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Psychotropic Medication Policy/Procedure for Children in Custody of Trumbull County Children Services

Policy

Rationale

National and statewide data show a high prescription rate of poly-psychopharmacology among children and youth in the custody of the child welfare system. A growing body of research has identified the high rate of trauma endured by children in the child welfare system, the value of trauma informed practice and care, and differences in environmental trauma vs. other types of mental illness, and the value of medications for addressing trauma. There is concern nationwide that the significant trauma issues for these children and youth have been treated at times with a greater focus on use of psychotropic medications, when trauma-based practice and services could or should be used in tandem with temporary, declining medication use.

As custodial agencies, Public Children Services Agencies have a profound responsibility (and statutory mandate) to focus on not only safety and permanency for our children, but also improving child well-being for the immediate time and as our children and youth age and transition out of our care. PCSAs are the ultimate consenting authority if birth/adoptive parents are unavailable to consent.

Definitions

Psychotropic Medication – Medications used to treat mental health conditions. Has the effect to alter a person's thoughts, feelings, mental/physical activity, mood or behavior.

Antipsychotic Medications – A class of psychotropic medications approved for treatment of autism, schizophrenia, bipolar disorder and severe aggressive behavior in children.

Polypharmacy – Use of more than one (1) psychotropic medication concurrently.

Authority to Grant Informed Consent

The Executive Director (ED) of Trumbull County Children Services (TCCS) will provide informed consent for psychotropic medication use for children in custody of TCCS. The informed consent will be necessary for any new medication prescribed to treat any behavioral health disorder, as well as for changes in dosages of psychotropic medications. Informed consent must be given before the medication is given to the child except in psychiatric emergencies.

When psychotropic medications do not fall within prescribing guidelines (**Attachment 1**), the ED or designee shall contact the prescriber to discuss the rationale. If the ED is still not comfortable granting informed consent, the ED shall consult with the Agency Medical Consultant who shall be a Board Certified or Eligible Child and Adolescent Psychiatrist.

Prescriber Limitations

Psychotropic medications will only be prescribed to children in custody of TCCS if the prescriber is one of the following:

a. A board Certified or Eligible Child and Adolescent Psychiatrist or Adult Psychiatrist with child experience;
b. An Advance Practice Nurse (APN) with Prescriptive Authority who is certified in child psychiatry;
c. A Pediatrician, Family Practice Physician, APN with Prescriptive Authority or Physician's Assistant for psychotropic medications that have been originally prescribed by a clinician listed in a or b, when the medication has stabilized the behaviors and the medication at the same dosage needs to be periodically represcribed for maintenance of symptom change.

Covered Medications

Medications requiring consent shall be defined as any medication that is used to treat symptoms related to a behavioral health diagnosis. This includes the following:

a. Psychotropic medications as described above;
b. Non-psychiatric medications that are used for symptoms related to a behavioral health diagnosis;
c. Over-the-counter (OTC) medications if prescribed for symptoms related to a behavioral health diagnosis; and
d. All psychiatric medications will be included if sued for a condition NOT related to a diagnosis found in the DSM IV.

After Hours/Emergency Informed Consent

A psychiatric emergency exists when a child needs to be treated by emergency healthcare providers for conditions, symptoms or behaviors that are causing or might cause a danger to self or others and are or might be related to a diagnosable behavioral health condition. If child is admitted to an emergency room (ER) due to a psychiatric emergency, the ER contacts our Agency for Permission to Treat. Permission to Treat shall cover any psychotropic medications prescribed during ER admission and any prescriptions written by ER personnel for 24 hours post discharge. If the child is transferred to a locked, inpatient child psychiatry unit/hospital, Permission to Treat at that site shall be considered informed consent for the use of psychotropic medications, as ordered by the treating physician, for the first 24 hours. Of his/her stay there. Except in an emergency while inpatient, hospitals shall follow the procedures described below to obtain informed consent from the ED for use of psychotropics. **A psychiatric emergency while in an inpatient setting shall be considered when a set of behaviors or symptoms exist that are related to the child's psychiatric diagnosis and may result in imminent harm to self or others**. Psychotropic medications may be used by the treating physician in the event of an inpatient emergency with simple notification of on-call staff.

Procedure

Informed Consent for Youth on Psychotropic Medication when Taken into Custody

1. Within the first 72 hours after being taken into custody, the caseworker shall complete the **Psychotropic Medication Information Checklist (CSB form #623, Attachment 2)**.
2. At the same time, a Request for Release of Information shall be sent to the prescriber requesting the

following:

a. Current psychotropic medications, dosage, route and times;
b. Diagnostic assessment with DSM diagnosis, if not available then 5 Axis DSM IV diagnosis;
c. Individualized Service Plan (ISP) if available;
d. Obtain medication history (may be part of diagnostic assessment if available); and
e. Most recent MD progress note.

3. The information above shall be sent to the ED designee who shall create a psychotropic medication file for the child.
4. The ED designee shall enter all existing information on the Psychotropic Data Collection spreadsheet (**Attachment 3**).
5. Following review of the above, the ED shall grant informed consent based on the judgment of the previous custodian in consultation with the prescriber unless the medication is outside of the prescribing parameters. In that case, the ED shall discuss this medication with the prescriber. If no common agreement can be reached, the ED shall consult the Agency Medical Consultant to assist with final decision.
6. Informed consent for these medications will be sent to the prescriber by the ED designee using the **Request to Administer Psychotropic Medication form (Attachment 4)** completed by the ED designee upon receipt of the information listed above and as granted by the ED.
7. Upon receipt of the information outlined above (#'s 1 & 2), the caseworker will document the information in SACWIS via the child's Education and Health Information form (JFS #1443). In addition, the caseworker will make a copy of the information to place in the child's case record and forward the original information to the ED/designee for inclusion in the Psychotropic Medication File.
8. Caseworker regularly monitors medication adherence and role of child and caregiver in adherence and documents in SACWIS.
9. Informed consent for new medications is described below.

Informed Consent for Newly Prescribed Psychotropic Medications

1. As soon as possible after being taken into custody, the child shall receive a psychological evaluation. If this evaluation indicates that the child may benefit from psychotropic medication and other behavioral health services, or if the child's team believes at any time that this may be needed, the child shall be referred for a comprehensive diagnostic assessment.
2. The caseworker shall notify the caregiver of the recommendation and provide the name of a provider to assess the child.
3. The caseworker is responsible for making the appointment, and communicating appointment date and time to the substitute caregiver.
4. The caseworker informs the provider of Agency policies on psychotropic medications before the appointment or during the appointment.
5. The appointment and communication for informed consent:
    a. The caseworker attends the initial appointment. For youth placed out of county, caseworker attends psychiatric appointments at least quarterly. An attempt to schedule to coordinate with time of team meeting in mind.
    b. The caseworker assures that the prescriber documents diagnosis, symptoms to be addressed with medications, potential risks, expected benefits, medication name, route, dose and time(s) to be administered.
    c. The caseworker ensures that the child and substitute care provider understand the name of the medication, the benefits and any potential side effects (as appropriate considering child's

developmental level). The caseworker obtains/documents their input into the decision.

d. The caseworker assures that the provider completes **Request to Administer Psychotropic Medication form** and faxes or emails it to ED designee.
e. The provider may request informed consent for a medication and indicate the maximum dosage he/she will titrate up to. This is to avoid repeated informed consent requests for a single medication titration.
f. ED reviews and provides informed consent for the psychotropic medications and communicates the decision to the caseworker and provider within 24 hours of receipt of the form. If the ED cannot provide informed consent, every effort is made to contact provider to share concerns. If still not able to provide informed consent following discussion with provider, ED contacts Agency Medical Consultant. Informed consent decision is emailed or faxed to the prescriber by the ED designee.
g. The caseworker communicates the final decision to the prescriber, care provider, child and biological parent (unless contraindicated).
h. **Out-of-home care provider fills and administers only after approval received.**
i. The caseworker contacts the pharmacy if the prescription was electronic and the informed consent is not given to have the prescription canceled.
j. The caseworker documents all the information in SACWIS. The ED designee makes the appropriate changes to the Psychotropic Medication File and adds the data to the spreadsheet.

Informed Consent for Changes in Type, Dose or Route of Psychotropic Medication

When an approved prescriber wishes to make changes to the medication and/or adjust the dose or route, the following shall occur:

1. The prescriber shall complete the **Request to Administer Psychotropic Medication form** and faxes or emails it to the ED designee. If the prescriber has an internal form with identical information, this form may be substituted. The provider may request informed consent for a medication and indicate the maximum dosage he/she will titrate up to. This is to avoid repeated informed consent requests for a single medication titration.
2. The ED designee shall contact the casew2orker for input into this change. The caseworker may contact the caregiver for additional input.
3. If the medication changes do not fall outside of the prescribing parameters and have the support of the caseworker and caregiver, ED shall grant informed consent. This will be faxed or emailed back to the provider within 24 hours of receipt of the request. If the ED has concerns, the prescriber shall be contacted to discuss. The Agency Medical Consultant will be contacted if ED has continued concerns about the change.
4. The caseworker communicates the child and substitute caregiver the name of the medication, and other changes and ensures he/she understands benefits and potential side effects (as appropriate considering child's developmental level). The caseworker obtains/documents their input into the decision.
5. The caseworker informs the biological parent of the medication or change unless contraindicated.
6. The caseworker communicates the final decision on informed consent to the care provider, child and biological parent (unless contraindicated).
7. **Out-of-home care provider fills and administers only after approval received.**
8. The caseworker contacts the pharmacy if the prescription was electronic and the informed consent is not given to have the prescription canceled.
9. The caseworker documents all the information in SACWIS. The ED designee makes the appropriate

changes to the Psychotropic Medication File and adds the data to the spreadsheet.

Informed Consent During Inpatient or Residential Placement

1. A psychiatric emergency while in an inpatient or residential setting shall be considered when a set of behaviors or symptoms exist that are related to the child's psychiatric diagnosis and may result in imminent harm to self or others. Psychotropic medications may be used by the treating physician in the event of an inpatient or residential emergency with simple notification of on-call staff.

2. Other changes to psychotropic medications, types, doses or routes shall follow the procedure outlined below:
   a. The prescriber shall complete the **Request to Administer Psychotropic Medication form** and faces or emails it to the ED designee. If the prescriber has an internal form with identical information, this form may be substituted.
   b. The ED designee shall contact the caseworker for input into this change.
   c. If the medication changes do not fall outside of the prescribing parameters and have the support of the caseworker, ED shall grant informed consent. This will be faxed or emailed back to the provider within 24 hours of receipt of the request. If the ED has concerns, the prescriber shall be contacted to discuss. The Agency Medical Consultant will be contacted if ED has continued concerns about the change.
   d. The caseworker communicates to the child the name of the medication, and other changes and ensures he/she understands benefits and risks (as appropriate considering child's developmental level). The caseworker obtains/documents his/her input into the decision.
   e. The caseworker informs the biological parent of the medication or change unless contraindicated.
   f. The ED designee notifies the prescriber of informed consent by fax or email within 24 hours.
   g. The caseworker communicates the final decision to the treatment team, child and biological parent (unless contraindicated).
   h. **Inpatient or residential provider administers <u>only after approval received</u>.**
   i. The caseworker documents all the information in SACWIS. The ED designee makes the appropriate changes to the Psychotropic Medication File and adds the data to the spreadsheet.

Orientation and Training

1. Training in this policy/procedure shall be provided to caseworkers, caregivers and supervisory staff. This training shall include the following:
   a. An overview of the statutory mandate requiring this policy;
   b. An overview of the difference in prescribing patterns for children in the child welfare system;
   c. Basic review of the risks and benefits of psychotropics and best practices when medication is accompanied by individual, family and group therapies;
   d. Provide a list of preferred providers;
   e. An explanation of each procedure and form.

2. Orientation of providers will occur face-to-face whenever possible. It will include the following:
   a. An overview of the statutory mandate requiring this policy;
   b. An overview of the difference in prescribing patterns for children in the child welfare system;
   c. An explanation of each procedure and form.

Ongoing Monitoring and Evaluation

1. Data to be collected, aggregated and analyzed:
   a. Denials by provider and reason;
   b. Serious medication reactions by provider and medication;
   c. Approved prescriptions that exceed parameters by medication and provider;
   d. Behavioral Health treatment outcomes by child, provider and service combination (This may be obtained from some providers (ODMH certified));
   e. Data identical to that collected by the Ohio Psychotropic Medication Quality Improvement Collaborative. (See draft of core measures attached)
2. PQI "dashboards" will be published every quarter.
3. Obtain Policy/Procedure feedback from providers, caseworkers, out-of-home care providers and youth.
4. Make quarterly reports to the state or county child welfare agencies regarding the rates and types of psychotropic medication use.

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