

Medication Monitoring Guidelines

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“...data on safety and efficacy of most psychotropics in children and adolescents remain rather limited and are in sharp contrast with the advances and sophistication of the adult field. In child and adolescent psychiatry, changes in clinical practice have, by far, outpaced the emergence of research data and clinical decisions are frequently not guided by a scientific knowledge base.” (Vitiello, B. et. al., JAACAP, 38(5), p.501, May 1999)

“It is important to balance the increasing market pressures for efficiency in psychiatric treatment with the need for sufficient time to thoughtfully, correctly, and adequately, assess the need for, and the response to medication treatment.” (AACAP policy statement 9/20/01)

Guiding Principles: These Guidelines are meant to be utilized by DCS staff in their monitoring of psychotropic medications prescribed for children in care. They are not intended to dictate treatment decisions by providers. Every child or adolescent has unique needs which require individualized treatment planning. At times, the appropriate treatment for a specific child will fall outside the parameters of these guidelines. Such cases should be considered for a review by Department of Children’s Services consultants (eg. Regional Centers of Excellence). It is the intent of DCS that children in care receive necessary mental health care, including psychotropic medications, in a rational and safe manner.

- Medication should be integrated as part of a comprehensive treatment plan that includes:
 - Appropriate behavior planning
 - Symptom and behavior monitoring
 - Communication between the prescribing clinician and the youth, parents, guardian, foster parents, DCS case manager, therapist(s), pediatrician and any other relevant members of the child or youth’s treatment team
- Medication decisions should be appropriate to the diagnosis of record, based on specific indications (i.e. target symptoms), and not made in lieu of other treatments or supports that the individual needs. There should be an effort, over time, to adjust medications doses to the minimum dose at which a medication remains effective and side-effects are minimized. Periodic attempts at taking the child off medication should also be tried and if not, the rationale for continuing the medication should be documented.
- Medication decisions need to be based upon adequate information, including psychiatric history and assessment, medication history, medical history including known drug allergies and consideration of the individual’s complete current medication regimen (including non-psychoactive medications, eg. antibiotics).

- “Anecdotally the prescribing of multiple psychotropic medications (“combined treatment” or “polypharmacy”) in the pediatric population seems on the increase. Little data exist to support advantageous efficacy for drug combinations, used primarily to treat co-morbid conditions. The current clinical “state-of-the-art” supports judicious use of combined medications, keeping such use to clearly justifiable circumstances.” (AACAP policy statement 9/20/01). Polypharmacy should be avoided.
- A child on more than one medication from the same class (eg. two anti-psychotic medications) should be supported by an explanation from the prescribing clinician and may warrant review by a DCS consultant.
- A child on more than three psychotropic medications should be supported by an explanation from the prescribing clinician and may warrant review by a DCS consultant.
- Medication dosages should be kept within FDA guidelines (when available). The clinical wisdom, “start low and go slow” is particularly relevant when treating children in order to minimize side effects and to observe for therapeutic effects. Any deviations from FDA guidelines should be supported by an explanation from the prescribing clinician and may warrant review by a DCS consultant.
- Unconventional treatments should be avoided. Medications that have more data regarding safety and efficacy are preferred over newly FDA-approved medications.
- Medication management requires the informed consent of the parents or guardians and must address risk/benefits, potential side-effects, availability of alternatives to medication, prognosis with proposed medication treatment and without medication treatment and the potential for drug interactions. (see DCS informed consent policy)
- The risk vs. benefit of a medication trial needs to be considered and continually reassessed, and justification should be provided, where the benefit of a medication comes with certain risks or negative consequences.
- Children on Psychotropic medications should be seen by their prescribing clinician no less than once every three months. This is a bare minimum and children in acute settings, displaying unsafe behavior, experiencing significant side-effects, or not responding to a medication trial or in an active phase of a medication trial should be seen more frequently.
- If laboratory tests are indicated to monitor therapeutic levels of a medication or to monitor potential organ system damage from a medication these lab studies should be performed every three months at a minimum (maintenance phase). If the medication is being initiated these lab studies will need to be performed more frequently until a baseline is achieved.

Portions of these guidelines were adapted from *Tennessee Department of Mental Health and Developmental Disabilities Best Practice Guidelines*.