

TDMHSAS BEST PRACTICE GUIDELINES

Psychosocial versus Pharmacological Treatments

A controversy continues to exist around the use of psychosocial versus pharmacological treatments with children and/or adolescents. **Psychosocial treatments** provide guidance, support, and education to persons with mental illness, as well as their families. It typically includes psychotherapy (talk therapy), play therapy (for younger children), and/or social and vocational training (NAMI, 2012). Psychosocial treatments should be given consideration as first-line treatments for children and adolescents. They take longer for improvements to be noticed, but have solid grounding in empirical support as stand-alone treatments and are safer than their pharmacological counterparts (American Psychological Association [APA], 2006). However, it may be more difficult to get insurance to cover payment for psychosocial services. **Pharmacological treatments** are another way of referring to medications.

Psychosocial Treatments

Psychosocial treatments come in a variety of packages. Some of the most commonly used treatments for children and adolescents include the following:

- **Behavioral therapy** – Using tools like reward charts to help increase positive behaviors and reduce negative, acting-out behaviors.
- **Cognitive behavioral therapy** – An intervention designed to correct the pattern of negative thoughts that interfere with the child's ability to relate to people.
- **Play therapy** – Primarily used with younger children, it can help heal past trauma and facilitate the child's return to normal functioning.
- **Child-parent psychotherapy** – This intervention focuses on working directly with the child and the parent to deal with relationship issues. It can further help the child increase healthy ways of functioning and interacting. Parents are taught to be more reflective and how to develop a deeper understanding of their child and the role they play in their child's life. Parents are also taught how to interact with their child, thus promoting a healthy and secure attachment process as well as a healthy growth and development trajectory. Often parent coaching is a component of this therapy.
- **Dialectical behavioral therapy (DBT)** – Used mostly with adolescents, it teaches skills such as emotional regulation and distress tolerance, helping the struggling adolescent to integrate these new skills in their daily interactions (Solchany, 2011).

Researchers investigating the overall effect of psychosocial treatments on early disruptive behavior problems found support for their use as a first-line treatment with very young children. Using meta analysis involving 36 controlled trials, the researchers observed a sustained, large effect on early disruptive behavior problems, with the greatest effects linked to behavioral treatments. The average age of the children included in the analyzed studies was 4.7 years (Comer, Chow, Chan, Cooper-Vince, & Wilson, 2012).

Regardless of the difficulty in helping parents, educators, and other caregivers understand the value of psychosocial treatments, the working group on psychotropic medications of the American Psychological Association (APA) recommends that, in most cases, psychosocial interventions should be the intervention considered first for children and adolescents. Clearly these interventions are safer than pharmacological medications (APA, 2006). However, when pharmacological treatments are necessary, their use should be carefully chosen, monitored, and tapered off as soon as possible (Tweed, Barkin, Cook, & Freeman, 2012).

The American Academy of Pediatrics (AAP) has developed a concise, single-page report of evidence-based psychosocial interventions for children and adolescents. This report was designed to guide persons who work with children and adolescents, including clinicians, educators, youth, and families, in developing appropriate plans using psychosocial interventions. It was created using the PracticeWise Evidence-Based Services (PWEBS) Database (www.practicewise.com). The report can be found at <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/CRPsychosocialInterventions.pdf>. Check the AAP web site, www.aap.org/mentalhealth for updates and/or the most current version.

Alternative treatments such as yoga are being explored as modalities that lead to the improvement of mental health in young people, especially adolescents. Yoga practices incorporate the mental and the physical, helping to develop self awareness and grounding, calm the nervous system, and build balance, flexibility and strength. A few studies involving control groups have demonstrated yoga's benefits on positive self regard, perceptions of wellbeing, and emotional regulation skills. Yoga has further been identified as a technique for treating trauma issues experienced by youth. Since 2003, the Trauma Center at Justice Resource Institute (Massachusetts) has adapted a form of yoga for traumatized youth that are housed in residential treatment settings. Street Yoga, an organization that has expanded its boundaries from Portland, Oregon, to New York, San Diego, and Seattle, uses yoga classes to help youth build assertiveness and strength with a sense of safety. Instructors who teach the classes must go through special training (Marino, 2012).

Pharmacological Treatments

Pharmacologic medications can be beneficial adjuncts to behavioral treatments. In fact, AACAP does not recommend solely using medications with children and adolescents.

Prior to prescribing medication for pediatric patients, it is recommended that the medical professional interview the young person so that a thorough diagnostic evaluation can be made. It is possible that some evaluations may include physical examinations, laboratory tests, electrocardiograms (EKGs), electroencephalograms (EEGs), other medical tests, and/or consultations with other medical specialists (AACAP, 2004; Stambaugh, Leslie, Ringeisen, Smith, & Hodgkin, 2012).

General Principles Regarding the Use of Psychotropic Medications with Youth

- There must be a DSM psychiatric diagnosis ***BEFORE*** psychotropic medications are prescribed.

- The medical record must contain clearly defined target symptoms and treatment goals for the use of psychotropic medications at the time of or before beginning treatment with a psychotropic medication.
 - Target symptoms and treatment goals should be assessed at each clinic visit with the child and caregiver.
 - Recognized clinical rating scales or other measures should be used to quantify the response of the youth's target symptoms to treatment and the progress made toward treatment goals, whenever possible.
- Clinicians should carefully consider potential side effects, including those that are uncommon but potentially severe, and evaluate the overall benefit-to-risk ratio of pharmacotherapy in their decision-making about prescribing a psychotropic medication in a specific young person.
- Informed consent should be obtained from all appropriate parties **BEFORE** beginning psychotropic medication, except in cases of extreme emergency.
- The presence or absence of medication side effects should be documented in the medical record at each visit while the youth is taking psychotropic medication.
- Additional factors that should be monitored and documented include height, weight, and blood pressure or other laboratory findings.
- Put youngsters on monotherapy regimens for a given disorder **BEFORE** starting polypharmacy regimens.
- Start doses as low as possible, titrating carefully as needed.
- Change only one medication at a time, unless clinically contraindicated by documentation in the medical record. (*Note: Starting a new medication and beginning the dose taper of a current medication is considered one medication change*).
- As needed (prn) prescriptions should be discouraged. **IF USED**, the situation indicating need of administration as well as the maximum number of prn doses per day and/or week should be clearly indicated. Frequency of administrations should be carefully monitored to keep prn medications from becoming regularly scheduled medications.
- Follow-up should be appropriate for the severity of the youth's condition and adequate to monitor response to treatment, including symptoms, function, behavior, and potential side effects.
- For depressed children and adolescents, carefully evaluate and monitor the potential for emergent suicidality.
- Whenever possible, the prescribing clinician should be a child psychiatrist. Referral to or consultation with a child psychiatrist (or general psychiatrist with significant experience in treating children) should definitely occur if the child's clinical status does not show meaningful improvement within the timeframe appropriate for the clinical response and medication regimen being used.
- Conduct further assessments **BEFORE** adding more psychotropic medications to a regimen. At minimum, the child should be assessed for adequate medication adherence, accuracy of the diagnosis, the occurrence of comorbid disorders (including substance abuse and general medical disorders), and the influence of psychosocial stressors.
- If a medication is being used in a child because of the presence of a primary target symptom of aggression associated with a DSM nonpsychotic diagnosis (e.g., conduct disorder, oppositional defiant disorder), and the behavioral disturbance has been in remission for six months, serious consideration should be given to slow tapering and discontinuation of the medication. If the medication is continued in this situation, its necessity should be evaluated and documented every six months, at minimum.

- Care should be clearly documented in the child’s medical record. Documentation should include history; mental status assessment; physical findings (when relevant); impressions; adequate laboratory monitoring specific to the drug(s) prescribed at intervals required and potential known risks; medication response; presence or absence of side effects; treatment plan; and intended use of prescribed medications (Stambaugh et al., 2012; Texas Department of Family and Protective Services and the University of Texas at Austin College of Pharmacy, 2010).

It is extremely important that medications be dispensed properly, not just when the patient is a child or adolescent, but for all patients, young and old. Clinicians should make every effort to adhere to the five rights of medication administration, as displayed in the table below.

***Five Rights of
Medication
Administration****

The **RIGHT** patient
Receives the **RIGHT** drug
In the **RIGHT** dose
By the **RIGHT** route
At the **RIGHT** time.

**Source: George Washington University, Center for Health and Health Care in Schools, School of Public Health & Health Services (2007).*

Criteria Indicating Need for Further Review of Clinical Status When Psychotropic Medications Are Prescribed

The criteria that follow were adapted from *Psychotropic Medication Utilization Parameters for Foster Children* (Texas Department of Family and Protective Services and the University of Texas at Austin College of Pharmacy, 2010). While the parameters indicate the need for further review, they do **NOT** necessarily indicate that treatment is inappropriate.

- 1) Absence of a thorough assessment of DSM diagnosis in the child’s medical record.
- 2) At least five psychotropic medications are prescribed concomitantly.
- 3) When the following have been prescribed:
 - a) Two or more concurrent antidepressants
 - b) Two or more concomitant antipsychotic medications
 - c) Two or more concurrent stimulant medications
 - d) Three or more concomitant mood stabilizer medications

(NOTE. Polypharmacy is defined as the use of two or more medications for the same indication, i.e., specific mental disorder.)

- 4) The prescribed psychotropic medications are inconsistent with appropriate care for the youth's diagnosed mental disorder or with documented target symptoms typically associated with a therapeutic response to the medication that has been prescribed.
- 5) A psychotropic polypharmacy regimen for a given mental disorder is prescribed **BEFORE** utilizing monotherapy.
- 6) The psychotropic medication dose exceeds what is usual and customary.
- 7) Psychotropic medications are prescribed for very young children, including children receiving the following medications with an age of:
 - a) Antidepressants: Child younger than four years of age
 - b) Antipsychotics: Child below the age of four years
 - c) Stimulants: Child under three years of age
- 8) Medication is prescribed by a primary care provider (PCP) for a diagnosis **OTHER** than the following, **UNLESS** recommended by a psychiatrist consultant or the PCP has documented previous specialty training in the diagnosis:
 - a) Attention Deficit Hyperactive Disorder (ADHD)
 - b) Uncomplicated anxiety disorders
 - c) Uncomplicated depression

¹The prescription of a long-acting stimulant and an immediate-release stimulant of the same chemical entity (e.g., methylphenidate) does **NOT** constitute concomitant prescribing.

The *Psychotropic Medication Utilization Parameters for Foster Children* document (2010) further contains medication charts for the following:

- Stimulants (for treatment of ADHD)
- Other ADHD treatments
- Antidepressants, SSRIs
- Antidepressants, SNRIs
- Antipsychotics: Second Generation (atypical)
- Antipsychotics: First Generation (typical)
- Mood stabilizers.

Each chart displays the name of the drug, initial dosage, literature based maximum dosage, FDA-approved maximum dosage for children and adolescents, schedule, black box warning, and warnings and precautions. The parameters can be downloaded from

<http://www.dfps.state.tx.us/documents/about/pdf/TxFosterCareParameters-December2010.pdf>

For children in state custody in Tennessee, all psychotropic medication requests for children age five and under must be approved by a psychiatrist in DCS's central office. Moreover, consultation with DCS's Chief Medical Officer is additionally required for certain requests such as the prescribing of four or more psychotropic medications or two of the same class of medications (DCS, personal communication, January 18, 2013).

How Often Should Children and Adolescents Taking Pharmacologic Medications Be Monitored

It is important that children and adolescents on psychotropic medications be carefully monitored, **especially if they are taking antidepressants**. The FDA recommends the following monitoring schedule

(*shown below*) when antidepressants are involved. An equivalent or similar schedule might be followed when children or adolescents have been prescribed other types of medications.

<i>Monitoring Schedule</i>	<i>Treatment Phase</i>
Weekly	First month of treatment
Bi-weekly	Second month of treatment
Follow-up	After 12 weeks of treatment
As recommended	Following 12 weeks of treatment

Source: *Mayo Clinic, 2007*

Further monitoring capabilities are in place for children in Tennessee’s child welfare system. DCS has an established database that allows appropriate staff to review prescribing patterns of children in DCS custody (DCS, personal communication, January 18, 2013).

Overuse of Antipsychotics

Research continues to point to increased prescribing of antipsychotic medication for children and adolescents. Using data from the National Ambulatory Medical Care Survey (NAMCS), researchers examined office visits resulting in a prescription of antipsychotic medication. Between 1993-1998 and 2005-2009, they found that office visits to doctors with a prescription of antipsychotic medications per 100 persons grew from 0.24 to 1.83 for children and from 0.78 to 3.76 for adolescents. (Children were defined as 0-13 years of age and adolescents were ages 14-20 years.) A diagnosis of disruptive behavior disorder (DBD) accounted for 63 percent of the child antipsychotic visits and 34 percent of the visits by adolescents in 2005-2009. The fastest rate of increase in use of antipsychotics was apparent when children and adolescents visited non-psychiatric physicians, many of whom were primary care doctors (Antipsychotic use, 2012), a finding that is troubling and indicative of the need for these guidelines.

Overprescribing of psychotropic medications has become a growing concern for children and adolescents in foster care as well. A 2008 General Accounting Office report based on Medicaid claims found that 21-39 percent of children in foster care received a prescription for psychotropic medication, compared to five to 10 percent of youth not in foster care. Moreover, they observed that as many as 41 percent of youth that took psychotropic medications received three or more medications within the same month. When considering type of placement, youth living in nonrelative foster parent care, residential treatment centers, or group homes had the highest rates of psychotropic medication use (almost 30 percent). The most common age group receiving psychotropic medications was the six-to-11-year olds (nearly 20 percent). About four percent of children ages five and younger were taking one or more psychotropic medications (Stambaugh et al., 2012).

A guide has been developed by the Children’s Bureau to empower youth and help them understand and make healthy choices about psychotropic medications (Children’s Bureau, 2012). Written expressly for

youth education and information, the guide can be obtained from <http://www.nrcyd.ou.edu/publication-db/documents/psychmedyouthguide.pdf>.

Special Psychotropic Prescribing Considerations for Preschool Children

Guidelines for using psychotropic medications with preschool children were crafted and published by the Preschool Psychopharmacology Working Group (PPWG). Those guidelines emphasize the consideration of multiple different factors, such as the assessment and diagnostic methods used to evaluate the child's psychiatric problems, when deciding about prescribing psychotropics to preschoolers. The guidelines also contain information to help with treatment decisions for anxiety disorder, attention deficit hyperactivity disorder, bipolar disorder, disruptive behavioral disorder, major depressive disorder, obsessive compulsive disorder, pervasive developmental disorders, post traumatic stress disorder, and primary sleep disorders. It should be noted that more emphasis is placed on treating children of preschool age with psychosocial interventions for up to 12 weeks before starting any pharmacological treatment. Assessment of the mental health needs and functioning of the child's parent is addressed along with training parents in how to use evidence-based behavioral management strategies (Gleason, 2007, as cited in Texas Department of Family and Protective Services and the University of Texas at Austin College of Pharmacy, 2010).

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