric or developmental evaluations;

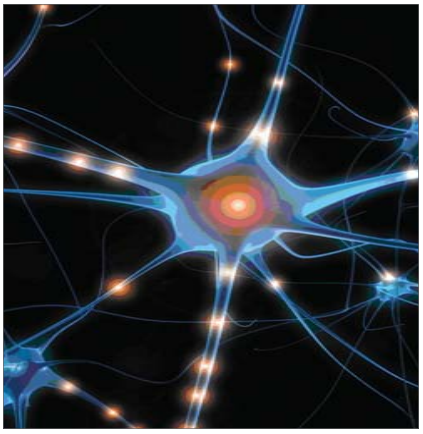
It is also helpful to describe:

- warning signs and behavior triggers;
- the context or setting in which the behavior occurs;
- the child's response to interventions;
- the child's ability to recognize the behavior as a problem;
- the child's ability to process or discuss the episode afterward;
- previous treatment successes or failures;
- the impact of the behavior or emotion on overall functioning.

Discuss recommendations and information from the Comprehensive Behavioral Health Assessment completed at intake;

Discuss the situation fully with the child to address the process and reasons for the evaluation (see Section on "Informing the Youth").

8. Will a child and adolescent psychiatrist be monitoring my child's response to medication and make dosage changes if necessary? How often will progress be checked and by whom?
9. Are there any other medications or foods which my child should avoid while taking the medication?
10. Are there interactions between this medication and other medications (prescription and/or over-the-counter) my child is taking?
11. Are there any activities that my child should avoid while taking the medication? Are any precautions recommended for other activities?
12. How long will my child need to take this medication? How will the decision be made to stop this medication?
13. What do I do if a problem develops (e.g. if my child becomes ill, doses are missed, or side effects develop)?
14. What is the cost of the medication (generic vs. brand name)?
15. Does my child's school nurse need to be informed about this medication?



What Is Addressed in the Psychiatric Evaluation?

A comprehensive psychiatric evaluation of a child/youth should include, but is not limited to:

- Biological, psychological, social, environmental, spiritual, and personal factors influencing diagnosis and treatment;
- Birth and developmental history;
- Estimated intelligence and cognitive functioning;
- Social and interpersonal skills;
- Medical history and results of any physical examinations, laboratory, allergies, or other tests (include all current prescribed or OTC medications, and/or herbal preparations);
- Psychiatric history (including prior psychiatric medications and their effects);
- Education and special needs;
- Safety in the community;
- Family circumstances and social history;
- Substance use;
- Legal issues;
- Mental status examination; and
- Strengths

INFORMED CONSENT

Informed Consent is when a parent, guardian or custodian provides consent for certain behavioral health services including psychotropic medication. According to DBHS, informed consent is "a voluntary agreement, oral or written, except when explicitly required to be written, following presentation of all facts necessary to form the basis of an intelligent consent by the person or guardian prior to the provision of specified behavioral health services." [9]

According to A.A.C. R9-21-206.01, a mental health agency is required to obtain written informed consent for the use of psychotropic medications.

Best Practice Tip:
Describe the child's symptoms and behaviors in detail that includes how long the symptoms have presented themselves, how often they occur and how severe they are.

What is included in an informed consent?

Signed by the client, the client's parent, guardian or custodian, it documents that the medical practitioner or registered nurse informed the client and the client's guardian about:

- the child's diagnosis,
- the nature and procedure of the treatment;
- the intended outcome;
- the risks and possible side effects of the medication;

- the risks of not proceeding with the proposed treatment;
- the alternatives to the proposed treatment;
- the fact that informed consent given may be withheld or revoked orally or in writing at any time;
- the potential consequences of revoking the informed consent; and
- any clinical indications that might require suspension or termination of the proposed treatment.

CPS Specialists and caregivers should ensure that these items were discussed in detail with the prescribing practitioner.

CPS Specialists document in the child's case record that informed consent was discussed and provided at the evaluation or medication monitoring appointments. The prescriber must include a copy in the child's behavioral health record. Caregivers and CPS Specialists can always request a copy of the written consent to include in the child's case record.

Best Practice Tip:
Any concerns foster parents or group home staff have about providing consent should be discussed with the CPS Specialists, the psychiatrist and in the CFT. Additionally, CPS Specialist should also discuss concerns with the psychiatrist, their supervisor, in clinical supervision, and in the CFT.

Who can provide consent?

According to A.R.S. § 8-514.05(C)(1)(b), "a foster parent, group home staff, foster home staff, relative or other person whose care the child is currently placed can give consent for treatment of common childhood illnesses or conditions." This includes psychotropic medication. DBHS protocol recommends that "for children who have been removed from the home by CPS, the person who is providing informed consent should be the person from the home where the child is currently residing, who is most knowledgeable about the child's condition." [10] CPS Specialists and Supervisors can also provide consent.

The caregiver must be informed if CPS, through discussion with the supervisor, determines that only the CPS Specialist or supervisor will provide consent. In these situations, the Specialist and caregiver should work collaboratively to coordinate and schedule medication appointments. The Specialist must work with the caregiver and providers to provide written consent either by fax or in person. When informed consent is signed, the caregiver or CPS Specialists may request a copy of that consent by the provider to include in the case file.

Informing the Youth

A study of family and youth attitudes toward psychiatric medication found that youth were concerned about side effects, societal views, shame and the short term effects of medication in their daily lives. One youth reported, "No one told be about the bad acne and weight gain." [11] These types of issues can affect a youth's compliance with their medication and their willingness to work as part of their treatment or Child and Family Team.

Best Practice Tip:
Ask the child or youth to explain why they are taking medication to ensure they understand. Pay close attention to any possible side effects the child may be experiencing.

Youth value being part of the decision making process and must experience ownership of the treatment process. Yet the conversations about medications often take place only between the parent or guardian and the prescriber. Youth in Arizona have the legal authority to make decisions regarding informed consent and treatment when they turn 18 years old. Youth must be prepared and knowledgeable about their treatment and medication to make fully informed decisions. This requires they be included as part of the discussion prior to their 18th birthday. Children and adolescents should be included in the discussion about medications, using words they understand.

It is important to discuss the reasons for taking medication as a way to assist the youth to reach his or her full potential. They should not receive the message that they are being prescribed medication because they are "bad", have no control over their behavior or are "sick."

When discussing medication, be sure to discuss the following with the youth in clear and direct terms:

- What symptoms is the medication supposed to address?
- What are the risks if they don't take the medication?
- What are the possible side effects and how long will they last?
- What can be done to minimize or alleviate side effects?
- Who to contact if they experience problems with the medication?
- How long must they take the medication?
- How will they know when they can reduce or stop taking the medication?
- What rights to privacy do they have regarding their medication (who CAN and who MUST know…schools, CPS Specialists, care givers, family, friends, etc.)?
- What special precautions must they take with the medication (e.g. limits on diet and physical activity)?

Informing the Birth Parents

Child Welfare League of America published a mental health best practice guideline for child welfare and recommended that when possible, "parents will be encouraged to be involved in mental and physical health promotion assessment, treatment, education, medical services, and other services as appropriate for their children." [12]

Best Practice Tip:
Inform the parents about all medications that are prescribed to their child unless contraindicated by the CPS case plan.

In September of 2008, 55% of Arizona foster youth had a case plan goal of reunification and almost 12% had a case plan goal of independent living. Parents and families need to know about the child's medication and treatment. They also need to support the ongoing treatment after they return home. This will help improve the chances for a successful reunification or transition to adulthood. Children's emotional and behavioral problems tend to escalate after they return home from foster

care [13] and the stress of re-establishing parenting with these children can lead to relapse for parents with substance abuse issues. [14] There is also data that indicates that there are lower rates of re-abuse when maltreating parents participate in mental services with their children.[15]

For Caregivers

Caregivers may share parenting with the birth parents. This includes communicating with them about the benefits, successes and responses to treatment and medication. Professional foster parents are required to complete psychotropic medication training which addresses symptomatic behaviors, medication reactions, and medication interactions.

Resource parents, group home staff, and relative and kinship placements can share their medication and reaction logs with birth parents to teach them what to look for when the child returns home. If caregivers attend family visits, they should provide the birth parents information about the child's services and their response to services and medications. Caregivers can help reduce birth parents' fears and concerns by maintaining positive and supportive communication about these services. Helping birth parents to understand the reason for the child's medication and teaching the parent to communicate this information to the child's pediatrician can promote better continuity of care after the child returns home.

FosterClub is a national network for young people in foster care that provides information to foster youth on a website (www.fosterclub.com), publications and events. Publications and information on their website are written in collaboration with foster youth. FosterClub identifies four steps for youth:

- Know what you are taking and why;
- Explore other treatments with your doctor;
- Keep a log (a list of medications, the date you started taking them and any bodily effects);
- Follow up with your doctor

For CPS Specialists

CPS Policy Manual (Chapter 9, Section 1) requires the use of a "family centered approach" which indicates that "family engagement and the perception the family has of the CPS Specialist's desire to hear their thoughts and ideas has a direct relationship to the family's success in carrying out the action steps within the plan." If the case plan goal is reunification and the youth is prescribed psychotropic medications which are benefiting the child, the parent will need to be able to monitor and maintain the child's treatment after reunification to help improve the chances for a successful reunification.

It is important to communicate with the parent about any behavioral health problems the child is experiencing and any recommendations for services that have been made, including medication. The case manager can help alleviate any fears a parent may have about medication by keeping them informed about the youth's response to services and medication.

Collaboration and support available to CPS Specialists

Invite the parents to the Child and Family Team unless there are safety concerns or clear evidence that their involvement would be contrary to the best interest of the child. Behavioral health professionals will be available to answer questions about the process and can take any questions a parent may have to the prescribing practitioner.

Best Practice Tip:
Utilize the Child and Family Team to address concerns with the child's medication, answer parents' questions, providing information to the child and family, and communicate with team members and the prescribing practitioner

CPS case managers can utilize Clinical Supervision to prepare for the discussion with the birth parent. Clinical Supervision can help identify specific information that should be shared with the parent and to obtain direction about possible concerns a parent may raise.

The prescribing practitioner can also provide direction and insight to concerns parents raise. Consultation with the practitioner can be made directly in medication monitoring appointments or through the CFT process. At a minimum, the parent should be provided the information that is required by informed consent since they will need to provide this consent after the child is returned to their care.

If a parent disagrees with the medication service, it is important to listen to their concerns and offer any information that would help address those concerns such as pharmacy information, literature provided by the prescribing practitioner, or other resources. Again, the parents' participation in the CFT will allow them to ask these questions directly from the behavioral health providers and to have those concerns addressed with the prescribing practitioner.

HOW ARE MEDICATIONS MONITORED?

Monitoring the Effectiveness of Medication

Once a youth has been prescribed medication, it is critical that ongoing oversight and monitoring occur to ensure that side effects are addressed, responses to the medication are assessed and decisions on continuing the medication are considered. DBHS establishes the policies and provides guidance to prescribing practitioners and behavioral health professionals for the ongoing monitoring of psychotropic medication. Caregivers and CPS Specialists' access to and understanding of these policies help support appropriate and sound decision-making about the ongoing use of psychotropic medications.

DBHS policies and procedures for the prescribing and monitoring of psychotropic medication can be found in their Provider Manual and Clinical Guidance Documents (also known as Practice Protocols).

Medication Monitoring Appointments

Once a youth is prescribed a medication, the prescribing practitioner will direct that the caregiver bring the child back for "medication monitoring" appointments. The frequency of these visits can vary depending on several factors including, but not limited to, the type of medication prescribed, the child's response to the medication, any possible side effects that occur, the age of the child and how recently the medication was prescribed. However, A.A.C. R9-21-207 states that each client receiving psychotropic medication shall be seen monthly or as indicated in the client's ISP:

DBHS policy and guidelin

Provider Manual Section 3.15

Provider Manual Section 3.11

Provider Manual Section 3.2

Provider Manual Section 4.3

Practice Protocol

Practice Protocol

Practice Protocol

Practice Protocol

es thataddress medication:

- "Psychotropic Medication: Prescribing and Monitoring"
- "General and Informed Consent to Treatment"
- "Appointment Standards and Timeliness of Service"
- "Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers"
- "Psychotropic Medication Use in Children, Adolescents, and Young Adults"
- "Informed Consent for Psychotropic Medication"
- "Polypharmacy Use: Assessment of Appropriateness and Importance of Documentation"
- "Psychiatric Best Practice Guidelines for Children Birth to Five Years of Age"

"Reassessments must be completed on an ongoing basis to ensure medication compliance and to substantiate that the prescribed psychotropic medication(s) are the most effective treatment for the person." [16]

"Psychotropic Medications that are not clinically effective after reasonable trials should be discontinued, unless the rationale for continuation can be supported and is documented in the persons' comprehensive clinical record." [17]

During medication monitoring appointments, it is important to discuss any possible side effects to a medication. While some side effects are anticipated and may dissipate after a period of time, others may be more serious and concerning. It is important that CPS Specialists and caregivers are prepared to discuss these in detail along with any environmental factors that may contribute to these side effects. In Arizona, the extreme heat can exacerbate some medication's side effects.

Some side effects may occur that impact more than physical health and should be considered when discussing medication with the youth, CFT, practitioner and other team members. For adolescents, side effects can create issues that affect the youth's self-esteem, socialization and willingness to comply with their medication regime. These issues should be addressed in the individual service plan, at the CFT and with the prescribing practitioner. CPS Specialists can also utilize clinical supervision and case staffings to further explore the impact of medication on a youth's physical and social development.

Many youth are concerned about their school and friends knowing that they take psychotropic medications. Discussion with the youth about confidentiality should occur in consultation with the CFT, therapists, supervisors and the practitioner.

Some prescribing practitioners may utilize rating scales, screening and assessment tools to help identify a child or youth's progress while taking psychotropic medication. The scales and tools help to quantify and qualify the types of symptoms still problematic for a child and determine whether a child or youth is experiencing any relief from those symptoms. Examples of such tools are the Brief Psychiatric Rating Scale for Children (BPRS-C-9), Modified Overt Aggression Scale (MOAT), Young Mania Rating Scale, Child Behavior Checklist and the Connors Rating Scale-Revised (CRS-R) for ADHD. Some of these can be completed by both the caregivers and teachers or have an additional special checklist specifically for a teacher to complete.

Best Practice Tip:

Always discuss the child's behavioral health services and psychotropic medication with the PCP.

Medications that Require Specialized Monitoring

As described in the DBHS Provider Manual, there are several different types of medications that require additional monitoring, several types are listed below.[18]

Medication Type	Monitoring Action
Antipsychotic Medications	• Administer the Abnormal Involuntary Movement Scale (AIMS) and document results. At a minimum it must be completed upon the initiation of a new antipsychotic and at least annually
Lithium Carbonate (or any related formulations of Lithium)	• Obtain Lithium levels, thyroid function tests and renal function test at least annually or more frequently as indicated on an individual basis.
Anticonvulsants (used for mood stablilization)	• Obtain blood levels and liver function tests, CBC or other lab tests at least annually, or more as indicated on an individual basis.
Medications known to affect health parameters	• Medications known to affect health parameters such as height, weight, heart rate, and blood pressure, assessments will be made of the person's as height, weight, heart rate, and blood pressure as indicated on an individual bases or established by the T/RBHA Medical Director.

Best Practice Tip:
Consult with the child's PCP and CFT when considering psychotropic medication for the youth.

ADHS/DBHS and each RBHA provide a formulary of approved medications. Links to the formulary can be found in "Resource Information." Additionally, each RBHA provides a formulary that can be found on their websites. The opposite page is a list of many medicatins commonly prescribed for children.

Coordination of Care

Coordination of Care with the PCP and inpatient hospital physicians is not only a best practice but also a requirement. DBHS policies address this issue quite clearly. "Behavioral health medical practitioners must coordinate with primary care providers or other health care providers to minimize the potential for adverse clinical outcomes when prescribing psychotropic medications." [19] Additionally, for all behavioral health recipients referred by the PCP or who have been determined to have a serious mental illness, the behavioral health provider must provide to the PCP the person's diagnosis and current prescribed medications including strength and dosage. This must also be done annually or when

COMMON MEDICATIONS USED FOR CHILDHOOD MENTAL DISORDERS

ANTI-ANXIETY

SSRI

Fluoxetine (*Prozac*)

Paroxetine (*Paxil*)

Sertraline (*Zoloft*)

BENZODIAZEPINES

Alprazolam (*Xanax*)

Lorazepam (*Ativan*)

Diazepam (*Valium*)

Clonazepam (*Klonopin*)

ANTIHISTAMINES

Diphenhydramine (*Benadryl*)

Hydroxizine *(Vistaril)*

NON-NARCOTIC

Buspirone *(BuSpar)*

ATYPICAL

Zolpidem (*Ambien*)

ANTI-DEPRESSANTS

SSRI

Fluoxetine (*Prozac*)

Paroxetine (*Paxil*)

Sertraline (*Zoloft*)

Citalopram (*Celexa*)

Escitalopram (*Lexapro)*

Fluvoxamine (*Luvox*)

SNRI

Venlafaxine (*Effexor*)

NE DOPA RI

Bupropion (*Wellbutrin*)

TRICYCLICS

Trazodone (*Desyrel*)

Amitriptyline (*Elavil*)

Clomipramine (*Anafranil*)

Imipramine (**Tofranil**)

Nortriptyline (**Pamelor**)

ATYPICAL

Mirtazapine (*Remeron*)

MAOI

Phenelzine (*Nardil*)

Tranylcypromine *(Parnate)*

ADHD MEDICATION

SHORT ACTING

Methylphenidate (*Ritalin*)

Mixed Amphetamine Salts *(Adderall)*

INTERMEDIATE ACTING

Methylphenidate *(Ritalin LA)*

LONG-ACTING

Methylphenidate HCl Extended-Release *(Concerta)*

Mixed Amphetamine Salts *(Adderall XR)* [B]

NON-STIMULANTS

Atomoxetine *(Strattera)* [A]

STIMULANTS

Methylphenidate (*Ritalin*)

Methylphenidate *(Metadate)*

Methylphenidate *(Concerta)*

Dextroamphetamine (*Dexedrine*)

Dextroamphetamine *(Adderall)*

MISCELLANEOUS

Clonidine (*Catapres*) [D]

Guanfacine (*Tenex*) [D]

ANTI-PSYCHOTICS

FIRST GENERATION

Chlorpromazine (*Thorazine*)

Thioridazine (*Mellaril*)

Fluphenazine (*Prolixin*)

Trifluoperazine (*Stelazine*)

Thiothixene (*Navane*)

Haloperidol (*Haldol*)

Loxitane *(Loxapine)*

Mesoridazine *(Serentil)* [B]

SECOND GENERATION

Clozapine *(Clozaril, Fazaclo)*

Risperidone (**Risperdal Consta**)

Quetiapine *(Seroquel)*

Olanzapine *(Zyprexa)*

Ziprasidone *(Geodon)*

Aripiprazole (*Abilify*)

ANTI-MANIA

MOOD STABLIZERS

Lithium Citrate [C]

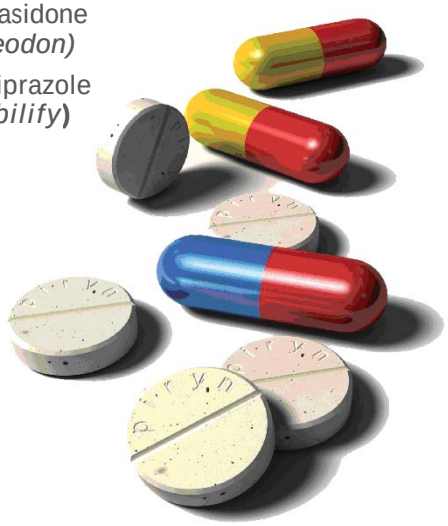
Lithium Carbonate [C]

Lithium (*Eskalith*) [D]

Valproic Acid (**Depakote**) [D]

Lamotrigine (**Lamictil**) [D]

Carbamazepine (**Tegretol**) [D]



[A] CMDP requires Prior Authorization as this is not appropriate as a first line medication.

[B] Not a covered medication on the DBHS Formulary.

[C] CMDP requires prior authorization for children/youth not eligible for RBHA services.

[D] Not a covered medication on the CMDP Formulary.

Best Practice Tip:
When asked to sign the Informed Consent, make sure that the prescribing practitioner discussed the required elements in detail and has answered any questions you may have.

there is a significant change in the person's diagnosis or medication dosage. [20] All AHCCCS health plans, including CMDP, have a Behavioral Health Coordinator who can assist with coordination of care questions.

Documentation

Caregivers must maintain a log of the medications being prescribed and when that medication is administered. Caregivers should also maintain a log of any adverse reactions to the medication, side effects, and medication errors or missed dosages. It is important to inform the CPS Specialist of the problems and provide these logs to the CPS Specialists. Specialists should document the details of this communication in the CHILDS case notes. Additionally, the types of medication can also be included in CHILDS in the "Medication Detail" window. When informed consent is signed, the caregiver or CPS Specialist may request a copy of that consent by the provider to include in the case file.

Additionally, it is helpful for prescribing practitioners to have documentation about the child's response to the medication. Practitioners may utilize standard tools. Caregivers and CPS Specialists can ask the practitioner to provide a tool or specific direction how to document the child's progress or lack of progress that is helpful to the practitioner.

DEFINITIONS & ABBREVIATIONS

APA (American Psychiatric Association) - is a medical specialty society composed primarily of medical specialists who are qualified, or in the process of becoming qualified, as psychiatrists. The APA physicians work together to ensure humane care and effective treatment for all persons with mental disorder, including mental retardation and substance-related disorders.

AACAP (American Academy of Child and Adolescent Psychiatry) – The AACAP is a 501(c)(3) non-profit organization whose members are child and adolescent psychiatrists and other interested physicians. The AACAP widely distributes information in an effort to promote an understanding of mental illnesses and remove the stigma associated with them; advance efforts in prevention of mental illnesses, and assure proper treatment and access to services for children and adolescents.

Caregivers – Resource parents/foster caregivers, group home staff, relative or kinship placements in whose care CPS has placed a child.

CFT (Child and Family Team) - The Child and Family Team (CFT) is a defined group of people that includes, at a minimum, the child and his/her family, a behavioral health representative, and any individuals important in the child's life and who are identified and invited to participate by the child and family . This may include, for example, teachers, extended family members, friends, family support partners, healthcare providers, coaches, community resource providers,

representatives from churches, synagogues or mosques, agent from other service systems like CPS or DDD. etc. The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by which individuals are needed to develop an effective service plan, and can therefore expand and contract as necessary to be successful on behalf of the child.

CMDP (Comprehensive Medical and Dental Program) - The AHCCCS health plan under DES which provides medical and dental services for children in out-of-home care, including foster children enrolled in ALTCS, in the custody of DES, the Administrative Office of the Courts (juvenile probation), and the Department of Juvenile Corrections.

CPS (Child Protective Services) –A specialized child welfare program that is administered by the Department of Economic Security and that investigates allegations of and seeks to prevent, intervene in and treat abuse and neglect, to promote the well-being of the child in a permanent home, and to coordinate services to strengthen the family. [ARS§8-801(4)]

DBHS (Division of Behavioral Health Services of the Arizona Department of Health Services) - serves as the single state authority to provide coordination, planning, administration, regulation and monitoring of all facets of the state public behavioral health system. ADHS/DBHS contracts with community based organizations, known as Regional Behavioral Health Authorities (RBHAs), to administer behavioral health services throughout the State.

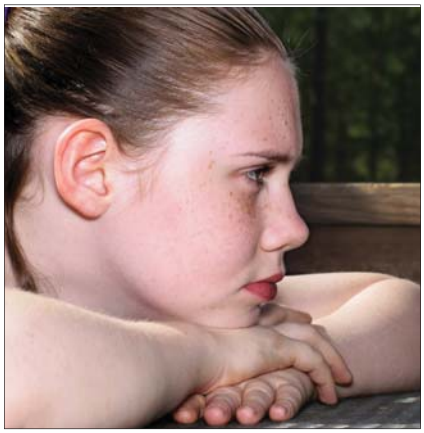
DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition-Text Revision) - the standard classification of mental disorders used by mental health professionals in the United States. It is intended to be applicable in a wide array of contexts and used by clinicians and researchers of many different orientations and has been designed for use across clinical settings (inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care), with community populations. It can be used by a wide range of health and mental health professionals, including psychiatrists and other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, and counselors. It is also a necessary tool for collecting and communicating accurate public health statistics.

MBHP (Medical Behavioral Health Practitioner) - Prescribing clinicians, including psychiatrists, nurse practitioners, and physician assistants.

PCP (Primary Care Provider) – acts a personal care doctor who will provide or arrange for needed health services.

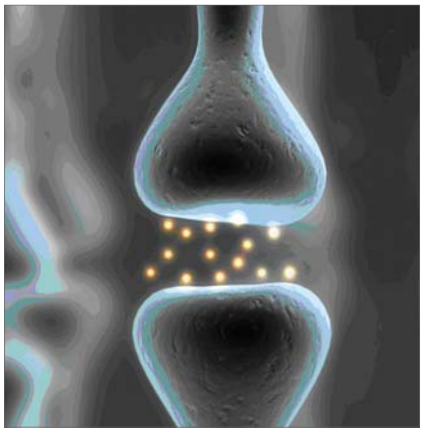
Prescribing Practitioner – a behavioral heath medical practitioner licensed to prescribe medications and includes a physician, a physician assistant, or a nurse practitioner.

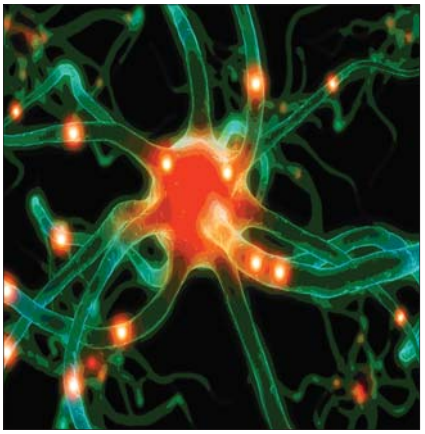
Best Practice Tip:
Avoid focusing only on problem behaviors. Also identify strengths and successes during medication monitoring appointments



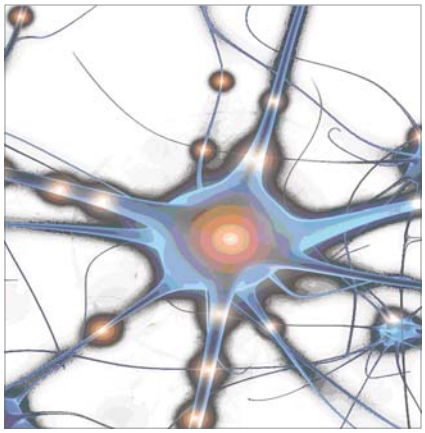
RBHA (Regional Behavioral Health Authority) - administers behavioral health services throughout the State. RBHAs function in a fashion similar to a health maintenance organization. RBHAs contract with a network of service providers to deliver a full range of behavioral health care services, including prevention programs for adults and children, a full continuum of services for adults with substance abuse and general mental health disorders, adults with serious mental illness, and children with serious emotional disturbance.

Urgent Response - A rapid and prompt response to a person who may be in need of medically necessary covered behavioral health services. An urgent response should be initiated in a punctual manner, within a timeframe indicated by the person's clinical needs, but no later than twenty-four hours from the initial identification of need. Urgent responses must be initiated upon notification by DES/CPS that a child has been, or will be, removed from their home.





RESOURCE INFORMATION



CPS Policy Manual, Exhibit 54 (Psychotropic Medication):
(https://www.azdes.gov/dcyf/cmdps/cps/Policy/ServiceManual.htm)

ADHS/DBHS
Phoenix: (602) 364-4558
Website: http://www.azdhs.gov/bhs/index.htm
Medication Formulary: http://www.azdhs.gov/bhs/md/medlist.pdf

DBHS Practice Protocols & Guidance Documents:
(http://www.azdhs.gov/bhs/guidance/guidance.htm)

CMDP
(https://egov.azdes.gov/cmsinternet/main.aspx?menu=136&id=1644)

CMDP Contact Information:
Main Phone: 602-351-2245 or 1-800-201-1795
Behavioral Health Coordinator: ext. 13631
Medical services: ext. 11280
"Ask CMDP Nurse" email (for CPS Specialist ONLY): +CMDP Nurse or CMDPNurse@azdes.gov

AACAP (http://www.aacap.org/)

APA (http://www.psych.org/)

Poison Control System:
Phoenix: 602-253-3334
Tucson: 520-626-6016
Statewide: 800-362-0101

Regional Behavioral Health Authorities (RBHA)

CBHS (Cenpatico Behavioral Health Services)
Member Services: 866-495-6738
Crisis Line: 866-495-6735
Website: https://www.cenpaticoaz.com/portal/public/cbh_az
Medication Formulary:
https://www.cenpaticoaz.com/portal/public/cbh_az

CPSA (Community Partnership of Southern Arizona)
Member Services: 520-318-6946 or 800-771-9889
Crisis Line (Pima County): 520-622-6000 or 1-800-796-6762
Crisis Line (Graham, Greenlee, Santa Cruz or Cochise Counties): 800-586-9161.
Website: http://w3.cpsa-rbha.org/
Medication Formulary:
http://w3.cpsa-rbha.org/static/index.cfm?contentID=1639

Magellan
Member Services: 800-564-5465
Crisis Line: 800-631-1314
Website: http://www.magellanofaz.com/
Medication Formulary:
http://www.magellanofaz.com/mypage-en/program--services/pharmacy/medication-formulary.aspx

NARBHA (Northern Arizona Regional Behavioral Health Authority)
Member Services: 800-640-2123
Crisis Line: 877-756-4090
Website: http://www.narbha.org/
Medication Formulary:
http://www.narbha.org/includes/media/docs/NARBHA-Medication-Formulary-3-16-1.pdf

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DEPARTMENT OF ECONOMIC SECURITY

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