SECTION 5, CHAPTER 11, POLICY 002-J

ATTACHMENT J – PRESCRIBING PSYCHOTROPIC MEDICATIONS TO MINORS

A. Purpose

1. To provide information regarding the role of psychotropic medications for the purpose of improving emotional and behavioral health in children and adolescents diagnosed with a mental health disorder.

B. Introduction

1. These parameters provide guidance for prescribing medications to minors and medication guidelines. Mental health professionals in child-serving agencies of Yolo County Health and Human Services Agency (HHSA) can best support the treatment of a minor with a mental health disorder by ensuring access to a comprehensive biopsychosocial treatment plan and psychotropic medication. Treatment with psychotropic medications can help many minors to remain in their homes, schools, and community.

2. The benefit from medication must be evaluated against potential untoward effects when considering whether medication should be prescribed. Parents and guardians and the minor must be informed about the potential risks and benefits when giving consent for treatment with psychotropic medications.

3. While medication consent must be obtained from parents and guardians, and in some cases the court, it is also necessary for the minor to agree, provided he or she has a developmentally appropriate understanding of why the medication is being prescribed and its risks and benefits.

4. Young adults over the age of 18 years can legally consent for themselves regarding treatment and medications, however, because young adulthood is a critical age of onset for many serious and persistent mental illnesses, these individuals may need additional support in making informed decisions.

5. Young children under the age of 5 years are typically more sensitive to medication side effects compared to older children and youth, and any consideration of psychotropic medication in this age range should be very carefully evaluated by a specially-trained clinician (i.e., child and adolescent psychiatrist).

6. For a child who is a ward or dependent of the juvenile court and living in an out-of-home placement or in foster care, Judicial Council forms (e.g., JV220) should be used by the psychiatrist to ask for an order to give, or continue giving, psychotropic medication.

C. Parameters for Classes of Medications Used for Children and Adolescents

1. First Generation (Typical) Antipsychotics

a. Medications in this class include: chlorpromazine; thioridazine; fluphenazine; perphenazine; trifluoperazine; haloperidol; thiothixene; loxapine; and pimozide. Contraindications include liver disease, respiratory distress, pregnancy, breast feeding, and allergy to the drug.

b. Clinical indications for use include: psychosis; mania; Tourette's disorder; and cases of severe behavior disorder with aggression and severe hyperactivity, in which standard treatments have been tried and failed, or contraindicated.

c. Frequency of dose changes should be as clinically indicated.

d. Avoid using more than one antipsychotic at a time.

e. Thioridazine (Mellaril) is mainly indicated for schizophrenia after other antipsychotics are ineffective. Avoid anticholinergics with thioridazine. Contraindications to this medication include: congenital QT syndrome; QTc interval over 500 msec; cardiac arrhythmias; and use of medications that prolong QTc interval (e.g., fluvoxamine, propranolol, fluoxetine, paroxetine).

f. Monitor for side effects of EPS, TD, NMS, sedation, cognitive dulling, weight gain, hyperprolactinemia, and seizure. Monitor for abnormal movements at each follow-up.

g. Laboratory monitoring should include baseline FBS, fasting lipid panel, LFTs, CBC, UA, BUN and creatinine. LFTs should be monitored every six (6) months and a chemistry panel, CBC, and UA annually. For pimozide, EKG should be performed at each dose increase and liver enzymes checked every three (3) months. For thioridazine, periodic EKGs and serum potassium levels should be monitored.

2. Second Generation (Atypical) Antipsychotics

a. Medications in this class include: olanzapine; quetiapine; risperidone; clozapine; ziprasidone; aripiprazole; paliperidone; asenapine; and lurasidone. Contraindications include liver disease, respiratory distress, pregnancy, breast feeding, myelosuppression, and uncontrolled seizure disorder. Avoid concurrent medications that increase QTc interval.

b. Clinical indications for use include: psychosis; bipolar, mania; severe behavior disorder with aggression; and in some cases, for severe hyperactivity in which standard treatments have been tried and failed, or contraindicated.

c. Frequency of dose changes should be as clinically indicated.

d. Avoid using more than one antipsychotic at a time.

e. Lurasidone is mainly indicated for schizophrenia in children ages 13 years and older. Clozapine is mainly indicated for treatment-resistant psychosis, bipolar disorder, TD, and severe EPS when other first-line treatments have been tried and failed.

f. Carbamazepine, phenytoin, phenobarbital, and smoking may lower the plasma level of the antipsychotic medication prescribed.

Fluoxetine, fluvoxamine, paroxetine, macrolide antibiotics, and cimetidine may increase the plasma level of the antipsychotic medication prescribed.

g. Monitor for side effects of weight gain, elevated lipids, elevated prolactin, elevated glucose, tachycardia, and restlessness. For clozapine, additionally monitor for agranulocytosis, seizures, constipation, hypotension, salivation, and myocarditis. Monitor for abnormal movements at each follow-up.

h. Laboratory monitoring should include baseline FBS, fasting lipid panel, LFTs, CBC, UA, and BUN and creatinine. A baseline EKG should be obtained for ziprasidone, and repeated after dose increases. LFTs for risperidone and olanzapine should be checked every six (6) months. Fasting lipids and FBS should be monitored every six (6) months, and CBC and UA annually. Clozapine should be monitored per protocol.

3. Long-acting Antipsychotic Injections

a. Medications in this class include: haloperidol decanoate; fluphenazine decanoate; piperazine phenothiazine; and Risperdal Consta. Contraindications include allergy to sesame oil (Haldol Dec and Prolixin Dec), liver disease, respiratory distress, pregnancy, breast feeding, and fever of unknown origin. Avoid concurrent medications that increase QTc interval.

b. A client must demonstrate positive response and tolerability to the oral form of the medication prior to initiating a long-acting injection, and have no history of NMS. Clinical indications for use include: maintenance antipsychotic therapy; prevention of non-compliance related relapse; and effective medication delivery. There is insufficient data at this time to support safe use in clients under age 18 years.

c. Frequency of injection should be as clinically indicated, and per manufacturer guidelines.

d. Avoid using more than one injectable antipsychotic at a time.

e. Carbamazepine, phenytoin, phenobarbital, and smoking may lower the plasma level of the antipsychotic medication prescribed.

Fluoxetine, fluvoxamine, paroxetine, and macrolide antibiotics may increase the plasma level of the antipsychotic medication prescribed.

f. Monitor for immediate side effects of sedation or cognitive dulling, hypotension, dizziness, and injection specific complications. Monitor for long-term effects of NMS,

EPS, TD, weight gain/obesity, diabetes mellitus II, dyslipidemia, and hyperprolactinemia. Monitor for abnormal involuntary movements, dyskinesia, blood pressure, and pulse at each follow-up.

g. Laboratory monitoring should include baseline FBS, fasting lipid panel, CBC, LFT, and UA. A baseline EKG should be obtained prior to initiating haloperidol and fluphenazine, and repeated when a therapeutic dose is established. Fasting lipid panel, FBS, and LFTs should be monitored every six (6) months, and CBC and kidney function annually.

4. Antiparkinsonian/Anticholinergics/Antihistamines

a. Medications in these classes include: benztropine; trihexyphenidyl; diphenhydramine; hydroxyzine pamoate (Vistaril); and hydroxyzine HCl (Atarax). Benztropine and trihexyphenidyl are contraindicated for children under the age of 3 years. Diphenhydramine and hydroxyzine are contraindicated for children under the age of 1 year. These medications are also contraindicated in those with severe physical stress, closed angle glaucoma, and obstructive bowel disorder or megacolon.

b. Clinical indications for use include: medication-induced extrapyramidal dysfunctions; anxiolytic/sedative/hypnotic; allergic reactions; and motion sickness.

c. Frequency of dose changes should be as clinically indicated.

d. Avoid use with other parasympatholytic agents (e.g., TCAs, low potency antipsychotics), MAOIs, and using more than drug of each class at a time.

e. Monitor for side effects of confusion, disorientation, delirium, hallucinations, cognitive dulling, impaired memory, vision problems, constipation, tachycardia, xerostomia, headache, worsening of pre-existing psychotic symptoms, aggravation of asthma, hyperthermia, and abuse potential.

f. Follow-up should be as clinically indicated and monitoring for side effects listed above.

5. Psychostimulants

a. Medications in this class include short-, intermediate-, and long-acting drugs.

i. **Short:** dextroamphetamine (Dexedrine, Dextrostat); amphetamine salts (Adderall); methylphenidate (Ritalin, Methylin, Metadate); and dexmethylphenidate (Focalin).

ii. **Intermediate:** methylphenidate (Ritalin SR, Metadate ER, Methlyn ER); methylphenidate (Metadate CD); and methylphenidate (Ritalin LA) capsule.

iii. **Long:** methylphenidate patch (Daytrana); methylphenidate (Concerta); Methylphenidate (Quillivant XR); dexmethylphenidate (Focalin XR) capsule; amphetamine salts (Adderall XR) capsule; and lisdexamfetamine (Vyvanse).

b. Clinical indications for use include Attention-Deficit/Hyperactivity Disorder (ADHD) and attention deficit symptoms associated with other mental health disorders. Contraindications include alcohol or drug abuse, anorexia nervosa, psychoses, severe anxiety, history of cardiovascular disease, thyroid disease, glaucoma, pregnancy and breast feeding, and allergy to the drug.

c. Frequency of dose changes should be no more than two (2) changes in any 7-day period.

d. Only one psychostimulant should be used at any one time.

e. Avoid heterocyclic antidepressants (unless trials of individual medications have failed) and MAOIs with psychostimulants.

f. Monitor for side effects of agitation, irritability, hyperactivity, exacerbation of obsessions and compulsions, insomnia, decreased appetite, weight loss, delayed growth, tachycardia, hypertension, dyskinetic movements/tics, depression, psychosis, and withdrawal effect or rebound phenomena.

g. A baseline EKG should be obtained if any positive cardiac risk factors are present. Height, weight, blood pressure, pulse should be monitored at each follow-up.

6. SNRIs

a. Medication in this class includes atomoxetine (Strattera), which is clinically indicated for ADHD. Contraindications include use of MAOIs, pressor agents, albuterol, narrow angle glaucoma, and allergy to the drug.

b. Monitor for side effects of decreased appetite, gastrointestinal symptoms, palpitations, mood swings, and hepatotoxicity (rare).

7. Alpha-adrenergic Agonists

a. Medications in this class include clonidine and guanfacine. Contraindications include pregnancy, breast feeding, and allergy to the drug. Caution should be used in individuals with a history of cardiovascular disease and renal insufficiency.

b. Frequency of dose changes should be no more than two (2) changes in any 7-day period.

c. Only one alpha-adrenergic agonist should be used at any one time.

d. Avoid MAOIs.

e. Monitor for side effects of sedation, hypotension, dizziness, rebound hypertension on discontinuation, constipation, headache, and dry eyes.

f. A baseline EKG should be obtained if there are positive cardiac risk factors, and repeat EKG as clinically indicated. Orthostatic blood pressure and pulse should be checked at each follow-up or dose change.

8. **Beta-adrenergic Blockers**

   a. Medication in this class includes propranolol. This medication is clinically indicated for aggression, anxiety, and PTSD. Cautions and contraindications include bronchospastic disease, cardiovascular disease, diabetes, MAOIs, hypothyroidism, and allergy to the drug.

   b. Monitor for side effects of hypotension, bradycardia, and depression.

9. **Antidepressants**

   a. Medications in this class include TCAs, serotonergic antidepressants, and other antidepressants. Cautions and contraindications include heart block, allergy to drug or class cross sensitivity, narrow angle glaucoma, seizure disorder, pregnancy, and breast feeding. Overdose may be lethal.

      i. **TCAs:** imipramine; desipramine; amitriptyline; nortriptyline; doxepin; clomipramine.

      ii. **Serotonergic:** fluoxetine; sertraline; paroxetine; fluvoxamine; citalopram; escitalopram.

      iii. **Others:** venlafaxine; trazodone; bupropion/bupropion SR/bupropion XL; mirtazapine; duloxetine.

   b. Clinical indications for use include depressive disorders, ADHD, anxiety disorders, obsessive compulsive disorder, eating disorders, impulsive aggression, and enuresis.

   c. Frequency of dose changes should be no more than two (2) changes in any 7-day period.

   d. TCAs and other antidepressants may be augmented with a MAOI, only if documented failure or a single agent. For serotonergic antidepressants, there should be a washout period before starting a MAOI: 5 weeks after fluoxetine; 2 weeks after sertraline, fluvoxamine, and citalopram; and 1 week after paroxetine. Avoid tryptophan.

   e. Monitor for side effects of sedation, dizziness, syncope, urinary retention, constipation, blurry vision, dry mouth, psychosis, mania, delirium, EKG changes, lowered seizure threshold, weight gain, agitation, restlessness, serotonergic syndrome, headache, sweating, sleep disturbance, gastrointestinal problems, and sexual dysfunction.

   f. A baseline EKG, liver enzymes, UA, TSH, and vitals should be obtained prior to initiating treatment with antidepressants.

   g. Monitor vital signs at each follow-up. For TCAs, obtain an EKG at steady state after each dose increase. Monitor TSH annually.

   h. Children, teenagers, and young adults to age 25 years with depression sometimes think about suicide. Antidepressants may increase these suicidal thoughts or actions in some

(FDA, 2007). Whenever an antidepressant is started or the dose is changed, closely monitor for new or worsening thoughts of suicide.

i. Additionally, watch for any of these behaviors: hyperactivity; agitation; restlessness; acting aggressive; angry or violent; acting on dangers impulses; trying to commit suicide; new or worse anxiety; panic attacks; new or worse irritability; difficulty sleeping; new or worse depression; and other unusual changes in behavior.

j. Generally, after starting an antidepressant, clients should have follow-up with their psychiatrist or clinician/case manager, if applicable, at least weekly for 8 weeks, every two weeks for 2 weeks, then once every other month, and if problems or questions arise (FDA, 2007).

10. Mood Stabilizers

a. Medications in this class include: lithium and these anticonvulsants: carbamazepine; valproic acid; divalproex; and lamotrigine. Contraindication to use of lithium is allergy. Caution and contraindications to anticonvulsants include pregnancy, breast feeding, myelosuppression, hepatic disease, risk of Stevens-Johnson syndrome, acute pancreatitis, and allergy to the drug.

b. Clinical indications for use include bipolar disorder, schizoaffective disorder, depression, and refractory impulsive aggression.

c. Frequency of dose change for lithium should be based upon the serum levels 5-7 days after each dosage change, then every 3-6 months, or more frequently, if clinically indicated. Frequency of dose change for anticonvulsants should be no more than one change in any 7-day period.

d. Chronic use of non-steroidal anti-inflammatory drugs (NSAIDs) can increase serum lithium level, and caution should be used if concurrently using the diuretic medication colchicine.

e. Monitor for signs of toxicity, which may include lethargy, stupor, confusion, and delirium.

f. A baseline EKG, chemistry panel, CBC, TSH, UA, and vital signs should be obtained prior to initiating treatment with mood stabilizers.

For lithium, a repeat EKG should be obtained after a therapeutic level is achieved. Monitor TSH at least every six (6) months, and UA and creatinine annually. Vital signs and weight should be monitored at each follow-up.

For anticonvulsants, vital signs and weight should be monitored at each follow-up, and chemistry panel and CBC monitored at least annually.

11. Anxiolytics

a. Medications in this class include: clonazepam; alprazolam; lorazepam; and buspirone. Cautions and contraindications include substance abuse or dependency, pregnancy, and allergy to the drug.

b. Short-term clinical indications for use include relief of anxiety and some sleep disorders. Other clinical indications include acute alcohol withdrawal. For older adolescents, indications include anxiety, tension, muscle relaxation, and sleep disorders. For younger children, indications include night terror and somnambulism (sleepwalking).

c. Frequency of dose change for acute care is recommended as daily or with each dose; for long-term use, adjust every four (4) days.

d. The medications in this class are potentiated by concurrent use of phenothiazines, opiates, barbiturates, MAOIs, TCAs, and cimetidine. The medications in the class potentiate hypnotics, sedatives, and alcohol. Additionally, half-life is extended by renal disease, hepatic disease, oral contraceptives, cimetidine, and obesity.

e. Monitor for CNS depression: fatigue, drowsiness, ataxia, confusion, and respiratory depression. Also monitor for paradoxical side effects: dyscontrol, disinhibition, excitation, increased anxiety, increased aggression, rage reaction, hallucinations, insomnia, and nightmares.

f. Monitor vital signs at each follow-up.

12. Pharmacotherapy for Substance Use Disorders

a. Medications that may be used in substance use disorders include naltrexone, nicotine patch, N-acetylcysteine, and buprenorphine-naloxone. Naltrexone is indicated for self-injurious behavior in IDD and autism; nicotine patch is indicated for tobacco use disorder; N-acetylcysteine is indicated for cannabis use disorder and buprenorphine-naloxone is indicated for opioid withdrawal syndrome and maintenance treatment.

b. For buprenorphine-naloxone, pediatric dosing is not available for 8/2 mg.

c. Cautions and contraindications to these medications include: liver dysfunction; acute myocardial infarction (MI) within 2 weeks; severe or worsening angina; asthma; hyperthyroidism; pheochromocytoma; hepatic and/or renal impairment; cardiovascular disease; hypertension; insulin dependent diabetes; and history of seizures and peptic ulcer disease (PUD).

d. Monitor for side effects of sedation with naltrexone. For nicotine patch, consider discontinuation if severe rash or swelling occurs, seizures, abnormal heartbeat or rhythm, and difficulty breathing.

13. Complementary/Alternative Medications

a. These medications include melatonin, indicated for insomnia, and omega-3 fatty acids, which are indicated for ASD (hyperactivity) and ADHD. Cautions and contraindications

include use of other sedating agents, poorly controlled seizures, hypersensitivity to omega-3 fatty acids, and allergy to the drug.

b. Frequency of dose change should be as clinically indicated.

c. Monitor for side effects of dizziness, headache, intense dreams, abdominal pain, diarrhea, nausea, eructation, and dyspepsia. Omega-3 fatty acids may rarely increase serum AST/ALT.

D. Psychotropic Medication Forms for Children Who Are Wards or Dependents of the Court

1. Judicial Council forms (JV-220, JV-221, JV-223, and JV-224) are used to ask for an order to give, or continue giving, psychotropic medications to a child who is a ward or dependent of the juvenile court and living in an out-of-home placement or in foster care (WIC, Section 727.4).

2. These forms are not required in these situations (Judicial Council of CA):

a. If the child lives in an out-of-home facility not considered foster care, unless a local court rule requires it, or

b. If there is a previous court order that gives the child's parent(s) the authority to approve or refuse the medication.

3. Required forms include the following (Judicial Council of CA):

a. JV-220: Application for Psychotropic Medication

i. This form gives the court basic information about the child and his/her living situation, and provides contact information for the child's social worker or probation officer.

ii. This form is usually completed by the social worker or probation officer, but is sometimes completed by the prescriber or his/her staff, or the child's caregiver. Whoever completes the form must identify him/herself by name and signing the form.

iii. If this form is completed by the prescriber, he/she must also complete and sign form JV-220(A) or form JV-220(B).

b. JV-220(A): Physician's Statement – Attachment

i. This form is used to ask the court for a new order. The prescriber fills out this form and gives it to the person who files the Application (JV-220).

ii. This form provides the child's medical history, diagnosis, previous treatments, and information about the child's previous experience with psychotropic

medications. The prescriber also lists his/her reasons for recommending psychotropic medications.

c. JV-220(B): Physician's Request to Continue Medication – Attachment

i. This form is a shorter version of the JV-220(A), and may only be used by the same prescriber who filled out the most recent JV-220(A) form if he/she is prescribing the same medication with the same maximum dosage. The prescriber fills out this form and gives it to the person who is filing the Application (JV-220).

d. JV-221: Proof of Notice of Application

i. This form shows the court that all parties with a right to receive notice were served a copy of the Application and attachments (California Rules of Court, rule 5.640).

ii. The person(s) in charge of notice must fill out and sign this form. A separate signature line is provided on each page of the form to accommodate courts in which the provision of notice is shared between agencies.

e. JV-223: Order on Application for Psychotropic Medication

i. This form lists the court's findings and orders about the child's psychotropic medications. The agency or person who filed the Application must provide a copy of the court order approving or denying the Application to the child's caregiver.

ii. The copy of the order must be provided (in person or mailed) within two days of when the order is made.

iii. If the court approves the Application, the copy of the order must include the last two pages of form JV-220(A) and all of the medication information sheets that were attached to the JV-220(A).

iv. If the child's placement is changed, the social worker or probation officer must provide the new caregiver with a copy of the order, the last two pages of form JV-220(A), and all of the medication information sheets.

f. JV-224: County Report on Psychotropic Medication

i. The social worker or probation officer must complete and file this form before each progress review. It contains information that the court must review.

ii. This form must be filed at least 10 calendar days before the progress review hearing.

4. Optional forms include the following (Judicial Council of CA):

a. JV-218: Child's Opinion About the Medicine

i. The child may use this form to tell the judge about him/herself and his/her opinion about the medication.

ii. The child may ask someone he/she trusts for help with the form.

iii. The child may also tell the judge how he/she feels in person at the hearing, by letter, or through social worker, probation officer, lawyer, or CASA.

b. JV-219: Statement About Medicine Prescribed

i. The caregiver, CASA, or Indian tribe may use this form to tell the court how they feel about the Application, and the effectiveness and side effects of the medication.

ii. This form must be filed within four court days of receipt of the notice of an Application, or before any status review hearing or medication progress review hearing.

c. JV-222: Input on Application for Psychotropic Medication

i. This form may be used when the parent or guardian, the attorney of record for a parent or guardian, the child, the child's attorney, the child's CAPTA guardian ad litem, or the Indian child's tribe does not agree that the child should take the recommended psychotropic medication.

ii. This form must be completed and signed within four court days of service notice of the pending application regarding psychotropic medication, with the clerk of the juvenile court.

5. All forms may be found at: www.courts.ca.gov