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August 23, 2017

Ms. Elaine M. Howle, CPA
State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Dear Ms. Howle:

On behalf of Los Angeles County, the Office of Child Protection (OCP) is providing the latest update on Los Angeles County's efforts to implement the recommendations contained in the August 2016 report entitled, "California's Foster Care System: The State and Counties Have Failed to Adequately Oversee the Prescription of Psychotropic Medications to Children in Foster Care."

As noted in our response of October 20, 2016, Los Angeles County agreed with the four main recommendations in the State Auditor's report. Specifically, these recommendations were:

1. Counties should monitor requests for authorizations of psychotropic medications.
2. Counties should ensure court approval or parental consent prior to prescribing psychotropic medications.
3. Counties should ensure physicians' follow-up within 30 days of their prescribing a new psychotropic medication.
4. Counties should ensure that proper mental health services are received along with psychotropic medications.

As noted in our report of February 23, 2017, Los Angeles County's efforts with respect to psychotropic medications are being coordinated by the Psychotropic Medication Workgroup (Workgroup) convened by the OCP in July 2016. The Workgroup has met monthly since that time, and has recently been joined by representatives from the California Youth Connection (CYC).

On April 15, 2017, Los Angeles County implemented revised protocols for the approval process and the monitoring process of the use of psychotropic medications for children and youth involved in both the child welfare and juvenile justice systems. These revised protocols incorporate the new forms mandated by the Judicial Council last year. **We believe that the new forms and protocols, along with practice changes, are implementing the recommendations made by the State Auditor in its August 2016 report.**

Specifically, we have revised our protocol for monitoring requests for psychotropic medications. The Juvenile Court now orders a 45-day progress report for every new medication or increased dosage on a previously approved medication. Among other things, that report requires information on whether or not the child was seen by the prescribing physician within the 30-day timeframe recommended by the State Auditor. Further, the forms mandated by the Judicial Council require assurances that proper mental health services are being received along with the medication, and also that alternatives to medication are being considered.

At the Workgroup's monthly meetings, the various member entities—including the departments of Children and Family Services, Probation, Mental Health, and Public Health, along with the Juvenile Court—report on how the protocols and practices are being followed and properly documented. While implementation is still a work in progress, we are satisfied that compliance is steadily improving.

We are also working with the Department of Children and Family Services, Probation, and other stakeholders (constituting the proverbial "village") to routinely inquire of children and caregivers on the use of medications and to fully document their answers. Our goal is to ensure that we are aware of every child involved in our systems who is being administered psychotropic medications, and to ensure that every one who *is* being medicated has in fact been the subject of the approval process designed to make sure that the use of these medications is appropriate.

In addition to implementing the forms and protocols and their monitoring, we have begun discussions on how we as a system can ensure that youth who reach the age of majority and age up and/or out of our systems are prepared to make medical decisions for themselves and to maintain their medication regimens should that be their choice. We anticipate that over the next several months, we will articulate the role of each of our stakeholders in helping to achieve this goal.

While further updates to the State Auditor may no longer be required, our work will continue. We will always be willing to share information on our progress with respect to this very important issue.

If you have questions or concerns, please contact me at (213) 893-1152, or via e-mail at mnash@ocp.lacounty.gov.

Very truly yours,



Judge Michael Nash (Ret.)
Executive Director
Office of Child Protection

Psychotropic Medication: Authorization, Review, and Monitoring for DCFS Supervised Children

0600-514.10 | Revision Date: 01/05/17

Overview

This policy reviews the administration of psychotropic medications when prescribed by the child's physician or psychiatrist.

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Version Summary

This policy guide was updated from the 07/01/14 version to address new state forms [JV-217-INFO, Guide to [Psychotropic Medication](#) Forms; JV-218 Child's Opinion About the Medicine; JV- 219, Statement About Medicine Prescribed; JV-220(B), Physician's Request to Continue Medication -- Attachment; and JV-224, County Report on Psychotropic Medication], revisions of existing state forms, and to update procedures as required by [SB 238](#) (2015) and [SB 319](#) (2015). [Back to Top ^](#)

POLICY

State of California law and the Los Angeles Superior Court have provided specific guidelines and limitations regarding a physician's provision of psychotropic medication to a child who is a dependent of the Los Angeles Juvenile Court and under the supervision of DCFS. These guidelines and Rules of Court were recently updated by [SB 238](#) and [SB 319](#). As a result, four (4) existing forms were revised, and five (5) new forms were introduced effective July 1, 2016. In addition, in accordance with the Superior Court of California, County of Los Angeles, Central District, Juvenile Division's Blanket Order dated July 27, 2016, any prescribing physician that submits an application for psychotropic medication authorization (JV-220A, JV-220B) for a foster child/youth in residential placement, seeking an order pursuant to WIC 369.5, shall be credentialed by the Los Angeles County Department of Mental Health.

Summary of Psychotropic Medication Authorization (PMA) Forms

Form Number	Form Name	Completed By	Description
JV-217-INFO	Guide to Psychotropic Medication Forms	N/A	A new informational guide that explains all the new, existing and revised PMA forms (formerly the JV-219-INFO)
JV-218	Child's Opinion About the Medicine	Child, child's attorney, caregiver, CASA, tribal representative, CAPTA guardian ad litem	Individuals may use this new, optional form to tell the judge about their opinion(s) about the medicine
JV-219	Statement About Medicine Prescribed	Parents/Legal Guardians, parent's attorney, caregiver, CASA, tribal representative	These individuals may use this revised, optional form to tell the court how they feel about the JV-220, and the effectiveness and side effects of the medicine
JV-220	Application for Psychotropic Medication	PMA Unit (#1-4) and Case-Carrying CSW (#5-13)	This revised form gives the court basic information about the child and his/her living situation, provides CSW/DPO contact information, and serves as the formal PMA request to court
JV-220 (A),		Prescribing physician*	This revised form is used to ask for a new PMA order Back to Top ^

JV-220 (A) S	Physician's Statement - Attachment		223); it provides a record of the child's medical history, diagnosis, previous treatments, and the child's previous experience with psychotropic medications; also available in Spanish [JV-220 (A) S]
JV-220 (B)	Physician's Request to Continue Medication - Attachment	Prescribing physician*	A shorter version of the JV-220 (A), this new form may only be used by the same doctor who filled out the most recent JV-220 (A) form if s/he is prescribing the same medication with the same maximum dosage
JV-221, JV-221 S	Proof of Notice of Application	PMA Unit and Court PMA desk clerk	This revised form shows the court that all parties with a right to receive notice were served a copy of the JV-220 and attachments; also available in Spanish (JV-221 S)
JV-222, JV-222 S	Input on Application for Psychotropic Medication	Parents/Legal Guardians, attorney of record for parent/guardian, the child, the child's attorney, the child's CAPTA guardian ad litem, tribal representative	This revised, optional form may be used when one or more parties do not agree that the child should take the recommended psychotropic medication, or one or more of the parties wishes to provide the court with additional information; also available in Spanish (JV-222 S)
JV-223, JV-223 S	Order on Application for Psychotropic Medication	Hearing Officer	This serves as the official court PMA order; it lists the court's findings and orders about the child's psychotropic medication; Back to Top

			be provided to the caregiver; also available in Spanish (JV-223 S)
JV-224	County Report on Psychotropic Medication	Case-Carrying CSW	This new form serves as the report DCFS submits to court that describes how the child is doing on the medication, replacing the DCFS 4157

* In accordance with the Superior Court of California, County of Los Angeles, Central District, Juvenile Division's Blanket Order dated July 27, 2016, any prescribing physician that submits an application for psychotropic medication authorization (JV-220A, JV-220B) for a foster child/youth in residential placement, seeking an order pursuant to WIC 369.5, shall be credentialed by the Los Angeles County Department of Mental Health.

Psychotropic Medication Review and Monitoring Process

Each JV-223, Order On Application for Psychotropic Medication for new or renewed medication(s), is routed to the Juvenile Court Services Psychotropic Desk Clerk, who then forwards it to the Psychotropic Medication Authorization (PMA) Unit. The PMA unit provides the JV-223 to the CSW and PHN, and uploads it into CWS/CMS. The Public Health Nurses input the medication information into CWS/CMS.

For children who are administered psychotropic medications on an ongoing basis, the Case-Carrying CSWs will contact the caregiver and complete the [JV-224, County Report on Psychotropic Medication](#), and submit it to court with their court report.

Psychotropic Medication Authorization Process


1. Physician/Psychiatrist -- Day 1

- The physician completes the [JV-220\(A\)](#) or [JV -220\(B\)](#), making sure to write in his/her correct return fax number in the "phone numbers" field (#4c on the [JV-220A](#) and #3c on the [JV-220B](#)), and faxes the form to the DCFS Psychotropic Medication Authorization (PMA) Unit at (562) 941-7205.
- Illegible or incomplete [JV-220\(A\)](#) or [JV -220\(B\)](#) forms submitted by physicians to the PMA Unit will be returned to the physician the same day or no later than the next business day for resubmission. Forms received for children with a Family Maintenance (FM) service component / Home of Parent (HOP) court order, or for dependent children from county jurisdictions other than Los Angeles, will also be returned.
- If the PMA desk rejects a PMA application, they will notify the CSW and SCSW via email and include a scanned copy of the rejected [JV-220 A/B](#) along with any lab results or other documentation that was sent with the application, and a copy of the fax confirmation rejection document. [Back to Top ^](#)

2. DCFS PMA Unit – Day 1-2 [Upon receipt of the completed JV-220(A or B)] form:

- a. Fills in information in questions 1 through 4 on the [JV-220, Application for Psychotropic Medication](#). Emails scanned copies of the JV-220 and JV-220(A or B) to the assigned CSW, SCSW, ARA, [regional PMA In-Box](#) and PHN, and [requests completion of the JV-220 pages 2-4 \(questions 5 through 13\) by the CSW](#) within two (2) judicial days.
- b. Mails to the child: the JV-217-INFO, Guide to Psychotropic Medication Forms, the JV-218, Child's Opinion About the Medicine (with a stamped return envelope addressed to the court), plus a cover memo requesting voluntary completion of the JV-218 and its return to court within four (4) judicial days after receipt of notice.
- c. Mails the JV-219, Statement About Medicine Prescribed, and the JV-217-INFO, to the parents, caregivers, and tribal representative (if applicable), along with the Notice of Hearing and a cover memo requesting voluntary completion of the JV-219 and its return to court within four (4) judicial days of notice..
- d. Sends the DCFS parental notification cover letter (of which there are separate versions for Monterey Park and Lancaster Children’s Courts) including the list of planned medications, and the [JV-222](#), Input on Application for Psychotropic Medication, to the child's parents/legal guardians (for all cases) and to the Tribal Chair/ICWA Coordinator (for ICWA eligible youth).
- e. Completes items 1 through 5 of the [JV-221](#), Proof of Notice of Application.

3. DCFS Case-Carrying CSW - Day 3-4

- a. [Completes pages 2-4 \(questions 5-13\) of the JV-220](#)  (question #5 can be answered by consulting the Health and Education Passport)
- b. Returns the completed JV-220 via email to the PMA unit (PMA@dcfs.lacounty.gov) within two (2) judicial days.

4. DCFS PMA Unit – Day 4 (upon receipt of the completed JV-220 form from the CSW):

- a. Sends a copy of the JV-220(A or B), the completed JV-220 (pages 1-3), and page 1 of the JV-221 via DCFS messenger within three (3) court days of receipt of the JV-220(A or B) (Note: court will not accept faxed or emailed versions of these forms).
- b. Emails the assigned CSW and SCSW to notify them that a PMA has been sent to court, and attaches a scanned copy of the PMA request.

5. Dependency Court Psychotropic Desk Clerks – Days 4-5:

- a. Issue a log number
- b. Enter information into psychotropic medication tracking system and validate case information in JADE
- c. Complete page 2-3 of JV-221
- d. Using the table below, distribute copies of the relevant documents:

Document Distribution	JV-218	JV-219	JV-220	JV-220 (A or B)	JV-222	Back to Top ^
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						Parent's Cover Letter
Child's Attorney	X	X	X	X	X	
CASA (if on weekly case list)		X			X	
Parents' Attorneys		X			X	X
Juvenile Court Mental Health Services			X*	X		

*Label with name of child's attorney and firm

6. Juvenile Court Mental Health Services (JCMHS) – Days 5-7:

- a. Reviews the JV-220 and JV-220 (A or B) and returns to Psychotropic Desk Clerk with recommendations/comments.
 - If additional time is necessary, JCMHS shall indicate on form and request that the court set a hearing date.
- b. Gives a copy to the child's attorney whenever a comment is made.

7. Dependency Court Psychotropic Desk Clerks – Days 5-7:


Upon receipt of the JV-220, JV-220 (A or B) and recommendations/comments from JCMHS:

- a. Enter date into the log
- b. Pull the file for the Children's Court case
- c. Provide the Court with the following forms:
 - JCMHS recommendation/comment form
 - JV-220
 - JV-220(A or B)
 - JV-221 (pages 1 and 2)
 - Any JV-218, JV-219 or JV-222 forms received thus far
 - JV-223
- d. For Lancaster Court cases, fax the above forms to Lancaster Court Clerk's office. Lancaster Court Clerk pulls the file and delivers it with the forms to the court.

8. Judicial Officers – Day 7:

- a. Review forms/files and complete the JV-223.
 - i. JV-223 form must be completed by the first available:
 - Judicial Officer
 - As-needed judicial officer
 - Buddy court judicial officer
 - Presiding Judge
- b. Court must complete JV-223 even if the matter is set for hearing.
 - i. Following the hearing, complete a new JV-223.

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- c. Court must wait until Day 7 to rule on the request in order to allow sufficient time for any JV-218, JV-219, and/or JV-222 to be submitted.
9. Court Assistant/Judicial Assistants – Day 7:
 - a. Make a copy of the completed and signed JV-223, and deliver it to the Desk Clerk in the Children’s Court.
 - b. Place JV-220, JV-220(A or B), JV-221, JV-222, JV-223, and JCMHS recommendation/comment forms in the child’s confidential legal envelope in the court file.
 - c. Return file to courtroom or file shelf.
 - d. If the Court sets the matter for a hearing, the Judicial Assistant notices all parties, JCMHS, and CASA (if applicable) with JV-223.
 - e. For Lancaster Court cases:
 - i. After the JV-223 is completed in Lancaster Court, deliver the file to the Lancaster Court Clerk’s office.
 - ii. Lancaster Court Clerk’s office responsibilities:
 - Put original forms in the child’s confidential envelope in the court file.
 - Fax the JV-223 to the Psychotropic Desk Clerk at Children’s Court to (323) 260-5082.
 - Provide copies of the JV-223 to all attorneys on the case and CASA (if applicable).
10. Dependency Court Psychotropic Desk Clerks – Days 7-8:
 - a. Log date the JV-223 is received from the courtroom and Lancaster Court.
 - i. For Children’s Court cases:
 - Provide copies of JV-223 to child’s attorney, parents attorneys, County Counsel, and CASA (if applicable)
 - ii. For all cases:
 - Provide copies of JV-223 to JCMHS and prescribing physician
 - Provide copies of JV-223 and coinciding JV-220 and JV-220(A or B) to the DCFS PMA Unit
11. DCFS PMA Unit – Days 9-10:
 - a. Imports completed JV-223 into CWS/CMS and notifies the CSW, SCSW, and PHN Supervisor via email that the child's PMA has been imported into CWS/CMS.
 - b. Provides copy of JV-223 to the child’s CSW and PHN.
 - c. Provides copy of JV-223, JV-220, and JV-220(A or B) to the child’s caregiver.
12. DCFS Case-Carrying CSW (upon receipt of completed PMA) - ongoing:
 - a. Completes the JV-224 , County Report on Psychotropic Medication and submits it to court at least 10 days prior to any court hearing that will be addressing psychotropic medication, such as:
 - for any special/progress hearing regarding psychotropic medication, [Back to Top ^](#)
or

- at a minimum, with every status review hearing report

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Authorization and Consent

Court Authorization Required

Court authorization is required to prescribe non-emergency psychotropic medication in the following circumstance:

- The court has made disposition orders on a child who resides in out-of-home care.
 - This does not apply in cases where the court has issued specific orders delegating authority to a parent/legal guardian (after determining that the parent/legal guardian poses no danger to the child and has the capacity to authorize psychotropic medications).

The court authorization is good for six months unless otherwise ordered by the Juvenile Court. A separate authorization is required if the physician believes a longer course of medication is necessary or decides to change the type of medication or dosage. A physician can continue to prescribe and administer medication while a renewal request is pending before the court.

If the court does not authorize the medication, it is the CSW's responsibility to contact the physician and advise the physician that he or she may not prescribe or administer the medication but has the option to respond to the JCMHS comments with a new JV-220(A) or JV-220 (B).

Court Authorization Not Required

Court authorization is not required to prescribe psychotropic medication in the following circumstances:

- Pre-disposition – The court has not yet made disposition orders on behalf of the child (in these cases the parent/legal guardian [consent](#) is required)
- Home-of-parent – The court has made disposition orders and the child resides in the home of a parent or legal guardian (in these cases the parent/legal guardian consent is required).
- Physician Determined Emergency – The physician has made a determination that an emergency exists, finding that due to a mental disorder, the child requires immediate psychotropic medication, and the purpose of the medication is to:
 - Protect the life of the child or others
 - Prevent serious harm to the child or others (It is not necessary for the harm to actually take place or become unavoidable)
 - To treat current or imminent significant suffering when it is impractical to obtain consent (i.e., waiting for the court's authorization would put the child or others at substantial risk)
- [Youth who are non-minor dependents \(NMD\)](#)

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Emergency PMA Requests

On occasion, children may be prescribed psychotropic medication on an emergency basis by a psychiatrist who is not their usual doctor. This might happen during psychiatric hospitalization or after-hours evaluation by an [Exodus](#) psychiatrist, and the newly-prescribed medications may not align with those included within an existing approved PMA. Please note that only one (1) PMA is valid at any given time. Therefore, in these cases, the treating psychiatrist will complete an “emergency PMA,” authorizing use of the newly-prescribed medication during the course of the hospitalization and up to thirty (30) days thereafter (if approved by the court). The psychiatrist must also address any previously-prescribed medications that will be continued or discontinued on the JV-220 (A), page 6. Court authorization must be sought as soon as practical but in no case more than two (2) court days after the emergency administration of the psychotropic medication.

With a copy of the emergency PMA, the CSW or caregiver is authorized to fill the prescription and administer the medication. As soon as possible after discharge, CSWs or caregiver should ensure the child is seen by their treating psychiatrist, who will evaluate the child’s psychotropic medication regimen and submit a regular PMA, per protocol.

Juvenile Court Authorization

The Juvenile Court authorizes psychotropic medication for children in the following circumstances:

- Children under Juvenile Court jurisdiction who are involuntarily detained under the Lanterman-Petris-Short (LPS) Act
- Children with suitable placement orders and voluntary hospital commitment
- Children committed to the State Department of [Developmental Services](#) by the Mental Health Court (D-95)

The Mental Health Court shall have exclusive power to determine issues of consent to medication in all cases in which a permanent LPS conservatorship has been established.

In situations where a child who enters the Juvenile Court system is being treated with psychotropic medication, the physician may continue the medication pending an order from the court.

For dependents of the Juvenile Court with a prescribed psychotropic medication, the court authorization or the parent/legal guardian consent for the administration of the medication must be documented in the child’s CWS/CMS case record including the date of consent.

Parent/Legal Guardian Consent

Parent/legal guardian consent is required in all pre-adjudication cases and post-disposition cases where the child is placed in the home of a parent/legal guardian or in out-of-home care and the court has delegated psychotropic medication decision making authority to the parent/legal guardian. The JV-220(A), Physician’s Statement -- Attachment, or JV-220 (B), Physician’s Request to Continue Medication -- Attachment, is not required in these cases.

Parent/legal guardian consent is not required in cases where parent/legal guardian consent cannot be obtained prior to disposition, or when the case is post-disposition and the child is placed [Back to Top](#)

home care and the court has not delegated psychotropic medication decision making authority to the parent/legal guardian. In these cases, the physician must fax the completed JV-220(A), Prescribing Physician's Statement, or JV-220 (B), Physician's Request to Continue Medication -- Attachment, to the DCFS PMA Unit. The DCFS PMA Unit phone numbers are (562) 903-5335, -5333, -5334, -5336 or -5326. The fax number is (562) 941-7205.

Non-Minor Dependent Consent

Youth who are 18 years old or older and are dependents of the court are defined as nonminor dependents (NMDs) and can consent to their own medical care without court authorization, unless there is a court order stating the contrary (e.g., conservatorship). If a NMD refuses medical treatment that places him/her in serious harm and/or at risk of death, contact the County Counsel on the case to discuss how to proceed. It is likely that under this scenario a court order will be required.

When a non-minor dependent (NMD) has legal-decision making authority, a JV-220(A), Prescribing Physician's Statement, or JV-220 (B), Physician's Request to Continue Medication -- Attachment, is not required. Decision-making authority includes privacy regarding psychiatric condition(s) and consenting to receive treatment or take psychotropic medication(s).

Information about known medical problems, medication, and other relevant health information for NMDs must be documented in the [Health and Education Passport](#) (HEP). Information in the HEP is confidential, but must be provided to the caregiver of any NMD placed in a licensed and approved setting (except for SILPs).

- A copy of the HEP may be included in the court report only if the NMD consents. The caregiver of a NMD, is not responsible for obtaining and maintaining the NMD's health and educational information, but may assist the NMD with any record keeping that the NMD requests of the caregiver.

[NMD caregivers](#) must keep all medical information confidential and cannot release information without the written consent of the NMD.

The CSW must advise the NMD of the CSW's obligation to provide the HEP summary to the new caregiver and the court. The CSW must discuss with the youth the benefits and liabilities of sharing that information.

Objection/Noncompliance

A child, child's attorney, caregiver, CASA, tribal representative or CAPTA guardian ad litem may submit an objection to the court on the JV-218, Child's Opinion About the Medicine. The JV-218 must be filed within four (4) judicial days of receipt of the notice of a PMA application, or before (or at) any Status Review Hearing or PMA Progress Hearing. A child also has the option to talk to the judge at the hearing, write the judge a letter, ask his/her attorney, CSW, DPO or CASA to tell the judge how s/he feels, in lieu of submitting a JV-218. A child's objection to, or noncompliance with, the approved psychotropic medication, is a treatment issue to be resolved by the physician prescribing the medication. A child cannot be [forced](#) to take psychotropic medication unless s/he is subject to an [involuntary hospitalization](#) or have a court appointed conservator.

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The parent/legal guardian, parent's attorney, caregiver, CASA, or tribal representative may use the new JV-219, Statement About Medicine Prescribed, to tell the court how they feel about the psychotropic medication application, the effectiveness of the medicine, and any side effects of the medicine.

A parent/legal guardian, the attorney of record for a parent/legal guardian, the child, the child's attorney, the child's CAPTA guardian ad litem, or a tribal representative can document their objection on the JV-222, Input on Application for Psychotropic Medication form, and submit it to court. The JV-222 must be completed, signed and filed with the Juvenile Court within four (4) judicial days of service of notice of the pending PMA application.

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PROCEDURE

Physician/Psychiatrist Treatment Plan Includes Psychotropic Medication

CSW Responsibilities

1. Instruct the caregiver to provide the [JV-220\(A or B\)](#) to the physician.
2. If the child has been adjudged a dependent of the court and has been removed from the physical custody of the parent/legal guardian, the CSW must:
 - a. Consult with the regional Public Health Nurse (PHN) to review the proposed treatment
 - b. Contact the physician/psychiatrist and explain that court approval is required, unless the court has issued specific orders delegating psychotropic medication decision-making authority to parent, legal guardian, etc.
 - i. The CSW can ask the PHN to communicate with the physician and serve as a liaison between the physician and DCFS.
 - c. Inform the physician/psychiatrist of responsibilities:
 - Physician/psychiatrist is responsible for explaining to the child (in age appropriate language), caregiver, and/or the parent/legal guardian the recommended course of treatment, the basis for the treatment, and the possible results of taking the medication, including possible side effects.
 - Physician/psychiatrist is responsible for attempting to obtain parental consent.
 - Physician/psychiatrist is responsible for completing the "Clinical Information" section of the JV-220(A or B).
 - Physician/psychiatrist is responsible for completing the "Medications" section of the JV-220(A or B), listing all prescribed medications the child currently takes and will be taking if the request is granted, whether or not these were prescribed by the requesting physician and indicating the range of dosages to be authorized (If the physician/psychiatrist does not indicate a range of dosages, a new JV-220(A or B) will be required for each change in the dosage schedule.

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3. Inform the physician/psychiatrist to fax a copy of the signed and completed JV-220(A or B) to the DCFS PMA Unit at (562) 941-7205.
 - When a JV-220 (A or B) is received from a physician, the PMA unit will generate the JV-220 form, answer questions #1-4 on the JV-220, then forward it to the case-carrying CSW (and the regional PMA Inbox) for completion.
4. Receive the emailed JV-220 form from the PMA unit, complete questions #5-13, and return the completed and signed JV-220 form via email to the PMA unit at PMA@dcfs.lacounty.gov within two (2) judicial days.
5. Document all communications with the child, caregiver, physician/psychiatrist, parent/legal guardian, and PHN regarding the Psychotropic Medication Authorization Request process in the child's Contact Notebook.
6. Upon receipt of a copy of the [JV-223](#) (Court's order) from the DCFS PMAUnit, review the court's order:
 - a. Note the next hearing date, type of hearing, and any special court orders. For any upcoming Progress Hearing to address psychotropic medication, or any Status Review Hearing, complete the JV-224 form and submit to court at least ten (10) days in advance of the hearing.
 - b. If the court approves the psychotropic medication authorization:
 - i. Verify with the caregiver that the prescription has been filled and that the medication is being administered.
 - ii. For new medications, encourage the caregiver to consult the prescribing psychiatrist to determine whether a [follow-up visit is needed within 30 days](#).
 - iii. Document this information in the child's CWS/CMS Health Notebook utilizing information provided on both the JV-220(A or B) and the JV-223.
 - c. If the court denies the psychotropic medication authorization request:
 - i. Contact the child's physician/psychiatrist to verify that (s)he has either cancelled the prescription and discontinued the medication (in accordance with proper medical practice) or has submitted a new JV-220(A or B).
 - ii. Contact the child's caregiver to verify that (s)he has discontinued the medication if the physician/psychiatrist has cancelled the prescription (or in accordance with proper medical practice as instructed by the child's physician/psychiatrist).
 - iii. Notify the court immediately if the order is not being followed.
7. Update the Case Plan incorporating the child's treatment plan, including the use of psychotropic medication.
8. File copies of the completed JV-220, JV-220(A or B) initialed by the physician/psychiatrist, and the JV-223 (Court's order) in the child's Psychological/Medical/Dental folder.
9. Provide the caregiver with a new, unsigned JV-220(A or B) for future use.
10. At each face-to-face contact with the child:
 - a. Discuss with the child and the caregiver:

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- i. The child's responses to the psychotropic medication, including behavior, mood, and cognitive functioning
 - ii. The caregiver's and child's observations about the medicine's effectiveness and any side effects
 - iii. The caregiver's and child's concerns about the medication, if any
 - iv. Any medication management or other follow-up appointments with medical and/or mental health practitioners
 - b. Document the discussion on the JV-224 (to be submitted to court at the next hearing addressing psychotropic medication) and in CWS/CMS.
11. If the child is having adverse side effects, instruct the caregiver to seek medical attention as soon as possible and follow up with the prescribing physician/psychiatrist.
 12. For any identified problems or concerns, consult with the PHN for assistance with contacting the prescribing physician/psychiatrist (and requesting a reevaluation of the child, if indicated).
 13. If caregiver/child does not indicate any concerns/complaints, obtain the date and time of the follow-up appointment with the prescribing physician/psychiatrist.
 14. Consult your regional Service Linkage Specialist (SLS) for assistance in linking the caregiver with any mental health services needed.
 15. If the authorization is within one month of expiring, notify the child's caregiver and prescribing physician/psychiatrist that a new PMA is needed.
 16. If the same prescribing physician/psychiatrist believes the psychotropic medication continues to be necessary (and at the same dosage), remind the physician/psychiatrist to fax a JV-220(B) to the DCFS PMA Unit at (562) 941-7205. If the child is no longer taking that medication or if the prescription has been discontinued, inform the PHN that the medication is no longer needed so the PHN can end date the medication in CWS/CMS.
 17. If the physician/psychiatrist submits a new JV-220(A), verify with the PMA unit to ensure that a new JV-220(A) has been received.
 18. For review and monitoring of initial administration, increased dosage, or ongoing administration of a current psychotropic medication, work collaboratively with Public Health Nurse to address identified concerns with the prescribing physician/psychiatrist.
 19. Document all communications with the child, caregiver, physician/psychiatrist, parent/legal guardian and PHN regarding the psychotropic medication authorization request process in the child's Contact Notebook.
 20. To inquire about the status of a PMA, email the PMA Unit at PMA@dcs.lacounty.gov

Psychotropic Medication Authorization (PMA) Unit Responsibilities

1. Receive the approved JV-223, coinciding JV-220 and JV-220(A or B) from the Juvenile Court.
2. Notify the case-carrying CSW, SCSW and PHN Supervisor of the Progress Report date, Hearing Officer, and Court Room via email.

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3. Provide copies of the completed JV-220, JV-220(A or B) initialed by the physician/psychiatrist , and the JV-223 (Court's order) to the CSW, SCSW and PHN.
4. Notify the designated contact person at the FFA or GH via email by attaching a scanned copy of the child's PMA and a copy of the "Information for Parents and Caregivers About Psychotropic Medications" pamphlet.
5. Notify the CSW, SCSW, PHN Supervisor via email when the child's PMA (JV-223) has been imported into CWS/CMS.

PHN Responsibilities

1. Assist with the child's linkage to the prescribing physician/psychiatrist, as needed.
2. Utilizing the completed JV-220, JV-220(A or B) and JV-223 (court's order), ensure that the information in the child's existing CWS/CMS Health Notebook is complete. ([see Attachment](#))

[Back to Procedure](#)

APPROVALS

None

HELPFUL LINKS

Attachments

[Filling Out the CWS/CMS Health Notebook](#)
[Regional PMA In-Box Contact List](#)
[JV-220 \(Application for Psychotropic Medication\) New Process for CSWs](#)

Form Tutorials

[JV-220, Application Regarding Psychotropic Medication](#)
[JV-224, County Report on Psychotropic Medication \(includes JV-220 tutorial\)](#)

Forms

CWS/CMS

[JV-220, Application Regarding Psychotropic Medication](#)
[JV-220\(A\), Prescribing Physician's Statement](#)
[JV-220 \(B\), Physician's Request to Continue Medication -- Attachment](#)

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LA Kids

[JV-217-INFO](#), Guide to Psychotropic Medication Forms
[JV-218](#), Child's Opinion About the Medicine
[JV-219](#), Statement About Medicine Prescribed
[JV-220](#), Application Regarding Psychotropic Medication
[JV-220\(A\)](#), Prescribing Physician's Statement
[JV-220 \(B\)](#), Physician's Request to Continue Medication -- Attachment
[JV-221](#), Proof of Notice: Application Regarding Psychotropic Medication
[JV-222](#), Opposition to Application Regarding Psychotropic Medication
[JV-223](#), Order Regarding Application for Psychotropic Medication
[JV-224](#), County Report on Psychotropic Medication

Referenced Policy Guides

[0080-505.20](#), [Health and Education Passport \(HEP\)](#)
[0600-500.20](#), Health and [Medical Information](#)
[0600-501.10](#), Medical Consent
[0600-505.20](#), Hospitalization of and Discharge Planning for DCFS-Supervised Children
[100-535.25](#), [Extended Foster Care \(EFC\)](#) Program

Statutes

[Rule of Court 5.640](#) - Provides instructions for Hearing Officers regarding the authorization of psychotropic medication.

[Welfare and Institutions Code \(WIC\) Section 369](#) - Outlines the provisions under which a court order is required in order to provide medical treatment to a child in temporary custody.

[WIC Section 369.5](#), - Outlines the provisions under which a court order is required in order to provide medical treatment to a child who is adjudged a dependent of the court and has been removed from the physical custody of his/her parent(s).

[WIC Section 739.5](#), - Outlines the provisions under which a court order is required for administration of psychotropic medications for a ward who has been removed from the physical custody of his or her parent.

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**COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES CHILDREN'S MEDICAL SERVICES
(CMS) CHILD WELFARE PUBLIC HEALTH NURSING PROGRAM (CWPHNP)
POLICY AND PROCEDURE
NURSING**

CWPHNP

POLICY # N-XXXX
PAGE 1 OF 2

EFFECTIVE DATE 04-20-17

REVISED DATE 04/17/17

SUBJECT:	PSYCHOTROPIC MEDICATION – ROLE OF THE PUBLIC HEALTH NURSE (PHN)
PURPOSE:	To establish guidelines for the PHN when consulting with the Children's Social Worker (CSW) and Probation Officer (PO) pertaining to the oversight and monitoring of children/youth that are on psychotropic medication. The purpose of the Psychotropic Medication Authorization (PMA) Form is to provide a mechanism by which the Court is informed of the need for psychotropic medication and to obtain permission from the Court.
POLICY:	The PHN will use the following procedures when consulting with the CSW and PO for the oversight and monitoring of children/youth that are on psychotropic medication.
PROCEDURE:	<ol style="list-style-type: none"> 1. Upon receiving the PMA forms JV220A, JV220B, JV221, JV222, JV223, and/or JV224, the PHN will review for accuracy and confirm the juvenile court has authorized the psychotropic medication(s) the child is taking based on sufficient medical/psychiatric information. 2. The PHN will assess for the right name, right medication, right dosage, right frequency and right documentation. 3. If PMA was not approved, the PHN will review the form to determine the reason for the denial and enter the information into the child's Health Notebook/Health and Education Passport (HEP) and notify CSW and PO. 4. Review and enter the information contained on the PMA into Child Welfare Services/Case Management System (CWS/CMS) in the child's Health Notebook/Health and Education Passport (HEP), as per <i>Public Health Nurse Documentation Policy</i>. 5. Review and assess for the completion of laboratory tests, other screenings, evaluations, and assessments required to meet the <i>California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care</i>. 6. Review, interpret, and document as necessary, the results of laboratory tests, screenings, and evaluations for the purpose of care planning and coordination. 7. Consult/collaborate with Child Social Workers (CSW), Probation Officers, Caregivers, Providers, Courts, CHDP Pediatrician & Behavioral Health.

**COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES □ CHILDREN'S MEDICAL SERVICES
(CMS) CHILD WELFARE PUBLIC HEALTH NURSING PROGRAM (CWPHNP)
POLICY AND PROCEDURE
NURSING**

CWPHNP

POLICY # N-XXXX

EFFECTIVE DATE 04-20-17

REVISED DATE 04/17/17

PAGE 2 OF 2

SUBJECT: PSYCHOTROPIC MEDICATION – ROLE OF THE PUBLIC HEALTH NURSE (PHN)

8. Provide psychotropic medication oversight and monitoring via phone contact with the child's caregivers or youth on all new and existing psychotropic medications to inquire about the child's/youth response to the medications, including adverse effects. Provide health education as needed.
9. Assist with referrals to the prescribing physician or other health care providers to ensure that any adverse effects are promptly addressed and brought to the attention of the social worker or probation officer.
10. Review medical records to assess the child/youth's progress in meeting the treatment plan as established by prescribing physician.
11. Provide consultation and education to social workers and probation officers as needed in the scheduling of periodic follow up visits with the prescribing physician, laboratory and other necessary health services.
12. If a child is placed out of county, the PHN will consult with the County of Placement CSW and PHN to assure the child receives appropriate care.
13. The PHN will document on Psychotropic Medications as per the CWPHN Instructional Manual and CWPHN Program Documentation Policy.

RESOURCE:

CWPHN Program Instructional Manual

Page 2 of 2

APPROVED: _____

Gina Miller
CMS NURSING DIRECTOR

DATE: _____

6/22/17

REFERENCES

- A. California Department of Social Services and Department of Health Care Services Foster Care Quality Improvement project “**California guidelines for the Use of Psychotropic Medication with Children and Youth in foster Care,**” August 19, 2015. Retrieved from:
http://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/QIP_Guidelines.pdf
- B. Los Angeles County Department of Children and Family Services. **For Your Information: Alerts for Psychotropic Medication (PMA) Renewals,** Issue 16-11. March 31, 2016. <http://lacdcfs.org/Policy/FYI/2016/FYI16-11PMAemailalertFYI.doc>
- C. Los Angeles County Department of Children and Family Services, **Procedural Guide 0600-514.10, Administration of Psychotropic Drugs to DCFS- Supervised Children.**
http://policy.dcfslacounty.gov/Default.htm#Psychotropic_Meds.htm?Highlight=0600-514.10
- D. Los Angeles County Juvenile Court, “**Court Authorization of Psychotropic Medication**” December 8, 2005. Retrieved from:
<http://www.courts.ca.gov/documents/jv220a.pdf>
- E. Los Angeles County Children’s Medical Services- Health Care Program for Children in Foster Care, “**Public Health Nurse Documentation Policy**”, March 3, 2016.
- F. Los Angeles County Children’s Medical Services- Health Care Program for Children in Foster Care, “**Psychotropic Drugs- Role of the PHN**”, December 30, 2014.
- G. Psychotropic Medication: Authorization, Review, and Monitoring for DCFS Supervised Children (DCFS Policy 0600-514.10)
- H. Public Health Nurse Documentation Policy
- I. 2016 California Rules of Court. Rule 5.640 Psychotropic Medications.
http://www.courts.ca.gov/cms/rules/index.cfm?title=five&linkid=rule5_640



COUNTY OF LOS ANGELES OFFICE OF CHILD PROTECTION

KENNETH HAHN HALL OF ADMINISTRATION
500 WEST TEMPLE STREET, ROOM 383
LOS ANGELES, CALIFORNIA 90012
(213) 893-2010

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EXECUTIVE DIRECTOR

August 30, 2017

Dale A. Carlson, MPA, CGFM
Senior Auditor Evaluator
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Dear Mr. Carlson:

On behalf of Los Angeles County, I am responding to your follow-up request based upon Los Angeles County's online response and supplemental materials dated August 23, 2017, regarding our county's efforts to implement the **first recommendation** contained in the State Auditor's August 2016 report, "California's Foster Care System: The State and Counties Have Failed to Adequately Oversee the Prescription of Psychotropic Medications to Children in Foster Care."

Specifically, you asked for copies of documents related to:

- Steps Los Angeles County will take when authorization requests for psychotropic medications exceed guidelines for multiple prescriptions, specific age groups, or dosage amounts
- Los Angeles County's follow-up contacts with prescribers when authorizations exceed guidelines
- Los Angeles County's documenting of follow-up monitoring in case files
- Los Angeles County's communication of concerns or recommendations to the courts or to parents

With respect to the first two bullets, Los Angeles County implemented a process in April 2013 to deal with the issues raised (Attachment 1). In May 2015, that process was revised (Attachment 2). On June 21, 2017, the Los Angeles County Department of Health supplemented that process with the publication of a document entitled, "Parameters 3.8 for Use of Psychotropic Medication in Children and Adolescents" (Attachment 3).

With respect to the third bullet, I have attached the latest version of the juvenile dependency court's Psychotropic Medication Monitoring Protocol (Attachment 4). That protocol requires monitoring the administration of medications that are documented on

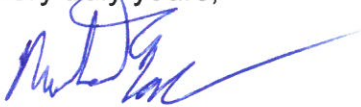
Dale A. Carlson, MPA, CGFM
August 30, 2017
Page 2

the Judicial Council's JV-224 form. Those forms are placed in each child's case file in a separate confidential envelope.

With respect to the final bullet, I have attached a form used by the Department of Mental Health's Juvenile Court Mental Health Services Unit every time a request is made to administer psychotropic medications for a child or youth in foster care. The unit evaluates each request and provides its recommendations, along with any comments, to the juvenile court judge before the judge rules on the request for medication. That form is also placed in a confidential envelope in the child's case file. The juvenile court judge receives input as well on requests that exceed the various parameters established by the Department of Mental Health, as noted in Attachments 1, 2, and 3.

I hope these documents adequately respond to your request. If you have questions or concerns, please contact me at (213) 893-1152, or via e-mail at mnash@ocp.lacounty.gov.

Very truly yours,

A handwritten signature in blue ink, appearing to read "Michael Nash", with a long, sweeping underline that extends to the right.

Judge Michael Nash (Ret.)
Executive Director
Office of Child Protection



CHAMBERS OF
MICHAEL NASH
PRESIDING JUDGE

JUVENILE DIVISION
The Superior Court
201 CENTRE PLAZA DRIVE, SUITE 3
MONTEREY PARK, CALIFORNIA 91754 2158

TELEPHONE
(323) 528 6377

April 23, 2013

TO: All Dependency Court Judicial Officers
All Interested Parties

FROM: Michael Nash, Presiding Judge *MN*
Juvenile Court

**SUBJECT: PAREMETERS FOR JUVENILE COURT MENTAL HEALTH
SERVICES (JCMHS) REVIEW OF PSYCHOTROPIC MEDICATIONS**

We are very fortunate in Los Angeles County in having a partnership between our juvenile courts and the Department of Mental Health (DMH) designed to assist juvenile court judicial officers in deciding whether to approve the administration of psychotropic medication for dependent and delinquent youth in out of home care. Traditionally, members of the DMH JCMHS unit review the requests for psychotropic medications and either recommend approval of the request, denial of the request or, in some cases, modification of the request.

Pursuant to the attached memorandum from the Office of the Medical Director of DMH, the parameters for JCMHS review will change somewhat on May 1, 2013. On that date, the following procedures will apply:

1. Upon receipt of request (PMA), JCMHS may still recommend approval, denial or modification.
2. For requests falling within certain categories delineated in Section IV of the DMH memo (which include multiple meds, multiple meds of certain types, and meds for children and youth of certain ages), JCMHS will alert the Court that the request falls within the parameter of its process and will make one of the following recommendations:
 - a. Approve
 - b. Deny
 - c. Approve for 45 days

3. If the Court decides to approve for 45 days, the Court may request a JCMHS consult in which JCMHS will take specific actions as delineated in the attached memo and will report back to the Court 30 days after the order issues.
 - a. If the Court requests a JCMHS consult, the Court shall order the child's attorney to fill out the attached Referral Form and Order For Juvenile Court Mental Health Assessment.
4. As the medication request is only valid for 45 days, a new PMA request will be required in order to administer psychotropic medication to the youth.
5. To the extent that a conflict arises between a prescribing physician and JCMHS, the Court can utilize appropriate legal procedures to resolve that conflict.

MN:ns
Attachments

Juvenile Court Mental Health Services
Referral Form to be Completed by Child's Attorney or Judge

Deliver referrals to JCMHS Clinician in Courtroom or Dept. 425 (JCMHS office) or FAX to (323) 268-2525
JCMHS Phone: (323) 528-6425

Child's Name: _____ Date of Referral: _____

Child's DOB: _____ Child's Court Case #: _____

Dept. Number: _____ Next Hearing Date: _____

Attorney's Name: _____ Phone: _____

- Firm (please check one):
- | | |
|--------------------------------|--------------------------------|
| <input type="checkbox"/> CLC 1 | <input type="checkbox"/> LADL |
| <input type="checkbox"/> CLC 2 | <input type="checkbox"/> Panel |
| <input type="checkbox"/> CLC 3 | |

Concern(s)/Question(s):

JCMHS Response: (See Attached Report Dated _____)

By: _____ Date: _____
JCMHS Clinician Signature

LACDMH NOTICE OF PRIVACY PRACTICE :
Acknowledgement of Receipt Effective Date: April 14, 2003

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Los Angeles County Department of Mental Health (LACDMH). Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to review it carefully.

Our *Notice of Privacy Practices* is subject to change. If we change our Notice, you may obtain a copy of the revised Notice by visiting our website at <http://www.dmh.co.la.ca.us> or on request from our Treatment Team.

I acknowledge receipt of the *Notice of Privacy Practices* of LACDMH.

Signature: _____ Date: _____
(client/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of Treatment Team Member: _____ Date: _____

Reasons why the acknowledgement was not obtained:

- Client refused to sign (see progress notes for explanation)
- Other Reason or Comments:

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF LOS ANGELES
JUVENILE COURT

IN THE MATTER OF:

Case Number:
Department:

CHILD

**ORDER FOR JUVENILE
COURT MENTAL HEALTH
UNIT ASSESSMENT**

Pursuant to this Order, the Los Angeles County Department of Mental Health Juvenile Court Mental Health Unit ("JCMHU") is authorized to conduct a mental health assessment of:

Name of Child

D.O.B

1. Such assessment is for the purpose of assisting the Court in determining the appropriate treatment and/or services for the child and as may be required in the conduct or implementation of such treatment and/or services.
2. The assessment may include interviews with the child and others who have information relevant to the child's mental health status and needs of the child if clinically indicated.
3. Upon presentation of this Order, the JCMHU shall be permitted to inspect and copy any records of any mental health care provider, agency, hospital or school relating to the child without consent of the child or the child's parent.
4. The assessment will be conducted after notice has been provided to the attorney for the child and the attorney has signed the acknowledgment of such notice below.
5. The JCMHU will provide a report to the Court regarding the assessment. The next court date is _____.

DATED:

Attorney for Child

DATED:

Judge/Commissioner/Referee
of the Superior Court

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

OFFICE OF THE MEDICAL DIRECTOR

3.8 PARAMETERS FOR JUVENILE COURT MENTAL HEALTH SERVICES REVIEW OF
PSYCHOTROPIC MEDICATION APPLICATION FORMS FOR YOUTH IN STATE CUSTODY

Effective Date: March 1, 2013

- I. **Purpose:** To help ensure that DMH recommendations regarding approval for medications for youth in state custody are based upon evidence-based considerations of safety and effectiveness
- II. **Background:**
 - a. Judicial approval is generally required for provision of medications to youth in state custody.
 - b. DMH clinicians are responsible for reviewing requests to the court from prescribers for approval of medication regimens for youth in state custody.
 - c. Based upon the reviews, DMH makes recommendations to the court regarding court approval.
 - d. There is a reasonable community expectation that DMH recommendations be based upon evidence-based considerations of safety and efficacy of requested medication regimens.
 - e. This parameter set can be used to guide determinations of safety and efficacy. They encompass a consensus in terms of numbers of medications, types of medications, and age of youths for whom medications are prescribed.
 - f. In cases where requested medication regimens do not fall within these parameters, procedures must be in place to assure, to the greatest possible extent, continuity of necessary medication services and provision of high-quality care. These parameters are designed to facilitate such procedures, which are attached.

II. CATEGORIES OF RECOMMENDATIONS

JCMHS generally will make three different recommendations regarding PMAFs reviewed:

- A. Recommend approval for 6 months (i.e., information supplied adequate and medication clearly safe and effective for long-term use);
- B. Recommend approval for 45 days only (e.g., more information needed); or
- C. Do not recommend approval

III. CATEGORIES OF APPROVALS

The general rationale for the approval decision is made after review of PMAF only and based on scientific literature, training, and clinical experience of JCMHS staff and is as follows (note that any combination of III. B, C, and/or D can be checked):

- A. Safe and effective ("Recommend approval");
- B. Not clearly safe for long-term use (i.e., greater than 45 days) ("Recommend approval for 45 days only, with expectation that regimen will be changed" or "Do not recommend approval" (at JCMHS discretion));
- C. Not clearly effective ("Recommend approval for 45 days only, with expectation that regimen will be changed" or "Do not recommend approval" (at JCMHS discretion)); or
- D. Inadequate information supplied ("Recommend approval for 45 days only" or "Do not recommend approval" (at JCMHS discretion)) (e.g., if diagnosis supplied is consistent with medication proposed, but specific symptoms not listed)

IV. AUTOMATIC TRIGGERS FOR A FINDING OF "NOT CLEARLY SAFE FOR LONG-TERM USE" OR "NOT CLEARLY EFFECTIVE" (See III. B and III. C above.)

These 2 categories, which necessitate a JCMHS finding of either "Recommend approval for 45 days only, with expectation that regimen will be changed" or "Do not recommend approval," include, but are not limited to, the following regimens in the age groups listed:

- A. Youth age 9-17 years:
 - 1. ≥ 4 psychotropic medications (benztropine excepted)
 - 2. ≥ 2 antipsychotics (any combination of atypical and typical)
 - 3. ≥ 2 mood stabilizers (atypical anti-psychotics not included)
 - 4. ≥ 2 anti-depressants (trazodone as hypnotic excepted)
 - 5. ≥ 2 stimulant medications (this does not include a long-acting stimulant and immediate-release stimulant that is the same chemical entity (e.g., methylphenidate-OROS and methylphenidate))
 - 6. ≥ 2 hypnotics (including trazodone, diphenhydramine, zolpidem, melatonin, benzodiazepines; not including clonidine, guanfacine, prazosin)
 - 7. Medication dose(s) exceeds the usual recommended dose(s) as defined in the most recent version of the Los Angeles County Department of Mental Health's "Psychotropic Guidelines for Children and Adolescents", which can be accessed at http://file.lacounty.gov/dmh/cms1_159938.pdf (Reference 2)
- B. Youth age 6-8 years:
 - 1. ≥ 3 psychotropic medications
 - 2. All other restrictions from IV. A. above

**V. ATTACHMENT I: JUVENILE COURT MENTAL HEALTH SERVICES (JCMHS)
APPROVAL PROCEDURES**

VI. REFERENCES:

- A. Psychotropic Medication Application Form (PMAF),
<http://www.courts.ca.gov/documents/jv220a.pdf>
- B. Psychotropic Guidelines for Children and Adolescents
http://file.lacounty.gov/dmh/cms1_159938.pdf

C. Youth age 0-5 years:

1. ≥ 2 psychotropic medications
2. Any psychotropic medication other than a stimulant, atomoxetine, guanfacine, clonidine, or risperidone (for Autistic Spectrum Disorders and associated aggression)
3. All other restrictions from IV. A. above

ATTACHMENT I:

JUVENILE COURT MENTAL HEALTH SERVICES (JCMHS) APPROVAL PROCEDURES

I. "DO NOT RECOMMEND APPROVAL" RECOMMENDATIONS (See Category II C. pg. 1)

If the JCMHS recommendation is "Do not recommend approval," the Court either can follow the JCMHS recommendation or order/request more information from the prescribing provider, Probation, DCFS, and/or other sources in order to inform better their decision.

II. "RECOMMEND APPROVAL FOR 45 DAYS ONLY WITH THE EXPECTATION THAT REGIMEN WILL BE CHANGED" RECOMMENDATIONS (See III B., C., and D., pgs. 1-2)

For this JCMHS recommendation, the Court can do one of or a combination of the following:

- A. Order/request additional information from prescribing provider, Probation, DCFS, and/or other sources.
- B. Request a targeted JCMHS Safety Consultation for purposes of determining degree of clinical risk (low, moderate, or high) of continuing the medication regimen, which may include, at the discretion of JCMHS, any of the following: record review, contact with collateral sources of information, and a face-to-face evaluation of the youth by a clinician and/or a JCMHS child psychiatrist.
 1. In this case, prior to or at the end of the initial 45-day approval period, if, after further investigation, JCMHS determines that the medication regimen is not clearly safe for long-term use, effective, or appropriate, or that other potential medication regimens that comport with these parameters are feasible or preferable, upon submission of the new PMAF, JCMHS will not recommend approval of the new PMAF (presuming the medication regimen is substantively unchanged).
 2. Also in this case, prior to or at the end of the initial 45-day approval period, if, after further investigation, JCMHS initially determines that the medication regimen is clearly safe for long-term use, effective, and appropriate, and that other potential medication regimens that comport with these parameters are not feasible to utilize, upon submission of the new PMAF, the following will occur:
 - a. JCMHS will forward both the initial and newly submitted PMAF and associated collateral information supporting the tentative recommendation for continued approval of the medication regimen to the Juvenile Justice Mental Health Program (JJMHP) Medical Director (or his designee) for review.

The JJMHP Medical Director (or his designee) will have two business days to review this information and to consult with JCMHS in order to determine JCMHS' ultimate recommendation to the Court regarding the medication regimen's long-term safety, efficacy, and appropriateness.

- b. If, after this consultation, JCMHS and the JJMHP Medical Director (or his designee) conclude that the medication regimen is not clearly safe for long-term use, effective, or appropriate, or that other potential medication regimens that comport with these parameters are feasible or preferable to utilize, JCMHS will not recommend approval of the new PMAF (presuming the medication regimen is substantively unchanged).
- c. If, after this consultation, JCMHS and the JJMHP Medical Director (or his designee) conclude that the medication regimen is clearly safe for long-term use, effective, appropriate, and that other potential medication regimens that comport with these parameters are not feasible to utilize, JCMHS will recommend approval of the new PMAF for 6 months (presuming the medication regimen is substantively unchanged).

In this situation, the prescribing provider shall be required to submit every 45 days to JCMHS documentation of the medication regimen's continuing safety, efficacy, and appropriateness, and that other potential medication regimens that comport with these parameters are not feasible to utilize. JCMHS briefly will review this information and provide input to the Court regarding the medication regimen as needed or appropriate.

ATTACHMENT 2

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH OFFICE OF THE MEDICAL DIRECTOR

03.9 PARAMETERS FOR JUVENILE COURT MENTAL HEALTH SERVICES' (JCMHS') REVIEW OF PSYCHOTROPIC MEDICATION AUTHORIZATION FORMS (PMAFS) FOR YOUTH IN STATE CUSTODY

Revised May 2015

I. INTRODUCTION

These parameters define both the general categories of Juvenile Court Mental Health Services' (JCMHS') findings after reviewing Psychotropic Medication Authorization Form(s) (PMAFs) and specific fact patterns that trigger a categorical finding of "Recommend Approval for 45 days only" or "Do not recommend approval" by JCMHS. (Attachment 1) These forms are required by the Court when prescribers would like to initiate or continue psychotropic medications for youth in state custody (e.g., Probation wards or Department of Children and Family Services dependents). The PMAF can be accessed at <http://www.courts.ca.gov/documents/jv220a.pdf>. (Reference 1) JCMHS must have a sufficient level of confidence in any given prescriber's PMAFs, based upon that provider's history of medication requests, accompanying clinical data, and cooperation with the review process, to permit JMHCS to make recommendations to the Court regarding approval of submitted requests. (Attachment 2)

II. CATEGORIES OF RECOMMENDATIONS

JCMHS generally will make three different recommendations regarding PMAFs reviewed:

- A. Recommend approval for six months (i.e., information supplied adequate and medication clearly safe and effective for long-term use);
- B. Recommend approval for 45 days only (e.g., more information needed); or
- C. Do not recommend approval

III. CATEGORIES OF APPROVALS

The general rationale for the approval decision is made after review of PMAF only and based on scientific literature, training, and clinical experience of JCMHS staff and is as follows: (Note that any combination of III. B, C, and/or D can be checked.)

- A. Safe and effective ("Recommend approval")
- B. Not clearly safe for long-term use (i.e., greater than 45 days) ("Recommend approval for 45 days only, with expectation that regimen will be changed" or "Do not recommend approval" [at JCMHS discretion])
- C. Not clearly effective ("Recommend approval for 45 days only, with expectation that regimen will be changed" or "Do not recommend approval" [at JCMHS discretion]) or

- D. Inadequate information supplied (“Recommend approval for 45 days only” or “Do not recommend approval” [at JCMHS discretion]), (e.g., if diagnosis supplied is consistent with medication proposed, but specific symptoms not listed)

IV. AUTOMATIC TRIGGERS FOR A FINDING OF “NOT CLEARLY SAFE FOR LONG-TERM USE” OR “NOT CLEARLY EFFECTIVE” (See III. B and III. C above.)

These two categories, which necessitate a JCMHS finding of either “Recommend approval for 45 days only, with expectation that regimen will be changed” or “Do not recommend approval,” include, but are not limited to, the following regimens in the age groups listed:

A. Youth age 9-17 years:

1. ≥ 4 psychotropic medications (benztropine excepted)
2. ≥ 2 antipsychotics (any combination of atypical and typical)
3. ≥ 2 mood stabilizers (atypical anti-psychotics not included)
4. ≥ 2 anti-depressants (trazodone as hypnotic excepted)
5. ≥ 2 stimulant medications (this does not include a long-acting stimulant and immediate-release stimulant that is the same chemical entity [e.g., methylphenidate-OROS and methylphenidate])
6. ≥ 2 hypnotics (including trazodone, diphenhydramine, zolpidem, melatonin, benzodiazepines; not including clonidine, guanfacine, prazosin)
7. Medication dose(s) exceeds the usual recommended dose(s) as defined in the most recent version of the Los Angeles County Department of Mental Health’s Parameters 3.8 For Use of Psychotropic Medication For Children and Adolescents, which can be accessed at:
http://dmh.lacounty.gov/wps/portal/dmh/clinical_tools/clinical_practice (Reference 2)

B. Youth age 6-8 years:

1. ≥ 3 psychotropic medications
2. All other restrictions from IV. A. above

C. Youth age 0-5 years:

1. ≥ 2 psychotropic medications
2. Any psychotropic medication other than a stimulant, atomoxetine, guanfacine, clonidine, or risperidone (for Autistic Spectrum Disorders and associated aggression)
3. All other restrictions from IV. A. above

V. ATTACHMENTS

- 1. JUVENILE COURT MENTAL HEALTH SERVICE (JCMHS) APPROVAL PROTOCOLS**
- 2. LEVEL OF CONFIDENCE DETERMINATION FOR RECOMMENDATIONS BASED ON PSYCHOTROPIC MEDICATION AUTHORIZATION FORM (PMAF) SUBMISSIONS**

VI. REFERENCES:

- A. Psychotropic Medication Authorization Form (PMAF)
<http://www.courts.ca.gov/documents/jv220a.pdf>
- B. DMH Parameters 3.8 For Use of Psychotropic Medication For Children and Adolescents
http://dmh.lacounty.gov/wps/portal/dmh/clinical_tools/clinical_practice

JUVENILE COURT MENTAL HEALTH SERVICE (JCMHS) APPROVAL PROTOCOLS

I. “DO NOT RECOMMEND APPROVAL,” RECOMMENDATIONS (See Category II C. pg. 1)

If the JCMHS recommendation is “Do not recommend approval,” the Court either can follow the JCMHS recommendation or order/request more information from the prescribing provider, Probation, DCFS, and/or other sources in order to inform better their decision.

II. “RECOMMEND APPROVAL FOR 45 DAYS ONLY WITH THE EXPECTATION THAT REGIMEN WILL BE CHANGED” RECOMMENDATIONS (See III B., C., and D., pgs, 1-2)

For this JCMHS recommendation, the Court can do one of or a combination of the following:

- A. Order/request additional information from prescribing provider, Probation, DCFS, and/or other sources.
- B. Request a targeted JCMHS Safety Consultation for purposes of determining degree of clinical risk (low, moderate, or high) of continuing the medication regimen, which may include, at the discretion of JCMHS, any of the following: record review, contact with collateral sources of information, and a face-to-face evaluation of the youth by a clinician and/or a JCMHS child psychiatrist.

1. In this case, prior to or at the end of the initial 45-day approval period, if, after further investigation, JCMHS determines that the medication regimen is not clearly safe for long-term use, effective, or appropriate, or that other potential medication regimens that comport with these parameters are feasible or preferable, upon submission of the new PMAF, JCMHS will not recommend approval of the new PMAF (presuming the medication regimen is substantively unchanged).

2. Also in this case, prior to or at the end of the initial 45-day approval period, if, after further investigation, JCMHS initially determines that the medication regimen is clearly safe for long-term use, effective, and appropriate, and that other potential medication regimens that comport with these parameters are not feasible to utilize, upon submission of the new PMAF, the following will occur:

- a. JCMHS will forward both the initial and newly submitted PMAF and associated collateral information supporting the tentative recommendation for continued approval of the medication regimen to the Juvenile Justice Mental Health Program (JJMHP) Medical Director (or his designee) for review.

The JJMHP Medical Director (or his designee) will have two business days to review this information and to consult with JCMHS in order to determine JCMHS’ ultimate recommendation to the Court regarding the medication regimen’s long-term safety, efficacy, and appropriateness.

- b. If, after this consultation, JCMHS and the JJMHP Medical Director (or his designee) conclude that the medication regimen is not clearly safe for long-term use, effective, or appropriate, or that other potential medication regimens that comport with these parameters are feasible or preferable to utilize, JCMHS will not recommend approval of the new PMAF (presuming the medication regimen is substantively unchanged).
- c. If, after this consultation, JCMHS and the JJMHP Medical Director (or his designee) conclude that the medication regimen is clearly safe for long-term use, effective, appropriate, and that other potential medication regimens that comport with these parameters are not feasible to utilize, JCMHS will recommend approval of the new PMAF for six months (presuming the medication regimen is substantively unchanged).

In this situation, the prescribing provider shall be required to submit every 45 days to JCMHS documentation of the medication regimen's continuing safety, efficacy, and appropriateness, and that other potential medication regimens that comport with these parameters are not feasible to utilize. JCMHS briefly will review this information and provide input to the Court regarding the medication regimen as needed or appropriate.

Attachment 2

“LEVEL OF CONFIDENCE” DETERMINATION FOR RECOMMENDATIONS BASED ON PSYCHOTROPIC MEDICATION AUTHORIZATION FORM (PMAF) SUBMISSIONS

Effective Date: May 1, 2015

Purpose: To help ensure that Department of Mental Health (DMH) has a sufficient level of confidence in the overall prescribing practices and reporting of prescribers to permit the making of recommendations to the Juvenile Court regarding approval of medications for youth in state custody based upon prescriber-reported clinical information.

Background:

- a. In accordance with the Superior Court Juvenile Division's Psychotropic Medication Protocol, judicial approval is generally required for provision of medications to youth in state custody.
- b. Prescribers petition the court to authorize administration of psychotropic medications to youth in state custody via the Psychotropic Medication Authorization Form (PMAF) (a.k.a. the JV-220A).
- c. The Los Angeles County Department of Mental Health's (LACDMH's) Juvenile Court Mental Health Services (JCMHS), a division of the Juvenile Justice Mental Health Program (JJMHP), reviews all PMAFs and makes a recommendation regarding approval to the court.
- d. Based upon its review, JCMHS makes recommendations to the court regarding court approval or non-approval of the proposed regimen.
- e. Occasionally, there may be prescribers for whom JCMHS has an insufficient level of confidence in their prescribing practices and/or ability or willingness to relay complete and accurate information to JCMHS via the PMAF or by other means.
- f. If JCMHS has insufficient confidence in a prescriber, it is unable to render a recommendation to the court regarding approval of a proposed medication regimen.
- g. The factors identified below help operationalize a determination of an insufficient level of confidence.

Factors for a Determination of Insufficient Level of Confidence:

JCMHS may identify a prescriber who demonstrates any one (or a combination) of the following:

1. A pattern of submitting PMAFs that do not comport with existing DMH parameters for prescribing of psychotropic medications to youth in state custody
2. A pattern of submitting PMAFs that trigger unsupportive secondary reviews (i.e., recommendation to court of “do not approve”) by JCMHS
3. A pattern of submitting PMAFs that are incomplete or inaccurate
4. A pattern of submitting PMAFs that are unsupportable because of concerns about clinical quality. Examples of this may include, but are not limited to:

- a. the proposed medication's lack of efficacy in treating the youth's diagnosis as listed on the PMAF
 - b. not adhering to recommended dose ranges or lab monitoring as defined in existing DMH parameters or other relevant practice parameters from recognized professional organizations (e.g., the American Academy of Child and Adolescent Psychiatry)
 - c. changing diagnoses to ones unsupported by clinical data to justify a particular medication regimen
5. A pattern of failing to follow standardized administrative procedures involving the PMAF submission and review process. Examples of this may include, but are not limited to:
- a. failure to return phone calls or other communications from JCMHS (which generally request clarification of the submitted PMAF) within 72 business hours
 - b. failure to submit PMAFs for youth on whom they are required.

For purposes of a making an "insufficient level of confidence" determination, "pattern" shall be defined as "three or more occasions in a two-year period."

Notification of Prescriber:

If a prescriber demonstrates any one (or a combination) of the listed factors for a preliminary determination of insufficient level of confidence, the JCMHS Medical Director may notify his/her immediate supervisor, the Juvenile Justice Mental Health Program (JJMHP) Medical Director. The JJMHP Medical Director and JCMHS Medical Director will meet to review the prescriber's submitted PMAFs and any assessments completed by JCMHS. The JJMHP Medical Director will notify the prescriber of his/her intent to make a final insufficient level of confidence determination.

Within 10 days of notification, the prescriber may request to meet with the JCMHS and JJMHP Medical Directors at Edmund D. Edelman Children's Court in order to jointly review the PMAF protocol, practice parameters, and other information relevant to the prescribing review and approval process for dependency and delinquency youth. The JJMHP Medical Director, with input from the JCMHS Medical Director, will consider whether or not to make a final insufficient level of confidence determination for that prescriber based on the factors for the preliminary insufficient level of confidence determination that had been demonstrated by the prescriber prior to the meeting, the results of the meeting with the prescriber, the prescriber's overall prescribing practices, and adherence to standardized administrative procedures and the PMAF protocol during the 30-day period after the meeting.

Notification of Court and Other Agencies:

If an insufficient level of confidence determination is ultimately made, JCMHS will immediately notify the prescriber, all delinquency and dependency court judicial officers, and the supervising agency (the Department of Children and Family Services (DCFS) or the Probation Department) of youth for whom the individual has prescribed.

Thereafter, any time a PMAF is submitted by the identified prescriber, JCMHS will notify the prescriber, the judicial officer presiding over the youth's case, and the youth's supervising

agency (DCFS or the Probation Department) of the insufficient level of confidence determination.

Effect of an Insufficient Level of Confidence Determination:

In order to ensure the well-being of children and adolescents, for a period of one year following a determination of an insufficient level of confidence by the JJMHP Medical Director, JCMHS will note on any PMAFs submitted by that prescriber that JCMHS cannot provide a recommendation to approve due to a lack of sufficient confidence in the quality of the associated clinical work.

After one year, the provider may request to meet with the JJMHP and JCMHS Medical Directors at Edmund D. Edelman Children's Court in order to jointly review the PMAF protocol, practice parameters, and other information relevant to the prescribing approval process for youth in state custody. After such a meeting has been completed, the insufficient level of confidence determination will be deemed to have lapsed, and JCMHS will resume review of PMAFs from that prescriber and make recommendations regarding approval. If JCMHS identifies, in the course of these new PMAF reviews, that the same or new factors exist for a determination of an insufficient level of confidence in that prescriber's practices, the JJMHP Medical Director may make a new insufficient level of confidence determination.

The JJMHP Medical Director can be contacted at 213-738-2078 regarding any questions or concerns about the foregoing.



CHAMBERS OF
MICHAEL I. LEVANAS
PRESIDING JUDGE

JUVENILE DIVISION
The Superior Court
201 CENTRE PLAZA DRIVE
MONTEREY PARK, CALIFORNIA 91754

February 22, 2017

TELEPHONE
(323) 307-8030

TO: All Dependency Court Judicial Officers and All Interested Parties

FROM: Michael I. Levanas, Presiding Judge
Los Angeles County Juvenile Courts

SUBJECT: PSYCHOTROPIC MEDICATION MONITORING PROTOCOL

Attached is the new Dependency Court Psychotropic Medication Monitoring Protocol. It takes effect on April 15, 2017. Please read it carefully and note the following:

1. It applies to all *new* requests to administer psychotropic medication to dependent children or requests to increase the dosage of a previously approved medication.
2. Judicial officers will schedule a progress report by completing line 7 of the JV-223—Order Regarding Application for Psychotropic Medication (see attached) with a 45-day date.
3. All judicial assistants must check each JV-223 to schedule the matter on calendar.
4. Children's attorneys, parents' attorneys, County Counsel, DCFS, PHNs and CASA volunteers on such cases must note the progress report date after they receive the JV-223 form. It is the only notice they receive.
5. Following the 45-day Progress Report, future progress reports shall be within the discretion of each judicial officer.
6. All progress reports shall utilize the JV-224 form.

MIL:ns
Attachments



CHAMBERS OF
MICHAEL I. LEVANAS
PRESIDING JUDGE

JUVENILE DIVISION
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Dependency Court Psychotropic Medication Monitoring Protocol

Introduction

Many children under the jurisdiction of the Dependency Court in Los Angeles are being administered psychotropic medication(s) approved by the Court pursuant to Welfare and Institutions Code section 369.5; California Rules of Court, Rule 5.640; and Los Angeles Superior Court Local Rules, Rule 7.7. To consistently monitor the well-being of these children receiving these medications, the following protocol has been developed by our Psychotropic Medication Committee.

Protocol

1. Whenever the Court approves a request to administer to a dependent child a new psychotropic medication, or an increased dosage of an already approved medication, the Court shall write in line 7 of JV-223—Order Regarding Application for Psychotropic Medication a date 45 days after the approval date. The judicial assistant shall proceed to calendar the matter.
2. Following the Court's approval of a request to administer psychotropic medication to a dependent child, the Court's Psychotropic Desk Clerk provides a copy of JV-223 to the DCFS PMA Unit, JCMHS, the prescribing physician, the child's attorney, parents' attorneys, CASA (if applicable), and County Counsel.
3. Upon receipt of the JV-223, the DCFS PMA Unit shall notify the CSW, SCSW, and PHN that a new PMA has been approved and that a progress report regarding the medication has been scheduled for a 45-day date. The PHN shall contact the child's caregiver to make sure the caregiver is aware of the purpose of the medication, potential side effects, and what action to take in the event of a negative reaction to the medication.¹ The PHN will also inform the caregiver that the child must be seen by the prescribing physician within 30 days of starting the medication. If necessary, the PHN will work with the caregiver to ensure that such a visit has been scheduled. The PHN shall record this activity in the CWS/CMS contact notebook.

¹ While this information should have been provided by the prescribing physician, this action offers an additional safeguard for the child.

4. Two weeks after the initial contact, the PHN shall contact the caregiver and the child and inquire about the effects, if any, of the medication. The PHN shall work with the caregiver and the child's CSW to ensure that any necessary action occurs. The PHN will also verify the date for the child's follow-up visit with the prescribing physician and document this activity in the CWS/CMS contact notebook.
5. On the date established by the Court for the progress report, DCFS shall report, using the JV-224 form, whether the child is taking the medication²; any perceived effects of the medication, positive or negative; any necessary steps that have been taken in light of the perceived effects; and the date of the follow-up visit with the prescribing physician. At a minimum, the CSW and PHN shall have communicated with the caregiver and the child and shall indicate the dates of those communications in the JV-224 submitted to the court by DCFS.
6. Future progress reports shall be within the discretion of the Court and shall be submitted on the JV-224 form.
7. After each monthly visit with the child, the CSW shall document within CWS/CMS the results of its inquiry with the child, caregiver, and other relevant persons such as family members, teachers, etc., regarding any perceived effects of the psychotropic medication. The CSW shall consult with the PHN if they receive reports of any negative perceived effects of the medication and the PHN shall review, interpret and document to ensure that any adverse effects are promptly brought to the attention of the prescribing physician.
8. It is important to note that every court report, at every stage of the proceedings, must address the well-being of every child. Required information includes reporting on every medication the child is taking; how the child is doing on the medication(s); how the child feels on the medication(s); and whether or not the medication is successfully treating the targeted symptoms. Court reports should also address how the doctor thinks the child is responding to the medication. This information should be attached to the court report by using the JV-224 form.

² If a child is refusing to take the medication, this refusal is a therapeutic issue that should be addressed, among others, by the caregiver, the physician, and the child. In addition, upon referral, the Juvenile Court Mental Health Services Unit may provide assistance.

DEPARTMENT OF MENTAL HEALTH
**PARAMETERS 3.8 FOR USE OF
PSYCHOTROPIC
MEDICATION
IN
CHILDREN
AND
ADOLESCENTS**

Treatment provided outside the parametric elements in this guide requires special justification or consultation and subsequent documentation in medical record.

June 21, 2017

INTRODUCTION

The parametric elements of this guide are the dose range and dosage schedule. Doses are expressed by range, and titration to clinical efficacy, and are not specifically calibrated or adjusted for children whose ability to metabolize and excrete these drugs may be compromised. A discussion of metabolic variations largely due to the ethnic/racial/genetic background is beyond the scope of this document. Furthermore, dosing parameters are not expressed by body surface area or in weight adjusted doses.

DMH Parameters 3.8 For Use of Psychotropic Medication for Children and Adolescents, is designed for the use of psychoactive medications for the treatment of diagnosed mental disorders (not exclusively behavioral problems) in children and adolescents, up to 18 years of age, who receive treatment by either directly-operated Los Angeles County Department of Mental Health clinics or the Department's contracted agencies. The use of psychotropic agents in early childhood is relatively infrequent; the use of such agents in children under the age of three is rare.

(A companion set of parameters regarding the use of psychotropic medications for the treatment of mental disorders is available at http://dmh.lacounty.gov/wps/portal/dmh/clinical_tools/clinical_practice and should be used in conjunction with these parameters.) The intent of this document is to provide a framework for quality management relating to the major classes of psychoactive medications used in children and adolescents. Also, this document serves as a framework by which to develop departmental sponsored training and education for its staff and others.

This document represents a consensus of best practices from among various experts from local training institutions and experienced community-based clinicians who provide treatment to children and adolescents. It is updated periodically to reflect improvements in evidence-based treatments. It is not intended to be a comprehensive treatment document, nor to guide therapy in children whose treatment planning is complicated by the presence of special healthcare needs. Psychosocial treatments which are often the first line of treatment are discussed in other sources. Various source documents that may serve as additional guides are identified in the section of references in this document.

Treatment provided outside of the parametric elements in this guide requires special justification and/or consultation and subsequent relevant documentation of the rationale. Changes in current medication regimens made for the purpose of conforming with this Guide should be initiated only after careful clinical consideration of the basis for the current medication regimen. Treatment noncompliance is a special situation that must be addressed by the prescribing physician; the general health risks inherent in this situation must be considered and the nature and outcome of such deliberations must be clearly documented in the medical record.

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FIRST GENERATION ANTIPSYCHOTICS

A. Clinical Indications For Use:

1. psychosis
2. mania
3. Tourette's d/o
4. * 2^o use in severe behavior d/o with aggression
5. * 2^o use in severe hyperactivity

B. Frequency of Dose Change:

As clinically indicated

C. Concomitant Medication Use:

1. Tegretol etc. may lower plasma level
2. avoid >1 antipsychotic at a time
3. avoid anticholinergics with thioridazine

D. Complications & Side Effects:

1. EPS
2. tardive dyskinesia
3. NMS
4. sedation
5. cognitive dulling
6. lowers seizure threshold
7. weight gain
8. hyperprolactinemia**

E. Cautions/Contraindications:

1. liver disease
2. respiratory distress
3. pregnancy
4. breast feeding
5. allergy to drug

F. Medical Work-up:

1. physical exam (incl. HT, WT, BP, P, dyskinesia)
2. lab: fasting serum glucose, fasting lipid panel, LFT's, CBC+differential, UA, BUN, creatinine
3. check for abnormal, involuntary movements

G. Medical Follow-up:

1. for each visit: abnormal movements
2. with each upper titration: BP, P
3. every 6 mos: AIMS, weight, LFT's
4. annual: PE, chemistry panel, CBC+differential, UA
5. for pimozide: EKG @ dose ↑, liver enzymes q 3 mos
6. for thioridazine: periodic EKG's and serum potassium level

DRUG <small>(Common brand name is indicated for convenience. No preference is implied.)</small>	MAIN INDICATIONS	DOSE (mg/d)	DOSAGE SCHEDULE	SPECIAL CONSIDERATIONS	CONTRAINDICATIONS
chlorpromazine (Thorazine)	psychosis	10 - 800	2-3 x/d	higher risk of sedation/hypotension	see class
thioridazine (Mellaril)	Only for schizophrenia after other antipsychotics are ineffective	10 - 800	2-3 x/d	higher risk of sedation/hypotension; retinitis pigmentosa	Congenital QT syndrome; QTc interval over 500 msec; cardiac arrhythmias; use of fluvoxamine, propranolol, pindolol, fluoxetine, paroxetine, agents that prolong QTc interval
fluphenazine (Prolixin)	psychosis	1 - 20	2-3 x/d	-	see class
perphenazine (Trilafon)	psychosis	2 - 20	2-3 x/d	-	see class
trifluoperazine (Stelazine)	psychosis	1 - 20	2-3 x/d	-	see class
haloperidol (Haldol)	psychosis	0.5 - 20	2-3 x/d	-	see class
thiothixene (Navane)	psychosis	1 - 50	2-3 x/d	-	see class
loxapine (Loxitane)	psychosis	5 - 150	2-3 x/d	-	see class
pimozide (Orap)	Tourette's Disorder	1 - 10	1-2 x/d	conduction delays ↑liver enzymes	hx of arrhythmia & use of other drugs that ↑ Q-T

* When standard treatments have been tried and have failed or are contraindicated.

** More so than novel antipsychotics.

SECOND GENERATION ANTIPSYCHOTICS

A. Clinical Indications For Use:

1. psychosis
2. bipolar, mania
3. severe behavior d/o with aggression
4. * 2^o use in severe hyperactivity

B. Frequency of Dose Change:

As clinically indicated

C. Concomitant Medication Use:

1. Drugs that lower plasma level: carbamazepine (CBZ), phenytoin (PHT), phenobarbital (PB), smoking
2. Drugs that increase plasma level: fluoxetine, fluvoxamine, paroxetine, macrolide antibiotic, cimetidine
3. Avoid >1 antipsychotic at a time

D. Complications & Side Effects:

1. see relative risks below
2. NMS, TD, withdrawal dyskinesia, EPS

E. Cautions/Contraindications:

1. liver disease, respiratory distress
2. pregnancy & breast feeding
3. avoid concurrent med that ↑QTc (ziprasidone, asenapine)
4. myelosuppression, uncontrolled seizure disorder (clozapine)

F. Medical Work-up:

1. physical exam (incl. HT, WT, BMI, BP, P, dyskinesia)
2. lab: fasting serum glucose, fasting lipid panel, LFT's, CBC+differential, UA, BUN, creatinine

3. check for abnormal, involuntary movements
4. baseline EKG (ziprasidone)

G. Medical Follow-up:

1. each visit: dyskinesias
2. each upper titration: BP, P
3. at least q2mos: wt
4. q6mos: abnormal, involuntary movements, weight, LFT's (Risperdal and Zyprexa), fasting serum glucose, fasting lipid panel
5. annual: PE, CBC+differential, UA
6. for clozapine: Per Protocol
7. for ziprasidone: repeat EKG after increases
8. if rapid weight gain, high risk for DM, and/or below age 7: more frequent monitoring

Relative risk of adverse side effects, from highest to lowest:	<ul style="list-style-type: none"> • <i>Diabetes/hyperlipidemia/weight gain:</i> • <i>Orthostatic hypotension:</i> • <i>Sedation:</i> • <i>Hyperprolactinemia:</i> • <i>EPSE:</i> 	clozapine ≥ olanzapine > quetiapine ≥ risperidone = paliperidone > asenapine > aripiprazole > lurasidone [□] > ziprasidone clozapine > risperidone = paliperidone > quetiapine > lurasidone [□] > asenapine > olanzapine = aripiprazole > ziprasidone clozapine > olanzapine > quetiapine > lurasidone [□] > risperidone > paliperidone = asenapine > aripiprazole = ziprasidone paliperidone > risperidone > olanzapine > ziprasidone, asenapine > quetiapine > lurasidone [□] >> aripiprazole risperidone > paliperidone > lurasidone [□] = aripiprazole = asenapine = ziprasidone > olanzapine >> quetiapine			
DRUG <i>Available dosage forms</i> (Common brand name is indicated for convenience. No preference is implied.)	MAIN INDICATIONS	DOSE (mg/d)	DOSAGE SCHEDULE	ADVERSE EFFECTS	SPECIAL CONSIDERATIONS
olanzapine (Zyprexa) tablet (do not crush), rapid-dissolve tab, IM	Psychosis Bipolar disorder	2.5 - 20	1-2 x/d	weight gain, ↑ lipids, ↑ prolactin ↑ glucose, tachycardia, restlessness,	high risk of weight gain, diabetes, and hyperlipidemia
quetiapine (Seroquel) tab that can be crushed XR cannot be crushed	Psychosis Bipolar disorder	25 - 800	1-2 x/d XR 1 x/d	weight gain, ↑ lipids, ↑ glucose	least EPS/↑ prolactin, moderate hypotension
risperidone (Risperdal)** scored tab(crushable), rapid-dissolve tab, soln	Psychosis Bipolar disorder Aggression/irritability in Autistic D/O	0.25 - 8	1-3 x/d 1-2 x/d	weight gain, ↑ lipids, ↑ prolactin, ↑ glucose, tachycardia, restlessness	highest EPS, highest ↑ prolactin, moderate hypotension
clozapine (Clozaril) tab, rapid-dissolve tab (Fazaclo)	Rx resistant psychosis, Bipolar disorder tardive dyskinesia, severe EPS	12.5 - 450	1-2 x/d	agranulocytosis, seizures, constipation, hypotension, salivation, wt gain, tachycardia, myocarditis ↑lipids, ↑glucose,	↑ weight gain, diabetes/hyperlipidemia high sedation, high hypotension, tachycardia, resp. depression

SECOND GENERATION ANTIPSYCHOTICS (Cont'd)

DOSE <i>Available dosage forms</i> (Common brand name is indicated for convenience. No preference is implied.)	MAIN INDICATIONS	DOSE (mg/d)	DOSAGE SCHEDULE	ADVERSE EFFECTS	SPECIAL CONSIDERATIONS
ziprasidone (Geodon) capsule, IM	Psychosis Bipolar disorder	20 - 160	1-2 x/d	prolongation of QTc;	nausea, headache, least wt gain, low EPS low hypotension/sedation,
aripiprazole (Abilify) tab, solution, rapid- dissolve, IM	Psychosis Bipolar disorder Aggression/irritability in Autistic D/O Tourette's	2 - 30	1 x/d	nausea, vomiting weight gain, restlessness psycho-motor activation	nausea, EPS, hypotension & sedation
paliperidone (Invega) ER tablet (Do not crush)	Psychosis	3-12	1 x/d	Weight gain, hyperprolactinemia, somnolence, tachycardia, extrapyramidal symptoms, ↑lipids, ↑glucose	≥51 kg 3 mg/d; max 12 mg/d <51 kg 3 mg/d; max 6 mg/d Active metabolite of risperidone. Limited hepatic metabolism. Potential for ghost tablet in stool.
asenapine (sublingual)	Bipolar disorder	5-20	1 bid	Fatigue, somnolence, dizziness, oral paresthesia, dysguesia	NPO for 10 minutes after admin; Q-T prolonged time
lurasidone (Latuda)	Schizophrenia (13 y.o. or older)	40-80 mg	1-2 x/d	dyspepsia, sedation, metabolic syndrome, akathisia, nausea, ↑glucose	take with food

* *When standard treatments have been tried and have failed or are contraindicated*

** *May be used for Tourette's, tics*

□ *Very limited pediatric data*

LONG-ACTING ANTIPSYCHOTIC INJECTIONS

A. Criteria For Use:

1. must demonstrate positive response and tolerability to oral form of medication
2. no history of NMS
3. maintenance antipsychotic therapy
4. prevention of non-compliance related relapse
5. effective medication delivery (if oral/GI delivery is not feasible)
6. insufficient data to support safe use under age 18

B. Frequency of Injection:

see each medication frequency/Indications

C. Concomitant Medication Use

1. drugs that lower plasma level: carbamazepine(CBZ), phenytoin(PHT), phenobarbital(PB), smoking
2. drugs that increase plasma level: Fluoxetine, fluvoxamine, Paroxetine, Macrolide Antibiotics
3. avoid >1 injectable antipsychotic therapy at a time

D. Complications & Side Effects:

Immediate

1. sedation or cognitive dulling
2. hypotension, dizziness
3. injection specific complications (sore, scars, infection at injection sites etc.)

Long Term

1. NMS, EPS, TD
2. weight gain /obesity / diabetes mellitus II
3. dyslipidemia, hyperprolactinemia

E. Cautions / Contraindications:

1. allergy to sesame oil (Haldol Decanoate, Prolixin Decanoate)
2. liver disease
3. respiratory distress
4. pregnancy & breast feeding
5. avoid concurrent medications that increase QTc interval
6. fever of unknown origin (need to r/o NMS)

F. Medical Work-up:

1. physical exam (incl. Ht, Wt, BP, P, dyskinesia)
2. lab: fasting blood glucose, fasting lipid panel, CBC, LFT, UA
3. EKG (for haloperidol & fluphenazine); repeat when therapeutic dose is established
4. check for abnormal involuntary movements

G. Medical Follow-up:

1. each visit: dyskinesia, vital signs (BP, pulse)
2. every 6 months: abnormal involuntary movements, weight, LFT's; fasting glucose & lipid panel
3. annual: PE, CBC, kidney function

Medication	Base / Form	Strength supplied	DOSE (mg/d)	DOSAGE SCHEDULE	ADVERSE EFFECTS	Peak Plasma Level
haloperidol decanoate	esterified with decanoic acid, (sesame) oil base	50mg / ml 100mg / ml	50 - 200	4 weeks	similar to oral haloperidol drowsiness, insomnia, EPS, (less often than oral form), inflammation & nodule at injection site (less common if deltoid used and lower concentration is used)	3-9 days
fluphenazine decanoate; piperazine phenothiazine	esterified with decanoic acid, (sesame) oil base	25mg / ml	12.5 - 40	2-4 weeks	similar to oral fluphenazine drowsiness, insomnia, EPS (more frequent with decanoate- up to 50%), dermatological reaction been reported, EKG changes in some patients, hematologic changes within normal variation	first peak at 24 hr, then peaks again in 8-12 days
Risperdal-Consta *must draw up entire vial	encapsulated microspheres, aqueous base	12.5mg / vial 25mg / vial 37.5mg/vial 50mg / vial	12.5 - 50	2 weeks	similar to oral risperidone drowsiness, insomnia, anxiety reported. akathisia & parkinsonism (7%), hypotension, hyperkinesia (12%), pain, redness, swelling at injection site (<5%)	1% released immediately, the main release begins 3 weeks. Peaks Plasma level in 4-6 weeks

ANTIPARKINSON / ANTICHOLINERGICS

A. Clinical Indications For Use:

medication induced extrapyramidal dysfunctions
(Parkinson's syndrome, dystonia, akathisia, dyskinesia)

B. Frequency of Dose Change:

1. as clinically indicated
2. may be withdrawn after a few days to 3 months of use to observe for EPS and assess need for use.

C. Concomitant Medication Use:

1. use only one of this class at a time
2. avoid use with other parasympatholytic agents (TCA's, low potency antipsychotics)

D. Complications & Side Effects:

1. confusion, disorientation, delirium, hallucinations, cognitive dulling, impaired memory
2. constipation, ↓ visual accommodation, tachycardia, xerostomia, pupillary dilatation, flushed-dry-hot skin, headache, coma, death
3. worsening of pre-existing psychotic symptoms
4. aggravation of asthma
5. abuse potential: may produce a "buzz"
6. hyperthermia

E. Cautions/Contraindications:

1. age < 3 y/o
2. exposure to heat, severe physical stress
3. closed angle glaucoma
4. obstructive bowel d/o, megacolon

F. Medical Work-up:

1. none suggested

G. Medical Follow-up:

1. as clinically indicated

DRUG <small>(Common brand name is indicated for convenience. No preference is implied.)</small>	DOSE (mg/d)	DOSAGE SCHEDULE	SPECIAL CONSIDERATIONS
benztropine (Cogentin)	0.25 - 6	1-2 x/d	available by injection
trihexyphenidyl (Artane)	0.50 - 6	2-3 x/d	abuse potential

ANTI-HISTAMINES

A. Clinical Indications For Use:

1. Anxiolytic/sedative/hypnotic
2. allergic reactions
3. motion sickness

B. Frequency of Dose Change;

- ◆ daily as indicated

C. Complications & Side Effects:

See Antiparkinson / Anticholinergic

D. Concomitant Medication Use:

1. avoid use with other parasympatholytic agents (TCA's, low potency antipsychotics)
2. avoid MAOI's
3. potentiates barbiturates, alcohol, tranquilizers, opiates

E. Cautions/Contraindications:

1. See Antiparkinson / Anticholinergic
2. age < 1 y/o

F. Medical Work-up:

1. none suggested

G. Medical Follow-up:

1. as clinically indicated

DRUG <small>(Common brand name is indicated for convenience. No preference is implied.)</small>	DOSE (mg/d)	DOSAGE SCHEDULE	SPECIAL CONSIDERATIONS
diphenhydramine (Benadryl)	12.5 - 150	1-4 x/d	tablet, capsule, liquid, IM or IV
hydroxyzine pamoate (Vistaril) hydroxyzine HCl (Atarax)	12.5 - 300	1-4 x/d	capsule, tablet, syrup

PSYCHOSTIMULANTS

A. Clinical Indications For Use:

1. Attention-Deficit/Hyperactivity Disorder
2. attention deficit symptoms associated with other mental disorders

B. Frequency of Dose Change:

- ◆ No more than two (2) changes in any 7 day period.

C. Concomitant Medication Use:

1. Only one psychostimulant at any one time.
2. No heterocyclic antidepressant unless trials of individual meds have failed
3. No MAO inhibitors

D. Complications & Side Effects:

1. agitation, irritability, hyperactivity
2. exacerbation of obsessions and compulsions
3. insomnia, decreased appetite, weight loss, delayed growth
4. increased heart rate & blood pressure
5. agitation, irritability
6. dyskinetic movements/tics
7. depression or psychosis in high doses
8. withdrawal effect or rebound phenomena

E. Cautions/Contraindications:

1. alcohol or drug abuse
2. anorexia nervosa
3. psychoses
4. severe anxiety
5. hx of cardiovascular disease or family hx of cardiovascular disease, including structural heart defects, or unexplained sudden death

E. (cont) Cautions/Contraindications:

6. thyroid disease
7. glaucoma
8. pregnancy & breast feeding
9. allergy to the drug

F. Medical Work-up:

1. physical exam (incl. Ht & Wt on graph)
2. EKG at baseline if positive cardiac risk factors

G. Medical Follow-up:

1. BP, pulse: periodic or when clinically indicated
2. periodic: height & weight (graph)
3. annual: physical exam

DRUG (Common brand name is indicated for convenience. No preference is implied.)	DURATION OF EFFECT	DOSE (mg/d)	DOSAGE SCHEDULE	SPECIAL CONSIDERATIONS
SHORT ACTING				
dextroamphetamine (Dexedrine, Dextrostat, Liquadd)	4-5 hours	2.5 - 40	1-3 x/d	Liquadd avail in liquid form
amphetamine salts (Adderall) *	4-5 hours	2.5 - 60	1-3 x/d	-
methylphenidate (Ritalin, Methylin, Metadate)	4-5 hours	2.5 - 60	1-3 x/d	Methylin avail in liquid form
dexmethylphenidate (Focalin)	3-5 hours	2.5 - 40	1-3 x/d	-
INTERMEDIATE ACTING				
methylphenidate (Ritalin SR, Metadate ER, Methyn ER)	6-8 hours	2.5 - 60	1-2 x/d	Must be swallowed whole
methylphenidate (Metadate CD)	8-9 hours	10 - 60	Once daily	Sprinkle on food as long as bead swallowed whole
methylphenidate (Ritalin LA) - capsule	8-10 hours	10 - 60	Once daily	Sprinkle on food as long as bead swallowed whole. High fat food may delay absorption
LONG ACTING				
methylphenidate patch (Daytrana)	as long as patch applied + up to 3 hours	10 - 30	Once daily for 9 hrs	Skin irritation, remove after 9 hours; persistent loss of skin color (chemical leukoderma)
methylphenidate (Concerta)	8-12 hours	18 - 72	Once daily	Must be swallowed whole. Inert portion of tablet may appear in stool
Methylphenidate (Quillivant XR)	8-12 hours	10-60	Once daily	Must be reconstituted with water.
dexmethylphenidate (Focalin XR) - capsule	12 hours	5 - 40	Once daily	Can sprinkle on food as long as Bead swallowed whole
amphetamine salts (Adderall XR) - capsule	10-12 hours	5 - 60	Once daily	Can sprinkle on food as long As bead swallowed whole
lisdexamfetamine (Vyvanse)	10-12 hours	20 - 70	Once Daily	Can be dissolved in water to drink immediately

* not to be ingested with citric products

SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITORS

DRUG	MAIN INDICATIONS	DOSE (mg/d)	DOSAGE SCHEDULE	ADVERSE EFFECTS	CAUTIONS/ CONTRAINDICATIONS
atomoxetine (Strattera)	ADHD	10 – 100	1-2 x/d	decreased appetite, gastrointestinal sx, palpitations, mood swings, rare hepatotoxicity	MAOI's, pressor agents, albuterol, narrow angle glaucoma

ALPHA-ADRENERGIC AGONISTS

A. Clinical Indications For Use:

1. Attention-Deficit/Hyperactivity Disorder
2. agitation, impulsive aggression, impulsivity
3. Tic D/O
4. PTSD

B. Frequency of Dose Change:

- ◆ No more than two (2) changes in any 7 day period.

C. Concomitant Medication Use:

1. Only one alpha-adrenergic agonist at any one time.
2. No MAO inhibitors

D. Complications & Side Effects:

1. sedation
2. decreased blood pressure
3. dizziness
4. rebound hypertension on discontinuation
5. constipation
6. headache
7. dry eyes

E. Cautions/Contraindications:

1. pregnancy & breast feeding
2. hx of cardiovascular disease and family hx of cardiovascular disease or unexplained sudden death
3. dosage adjustment for renal insufficiency

F. Medical Work-up:

1. physical exam
2. EKG at baseline if positive cardiac risk factors

G. Medical Follow-up:

1. At each dosage change: orthostatic BP, pulse,
2. annual: physical exam
3. Repeat EKG as clinically indicated

DRUG (Common brand name is indicated for convenience. No preference is implied.)		MAIN INDICATIONS	DOSE (mg/d)	DOSAGE SCHEDULE	ADVERSE EFFECTS	SPECIAL CONSIDERATIONS
clonidine	(Catapres)	see class	0.05 - 0.60	1-4 x/d	—	cautious use in combination with psychostimulants
	patch (Catapres) TTS-1, 2 or 3	see class	0.10 - 0.60	1 patch/wk	— localized dermatitis fatal overdose if ingested	cautious use in combination with psychostimulants
	extended release (Kapvay)	-	0.1 – 0.4	bid	URI sx's; mood sx's irritability, sore throat, trouble sleeping (insomnia), nightmares, change in mood, and ear pain	adjunctive tx with psychostimulants
guanfacine	(Tenex)	see class	1 - 4.0	1-3 x/d	—	cautious use in combination with psychostimulants
	(Intuniv) extended release	see class	1-4	1/d	—	adjunctive tx with psychostimulants

TRICYCLIC ANTIDEPRESSANTS*

A. Clinical Indications For Use:

1. depressive disorders**
2. ADHD **
3. anxiety disorders
4. enuresis ***

B. Frequency of Dose Change:

- ◆ No more than two (2) changes in any 7 day period

C. Concomitant Medication Use:

augment with MAOI only if documented failure of single agent

D. Complications & Side Effects:

1. sedation, dizziness, syncope
2. urinary retention, constipation, blurry vision, dry mouth
3. psychosis, mania, delirium
4. EKG changes
5. ↓ seizure threshold
6. wt gain

E. Cautions/Contraindications:

1. heart block
2. allergy to drug/class cross sensitivity
3. narrow angle glaucoma
4. seizure disorder
5. pregnancy & breast feeding
6. overdose may be lethal

F. Medical Work-up:

1. physical exam (incl. HT, WT, BP, P,)
2. lab: liver enzymes, UA
3. EKG at baseline

G. Medical Follow-up:

1. annual: PE
2. EKG at steady state after each dose increase
3. Pulse[□], blood pressure[□]

DRUG <small>(Common brand name is indicated for convenience. No preference is implied.)</small>	MAIN INDICATIONS	DOSE (mg/d)	DOSAGE SCHEDULE	SPECIAL CONSIDERATIONS
imipramine (Tofranil)	see class	5 - 300	1-4 x/d	Most well-studied for enuresis in low doses
desipramine (Norpramin)	see class	10 - 300	1-4 x/d	Most well-studied for ADHD, sudden death reported
amitriptyline (Elavil)	see class	2.5 - 300	1-4 x/d	High sedation, dry mouth and constipation
nortriptyline (Pamelor)	see class	10 - 150	1-4 x/d	Least orthostasis, therapeutic blood level 50-150 ng/ml
doxepin (Sinequan)	see class	10 - 300	1-4 x/d	Highest antihistamine effects
clomipramine (Anafranil)	see class + OCD	25 - 250	1-4 x/d	Do not use with MAOI; only TCA effective for OCD. Give w/ food to minimize GI upset

* Antidepressants may increase suicidality (thoughts or behaviors) in children, teenagers and young adults when first started. Depression and other serious mental illnesses are the most important causes of suicidal thoughts and actions.

** generally not considered first line treatment

*** imipramine, amitriptyline

□ If clinically indicated

SEROTONERGIC ANTIDEPRESSANTS*

A. Clinical Indications For Use:

1. depressive disorders
2. obsessive compulsive disorder
3. anxiety disorders
4. bulimia, binge eating disorder
5. impulsive aggression

B. Frequency of Dose Change:

- ◆ No more than two (2) changes in any 14-day period

C. Concomitant Medication Use:

1. washout period before starting MAOI
 - ◆ 5 weeks after fluoxetine
 - ◆ 2 weeks after sertraline, fluvoxamine, citalopram
 - ◆ 1 week after paroxetine
2. no tryptophan
3. Drug interactions (CYP enzyme and related pharmacokinetics)

D. Complications & Side Effects:

1. agitation, restlessness
2. bipolar (Manic) switching
3. withdrawal symptoms on discontinuation
4. serotonergic syndrome
5. obesity
6. headache
7. sweating
8. sleep disturbance
9. gastrointestinal problems
10. sexual dysfunction

E. Cautions/Contraindications:

1. allergy to drug
2. liver failure
3. pregnancy, breast feeding
4. do not use with MAOI's

F. Medical Work-up:

1. (incl. Ht, Wt, BP, P,)

G. Medical Follow-up:

- ◆ Ht, Wt, BMI at least q 3 mos

DRUG <small>(Common brand name is indicated for convenience. No preference is implied.)</small>	MAIN INDICATIONS	DOSE (mg/d)	DOSAGE SCHEDULE	SPECIAL CONSIDERATIONS
fluoxetine (Prozac)	see class	5 - 90	1 x/d	Most activating, dose in am High drug interaction risk
sertraline (Zoloft)	see class	12.5 - 200	1-2 x/d	Moderate drug interaction risk, dose in am or pm
paroxetine (Paxil)	see class	5 - 60	1-2 x/d	Higher propensity for suicidality, high risk of serotonin withdrawal
fluvoxamine (Luvox)	see class	25 - 300	1-2 x/d if >100mg/d	Dose at bedtime for improved tolerability, high drug interaction risk
citalopram (Celexa)	see class	5 - 40	1 x/d	Low drug interaction risk, dose in am or pm; > 40 mg QT prolongation risk increases
escitalopram (Lexapro)	see class	5 - 20	1 x/d	Low drug interaction risk, dose in am or pm

**Antidepressants may increase suicidality (thoughts or behaviors) in children, teenagers and young adults during initiation. Higher initial starting doses pose a greater risk of suicidality compared to lower initial starting doses (1% vs 0.5%). Depression and other serious mental illnesses are the most important causes of suicidal thoughts and actions.*

OTHER ANTIDEPRESSANTS*

A. Clinical Indications For Use:

1. depressive disorders
2. ADHD (bupropion)
3. anxiety disorders

B. Frequency of Dose Change:

- ◆ No more than two (2) changes in any 7 day period

C. Concomitant Medication Use:

- ◆ use with MAOI only if documented failure of single agent

D. Complications & Side Effects:

1. sedation
2. dizziness, syncope

E. Cautions/Contraindications:

1. allergy to drug
2. uncontrolled seizure disorder (Wellbutrin)
3. eating disorder or active drug/etoh abuse (Wellbutrin)
4. MAOI use (except trazodone)

F. Medical Work-up:

1. BP (venlafaxine)

G. Medical Follow-up:

1. BP at least q 3 mos (venlafaxine)

DRUG (Common brand name is indicated for convenience. No preference is implied.)	MAIN INDICATIONS	DOSE (mg/d)	DOSAGE SCHEDULE	ADVERSE EFFECTS	SPECIAL CONSIDERATIONS
venlafaxine (Effexor)	depression Anxiety disorders	12.5 – 225	1-3 x/d	Nausea, sustained hypertension (regular monitoring of BP recommended)	Serotonin discontinuation syndrome Higher propensity for suicidality
trazodone (Desyrel)	depression Insomnia anxiety	25 - 400	1-2 x/d	Priapism in males orthostatic hypotension, dizziness, sedation, constipation	Fluoxetine and paroxetine can increase blood level, increasing side effects
bupropion (Wellbutrin) bupropion SR, bupropion XL	depression	IR: 75 - 450 Max/dose SR: 100 - 400 Max/dose XL: 150 - 450	1-3 x/d	Agitation, headache, insomnia, ↓ seizure threshold more than most	Take early in day to prevent insomnia
mirtazapine (Remeron)	depression	7.5 - 45	1 x/d	Rare-agranulocytosis, weight gain, hyperlipidemia	7.5 mg strength not available as oral disintegrating tablet, low drug interaction risk
duloxetine (Cymbalta)	anxiety (generalized anxiety disorder) 7-17 y.o.	30-60 mg Max: 120 mg	1 x/d	Dry mouth, fatigue, headache, somnolence, nausea	Monitor blood pressure

**Antidepressants may increase suicidality (thoughts or behaviors) in children, teenagers and young adults when first started. Depression and other serious mental illnesses are the most important causes of suicidal thoughts and actions.*

MOOD STABILIZER - lithium

A. Clinical Indications For Use:

1. bipolar disorder
2. schizoaffective disorder
3. depression (as adjunctive treatment when antidepressant med alone is not effective)
4. refractory impulsive aggression

B. Frequency of Dose Change:

- ◆ See F.2.

C. Concomitant Medication Use:

1. no common rules
2. chronic non-steroidal anti-inflammatory drugs usage can increase blood drug level
3. cautious use of diuretic medication, colchicine

D. Signs of Toxicity:

- ◆ lethargy, stupor, confusion, delirium

E. Medical Work-up:

1. Wt
2. chemistry panel, CBC, urinalysis
3. TSH
4. consider EKG with multiple medications and relevant hx and medical conditions

F. Medical Follow-up:

1. Wt
2. serum levels 5-7 days after each dosage change then q 3-6 mos or more frequently if clinically indicated
3. repeat EKG after therapeutic level achieved
4. at least q 6 mos: TSH
5. annual: U/A; serum creatinine

DRUG <small>(Common brand name is indicated for convenience. No preference is implied.)</small>	DOSE (mg/d)	DOSAGE SCHEDULE	ADVERSE EFFECTS	CONTRAINDICATIONS	SPECIAL MEDICAL FOLLOW-UP
lithium	150 – 2100 maximum serum level of 1.5 mEq/L	1-3 x/d	polyuria, polydipsia, tremor, EPS, nausea, diarrhea, vomiting, ataxia, ↑ WBC dysarthria, change in thyroid & renal function, weight gain	1. BUN > 50, serum creatinine level > than 1.5, dehydration, renal, cardiovascular or thyroid disease, 2. use of diuretic medication. 3. salt free diet	1. at least q6 mos: TSH 2. annual: U/A; serum creatinine

Lithium citrate syrup or solution: sugar-free, raspberry flavored, alcohol 0.3%

MOOD STABILIZER – anticonvulsants

A. Clinical Indications For Use:

1. bipolar disorder
2. schizoaffective disorder
3. impulsive aggression ^Δ

B. Frequency of Dose Change:

- ◆ No more than one change in any 7 day period

B. Concomitant Medication Use:

- ◆ no common rules

C. Complications & Side Effects:

- ◆ lethargy, stupor, confusion, delirium, weight gain except lamotrigine and topiramate

D. Cautions/Contraindications:

1. pregnancy & breast feeding
2. myelosuppression
3. hepatic disease
4. risk of Stevens-Johnson syndrome
5. monitor for suicidality &/or depression
6. acute pancreatitis^Δ

E. Medical Work-up:

1. physical exam (incl. Ht & Wt, BP)
2. chemistry panel, CBC
3. EKG with CBZ

F. Medical Follow-up:

1. each visit: WT
2. annual: PE, chemistry panel, CBC

DRUG <small>(Common brand name is indicated for convenience. No preference is implied.)</small>	DOSE (mg/d)	DOSAGE SCHEDULE	ADVERSE EFFECTS	CONTRAINDICATIONS	SPECIAL MEDICAL FOLLOW-UP
carbamazepine (CBZ) (Tegretol) (Equetro) (Carbatrol)	100 - 1200 and/or serum level max 12 mg/ml	2-4 x/d	1.syncope, ataxia, dysarthria, ↑ liver enzymes, bone marrow ↓, skin rash, EKG changes, dizziness, drowsiness, nausea 2.induces liver enzymes 3.(↑ hepatic metabolism esp. estrogen)	1.use of MAOI in last 2 wks 2.history of glaucoma or Sjogren's disease 3.hypersensitivity to TCA 4.MI in last 6 wks 5.hx of severe ↑or ↓ BP	1.serum level 5-7 days after dose change 2.g 3 mos: CBC + diff & liver enzymes 3.CBC if rash, sore throat or fever
valproic acid (VPA) Divalproex sodium (Depakote, Depakote ER)**	125 – 2500 or max serum level max of 125 μg/ml	2-4 x/d	nausea, vomiting, headache, sleep/appetite changes, sedation, tremor, rash, ataxia, visual disturbance, obesity, polycystic ovary disease, fatal pancreatitis, thrombocytopenia	1.congenital metabolic d/o 2.aspirin\barbiturate use 3.age < 2 y/o	1.serum level 5-7 days after dose change 2.g 3 mos.: CBC & liver enzymes
lamotrigine* □ (Lamictal)	12.5 – 400	1-2 x/d	benign rash, headache, stomachache, ↑appetite, insomnia; aseptic meningitis (rare)		Special consideration: carefully adjust valproate/lamotrigine combination, see appendix

** Depakote ER produces 10-20% lower blood levels than regular valproic acid - Depakene syrup alcohol free but not sugar free
Optimal blood draw time for Depakote is 12 hours post-dose - Optimal blood draw time for ER is 20-24 hours post-dose

□ Depression (as adjunctive treatment when antidepressant medication alone is not effective)

Δ carbamazepine and valproic acid

A. Clinical Indications For Use:

1. short term: relief of anxiety & some sleep disorders
2. acute alcohol withdrawal
3. older adolescents: anxiety, tension, muscle relaxation, sleep disorders
4. younger children: pavor nocturnus, somnambulism

B. Frequency of Dose Change:

1. acute care: daily or with each dose
2. long term Rx: adjust every 4 days

C. Concomitant Medication Use:

1. potentiated by: phenothiazines, opiates, barbiturates, MAOI's, TCA's, cimetidine
2. potentiate: hypnotics, sedatives, alcohol
3. half-life extended by: renal disease, hepatic disease, oral contraceptives, cimetidine, obesity

D. Complications & Side Effects:

1. CNS depression: fatigue, drowsiness, ataxia, confusion, respiratory depression, death
2. paradoxical: dyscontrol, disinhibition, excitation, ↑ anxiety, ↑ aggression, rage reaction, hallucinations, insomnia, nightmares

E. Cautions/Contraindications:

1. substance abuse or dependency
2. pregnancy

F. Medical Work-up:

- ◆ physical exam (incl. HT, WT, BP, P,)

G. Medical Follow-up:

- ◆ as clinically indicated

DRUG <small>(Common brand name is indicated for convenience. No preference is implied.)</small>	MAIN INDICATIONS	DOSE (mg/d)	DOSAGE SCHEDULE	ADVERSE EFFECTS	CONTRAINDICATIONS
clonazepam (Klonopin) *	see class	0.125 - 3	1-2 x/d	see class	see class
alprazolam (Xanax) **	see class	0.25 - 4	3-4 x/d	see class & increased risk of rebound and withdrawal reactions	see class
lorazepam (Ativan) **	severe adjustment d/o agitation, anxiety	0.25 - 6	3-4 x/d	see class & increased risk of rebound and withdrawal reactions	see class
buspirone (Buspar)	anxiety, aggression	2.5 - 90	3-4 x/d		

* long acting

** short acting

COMPLEMENTARY/ALTERNATIVE MEDICATIONS

DRUG <small>(Common brand name is indicated for convenience. No preference is implied.)</small>	MAIN INDICATIONS	DOSE (mg/d)	DOSAGE SCHEDULE	ADVERSE EFFECTS	CAUTIONS/ CONTRAINDICATIONS
melatonin	insomnia	1.0 - 10	bedtime	dizziness, headaches, intense dreams, abdominal pain	other sedating agents poorly controlled seizures
omega-3 fatty acids	ASD (hyperactivity) ADHD	750-1500 EPA 150-750 DHA	1 x/d	diarrhea, nausea, abdominal pain, dysguesia, eructation, dyspepsia, may increase serum AST/ALT (rare)	hypersensitivity to omega-3 FA or any components of formulation, ALT may increase without concurrent AST. Increase, may increase LDL, may prolong bleeding time

BETA-ADRENERGIC BLOCKERS

DRUG <small>(Common brand name is indicated for convenience. No preference is implied.)</small>	MAIN INDICATIONS	DOSE (mg/d)	DOSAGE SCHEDULE	ADVERSE EFFECTS	CAUTIONS/ CONTRAINDICATIONS
propranolol (Inderal)	aggression anxiety PTSD	10 – 40	1-4 x/d	hypotension bradycardia depression	bronchospastic disease, cardiovascular disease, diabetes, MAOI, hypothyroidism

OPIOID BLOCKERS

DRUG <small>(Common brand name is indicated for convenience. No preference is implied.)</small>	MAIN INDICATIONS	DOSE (mg/d)	DOSAGE SCHEDULE	ADVERSE EFFECTS	CAUTIONS/ CONTRAINDICATIONS
naltrexone (Vivitrol, Revia)	self-injurious behavior in IDD & autism	25 – 50	1 x/d x1-2/d	sedation	liver dysfunction, concurrent opiate

ANTI-CRAVING OR PHARMACOTHERAPY FOR SUBSTANCE USE DISORDERS

DRUG <small>(Common brand name is indicated for convenience. No preference is implied.)</small>	MAIN INDICATIONS	DOSE (mg/d)	DOSAGE SCHEDULE	ADVERSE EFFECTS	CAUTIONS/ CONTRAINDICATIONS
nicotine (Nicoderm CQ) patch (7mg/24h; 14mg/24h; 21mg/24h)	tobacco use disorder (smoking cessation)		1x/d	consider discontinuation if severe rash or swelling; seizures; abnormal heartbeat or rhythm; difficulty breathing	acute MI within 2 weeks, severe or worsening angina Asthma/reactive airway disease hyperthyroidism, pheochromocytoma, hepatic, renal impairment, cardiovascular disease, HTN, insulin dependent diabetes, Hx of seizures and peptic ulcer disease
N-acetylcysteine	cannabis use disorder	1200 mg	2x/d		common adverse effects: abdominal discomfort, muscle pains/aches, insomnia, headache, nasal congestion/runny nose, nausea, weight decrease, restlessness, and dizziness. contraindication: seizures, glutathione deficiency, acute asthma
buprenorphine-naloxone (sublingual tablet, sublingual film, buccal film)	opioid withdrawal syndrome and maintenance Tx.	pediatric dosing not available **8/2mg BUP/NAL SL bid	2x/d		hepatic impairment

APPENDIX

PHARMACOKINETIC DRUG INTERACTIONS - P450 CYP ENZYME METABOLIZING SYSTEM*

- **Substrate:** a psychotropic drug that is metabolized by a P450 CYP isoenzyme
- **Inhibitor:** coadministration of this drug and any substrate in isoenzyme (3A4, 2D6, 1A2) category would result in ↑ substrate levels
- **Inducer:** coadministration of this drug and any substrate in isoenzyme (3A4, 2D6, 1A2) category would result in ↓ substrate levels

3A4			2D6			1A2		
Substrate	Inhibitor	Inducer	Substrate	Inhibitor	Inducer	Substrate	Inhibitor	Inducer
alprazolam	fluoxetine	phenobarbital	aripiprazole	bupropion	carbamazepine	amitriptyline	cimetidine	phenobarbital
aripiprazole	fluvoxamine	phenytoin	atomoxetine	cimetidine	phenobarbital	caffeine	ciprofloxacin	phenytoin
carbamazepine	<i>grapefruit juice</i>	rifampin	clozapine	duloxetine	phenytoin	clomipramine	duloxetine	rifampin
clonazepam	macrolide	ritonavir	dextroamphetamine	fluoxetine	rifampin	clozapine	fluoxetine	ritonavir
eszopiclone	nefazodone	<i>smoking</i>	duloxetine	haloperidol	ritonavir	desipramine	fluvoxamine	<i>smoking</i>
guanfacine	ritonavir	St. John's wort	haloperidol	paroxetine		diazepam	<i>grapefruit juice</i>	
nefazodone		oxcarbazepine	mixed amphetamine salts	ritonavir		haloperidol	isoniazid	
olanzapine		carbamazepine	risperidone	sertraline		imipramine	levofloxacin	
quetiapine			TCA	TCA			sertraline	
ritonavir			trazodone					
sertraline			venlafaxine					
trazodone								
zaleplon								
ziprasidone								
zolpidem								

Other Common Mood Stabilizer Pharmacokinetic Drug interactions		
Interacting drugs	Mechanism	Recommendation
lamotrigine & valproate	valproate inhibits glucuronidation	Give ½ lamotrigine dose: monitor more closely for rash.
valproate & aspirin	aspirin ↑ free valproate levels	Give acetaminophen instead of aspirin.
lithium & NSAID	NSAID ↓ clearance of lithium	Give acetaminophen instead of NSAID.

* Partial List

A

Abilify 5
 Adderall XR 8
 alprazolam 16
 Ambien CR 17
 amitriptyline..... 11
 amphetamine 8
 Anafranil.....11
 aripiprazole 5
 Artane 7
 Atarax 7
 Ativan..... 16
 atomoxetine 9
 asenapine5

B

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 benztropine 7
 buprenorphine-naloxone..... 19
 bupropion.....13
 bupropion SR, XL.....13
 Buspar 16
 buspirone..... 16

C

carbamazepine 15
 Carbatrol.....15
 Catapres10
 Celexa 12
 chlorpromazine 3
 citalopram 12
 clomipramine 11
 clonazepam 15
 clonidine..... 10
 clozapine..... 4
 Clozaril..... 4
 Cogentin 7
 Concerta..... 8
 Cymbalta 13

D

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 Depakote 15
 Depakote ER 15
 desipramine 11

Desyrel 13
 Dexedrine 8
 dexmethylphenidate 8
 dextroamphetamine..... 8
 dextrostat 8
 diphenhydramine 7
 divalproex sodium..... 15
 doxepin 11
 duloxetine 13

E

Effexor 13
 Elavil 11
 Equetro 15
 escitalopram 12

F

Fazaclor 4
 fluoxetine 12
 fluphenazine 3
 fluphenazine decanoate 6
 fluvoxamine 12
 Focalin XR 8

G

Geodon..... 5
 guanfacine 10

H

Haldol 3
 haloperidol 3,6
 haloperidol decanoate 6
 hydroxyzine HCl 7
 hydroxyzine pamoate..... 7

I

imipramine..... 11
 Inderal..... 18
 Intuniv 10
 Invega5

K

Kapvay..... 10
 Klonopin 16

L

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 Lexapro 12
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 Liquadd..... 8
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 lorazepam..... 16
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 Loxitane 3
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M

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 Mellaril.....3
 Metadate ER, CD8
 Methylin ER8
 methylphenidate 8
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N

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O

olanzapine 4
 omega-3 17
 Orap 3

P

paliperidone5
 Pamelor..... 10
 paroxetine..... 12
 Paxil..... 12
 perphenazine..... 3
 pimoziide 3
 piperazine phenothiazine..... 6
 Prolixin 3
 propranolol..... 18
 Prozac 12

Q

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Quillivant XR..... 8

R

Remeron..... 13
 Revia 19
 Risperdal 4
 Risperdal-Consta 6
 risperidone4
 Ritalin LA 8

S

Seroquel 4
 sertraline..... 12
 Sinequan 11
 Stelazine..... 3
 Strattera..... 9

T

Tegretol 15
 Tenex 10
 thioridazine 3
 thiothixene 3
 Thorazine 3
 Tofranil 11
 trazodone 13
 trifluoperazine..... 3
 trihexyphenidyl..... 7
 Trilafon 3

V

valproic acid 15
 venlafaxine 13
 Vistaril..... 7
 Vivitrol 19
 Vyvanse.....8

W

Wellbutrin 13

X

Xanax 16

Z

ziprasidone 5
 Zoloft 12
 zolpidem 17
 Zyprexa 4

Suggested References

American Academy of Child and Adolescent Psychiatry, Practice Parameters
(periodical)

American Journal of Psychiatry: Journal of the American Psychiatric Association (periodical)

Annual of Drug Therapy. W.B. Saunders; Pennsylvania

Child and Adolescent Psychiatric Clinics of North America. W.B. Saunders; Pennsylvania

Journal of Child and Adolescent Psychopharmacology, (periodical)
Larchmont, NY: Mary Ann Liebert, Inc.

Journal of the American Academy of Child and Adolescent Psychiatry, (periodical).
Baltimore, MD, William & Wilkins

*Parameters for Juvenile Court Mental Health Services (JCMHS),
Review of Psychotropic Medication Application Forms (PMAFS) for Youth in State Custody*
http://dmh.lacounty.gov/wps/portal/dmh/clinical_tools/clinical_practice

Pediatric Dosage Handbook.
Taketomo, C.K., Hodding, J.H., Kraus, D.M., Hudson, OH: Lexi-Comp

Physician Desk Reference
<http://www.pdr.net>

Psychiatric Clinics of North America. W.B. Saunders; Pennsylvania

Psychiatry Drug Alerts (periodical). Morristown, NJ: M.J. Powers & Company

Psychotropic Medication Utilization Parameters for Children and Youth in Foster Care
http://www.dfps.state.tx.us/documents/Child_Protection/pdf/TxFosterCareParameters-September2013.pdf

JUVENILE COURT MENTAL HEALTH SERVICES

(CHILD'S NAME)

THE MEDICATION TREATMENT PROPOSED IS GENERALLY APPROPRIATE GIVEN THE CLINICAL CONDITION AND OTHER INFORMATION INDICATED ON THE FORM.

YES **NO** **?**

COMMENTS:

THIS FORM IS FOR JCMHS COMMENTS ONLY.
PLEASE DO NOT WRITE NOTES ON THIS PAGE.

REVIEWED BY

DATE 7/8/2016

**Jane Tesoro, PharmD
& Gia Crecelius, MD**

The attached form has been reviewed by staff of Juvenile Court Mental Health Services. This review is intended to give the court general information regarding the appropriateness of the psychotropic medication(s) prescribed given the clinical information presented on the form (age, diagnosis, symptoms, etc.). This does not constitute a definite recommendation as to whether this child needs this medication at this time as there may be factors unknown to the reviewer(s) which may influence the decision. The comments reflect concerns of the reviewer(s) and should be used as guidelines for obtaining further information from the treating physician.

If further consultation is desired, please contact JCMHS staff.

**Jane Tesoro, PharmD
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