COLORADO
Office of Children, Youth & Families
Department of Human Services

COLORADO
Department of Health Care Policy & Financing

PSYCHOTROPIC MEDICATION GUIDELINES FOR CHILDREN AND ADOLESCENTS IN COLORADO'S CHILD WELFARE SYSTEM

October 23, 2017

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WELCOME TO COLORADO!

The Colorado Department of Human Services (CDHS) and the Department of Health Care Policy and Financing (HCPF) joined together with representatives of the county directors in Colorado, the University of Colorado, residential child care facilities, former foster youth, the Foster Care Advisory Board, Colorado Access, Colorado Association of Family and Children's Agencies (CAFCA), the Kempe Center, Children's Hospital, Beacon Health, Office of the Child's Representative, Denver Health, Aspen Pointe, Colorado University School of Pharmacy, Banner Health, Value Options, Colorado Regional Health Information Organization (CORHIO), and the Department of Public Safety to form the Psychotropic Medication Steering Committee in 2012. The Committee was charged with developing the recommended guidelines for the state of Colorado in keeping with the requirements of the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110-351), and the Child and Family Services Improvement and Innovation Act (P.L. 112-34).

The original Guidelines were produced in 2013, and since then, much has changed. Here, we update the Guidelines to reflect newer prescribing data, new guidelines and treatment algorithms, and also to update on the progress made in pursuing nationally recognized standards for appropriate prescribing of psychotropic medications.

The vision of the Committee continues to be the same: To ensure the appropriate use of psychotropic medications for Colorado's children and youth in out-of-home care, and to integrate medications into high quality, comprehensive physical and behavioral health care.

We again thank the many agency and community leaders who made this report possible.

Sincerely,

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Executive Summary

Psychotropic Medication Guidelines for Children and Adolescents in Colorado's Child Welfare System

Children and youth who come to the attention of the child welfare system have disproportionally high rates of emotional and mental health challenges, and are prescribed high rates of psychotropic medications. The Psychotropic Medication Steering Committee first published the Guidelines in 2013, in keeping with the requirements of the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110-351), and the Child and Family Services Improvement and Innovation Act (P.L. 112-34). The primary rationale for the Guidelines is to affirm best practices and guidelines in caring for our foster youth in accordance with federal guidelines, and to highlight the progress occurring in Colorado as we address concerns around psychotropic prescribing. It is predicated upon the assumption that treatment with psychotropic medication should be used to reduce unwanted mental health symptoms and to restore meaningful quality of life for youth. Medication should never be used as a punishment, as a condition of placement, as a means to restrain a youth except in emergency situations, or for the convenience of caregivers. Whenever possible, the youth should have a voice in their treatment, and should clearly understand why they are being given a medication. Above all else, medication prescribing should keep youth safety in mind, with constant vigilance for short-term and long-term adverse effects from taking it.

The 2017 report improves upon the 2013 by including more detailed data on psychotropic prescribing, such as trending prescribing patterns over time, and breaking down prescribing patterns in more detail. For example, we now know that psychotropic prescribing increased overall for all Medicaid youth in Colorado between 2012-13 and 2015-16, but increased at a lower rate for youth in foster care.

- 26% of foster youth across Colorado received at least one psychotropic medication.
- 7% received two or more, 2% received three or more
- less than 1% received four or more.
- Psychotropic prescriptions fell for youth committed to DYS in 2015-16 compared to 2014.

This update also showcases decision aides for obtaining mental health services for foster youth, and for obtaining consent to treat for mental health. Treatment algorithms for common forms of mental illnesses have also been adapted from Seattle Children's Hospital, as have standardized side effect rating scales from the Ministry of Government Services in Ontario, Canada. The Guidelines also discuss best prescribing practices, and show instances of prescribing patterns that are likely to trigger a review and prior authorization from Medicaid, as well as discussing prescribing practices that may in the future be considered for prior authorization.

Finally, the Guidelines discuss a number of developing initiatives aimed at providing improved mental health access and prescribing practices, such as ECHO modules to train pediatricians about safe prescribing, child psychiatric consultation hotlines for GALs and caseworkers to aid the informed consent process, and telehealth to increase access to care.

TABLE OF CONTENTS

INTRODUCTION

Thank you for taking care of our foster youth!

Children/Youth in foster care are among the most vulnerable members of society, and you do an honorable service in caring for them. We know that the myriad of rules, regulations, and guidelines seem imposing to the practitioners who simply wish to take good care of their patients, as well as families, caregivers, caseworkers and advocates for the children and adolescents. Therefore, we write these with the hope that they provide a user-friendly guide to good practice and for locating resources, but we realize they cannot address every unique situation that may occur. We welcome ongoing feedback, and fully expect that these Guidelines must change and adapt as we continually learn more about the best way to care for our foster children/youth.

Why Have State-Specific Guidelines?

A fair question is why a state needs to publish its own psychotropic guidelines. After all, there are plenty of excellent resources on safe, effective prescribing already freely available. The reason is two-fold: (1) we want to, as a state, affirm best practices and guidelines in caring for our foster youth in accordance with federal guidelines, and (2) we want to highlight the progress occurring in Colorado as we address concerns around psychotropic prescribing. Exciting new things are happening that can assist you in caring for these children/youth!

General Principles for Safe Prescribing in Colorado

The Committee believes that the overall purpose of treatment with psychotropic medication is to reduce unwanted mental health symptoms and to restore meaningful quality of life for the youth. Medication should never be used as a punishment, as a condition of placement, as a means to restrain a youth except in emergency situations, or for the convenience of caregivers. Whenever possible, the youth should have a voice in their treatment, and should clearly understand why they are being given a medication. Above all else, medication prescribing should keep youth safety in mind, with constant vigilance for short-term and long-term adverse effects from taking it.

Information Sources for the Guidelines

We aim to provide cutting-edge practice guidelines around psychotropic medication use, based on the best data currently available. As such, we have referenced other guidelines published by the American Association of Child and Adolescent Psychiatry (AACAP), American Psychological Association (APA), American Association of Pediatrics (AAP), Administration for Children and Families (ACF), the Ministry of Government Services in Ontario, Seattle Children's Hospital, as well as the published research literature. We have also referenced information contained in other state guidelines, and are thankful for their contributions to this complicated problem. We are also grateful to Robert Hilt and Seattle Children's Hospital for providing useful, easy to use treatment algorithms that we have adapted for this report. The list of resources and references can be found in Appendix A.

QR Codes in the Guidelines

You may notice the use of "QR codes" throughout the Guidelines. These objects are similar to bar codes, can be easily created on the web (e.g. here), and contain information that you can scan with your smartphone if you have a QR reader app on your phon. Scanning QR codes will take you to various webpages associated with the text you are reading about. This is helpful to add in addition to hyperlinks also found in this text, since a QR code can be scanned even if these Guidelines are printed out on paper.

ABBREVIATIONS

AACAP = American Academy of Child and Adolescent Psychiatry

AAP = American Academy of Pediatrics

ACF = Administration for Children and Families

APA = American Psychological Association

ARD = Administrative Review Division

BHO = Behavioral Health Organization

CASA = Court-Appointed Special Advocates

CDHS = Colorado Department of Human Services

CHP = Child Health Plan

CHIP = Children's Health Insurance Program

C-PACK – Colorado Psychiatric Access & Consultation for Kids

CRS = Colorado Revised Statutes

CTN = Colorado Telemedicine Network

DCW = Division of Child Welfare

DUR = Drug Utilization Review

DYS = Division of Youth Services (formerly Department of Youth Corrections=DYC)

ECHO = Extension for Community Healthcare Outcomes

EPSDT = Early and Periodic Screening, Diagnostic and Treatment

FAR = Family Assessment Response

HCPF = Health Care Policy and Financing

ICD – 10 = International Classification of Diseases and Related Health Problems

MHC = Mental Health Center

OCYF – Office of Children, Youth & Families

PCG = Public Consulting Group QR – Quality Review

QR – Quality Review

RCCO - Regional Care Collaborative

TRAILS – CDHS Data Management System

PSYCHOTROPIC PRESCRIBING DATA FOR COLORADO

Children/Youth who come to the attention of the child welfare system have disproportionally high rates of emotional and mental health challenges.[1]

Nationwide, over 10% of children/youth in foster care take psychotropic medications. In Colorado, 18% received at least one psychotropic medication, and 5% took at least two psychotropic medications. According to the Department of Health Care Policy and Financing data, the percent of foster children/youth on psychotropic medications in the 2012 Medicaid system was 4.9% ages 5 and under; 24.3% ages 6-11; 34.6% ages 12-17; and 25.7% ages 17 and older. The percent of non-foster children on psychotropic medications was 1.0% ages 5 and under; 5.5% ages 6-11; 8.5% ages 12-17; and 4.5% ages 17 and older.

Psychotropic medications are often prescribed to treat these challenging behaviors and mental health issues. National surveys consistently show that prescriptions for these medications are disproportionately high among children/youth in foster care and prescriptions for these medications increased dramatically through the 90's and early 2000's. Encouragingly, since around 2008 the rate of prescribing appears to have levelled off and may, in some cases, even be decreasing. The reasons for this global decrease are not yet clear, although individual states have shown decreased incidence of polypharmacy when new oversight and educational policies were put in place. Psychotropic prescribing to Colorado youth increased slightly from 2012-13 until 2015-16, however, the increase in prescribing was slower for youth in foster care compared to those not in foster care (see Figure 1 below).

The 2013 psychotropic guidelines showcased Psychotropic Prescribing Data with a focus on children/youth in foster care. In 2016, the Department of Health Care Policy and Financing and the Drug Utilization Review team generated updated psychotropic prescribing data for Colorado, which is shown and discussed below (Figure 2, Figure 3 and Figure 4).

DATA ANALYSIS METHODS

This analysis focused on psychotropic medication claims for children/youth that were enrolled in Medicaid (< 18 years of age) during the time period from April 1, 2015 - March 21, 2016. It compared children/youth in foster care versus those not in foster care, and also stratified by age (< 5 years, 6-11 years, 12-17 years of age), type of psychotropic medication (an antipsychotic, antidepressant, mood stabilizer, stimulant, or antianxiety medication), and overlapping use within and outside the same therapeutic class. Logistic regression was used to determine the odds of receiving a psychotropic medication or a specific therapeutic class of psychotropic medication based on foster care status controlling for age, sex, and race.

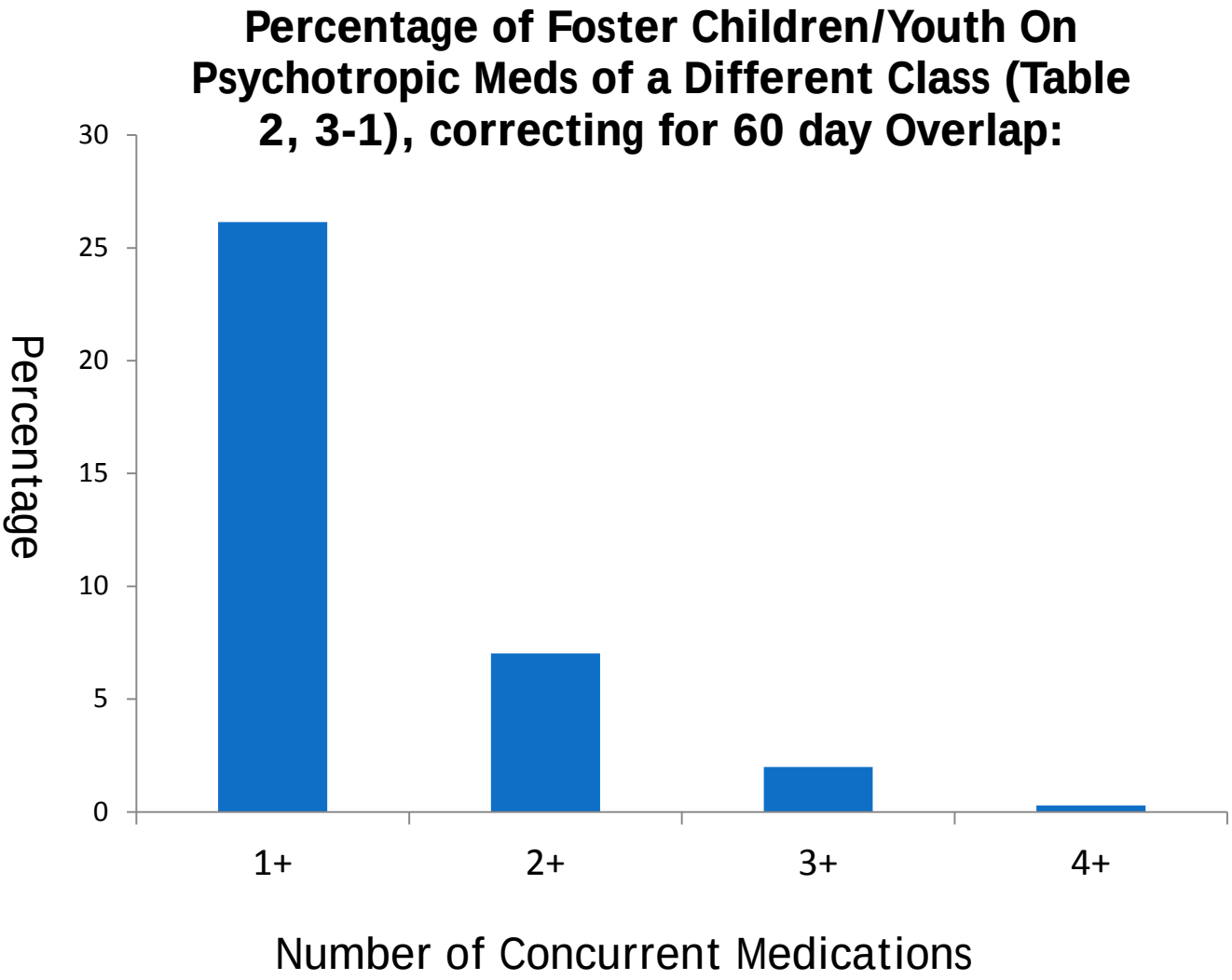


FIGURE 1 - Percentage of foster children/youth (years 2015-16) who are receiving one or more (1+), two or more (2+), three or more (3+), or four or more (4+) psychotropic medications. As shown, 26% of foster youth across Colorado received at least one psychotropic medication. 7% received two or more, 2% received three or more, and less than 1% received four or more. Data is from Colorado Health First pharmacy claims, and youth were counted as receiving multiple medications only if the medications overlapped by more than 60 days.

PERCENTAGE OF CHILDREN/YOUTH TAKING PSYCHOTROPIC MEDICATIONS BY FOSTER CARE STATUS

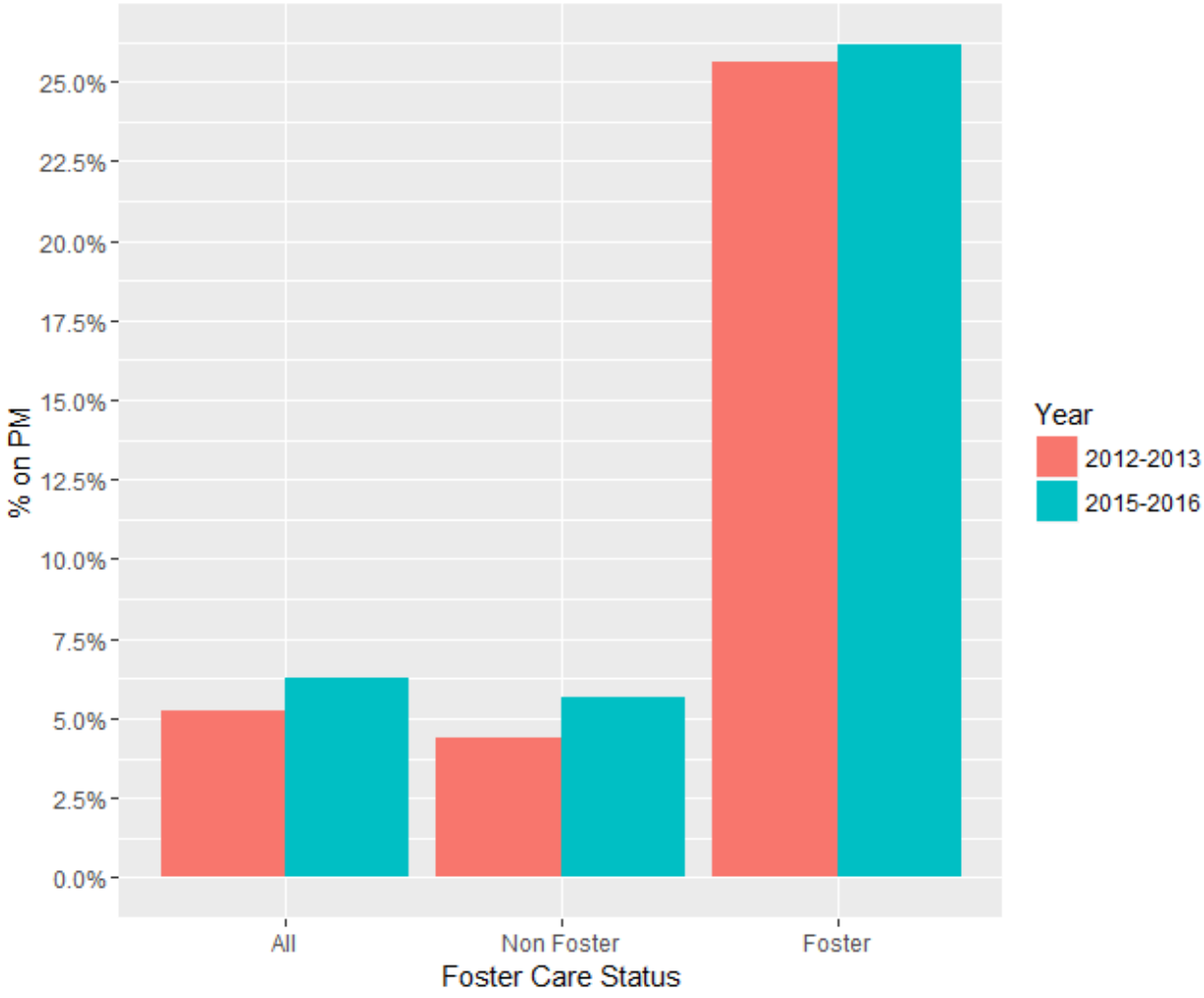
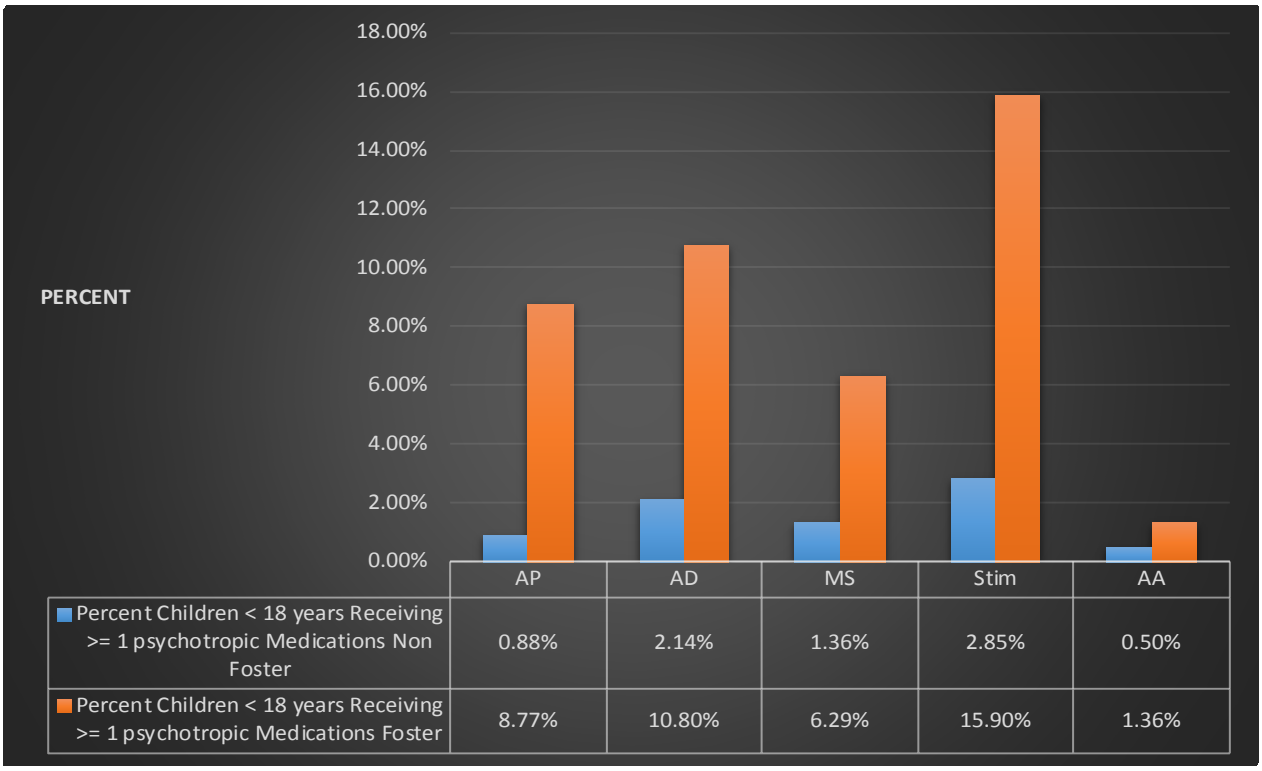


FIGURE 2 - The percentage of children/youth taking psychotropic medications by foster care status, comparing data from 2012-12, and 2015-16. All youth experienced an increase in the percentage taking psychotropic medication, but the percentage increase for foster children/youth was notably less than for non-foster children/youth.

PERCENTAGE OF CHILDREN/YOUTH RECEIVING AT LEAST ONE PSYCHOTROPIC MEDICATION BY CLASS AND FOSTER VERSUS NON-FOSTER CARE



	AP	AD	MS	Stim	AA
Percent Children < 18 years Receiving >= 1 psychotropic Medications Non Foster	0.88%	2.14%	1.36%	2.85%	0.50%
Percent Children < 18 years Receiving >= 1 psychotropic Medications Foster	8.77%	10.80%	6.29%	15.90%	1.36%

FIGURE 3 – The percentage of children/youth receiving at least one psychotropic medication, by medication class, and by foster versus non-foster care. AP: Antipsychotic, AD: Antidepressant, MS: Mood Stabilizer, Stim: Stimulant, AA: Anti-anxiety Medication.

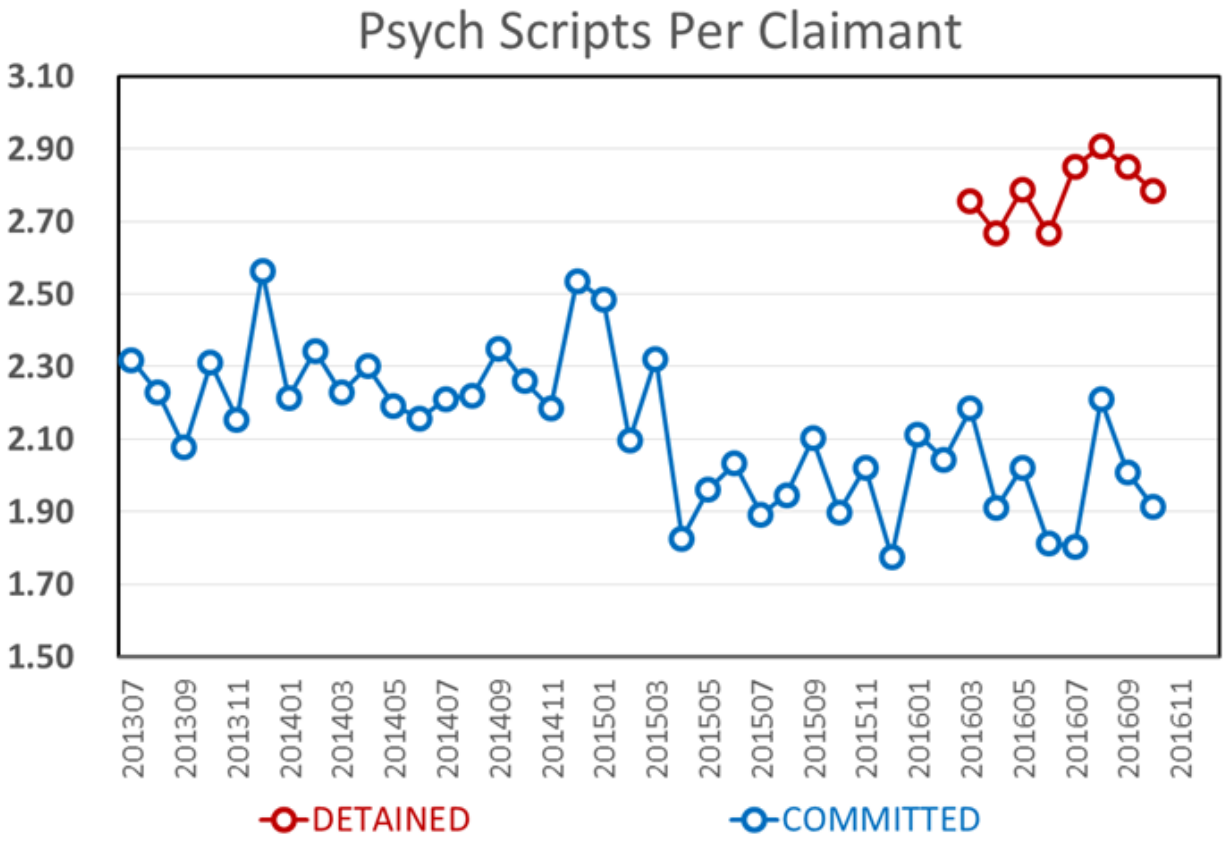


FIGURE 4 - The average number of psychotropic prescriptions for youth receiving any psychotropic prescriptions, according to whether they were detained or committed to the Division of Youth Services. Dates shown range from July 2013 (201307) through Nov 2016 (201611). The average numbers of prescriptions fell around mid-2015 (e.g. 201505), and have remained lower since. Of note, the average detained youth (shown in red) takes considerably more psychotropic prescriptions than the average youth committed to the Division (in blue).

TIMELY HEALTH ASSESSMENT AND TREATMENT

Knowledgeable psychotropic prescribing rests on a thorough evaluation of a child/youth's mental and physical health. As such, it is critically important that children/youth placed into foster care receive timely evaluations and follow up appointments.

Colorado law (CRS 19-7-101) broadly states that "children/youth in foster care… should enjoy the following…Receiving medical, dental, vision, and mental health services as needed." On a federal level, the Fostering Connections to Success and Increasing Adoptions Act of 2008 calls for the creation of a health plan, which should include a schedule for health care assessments for children/youth placed into foster care.

Ensuring that all foster children/youth receive health assessments in a timely manner is a major undertaking. In 2015, the Colorado Department of Human Services (CDHS) had 21,218 open child welfare cases, and of these, 4,951 involved children and/or youth placed out of home in foster care, residential treatment, group homes, or kinship care[9]. At any given time, around 2,000 children actively reside in foster care in the state of Colorado[10]. According to national statistics, almost half of youth (49%) in foster care are likely to be suffering from mental health concerns that could benefit from specialized treatment, sometimes including psychotropic medications[11].

In 2016 the Public Consulting Group (PCG), in partnership with the Department of Health Care Policy and Financing (HCPF), surveyed approximately 60 child welfare staff regarding healthcare access for foster youth[12]. Of this staff, sixty-two percent disagreed with the survey question, "Children/Families are generally able to access quality mental and behavioral health services to meet their needs." Seventy-one percent disagreed that those needs were met in a timely manner.

Challenges remain for obtaining timely health care for foster children/youth in Colorado. To address these concerns, we first examine our regulatory requirements, and then discuss efforts underway to increase timely access to care.

COLORADO REGULATORY REQUIREMENTS FOR HEALTH ASSESSMENTS

Physical Health Exam Requirements

Colorado regulations require a physical health exam be scheduled (not necessarily completed) within 14 days of placement in foster care[13]. The health exam must, at minimum, include examination for injury and disease, vision and hearing screening, and an "assessment of the foster child/youth's health." There currently is no distinction in Colorado state regulations between an initial health "screen" versus a later, more in-depth "health assessment." This is different from most other states that do distinguish these, and so should be kept in mind when practices and terminology are compared to other states[14].

Beyond the initial required health assessment, ongoing medical care for foster children/youth is to be "provided in a timely manner as defined by the Division of Child Welfare and the health care provider." [15] CDHS and HCPF follow the Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health

Care[16], along with the periodicity schedule included with this plan for routine care and follow-up health reassessments[17,18].

The AAP schedule recommends physical health exams at age 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, and 30 months, then every year between the ages of 3 and 20. The AAP also recommends that "reassessments should occur… "at times of significant changes in placement (foster home transfers, approaching reunification)." [19] The schedule itself can be quickly accessed by scanning the QR code to the right with your smartphone.

From October 2014 through Sept 2015, 64% of 2,393 foster children/youth had a documented health assessment either scheduled or completed within the required timeframe[20]. This is roughly similar to the prior year, and may be slightly lower than the true percentage since not all health exams are documented correctly. The eventual goal of CDHS is 95% or greater.

Mental Health Exam Requirements

Colorado does not have a specific regulatory requirement for mental health screening after placement in foster care, instead providing direction that whenever indicated, a foster child/youth shall be referred to an appropriate specialist for either further assessment or treatment. [21] Research data indicates that about 49% of children/youth in the foster system nation-wide have symptoms consistent with at least one psychiatric diagnosis. [11] Colorado data from 2014/15 indicates that 27.5% of foster children/youth in Colorado have had at least one visit with a Colorado Health First mental health provider of any kind[3], thus highlighting a potential gap between estimated need based on national figures, and current treatment.

The Administrative Review Division (ARD) within the Office of Performance and Strategic Outcomes, conducts qualitative case reviews[22] of every child/youth placed in foster care for at least six months and for every six months thereafter, for as long as the child/youth is in foster care. ARD reviews indicate that a number of mental health concerns in Colorado foster care are unmet. For example, case review data from October 2015 through June 2016 of children/youth placed in out-of-home care shows that 66.8% of children/youth had mental health services provided to meet the child/youth's identified needs, indicating that a third did not receive needed services. While concerning, nation-wide research data suggests an overall worse picture, with only around 1 in 4 foster child/youth receiving needed mental health services. [23]

The ARD data for 2016 showed that nearly 30% of "no" responses to a youth getting needed mental health services was at least partly because of delays 2 weeks or longer in receiving services. A consulting report from PCG (Public Consulting Group) in 2016 surveyed child welfare staff, and similarly found that the most common length of time from the initial intake with a mental health provider until the first treatment services was 2-4 weeks.

With regard specifically to psychotropic medication, the AAP recommends that any child prescribed psychotropic medication must be closely monitored by the prescribing provider for potential adverse effects and that each visit should "attempt to assess the child/youth's developmental, educational, and emotional status." The PCG and ARD data do not specifically separate out utilization of psychotropic prescribing services, or the average length of time to obtaining them. This represents a gap in knowledge about foster children/youth care at the state level that should be explored further.

Developmental Screening Requirements

Colorado state regulations specify that "prior to closing an assessment, county departments shall refer all victim child(ren) under the age of five (5) to the appropriate state or local agency for developmental screening when the county department makes a finding of founded abuse and/or neglect."[24] In addition, "county departments may refer any child under the age of five (5) to the appropriate state or local agency for developmental screening in a Family Assessment Response (FAR) or Traditional Response Assessment (TRA), if a parent consents and the child

presents with needs that might benefit from a developmental screening as determined by the county department."[25]

Colorado Health First rules also call for "developmental screening including a range of activities to determine whether a child's emotional and developmental processes fall within a benchmarked range of achievement schedule according to the child's age group and cultural background. This screening shall include self-help and self-care skills, gross and fine motor development, communication skills or language development, social-emotional development, cognitive skills and appropriate mental/behavioral health screening."

During Colorado's 2015 Federal Fiscal Year, 70% of children under the age of five were referred for a developmental screening. The 30% not referred were either already receiving services or had already completed a developmental screening. This information is now documented and tracked in the statewide case management system (Trails).

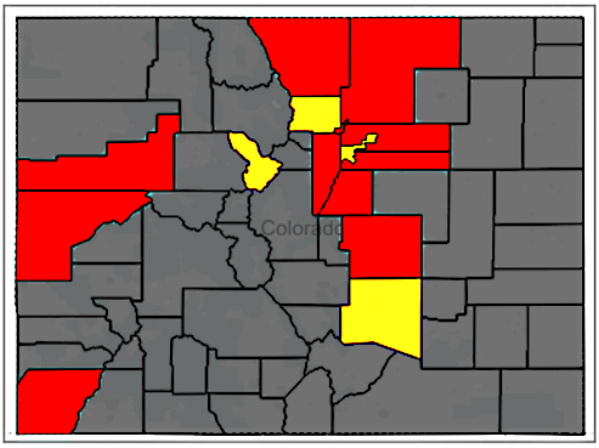
For more information, please visit here. Or scan the QR code to the right:

COLORADO INITIATIVES FOR TIMELY TREATMENT OF YOUTH WITH MENTAL HEALTH NEEDS

Youth placed into foster care often have severe, acute mental health needs that require more intensive diagnostic investigation and treatment than a general health assessment can provide. For example, a youth may be having thoughts of wanting to harm themselves or other people, may be feeling disconnected with reality and actively hallucinating, or may feel out of control and unable to stop themselves from engaging in dangerous behavior. These symptoms require quick access to specialized services to prevent dangerous outcomes.

Colorado has a shortage of mental health providers in many parts of the state. For example, most counties do not have any child psychiatrists serving in them[27], including almost all of the eastern plains, and most of southern and middle regions of the state (see figure to the right). A patient living in these areas might have to drive for hours each way to access needed care. One can easily imagine the difficulties of transporting a hyperactive, aggressive youth in a car for this length of time, especially if they must do so, on a recurring basis.

Practicing Child and Adolescent Psychiatrists by County 2015
Rate per 100,000 children age 0-17



Judging by the PCG data on the wait time to obtain general therapy services[12] and the known scarcity of prescribing providers, it is likely that a number of foster youth in the state face delays of weeks or months for appointments for psychotropic medication management.

To address this, stakeholders and agencies in Colorado are actively engaged in several initiatives to increase access to timely and high quality health care.

Telemedicine

The Department of Health Care Policy and Financing defines telemedicine as the audio-video interaction

between the patient with the specialist, or between the client and their physician with a distant specialist. Across the world and in Colorado, telemedicine is helping connect areas with a high density of specialized providers to areas that have a much lower density, or that lack any providers at all.

Several years ago, setting up a telemedicine service involved purchasing specialized cameras and internet connections that cost thousands of dollars, and required some technical expertise to set up. Since then, cost and setup difficulty have fallen dramatically. In many cases, existing office computer equipment can now be used, and sometimes members can connect with their own computers or tablets, even from home, although this is still in the development stages in Colorado. HCPF just updated their Telemedicine policy in November 2016 to remove the requirement for an originating provider, so the member can be in the convenience of their home when doing the interactive audio-video call with the distant provider.

Research suggests that telemedicine services are a reasonable substitute from a clinical standpoint for in-person visits for many kinds of care, including mental health.[28] In fact, some youth are more comfortable in a tele-setting and may be more likely to openly discuss their problems during therapy.[29] Telemedicine consultation services to assist in treatment planning and medication management of foster youth have also decreased psychotropic medication usage and residential placement, resulting in significant cost savings[30].

Parity of Telemedicine

Payment for telemedicine services has been an evolving issue nationwide, and states are rapidly updating laws and regulations so that telemedicine visits are legally viewed as equivalent in-person encounters. For instance, prior to 2015, Colorado had only required that private insurers reimburse telemedicine services for services to counties with populations of 150,000 or fewer (Colorado Health First had no such restriction). In 2015, House Bill 15-102931 was passed to eliminate this population requirement, starting in 2017, for private insurers. HCPF continues to assess the expanding list of services possible through telemedicine to better align with private insurance.

HB15-1029 also eliminated the need for providers to first establish in-person relationships with patients before telemedicine services could be started. The Colorado Medical Board also clarified in 2015 that in their view, providers could establish a treatment relationship with a patient "whether or not there has been an in-person encounter between the patient and the provider." In other words, no in-person encounter is necessary to begin treatment.[32]

Under HB15-1029, providers are not required to demonstrate that a barrier to in-person care exists that requires the use of telemedicine services, such as a distance from provider requirement (i.e. the patient has to live far away in order to use telemedicine). Insurance carriers also cannot refuse to pay for covered services delivered via telemedicine, or reimburse differently for them compared to in-person services, such as by charging a different co-pay for the visit.

Who May Deliver Telemedicine

A wide variety of clinicians may deliver care to foster youth via telemedicine. The list includes (but not limited to): physicians, nurse practitioners, physician assistants, psychologists and clinical social workers.

Colorado Health First, Foster Youth, and Telemedicine

Colorado Health First covers telemedicine services through any qualified provider. It does not require in-person contact for reimbursement of telemedicine, and pays similarly to in-person contact whether the youth lives in a rural or urban area.[33, 34] Of note, Colorado Health First only pays for live video conferencing when interacting remotely with a foster youth. Telephone calls or pre-recorded videos from the provider, for instance, would not be reimbursed.

Telemedicine at Home

In Colorado, we did not find any law or regulations preventing a patient from calling a provider from their home, or from a foster home.[35] Providers are advised to instruct their patients on confidentiality when accessing telemedicine services from a home location, and to make reasonable efforts to ensure that the conversation is private. Security of the patients at their end should also be considered, especially if a patient appears at risk for harm to self or others.

Consent for Telemedicine

Prior to starting telemedicine, providers must notify their patients in writing about their right to refuse telemedicine services, privacy notices, and their access to all relevant medical information about the service.[36] The consent must be signed by the patient. Note that this is different from needing to actually meet the patient in-person at the first visit, which is not required by the Colorado Medical Board.[32]

That said, this can all be done virtually with email/fax as well as in real-time as you obtain consent like you do before every medical service. If the patient then refuses telemedicine, the visit is over at consent and not billed. The requirement for written consent prior to initiating telemedicine is seen by some as a potential barrier that can slow the delivery of care, especially if the consent form must be sent by postal mail. Electronically delivered and signed consent can potentially streamline this process. Since the Department of Health Care Policy and Finance allows electronic signatures for consent, the Committee recommends that this option be examined further.

Remote/Electronic Prescribing

If a patient interacts via telemedicine, having to pick up hand-written prescriptions would pose a barrier to care, especially when telemedicine is exclusively used. As of 2012, Colorado law allows for e-prescribing of all medications, including controlled substances.[37] Not all practices or medical record systems are set up to do this yet, and so this remains an ongoing area for improvement.

DYS and Telemedicine

Many Division of Youth Corrections (DYS) facilities are too small to house an in-person psychotropic prescriber or other highly specialized mental health providers, therefore, youth in these facilities may have limited access to them. In 2016, the DYS completed an update of the facility internet infrastructure, in part to allow for the implementation of telemedicine. This will particularly aid in assessment of youth needing psychotropic medication management, as such prescribers are often not available in person. The Division has begun offering telemedicine visits as of July, 2017.

Colorado Telemedicine Network (CTN)

Telemedicine depends on a strong, high speed internet connection. This can be particularly problematic in rural areas, which may not have such architecture in place. In part to address this CTN[38] was formed in 2008 through joint efforts of the Colorado Hospital Association and the Colorado Behavioral Health Council, using federal grant money. CTN's broad purpose is to use information technology to expand access to healthcare, especially in rural areas. It provides high speed internet service at a discounted fee to qualified providers, which can include hospitals, community health centers, and clinics that assist with their mission. These providers are able to use their own telemedicine service providers, and can then use CTN's broadband internet architecture to connect with clients. Providers interested in assistance from this service can call (720) 330-6069.

Updates to Colorado Telemedicine Law

Rules and laws relating to telemedicine can rapidly change, and may change prior to the next update to these Guidelines. The Center for Connected Health Policy monitors and updates laws and rules around telemedicine, including for Colorado. They have an easy-to-use website that contains recent updates. It can be accessed for free here:

Project ECHO and Training Primary Care Prescribers

Telemedicine not only increases the ability of providers to connect with their patients, it can also connect providers to each other for collaboration and teaching. Project ECHO[39] is a physician teaching model that connects doctors in the community via live videoconference with specialists at a "hub." The subject experts use both didactic teaching and case examples (often brought by the participants) to train providers on complex, difficult topics.

The ECHO teaching model has already demonstrated strong provider education outcomes among a number of specialties,[40] and is of major interest at the federal level with the recent passage of the ECHO Act. In Colorado, the state chapter of the AAP, CCAPS, Beacon Health, and CDHS are discussing formation of ECHO project(s) specifically to address concerns around psychotropic medication. Topics will likely include ways to avoid polypharmacy and utilize evidence-based psychotherapeutic interventions to address behavioral concerns, and how to efficiently approach this issue in a busy practice.

These ECHO module(s) will be intended for primary care physicians, in part since they are often the sole available prescriber for these complicated medicines, especially in rural areas. The first ECHO modules aimed at psychotropic prescribing are expected go live in fall of 2017.

Child Psychiatrist Telephone Consultation for Primary Care Providers

Primary care providers (e.g. pediatricians) are often the sole providers for psychotropic medication for youth, especially in underserved areas. In some cases, foster youth present with such complex mental health problems that the provider must either practice outside of their comfort level or not take the youth on as patients and leave them with few other options.

Teaching models such as Project ECHO (see section above) can provide training to increase a provider's comfort level in treating more complex cases, but this teaching model will not directly answer a question with a particular youth in a timely way. To solve this problem, a more customized psychiatric consultation process is needed.

States such as Washington[41] and Massachusetts[42] now offer a telephone hotline service in which providers can call a child psychiatrist to discuss the case. They can discuss a range of things from best medication practices, for example, to how best to integrate psychotherapy services. This approach allows primary care providers to have greater confidence when they take on complex youth, as they now have a mechanism to quickly get help when needed.

The Drug Utilization Review vendor, University of Colorado Skaggs School of Pharmacy, has also hired contracted child psychiatrists to provide tele-consultations for Colorado Health First-enrolled providers (Colorado's Medicaid Program). It is voluntary and free to use for any Colorado Health First-enrolled provider, and utilization of it is steadily growing. Once a request is initiated by the provider, an administrative staff member schedules a phone appointment with the consulting child psychiatrist. After the phone consultation is completed, a recommendation is made to the provider and the Department of Health Care Policy and Financing regarding continuation versus change of the current psychotropic treatment plan. Clinicians with particularly complex cases are reporting that

this hotline has assisted them in finding creative, alternative ways to treat their patients, often using fewer medications. Per the Department of Health Care Policy and Financing Provider Bulletin, Reference # B1700300: "The teleconsultation service is currently for pain management and child psychiatry consults and is available by request for members who meet specific criteria. If you have a complex pain management or child psychiatry case and would like another opinion from an MD/DO in those fields, please send an email to Brandon Utter for more information at **mailto:SSPPS.co-dur@ucdenver.edu.**

Computerized Therapy Services

The need for in-person psychotherapy services far exceeds the supply for foster youth. This is particularly true if defining adequate access more rigorously, such as weekly or greater than weekly therapy sessions for many youth that would benefit from them.

One emerging method to address this need is through computer-based therapy. Several programs (unaffiliated with any Colorado entities) have already been developed around the world to deliver cognitive behavioral therapy, including MoodGym[44] and Beating the Blues.[45] These programs deliver multiple interactive sessions of CBT, and have been shown in some studies to produce positive mental health outcomes at low cost.[46] Unfortunately, retention in these programs can be low, and so the real-world efficacy for foster youth is still uncertain. One of the limiting factors with these types of programs is their relatively static interface, meaning that they do not intelligently interact and engage with the user as a real person would.

New Zealand has recently developed a more immersive, 3D computer therapy program called Sparx.[47] Sparx is a role-playing fantasy game that administers cognitive behavioral therapy for depression. A randomized trial of Sparx vs standard care (usually involving in-person counseling) showed that Sparx led to slightly better outcomes, with high satisfaction, and had identical adverse outcomes as usual care.[48] These results are particularly impressive as this computer-based therapy was almost entirely self-directed; meaning that these youth did not also receive help or guidance from an in-person counselor. The positive effects on mood were still robust 3 months after the last session.

Statewide Mental Health Crisis Services

In moments of crisis, it can be unrealistic to attempt to navigate the usual mental health intake process to get help, although most Community Mental Health Centers now have same-day intake appointments available. To address this, the state of Colorado has developed a crisis phone line, and a texting service, as well as eleven crisis walk-in centers across the state. These services are staffed by master's level clinicians 24/7, or trained peer support specialists (who have gone through similar mental health experiences and are now providing insight and guidance to others), and have translation options for non-English speakers. These services can be extremely helpful and confidential resources for foster youth and their caregivers during times of crisis, and caregivers should become familiar with how and when to contact them.

The Crisis Line can help those who need:

- A mental health professional or trained peer specialist to talk to on the phone, 24/7;
- A place to walk in for a rapid mental health assessment;
- Respite care up to 14 days for caregivers who need a rest;
- Help with substance abuse;
- A clinician who can do an assessment at your location.

Youth, foster parents, and caseworkers are encouraged to use this service if the foster youth is experiencing urgent mental health needs. As always, if needs are an immediate, life threatening emergency, calling 911 or going to the nearest emergency room (if the youth can be safely transported without an ambulance), is still the safest, most appropriate option.

The Crisis Line can be called at **1-844-493-TALK, or text: TALK to 38255**. More information can be found here or at this QR code:

Of note, telemedicine technology is rapidly expanding, and more patients now have access to phones and tablets with video technology. In the coming years, it would be advisable to consider how telemedicine may integrate as another connection option for the Crisis Line.

Colorado Health First Nurse Advice Line

From a physical health perspective, if an infant or child in foster care appears to be ill or injured, the caregiver has the option of calling the Colorado Health First Nurse Advice Line for assistance in determining what level of medical care is appropriate at that time (or for the situation, etc.). The Colorado Health First Nurse Advice Line is available 24/7 and is free for all Colorado Health First members.

Centralized Scheduling for Foster Youth Appointments

Approximately one-third of foster youth in Colorado do not have documented evidence of a medical appointment scheduled within 14 days after removal from the home. This can directly impact physical health, but can also reduce the chances that an ongoing mental health concern is discovered, including one that involves psychotropic medications.

Making an appointment for this health assessment can be a challenge for foster parents and case workers. They face a number of immediate demands when a youth is placed out of home, and it can be difficult to keep track of these appointment needs and also find a provider who will accept the patient.

To address this, members of the Psychotropic Medication Steering Committee met in September 2016 and proposed that DCW consider using a centralized scheduling system to help make these required appointments.

A centralized scheduling center would ideally:

- Receive a daily update of who was placed into foster care, and immediately begin reaching out to the case worker and foster parents to get an appointment scheduled within 14 days

- Maintain a list of medical practices that demonstrate competence in caring for foster youth, and who can offer an appointment within a reasonable timeframe.

- Document the appointment in a uniform way in Trails and the Health Passport, so that proof of the appointment can easily be found and recorded for reporting statistics.

This centralized scheduling system would reduce the administrative burden on case workers and foster parents, reduce paperwork errors and variance, and increase the quality of care for foster youth by offering them appointments at practices most adept at caring for them.

The Medical Oversight Team and Division of Child Welfare have recently collaborated with HCPF and Healthy Communities to explore the feasibility of having Healthy Communities provide this centralized scheduling service. One barrier so far has been timely transmission of notification of foster placement to Healthy Communities, along with correct contact information so that an appointment can be made.

Colorado Health First and the Early Periodic Screening and Diagnostic and Treatment (EPSDT) Program

All children entering foster care are eligible for enrollment in Colorado Health First. Children age 20 and under receive a package of Colorado Health First benefits known as Early and Periodic Screening, Diagnostic and Treatment services (EPSDT)[49]. This package includes prevention, diagnostic, and treatment services. EPSDT is often incompletely understood by providers and caregiver.

The goal of EPSDT is to provide preventative and well-child care and proactively detect and treat illness as early as possible in order to avoid later more difficult and costly treatment. EPSDT includes both physical and mental health services, as well as treatment for substance use. Importantly, EPSDT includes services that may not normally be covered under the state plan for adults, as long as the services are medically necessary (see the Understanding Medical Necessity section below).[50] Of note, EPSDT provides that "a state may not limit the number of medically necessary screenings a child receives and may not require prior authorization for either periodic or "interperiodic" screenings." Unit limitations, (as seen with adult benefits), are not allowed under EPSDT, such as limiting the number of eye glasses or physical therapy visits a youth may receive per year if it is determined to be medically necessary. While unit limits are not allowed under EPSDT, some services/supplies (example: some Durable Medical Equipment (DME) products) may require a prior authorization if the request exceeds the current limits. Medical necessity is not determined by the ordering physician, but may require a Prior Authorization Request (PAR) from the Department's third party vendor, Behavioral Health Organization (BHO), Community Centered Board (CCB), etc.

Who Can Provide Mental Health Services Under EPSDT

It is worth noting that <u>any</u> qualified provider can provide screening services, whether located in the youth's region or not. The provider also does <u>not</u> need to be a Colorado Health First provider in order to initiate EPSDT coverage for follow up services by a Colorado Health First provider (follow up services must be from a qualified provider). In other words, a child who has needs identified during an exam under private insurance, for example, would still be qualified to receive follow up care when they entered foster care and became enrolled in Colorado Health First.

Education for Caseworkers Navigating EPSDT

Because EPSDT is often misunderstood and incompletely utilized, CDHS and HCPF have partnered together to integrate training around EPSDT into the Child Welfare Training System (CWTS). These training sessions began on July 1, 2017 and will help child welfare teams more effectively find and utilize Colorado Health First services.

Accountable Care Collaborative and Medical Homes

Enrollment in medical homes can improve the quality of care for youth needing healthcare services. A medical home is "not a house, office, or hospital, but rather a team who will provide comprehensive primary care." In a medical home, a medical provider or clinic, including mental health and oral health providers, works with the family/client to assure that the medical and non-medical needs of the child or youth are met. Through this

partnership, the provider can help the family access and coordinate specialty care, educational services, out-of-home care, family support, and other public and private community services that are important to the overall health of the child and family."[52]

Public Law 110-351- *Fostering Connections to Success and Increasing Adoptions Act of 2008* promotes the continuity of health care services, which *may* include establishing a medical home. Colorado law similarly states that the "state department should strive to find a medical home for each child receiving services through the state medical assistance program".[53]

In part to address the need for high quality primary care, Health First Colorado formed the Accountable Care Collaborative (ACC)[54] in 2011. The ACC promotes improved health for members by delivering care in an integrated way. As of June 2016, of the slightly more than 20,000 foster care youth (including former foster care youth) enrolled in Health First Colorado, 86% were enrolled in the Accountable Care Collaborative.

Under the ACC model, a Primary Care Medical Provider (PCMP), which includes pediatricians, serves as the medical home that leads the member's health care team, connecting members to health care and tracking their progress and outcomes. Members of the ACC are assigned to a Regional Care Collaborative Organization (RCCO)[55] that helps connect foster youth to health services.

What is an RCCO?

Accountable Care Collaborative members and their PCMPs belong to a Regional Care Collaborative Organization (RCCO).[55] The RCCO has a network of both medical and non-medical service providers to help ACC members, such as foster youth, get health services. Youth enrolled in the Accountable Care Collaborative are assigned to the RCCO serving their region. There are seven RCCOs in the state, and a map of RCCO locations can be found here [56], and also by scanning the QR code.

RCCOs support youth and their child welfare teams in a number of ways by:

- Offering care coordination;
- Providing medical care management;
- Connecting member to a medical home - or PCMP; and
- Providing referrals for all members, including individuals who have medically and behaviorally complex conditions.

Did You Know?
If your foster youth has not received a notice about the ACC and RCCO, these organizations may not have the youth's correct mailing address. This is a major reason for not being contacted!

RCCOs work with PCMPs to coordinate the care of Accountable Care Collaborative members with complex health needs. Care coordinators help these members find the right health care, learn self-care, and find non-medical services like housing, childcare, food and fuel assistance.

How does the Accountable Care Collaborative work for providers?

PCMPs, primary care providers who have contracted with an RCCO to serve as a medical home, receive a per-member-per-month payment to coordinate and manage the care of ACC members in their practice. Providers continue to be reimbursed for the services they deliver through "fee-for-service"—they receive payments for each health service delivered.

RCCOs also make it easier for providers to navigate the Health First Colorado system and improve their practices,

so that they can focus on delivering care. They also track trends in health services and health outcomes, so PCMPs can be rewarded for good outcomes and not just for delivering services.

How do foster youth enroll in the Accountable Care Collaborative?

The Department assigns Health First Colorado members eligible for the Accountable Care Collaborative to the RCCO in their geographic area, based on existing patient-provider relationships. Almost all children being placed into foster care will qualify for this.

The foster youth and caregivers should receive notification in the mail 30 days prior to automatic enrollment, allowing them the time and opportunity to make an informed choice about being in the Accountable Care Collaborative. Those who do not wish to be in the Accountable Care Collaborative may opt out. Regardless of enrollment status, access to Health First Colorado services stays the same. In other words, you do not have to enroll in the ACC to receive Colorado Health First services, although opting out means no longer having access to the coordinating services that the RCCO provides.

Caregivers can also specifically opt a foster youth in to the ACC, instead of waiting for automatic enrollment that can take longer to occur. If you or your foster youth would like the youth to be part of the ACC, you can contact Health First Colorado Enrollment to select the Accountable Care Collaborative as that youth's health plan. Scan the QR code to the right in order to get started, or click here.[57]

Foster youth (and their caregivers) who are already enrolled in the Accountable Care Collaborative are encouraged to contact their RCCO[55] for assistance in finding a provider, care coordination services, and/or referrals to other community services.

Some specific examples of RCCO support of foster care youth in Colorado:

Colorado Access, the RCCO serving Regions 2, 3 and 5, has partnered with their local child welfare offices to help identify and connect foster care youth to a primary care medical home and other services as needed. Colorado Access reported that obtaining accurate addresses and guardianship information can be a barrier for them. Accurate contact information is known to be an issue statewide, and caseworkers and foster parents should bear this in mind when a new foster youth comes in to their care.

Community Care of Central Colorado, the RCCO serving Region 7, has partnered with the Colorado Department of Public Health and Environment to co-locate a care coordinator at the county health department. This care coordinator works with high-acuity children who need specialized care coordination (e.g. foster care youth). This RCCO has also created an internal care coordinator position that is devoted to working specifically with foster care youth.

In addition to providing education and forming community partnerships, RCCOs are also exploring methods for data sharing for better coordinating and integrating care for foster youth. This includes identifying foster youth and the various agencies serving them, as well as enhancing data sharing to improve coordination of care for foster care youth. One example of this is RCCO 7, which currently has an agreement in place with their county department of human/social services to share data on foster care youth.

This data sharing agreement has allowed RCCO 7 to accurately identify and stratify foster care youth and coordinate among the local agencies serving these youth. Additionally, this agreement has resulted in cross-referencing data, which allows both the RCCO and the county department of human/social services access to a more complete picture of the medical and behavioral health services utilized to ensure foster care youth are receiving appropriate services.

Colorado Access, RCCO 2, is implementing a clinic-based pharmacy program whereby pharmacists and residency

students work with primary care providers to assist with medication therapy for members with chronic conditions, including foster care youth. This same RCCO is facilitating a specialized care program to provide telemedicine and care coordination for foster care youth and families in two rural communities.
Rate of well-child checks for foster children in the Accountable Care Collaborative continues to be an area of concern. While the rate of well-child checks for foster care youth are slightly higher than for all other children in the Accountable Care Collaborative, both rates are low. To address this, RCCOs have identified priorities to help increase the rate of well-child checks, including: conducting outreach and providing education on medical homes and the importance of wellness visits; aligning providers and stakeholders to set common goals, and increasing collaboration and data sharing with the Healthy Communities program.[58]

While these efforts are broad and targeted at all children in the Accountable Care Collaborative, HCPF is hopeful that these efforts will help improve the rate of well-child checks for foster youth as well.

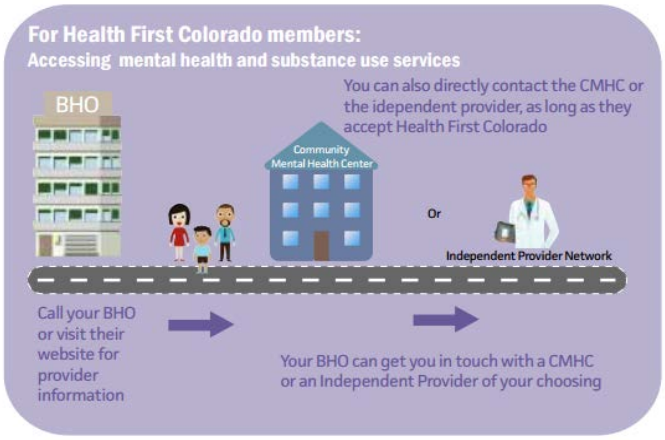
Providers interested in learning more about the initiatives in their region are encouraged to contact the RCCO in their area.

Behavioral Health Organizations (BHOs)

When foster youth are enrolled in Colorado Health First, they are automatically enrolled in a Behavioral Health Organization serving the county where they are receiving child welfare services. If the youth is placed in a foster home in a different county that is in a different BHO, the BHO's negotiate an agreement around who pays for the service. Foster youth and caregivers can get mental health treatments started in two ways:

1) By calling the BHO to inquire about services;

2) By calling a qualified mental health provider directly to inquire about services.



Behavioral health organizations are tasked with ensuring that members receive timely, needed care. This means connecting to services, and also monitoring if services were late or inadequate. Many caseworkers and foster families are not aware that a BHO can help ensure that a foster youth has timely access to care in this way.

The most robust approach to ensure that a foster youth gets behavioral health services, then, is to first call the BHO and inform them that the youth needs care. This notifies the BHO of the need, and allows it to start tracking the time it takes to receive needed services. The caregiver can then call the mental health center or independent provider of his/her choice next to inquire about setting up an intake.

By calling both the BHO and the provider, the foster youth will have better tracking and coordination of their case to ensure that their needs were met. If the BHO is never called, it will have a much more difficult time tracking whether the services were delivered on time. Once the BHO has been notified of the need for service, it is required for the initial assessment to take place within 7 days.

For more information, the Medical Oversight Team and HCPF have created a decision tree for getting mental health services for your foster youth. (See **Appendix A**)

Defining "Medical Necessity" in Colorado

Providers and caregivers are sometimes informed through their BHO or treatment provider that certain treatment services were deemed not "medically necessary" and/or "not covered", and thus would not be reimbursed.

Understanding the difference between "does not meet medical necessity" and a service or diagnosis not being "covered" by the BHO can be confusing, as can knowing what to do when services are denied for either reason.

EPSDT is clear that all medically necessary services for a youth enrolled in Colorado Health First must be reimbursed. Importantly, this even includes mental health services that either the BHO or a particular provider may not offer (see the Colorado Health First fee-for-service section below for more details). EPSDT is also quite clear that there may be no arbitrary limitation on services, such as a limitation on the number of therapy services a youth can receive in a year.

The term "medical necessity" means any health care services that evaluate, diagnose, or treat an illness, injury, disease. It should be done in accordance with generally accepted standards of medical practice, and also needs to meet the following criteria:

1. Is an equally effective treatment among other less conservative or more costly treatment options; and
2. Meets at least one of the following criteria:
    a. The service will, or is reasonably expected to prevent or diagnose the onset of an illness, condition, primary disability, or secondary disability.
    b. The service will, or is reasonably expected to cure, correct, reduce or ameliorate the physical, mental**,** cognitive or developmental effects of an illness, injury or disability.
    c. The service will, or is reasonably expected to reduce or ameliorate the pain or suffering caused by an illness, injury or disability.
    d. The service will, or is reasonably expected to assist the individual to achieve or maintain maximum functional capacity in performing Activities of Daily Living.

Medical necessity may also be a course of treatment that includes mere observation or no treatment at all.[59]

The determination of whether a particular service for a youth is medically necessary rests ultimately at the state level (i.e. HCPF), and is made on a case-by-case basis. Provider recommendations are taken into consideration, but are not the sole or final factor in determining coverage. This means that your provider may think that a service is necessary, but it might still not be covered.

Per EPSDT regulations, health providers and BHOs may not use another definition of medical necessity (other than the one shown here) to determine care for youth age 20 and under. EPSDT also allows for expanded benefits beyond what may be provided through a BHO if the need for such services is identified during a periodic screening or inter-periodic exam.

If a patient, caregiver, or provider learns that a service has been deemed not medically necessary, they can file an appeal with the BHO by phone, in person, or in writing within 30 days of the notice. If concerns continue or aren't adequately addressed by the appeals process, the patient or caregivers can contact the Ombudsman for Colorado Health First Managed Care (also see **Appendix A**). The Ombudsman is an independent entity separate from Colorado Health First, Human Services, or any of the BHOs and thus can be an objective source of help during difficult situations.

Defining "Covered Services" for Mental Health in Colorado

Under current state rules, most mental health services for youth enrolled in Colorado Health First are paid for

under the Behavioral Health Organization where the youth is placed.

The BHOs have contracts with Colorado Health First to deliver a number of mental health services termed "benefits." A benefit is a mental health service provided by the BHO for a "covered diagnosis." A covered diagnosis is simply a diagnosis that the BHO has agreed to treat in its contract with Colorado Health First.

What can be confusing is that not all medically necessary treatments are paid for as a benefit by the BHO, and not all valid mental health diagnoses are covered under the BHO as a covered diagnosis. This again can lead to confusion about the difference between mental health services Colorado Health First will pay for (which is all things medically necessary) versus mental health services a BHO will cover (only those that are benefits for covered diagnoses). The vast majority of the time, benefits and covered diagnoses are in alignment, but sometimes they are not.

Services are a benefit when they meet the following requirements:

1) The service is in accordance with generally accepted standards of medical practice;

2) The service is clinically appropriate in terms of type, frequency, extent, and duration;

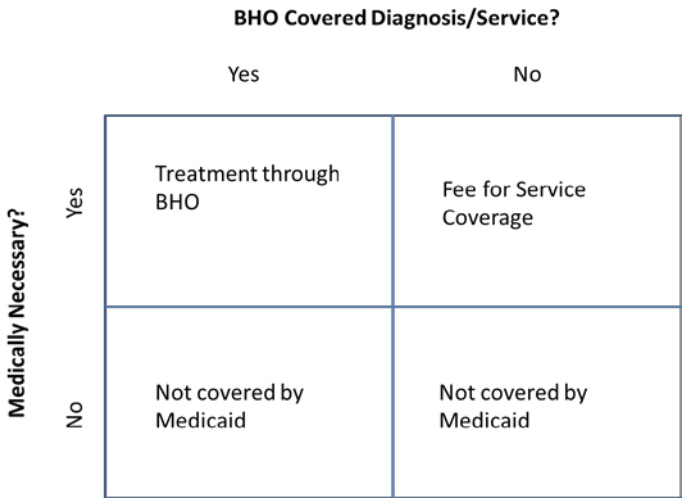
3) The service provides a safe environment or situation for the child;

4) The service is not for the convenience of the caregiver;

5) The service is medically necessary;

6) The service is not experimental or investigational and is generally accepted by the medical community for the purpose stated;

7) The service is the least costly, effective means.[59]



It should be noted again that if a service is deemed medically necessary but is not a covered service; the youth is still entitled to that care. This may fall under the fee-for-service option (below).

Colorado Health First Fee-For-Service Option

In some cases, a foster youth may have an identified health or psychiatric problem that meets medical necessity for treatment, but falls outside of the services and/or diagnoses that the behavioral health organizations cover. A common example of this is autism, which is not a covered diagnosis under BHO contracts.

A foster youth needing care for autism may be told by their provider that autism is not a "covered diagnosis" thus the BHO does not cover treatment for it. This could lead clients and caregiver teams to mistakenly believe that this means Colorado Health First itself will not cover treatment. In reality, it may instead simply mean that this diagnosis falls outside of the normal BHO treatment services, and is instead covered by Colorado Health First's fee-for-service arrangement.

The summary point is that a provider or caregiver being denied care for a particular mental health condition should carefully note whether the condition is deemed not medically necessary (thus not covered in any circumstance) versus not being a diagnosis or treatment provided by that particular BHO, in which case it would be covered by fee for service[60]. Two examples of this FFS (Fee for Service) coverage are the use of inpatient treatment and buprenorphine for the treatment of adolescent Substance Use Disorder.

Understanding medical necessity and the options for treatment under EPSDT and fee-for-service can greatly aide foster youth and their caregivers in obtaining needed mental health services, including for psychotropic medications. More information can be found here and at the QR code on the right:

Measuring Access to Mental Health Providers

Foster youth often need quick access to mental health services, and may also need rapid and consistent follow-up appointments, such as weekly psychotherapy and intensive medication management.

The PCG consulting report from 2016[12] suggested that the average wait time for receipt of any mental health services after the initial intake was 2-4 weeks, with 15% reporting that the typical wait was 5-10 weeks. Long delays in accessing care can affect a foster child in a number of ways, including making it more difficult to sort out complex polypharmacy concerns.

To measure patient access to mental health care, OBH and HCPF specifically examine the percentage of clients who receive 4 visits within 45 days for each BHO. This allows a rough estimate of clients who are receiving recurring services. The goal is to have 65% of clients achieve this benchmark, and the last measurement in June 2016 showed that 61% across the state had achieved it.

BHOs must offer access to urgent care within twenty-four (24) hours and must offer routine services, e.g. initial individual intake and assessment, within seven (7) business days. The BHO cannot place a member on a waiting list for initial routine service requests. If a member is having difficulty accessing behavioral health services, the member is encouraged to contact their BHO. Members who are not satisfied with their ability to access services are able to file a grievance with their BHO and are able to obtain help from the Ombudsman for Health First Colorado Managed Care at **303-830-3560** or **877-435-7123**; for TDD/TTY, call 888-876-8864.

Another project now being developed to measure access to care will pull information from the child welfare case management system (Trails) on referrals made by case workers requesting a behavioral health assessment. Data on the date of request from the case worker will be sent to HCPF, and compared with the date the evaluation was actually completed. Doing so will help clarify any gaps that may exist in foster youth receiving a timely first mental health assessment.

Finally, tracking all funded mental health services across the state presents a logistics challenge. HCPF and CDHS have been examining methods to have all funded psychiatric services go through one centralized Colorado Health First payment portal, in order to accurately track timely access to first appointments, follow-ups, and to reduce errors in payment for these services.

Measuring Mental Health Staff Turnover and Caseload

Treating foster youth with high needs can be a stressful job for clinicians. These youth often require communication with multiple team members, and often present with severe behavioral concerns that require strong clinical guidance. Clinicians anecdotally have reported having large caseloads, administrative paperwork, vicarious trauma from treating incidents of trauma, and overall struggling with job burnout in some regions. This could potentially lead to higher staff turnover.

Clinician staff turnover, as well as new clinicians hired without experience in child welfare-specific issues, causes inconsistency and concern regarding treatment of foster youth. This reduces the continuity of care, and can also make the youth less likely to want to continue to engage in the therapeutic process. Despite the importance of clinician staff turnover, the extent of this issue is largely unknown at the state level. It is thus difficult to pinpoint regions that may be struggling with this and in need of additional assistance.

HCPF and CDHS have been discussing ways to better understand this concern, and are exploring ways in which the state might gather statistics on clinician turnover rates. The Committee agrees that this is an important start in understanding the extent of clinician burnout.

Measuring How Many Youth on Psychotropic Medications are Engaged in Non-Pharmacological Mental Health Services

Research clearly shows that non-pharmacological interventions, such as evidence-based psychotherapies, are effective in treating many youth with psychiatric concerns[61, 62]. For cases involving trauma, psychotherapeutic treatments may be more effective than medications in youth.[63] In addition to being effective, these interventions also do not carry the risk of serious side effects that many psychotropic medications do.

It is thus generally considered best practice that non-pharmacologic interventions be considered as first line in the treatment of mental health concerns, except in cases in which the youth is acutely ill (e.g. active psychosis, severe depression, or mania), or presents an immediate danger to themselves or others and would likely benefit from immediate medication.

In many cases, youth also experience better clinical outcomes if they receive therapy services in addition to any ongoing psychotropic medication. Youth enrolled in therapy services may also be less likely to receive excessively high amounts of psychotropic medications. For example, a clinician in an underserved area may be faced with addressing highly concerning behavior in the absence of therapeutic support, and thus may opt to attempt to use increased amounts of medication to control behavior.

Despite evidence for effectiveness of non-pharmacological interventions (e.g. psychotherapy), youth in foster care who are taking psychotropic medications often do not engage in them. Nationwide, we know that only about 50% of children taking psychotropic medications received identifiable mental health services such as therapy.[64]

The Committee thus recommends that CDHS and HCPF partner to measure the percentage of foster youth who are taking a psychotropic medication, who are also engaged in therapy services. Furthermore, there may be a difference in therapy needs between a youth taking one psychotropic medication and those taking several at once, and so a separate measure of youth who are taking 3 or more psychotropic medications concurrently (defined as 60 days or greater overlap in medication), should also be considered.

The frequency of therapy services also matters[65, 66], and youth engaged in therapy too infrequently are unlikely to derive sufficient benefit from it. In light of this, the Committee recommends measurement of the percentage of medicated foster youth who are engaged in at least monthly therapy services. These statistics should ideally be shown by county and region, to further assist in understanding where the greatest need is.

Streamlined Clinician Credentialing Process:

Clinicians have anecdotally observed that the credentialing process for becoming enrolled as a Colorado Health First provider can be lengthy. This could restrict the number of available clinicians, and thus delay needed psychotropic medication management and/or therapy services.

Despite the gravity of this concern, the average time for clinicians to become credentialed to provide services for Colorado Health First clients is not measured on a state level, in a way that would allow comparison of different regions. To address this, the Committee recommends that the average processing time of credentialing applications for mental health providers be measured across the state, and examined at least yearly to identify any regions with unusual wait times.

Clinicians also have anecdotally reported being denied credentialing, despite what they felt to be good qualifications. Currently, there is no measurement of the rates of application denials. There is also no consistent appeals process for clinicians at the state level. The Committee thus recommends that OBH and HCPF explore if it is feasible to measure the rate of credentialing denials by county, and develop a statewide appeals process for clinicians, led by an independent review committee.

Contractually, there is not a prescribed timeframe in which a BHO must credential a provider. The BHOs are allowed to develop their own credentialing process. The BHOs are required to maintain a network of providers that can adequately provide the services covered in their contracts. If a provider is enrolled in CO Health First, and wants to be become part of a BHO network, the provider should contact the BHO in their area to inquire about the credentialing process**.**

Specific Measures of Care for Youth in Foster Care

The current BHO contracts measure indicators of health and services for their regions, but they do not specifically look at foster care youth as a separate population. Foster youth comprise a relatively small percentage of the total population and deficiencies in caring for foster youth might go unnoticed in reporting statistics regarding the general population. To address this, HCPF has been exploring ways to specifically measure health care outcomes for foster youth.

Child Welfare Training Surrounding EPSDT and the Child Mental Health Treatment Act

EPSDT and the Child Mental Health Treatment Act[67] provide guidance on treatment services that foster youth are entitled to, but are often poorly understood by child welfare workers and providers. To address this, HCPF and CDHS are collaborating to add an educational module to the CWTS to educate caseworkers about these laws, and what options it gives to youth in foster care or who are at risk for foster care. Educational resources for existing workers have been developed and training on these resources went live on July 1, 2017.

A short (1 minute) video clip is available from HCPF, which helps explain EPSDT and how to best make use of it.

Additionally, HCPF's Managed Care Manager and EPSDT Program Administrator and have provided training for Child Welfare and County Human Services Directors on access to Behavioral Health services and EPSDT.

Requests for training can be sent to EPSDT@state.co.us.

STANDARDS FOR PRESCRIBING PSYCHOTROPIC MEDICATIONS TO FOSTER YOUTH

Youth who are being evaluated for psychotropic medications need to have a thorough medical and psychiatric assessment. The Division of Youth Services follows the *Clinical Guidelines in Family Practice, 5th Edition* (by Uphold/Graham)[68] for medical practice guidelines. For psychotropic medication prescribing, they follow the *Parameters for the Use of Psychotropic Medication in Children and Adolescents* (i.e. "Parameters"), which is an adaptation of the *Los Angeles Department of Mental Health DMH Parameters 3.8 For Use of Psychotropic Medication for Children and Adolescents*, published September 18, 2013, and found here as well as at the QR code to the right:

As stated in the above psychotropic Parameters, "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 to this Guide should be initiated only after careful clinical consideration of the basis for the current medication regimen."

Clinicians serving youth in county custody should also consider referencing these two sets of guidelines as examples of best practices.

Standards of a Comprehensive Psychiatric Exam in Youth Receiving Psychotropic Medications

Psychotropic medication management must be undertaken within a broader assessment for a foster youth's mental health needs. CDHS and HCPF agree with the practice parameters set forth by the American Academy of Child and Adolescent Psychiatry (AACAP). Many of these pertain to psychotropic prescribing best practices, and discuss it in the context of a comprehensive biopsychosocial approach to the foster youth. These parameters can be found here or at the QR code on the right:

Of particular interest with regard to AACAP publications and foster care is the *Guide for Child Serving Agencies on Psychotropic Medications for Children and Adolescents* found here:

The Guide referenced above states that "psychotropic medications are only one component of a comprehensive biopsychosocial treatment plan that must include other components in addition to medication." A biopsychosocial[69] approach to assessing a youth provides a useful framework for examining all major domains contributing to a youth's mental health. A good psychiatric assessment should thus explore each of these, discussed separately below:

Bio:

This refers to the biological aspect of a youth's mental health and functioning. This typically means aspects of dysfunction arising from a chemical imbalance and/or brain structure abnormality that then presents itself as a psychiatric or behavioral disturbance.

For example, many cases of major depression arise in part due to changes in brain chemicals (e.g. serotonin, norepinephrine, dopamine, BDNF), and also from altered structure of the brain neurons themselves (e.g. reduced

synaptic connections). These changes can alter the youth's behavior in unhelpful ways, leading them to feel tired, apathetic, sad, and unable to focus. Similarly, a child with a psychotic disorder may have changes in brain dopamine levels that cause them to experience sensations that are not real, such as hearing voices or seeing ghosts.

Biological changes contributing to mental illness are typically the most appropriate target for psychotropic medications. These medications can in many cases ameliorate the symptoms arising from the changes, and in some cases, may even prevent or reverse unwanted changes in physical brain structure.[70]

When examining the "bio" component of a youth's functioning, is important to consider family history, any health concerns or illnesses that could cause symptoms, any trauma to the brain, and genetic abnormalities.

Psycho:

This refers to the psychological component of a child's dysfunction. This means the thoughts and feelings that a youth has, and how they understand themselves and their relationship to their world. Examples of unhelpful psychological patterns contributing to dysfunction can include cognitive distortions, such as black and white thinking, jumping to conclusions, and catastrophizing. Unhelpful behavioral patterns arising from psychological concerns can include behaviors such as attempting to harm one's self when distressed.

Unhelpful psychological patterns are often not as directly amenable to psychotropic medications, as medications do not alter higher-order cognitive processes directly. That said, if an illness becomes too severe, it can make distorted thinking much more likely to occur, and much harder to fix through talk therapy. Thus, a thorough understanding of the degree and nature of the psychological dysfunction can be very helpful.

Talk therapy is a mainstay treatment for most psychological concerns. For instance, cognitive behavioral therapy can be used to tackle cognitive distortions, while dialectical behavioral therapy can teach people heathy coping skills to use when reacting to triggers.

Social:

This refers to the environment around the youth that affects their mental health functioning. This includes family circumstances, such as abuse or neglect, as well as relationships to others in the community, such as health care providers and human service workers.

Trauma is a major component for most foster youth, and can greatly impact their mental health. It can also affect their response to medication and talk therapies. As such, a thorough trauma history is essential when treating any foster youth with psychotropic medications.

Family and school involvement in the therapeutic process, when possible, is also a vital part of good care for foster youth. Family and school personnel are the individuals that foster youth spend the vast majority of their time with, and understanding interaction with them is a critical piece to understanding the whole child, and how they are likely to function in their usual environment. Having strong caregiver involvement also can help the youth to understand and remember aspects of their treatment (since caregivers can help summarize and remind them later), and can be critically important in ensuring compliance with treatment.

The Role of Physical Health Exams and Psychotropic Medications

Psychotropic medications have many well-known side effects that must be monitored before and during treatment with certain medications. Certain physical health problems (e.g. seizures, migraines, anemia) can also produce symptoms that mimic common mental health concerns. Given this, youth who are being evaluated for psychotropic medications also need a comprehensive physical health examination.

For those employed by or contracted with CDHS, the Clinical Guidelines in Family Practice, currently in its 5th edition, serves as our model for good physical health care of foster youth. Clinicians in the community who serve foster youth are also welcome to reference these standards.

AACAP Practice Parameters also outline physical health assessment standards as they pertain to psychiatric assessment and/or psychotropic medications. These parameters can be found here.

These Guidelines additionally contain treatment algorithms that provide general guidelines for approaching common mental health concerns (see **Appendix E**).

Documentation Basics for Psychotropic Medications

Youth in foster care placed on psychotropic medications often experience multiple breaks in continuity of care. They may change placement (e.g. from foster care to DYS), or may move to a different county. Practices serving these youth are often quite busy, and so lengthy conversations about the youth's health between providers can be hard to come by. Given this, it is essential that treatment notes and/or discharge summaries provide clear rationale for psychotropic medications. In general, clinical notes should always provide:

- **Why the medication is being taken** (i.e. the diagnosis and any key symptoms specifically being targeted).
- **What the response has been so far** (improvements as noted by rating scales and clinical impression), and any side effects (see the adverse effect rating scales in **Appendix F**).
- **What the future plans for the medication are.** Is it being slowly increased or decreased? Is there a certain symptom or key indicator to suggest changing it? Is there a plan in place for signs to discontinue the medication in the future?

Documenting these three areas in each clinical note helps ensure a strong rationale for prescribing the medication, and also provides good handoff documentation if another provider takes over the case.

The Division of Youth Services prescribing practice is currently being assessed to this standard. The Committee suggests that other child-serving agencies consider adopting similar standards in their clinical notes.

Treatment Algorithms for Providers

Psychiatric conditions can be difficult to treat, especially in a busy primary care setting. Treatment algorithms are a well-known method to assist with medical decision making, and can improve clinical outcomes[71]. In 2016, the Office of Behavioral Health collaborated with the Medical Oversight Team to create a set of easy-to-use treatment algorithms, free of charge, for primary care providers across the state. Material from Dr. Hilt and Seattle Children's hospital[72] has been adapted for use in Colorado. See **Appendix E** for the complete Colorado treatment algorithms.

Multimedia engagement is also important for engagement with clinicians and patients. OBH and CDHS are collaborating to produce a series of videos, hosted on the internet, to help explain prescribing Guidelines and highlight some of the important changes occurring. QR codes found in the algorithms and other materials can also be used to direct the user to these additional resources.

NFORMED CONSENT FOR PSYCHOTROPIC MEDICATIONS

Case workers, Guardian ad Litems (GALs), Court-Appointed Special Advocates (CASAs), foster parents, and biological parents can all be involved in aspects of a foster youth's psychiatric care. Understanding who may give consent for treatment can thus be confusing to the provider, as well as to the youth and their caregivers. This confusion can cause treatment delays and/or failure to obtain appropriate consent.

AACAP practice guidelines[73] specify that Child Welfare systems should "identify the parties empowered to consent for treatment of youth in state custody in a timely fashion." The original Psychotropic Medication Guidelines for Children and Adolescents in Colorado's Child Welfare System, published in 2013, identified the consent process as a major concern for clinicians serving foster youth in Colorado. Adding to complexity in Colorado is that counties can have varied requirements for consent. For example, some require the county director to approve treatment changes, while others place this authority with the case worker. This can present a challenge to clinicians and facilities who serve clients from multiple counties.

The length of time required to obtain consent for foster youth has also been a major complaint from clinicians in prior years. Delays of several days to weeks in getting consent were anecdotally reported, although delays in consent were never systematically measured statewide, limiting our knowledge of the extent of the problem. Currently, there is no requirement in state law or in regulations for consent to be obtained within a specific amount of time. The Psychotropic Steering Committee in 2013 urged that consent should be obtained within a specific amount of time (24 hours for urgent cases, 48 hours for non-urgent cases).

Since the 2013 Guidelines, the Medical Oversight Unit, members of the Steering Committee and Division of Child Welfare have revisited these concerns. Several new initiatives are now underway to make the consent process less confusing, and ensure that it is not unnecessarily delayed. In this edition of the Guidelines, we first present what Colorado law and regulations say about consent:

COLORADO LAW AND REGULATION GOVERNING THE PROCESS PSYCHOTROPIC MEDICATION CONSENT

Colorado state law lays out the ages at which youth may consent to his/her own treatment, and these ages vary depending upon the type of treatment being sought. The Colorado Association for School-Based Health Care has published a detailed guide[74] on this subject that can also be accessed via the QR code to the right.

Ages of consent related to psychiatric treatment are also summarized below:

Age 15 and Mental Health Consent

Generally speaking, Colorado law allows youth age 15 and over to consent to mental health treatment without parental involvement.[75] Importantly, individuals of any age may consent to substance use treatment without parental or guardian involvement[74].

Historically, confusion has arisen over whether placement into foster care affects a youth's ability to consent to

(or refuse) treatment, including with psychotropic medications. In short, it does not, unless the youth is committed to a facility for psychiatric reasons (i.e. a 27-65 hold). Thus, a youth in foster care who is age 15 or older may consent (or decline) mental health, and Psychotropic medication treatment, on their own unless on a mental health hold, or unless ordered to treatment by the courts.

Youth of any age may consent or decline substance use treatment. This again means that the child welfare team is not required to provide additional consent for treatment though seeking parental involvement and assent is still preferred, when appropriate.

Consent for Age 14 and Under

For youth under age 14, written consent by a parent or legal guardian is generally required for mental health treatment, and for administration of psychotropic medication. As a general rule, the Division of Child Welfare seeks parental consent whenever possible, unless parental rights are terminated. Foster parents may not provide consent for foster youth. Again, this does not apply to youth seeking treatment for substance use.

Assent from a Minor

For youth under the age of consent (e.g. 14 or under for mental health treatment), assent to treatment should be sought from the youth whenever possible. Assent simply means that the youth agrees to the treatment in an informed way, although they cannot legally give consent to it.

The reasons for seeking youth assent are numerous. If a youth does not understand or disagrees with a treatment, they are far less likely to comply with it. Leaving a youth out of the assent process may also make them less likely to participate in ongoing treatment by reporting side effects or treatment benefits. Forcing a youth to take a medication against their will is also likely to increase hostility towards the treatment process, and may make the youth less likely to continue treatment once they are old enough to refuse consent.

Is Verbal Consent OK?

Foster youth typically live in chaotic circumstances, and getting signed, written permission for treatment can be difficult to obtain. This can delay necessary treatment. A question often arises about when verbal consent to treatment is appropriate. Generally speaking, child welfare regulations require written consent.[76] As such, verbal consent is not likely to suffice when seeking permission for medical or mental health treatment, including medications. Exceptions may be made (e.g. may not need consent at all from parents) for emergency treatment when the treatment is needed to prevent immediate harm.

Several states are exploring more efficient ways to obtain written consent, including online forms. Online forms would allow immediate access to the forms and ability to sign them, rather than having to wait for the parents to print/scan a form, or mail it back. One barrier is that families may not have easy web access or may be generally unreachable, and so this technologic innovation would not address some of these causes of delay. Nevertheless, the Committee recommends that the Division of Child Welfare explore ways in which consent forms might be placed online in the future, as this would speed up the process in many instances.

Can Patients/Guardians Refuse to Stop a Medication?

Clinicians in the past have expressed concern about parents or guardians who refuse to "consent" to a clinician tapering or stopping a medication for a youth. After all, if patients may refuse consent to having a medication started, can they likewise refuse consent to having it stopped. We are aware of no laws or rules mandating that clinicians must continue a treatment for a patient, even over the objection of other parties, as long as the clinician does not believe it is in the best interest of the patient. The clinician should, however, make reasonable arrangement for the patient to see another provider for a second opinion, if desired. This does not mean that the

clinician must ensure that the patient has a second opinion appointment made, only that they have provided reasonable information that would allow them to pursue this. An example would be assisting the patient/caregiver in contacting their BHO to find other available clinicians.

Consent in Facilities

The age at which a youth may consent (or refuse) medication when at a state-associated facility (e.g. residential center or DYS facility) can sometimes cause confusion. Some clinicians have wondered, for example, if any youth in a facility loses their right to consent, or if the age of consent changes. The age of consent for treatment, as provided by law, does not change regardless of where a child is placed. For instance, the requirement to be at least 15 years old for mental health treatment is the same whether a youth is in a residential facility, DYS facility, or out in the community. Please note that this is different from the change in consent ability when a youth is committed to a facility (e.g. 27-65) for mental health reasons, and/or is ordered to treatment by a court.

Verbal Consent and DYS

The Division of Youth Services is often faced with highly complex, fast moving mental health concerns, and parents are often extremely difficult to contact. By policy, DYS allows for verbal consent from parents, provided that two witnesses observe the parent or guardian giving the verbal consent. This has expedited treatment in a number of cases in which there was a time-sensitive need for treatment.

Child Welfare Regulations Governing Consent

Child welfare rules[76] specify how consent is to be obtained for youth in the Colorado child welfare system. Rule 7.702.52 states: "any routine medication, prescription or non-prescription (over-the-counter) must be administered only with a current written order of a health care provider with prescriptive authority and with written parental consent."

In other words, if parental rights are intact, their written (not verbal) consent is sought for treatment with psychotropic medications. If rights have been terminated, the guardian (as designated by the County Department) provides consent. In cases where parents withhold treatment deemed necessary by the state, the court must be petitioned to provide temporary custody of the child, or to order that the treatment requested be given.

Although this process is spelled out in Colorado regulations (Volume 7), prescribers and child welfare workers may not always fully understand the process. To address this, the Committee recommends that the caseworker be designated as the main point of contact for these questions, and that caseworkers be trained to specifically let the prescriber know that they are the primary resource for consent questions for that youth. This can help clear up confusion that the prescriber may have about who to ask first (e.g. asking the foster parent if that is who brought the youth).

These Guidelines also now provide an easy-to-use consent decision tree (see **Appendix B**), and also spell out the process for obtaining help regarding the consent process when this decision tree is insufficient.

Of note, caseworkers are instructed to adhere to child welfare regulations (found primarily in Volume VII). They also have an established protocol for obtaining consent and ensuring family involvement, as appropriate. This protocol is not currently available on the web, but is available through the electronic medical record (Trails). A copy of the protocol can now also be found in these Guidelines, in **Appendix C.**

What Constitutes a Reasonable Effort to Obtain Consent?

It is often difficult to reach parents of youth involved in foster care, residential placement, or the corrections system. Obtaining consent in a timely manner can thus be a major challenge. This raises the question of what

constitutes a reasonable attempt by the medical provider to obtain consent from the guardian, prior to seeking alternate means of consent. For example, how many times should a provider attempt to contact parents before trying something else? How long should they wait to hear back from the parents?

To address this concern, the Division of Youth Services and Medical Oversight Team explored the question of "reasonable effort" in more detail. It appears that Colorado law and regulations do not provide specific parameters as to what constitutes a reasonable attempt (such as specific timelines or number of tries a clinician must make), but instead give latitude to providers and facilities to determine what they believe constitutes a reasonable effort on a case-by-case basis.

In deciding on reasonable effort, providers should consider the severity of the juvenile's medical needs, the available parental contact information, and any other factors relevant to inform their professional medical judgment. In all instances where a medical provider makes a reasonable effort to obtain parental consent, the medical provider must clearly document his or her efforts.

The Committee recommends that facilities concerned about their clinicians' efforts to obtain consent demonstrate what they generally believe to be reasonable efforts to obtain consent. They should, for instance, consider developing internal policies, and perhaps educational case studies, that guide their medical providers on generally accepted parameters of reasonable efforts. Any policies should provide flexibility for providers to exercise their best professional judgment, and should also outline the requirements for documenting the efforts taken to obtain consent.

Youth Who Turn of Age but Lack Capacity to Give Informed Consent

An interesting question arises when a youth turns of sufficient age to give consent (e.g. 15 years old for mental health treatment), but who may not be able to give informed consent for other reasons. For example, a youth who is actively psychotic or who has very low IQ may not be able to consent to treatment with medication, even though they are otherwise old enough to do so.

In these situations, it is important that concerned caseworkers, foster parents, and health care staff know what to do next, and how to seek an opinion on whether the youth needs a guardian appointed to make these decisions for them. The Medical Oversight Team is currently working to develop a proposed process for caseworkers and clinicians questioning the capacity of a youth to make medical and mental health decisions.

Defining Routine, Urgent, and Emergency Mental Health Needs

Counties in Colorado have expressed concern over knowing if a youth's care needs are routine, urgent, or emergent. Knowing the level of care needed impacts how consent for treatment is obtained. To assist with this, the Medical Oversight Team at Office of Children, Youth, and Families offers the following general guidance around these various definitions. Please be aware, however, that these are merely guidelines and the decision on how urgent a need is ultimately rests with the caregivers and clinicians, as circumstances can vary and have additional complexities that cannot be covered in a document such as this.

Concerns about routine versus urgent psychiatric care are typically best triaged by discussing with a qualified healthcare provider. Examples include licensed clinical social workers, psychologists, nurse practitioners, and physicians, including psychiatrists. For life-threatening emergencies, if a provider is immediately available, they should be notified and included in the treatment process if possible. However, transfer to emergency care should not wait for provider feedback in situations in which a prudent layperson is concerned about immediate safety.

Defining Routine Needs

This is the regular services that you would receive from your therapist, or physician; or any other care besides

urgent and emergency care.

Examples of routine mental health needs include:

- Refills for medications already discussed with your provider as non-urgent to refill, such as some ADHD or sleep medications;

- Side effects previously discussed as not dangerous but still potentially bothersome, such as mild stomach upset, headaches, tiredness, etc.;

- Slowly worsening mental health symptoms that are concerning, but not immediately dangerous or causing impairment in daily functioning

Obtaining care for routine concerns generally means contacting your regular provider. They should discuss concerns you may have in terms of how quickly the youth should present for a follow-up appointment to address the need, and also briefly assess if the need might be more urgent. Routine requests should generally be completed within 3 business days of the request.

Defining Urgent Needs

Urgent mental health needs have been defined by the Colorado Department of Human Services (CDHS) as "a condition that appears to, if not addressed within twenty four (24) hours, be likely to escalate to an emergency situation." This can also mean a need that must be addressed within 24 hours to prevent harm or loss of function, but that is not immediately life threatening or not actively causing irreversible harm to the patient.

Urgent needs can also be defined as an impairment that is preventing normal activities of daily living, such as a mental health condition severe enough that it prevents attendance at school, or prevents the youth from eating or otherwise caring for themselves normally. Such needs may potentially require hospitalization for stabilization.

Examples of urgent mental health needs include:

- running out of certain psychiatric medications as discussed with your provider.

- rapidly worsening depression symptoms that prevent functioning but are not immediately life threatening

- worsening psychosis that is now constantly distracting the patient (but not commanding them to harm self or others)

- aggressive behavior that is causing active problems, but is not overtly dangerous or life threatening

To obtain urgent care, caregivers can attempt to contact their regular provider to inquire about an urgent appointment, which should be completed within 24 hours. They can also contact the Colorado Crisis Line at 1-844-493-TALK or present to one of the 11 crisis walk in centers. More information can be found here:

Defining Emergency Needs

Emergency psychiatric needs have been defined by CDHS as "a condition that appears to require unscheduled, immediate or special mental health intervention in response to a crisis situation involving the risk of imminent harm to the person or others." Emergency care can be sought either on the advice of health care professionals, or from a prudent layperson (with no specialty training), who suspects that the behavior might be life-threatening or actively causing harm to the patient.

Examples of emergency mental health needs include:

- Active thoughts or behaviors of self-harm, or of harming others
- Worsening command hallucinations, especially if the hallucinations are suggesting dangerous things
- Serious side effects such as: trouble breathing, swelling of the face, tongue or hands, chest pains, loss of consciousness, rapidly worsening rash, intractable muscle spasms, or seizures
- If the youth appears suddenly confused about who they are, what day it is, or where they are

To obtain emergency psychiatric care, caregivers should take the youth to the nearest emergency room for an immediate evaluation, or call 911 if they are unable to transport the youth for safety reasons. Emergency evaluations should be completed within 6 hours of request.

Ways to Assess Level of Care Need in a Foster Youth

In situations where the youth and/or others are at risk for immediate harm, a prudent layperson or clinician should call for immediate help. These kinds of situations should generally not wait for a more in-depth on-site assessment, in order to prevent harm.

In situations in which there does not appear to be immediate risk for harm, but where the urgency of need is not entirely clear, qualified clinicians can assess the youth to determine the needed level of care. This can be accomplished through a clinical interview with the youth, and with talking to caregivers for collateral information. Generally speaking, the clinician should meet with the youth either in person or via a telemedicine link (if available). Phone conversations are less desirable in terms of ruling out potential mental health concerns, although if a phone call is the only means available a clinician should use their best judgment on triaging level of urgency.

Standardized rating scales are another potential method to assess level of care, although few have been extensively tested. The Crisis Triage Rating Scale[77] is a scale developed 30 years ago, and re-tested[78] in several other triaging environments. Note that most testing was conducted in adults, although some adolescent-based clinics[79] have also used it.

The Crisis Triage Rating Scale can be found here and in the QR code on the right. Clinicians and administrative staff should decide before a crisis whether incorporating a triaging scale such as this might be helpful for them.

SOLUTIONS FOR DELAYS AROUND CONSENT

General consent/assent to treat should be in place before the first appointment

One source of frustration among clinicians is when a foster youth presents for a psychiatric evaluation, and the clinician discovers that the parents have not been notified and/or are not in agreement with such an evaluation. Alternatively, the parents might have verbally agreed, but a consent form may not have been signed prior to the appointment.

These situations leave the provider in the predicament of wishing to evaluate the child, but being uncertain if they are allowed to do so. In 2013, the Committee recommended that child welfare teams develop a consistent process to engage with parents around mental health appointments and evaluations. A process for doing so has now been outlined for caseworkers, and can be found in the Trails medical record system, and can also be found in **Appendix C**. It states that "when a child or youth involved with the child welfare system is referred for psychotropic medications, the following process should be followed:

1. Before referring a child/youth to a provider for psychotropic medications, the child welfare worker should determine whether the individual(s) who has the legal right to consent for treatment would support the initiation of psychotropic medications. The child welfare worker should also identify individuals who may have the relevant information about the child's/youth's medical and psychiatric history.

2. The child welfare worker should ensure that the child/youth is sent to the medical appointment with the Consent Form for Psychotropic Medications. When possible the child welfare worker should also:

    a. Provide information about the child's/youth's medical and psychiatric history or the contact information for the individual(s) who may have relevant information about the child's/youth's medical and psychiatric history.

    b. Have the individual who has the legal right to consent for treatment accompany the child/youth to the medical appointment."

By following these guidelines, caseworkers can help ensure a smooth appointment and greater chances of parental understanding and cooperation.

Having a Knowledgeable Caregiver Come to Appointments

Knowledgeable caregivers sometimes do not accompany a minor patient to their psychiatric appointment. This is concerning, since children might:

- not be fully aware of their own medical and psychiatric history

- not understand the reason for the appointment

- quickly forget what was discussed in the appointment

- exaggerate or downplay symptoms with the medication prescriber

A knowledgeable caregiver should, whenever possible, accompany the youth for appointments. The caregiver should be available to provide collateral information, ask questions about the treatment, and potentially follow up with the youth after the visit to remind them about what was discussed and prescribed. Ideally, this person would also be the one capable of giving consent for treatment, if needed.

Of note, case workers have expressed concern that they often know little about the youth recently placed into their custody, and are concerned about trying to fill the role of the "knowledgeable" caregiver. It may be helpful to keep in mind that incomplete information is to be expected in some foster cases, but that even in chaotic, uncertain cases the case worker will still often know at least a few facts about the case that can be very helpful (e.g. when and why the youth was removed, and if there are major upcoming changes that would affect treatment decisions). The case worker can also help ensure that medications are filled, that follow up appointments are made, and that basic information about the session is accurately transmitted.

The Division of Child Welfare has already offered guidance that knowledgeable caregivers accompany minors to their appointments. It is additionally exploring ways to measure adherence to this guidance, so that areas for improvement can be identified.

Consistent Consent Forms

Prescribers have voiced frustration at having a youth sign their clinic's consent forms, only to later discover that the county child welfare agency required its own unique consent form. This duplication of requirements can

lead to delays in treatment, and frustrate the provider and patient who must sign another (perhaps seemingly redundant) form.

The Committee recommends that counties discuss consent forms with mental health providers in their area in order to streamline the process, such as by adopting a common consent form (see below, and also **Appendix G** for an example of a freely available consent form approved by the Committee). Doing so would save considerable administrative time in subsequent appointments, and reduce provider frustration.

If a child welfare agency still requires a unique form for medication consent, this should be clearly communicated to the prescriber during the appointment, and that form should accompany the youth to the appointment. It may be necessary for the caseworker to point out to the prescriber that their agency requires a separate form, and that this is in addition to the one the prescriber has used.

Standardized Consent Form for Colorado

The 2013 Guidelines proposed that a single, common consent form be used across counties and providers for foster youth. This would ensure that providers do not have to use multiple different forms, and also that all legally required information is captured. The consent form developed by the Committee is available (**Appendix G**) for use, free of charge, and can also be used as a reference for counties and providers wishing to compare with their own forms.

If Counties and providers use their own consent forms, they should keep in mind that adequate consent requires:

- Information regarding risks and benefits of the medication
- Details of the route and frequency of the medication dose, and duration of the medication treatment
- Rationale for adding any medication(s)
- Information about when/why to discontinue the psychotropic medication

Required Turnaround Time for Consent

The Psychotropic Medication Steering Committee recognized that delays obtaining consent were leading to treatment delays. It was recommended by the Committee in the 2013 Guidelines that a prescriber's request for medication consent should be completed within 24 hours for urgent requests and 48 hours for routine requests. Failure to obtain consent in a timely manner increases the potential for psychiatric hospitalization, unnecessary additional care costs, and disrupted placements.

The process of obtaining consent varies by county, and so meeting these timelines is likely to pose a major challenge. Counties with fewer staff, for instance, may find this particularly difficult.

The Medical Oversight Team and members of the Committee have recently collaborated with the Division of Child Welfare to discuss reasonable expectations for timelines around obtaining consent. It was generally felt that 3 calendar days balanced a need for timely treatment with realistic capabilities of the counties. The Medical Oversight Team is sending guidance out to counties advising of this expectation, and will be collaborating with DCW and clinician stakeholders to monitor whether this expectation is sufficient for good care, and whether it is being met.

Clinicians have also noted that when requests for consent go unanswered for lengthy periods of time, it is often not clear who to contact for help when this occurs. The Committee recommends that each county

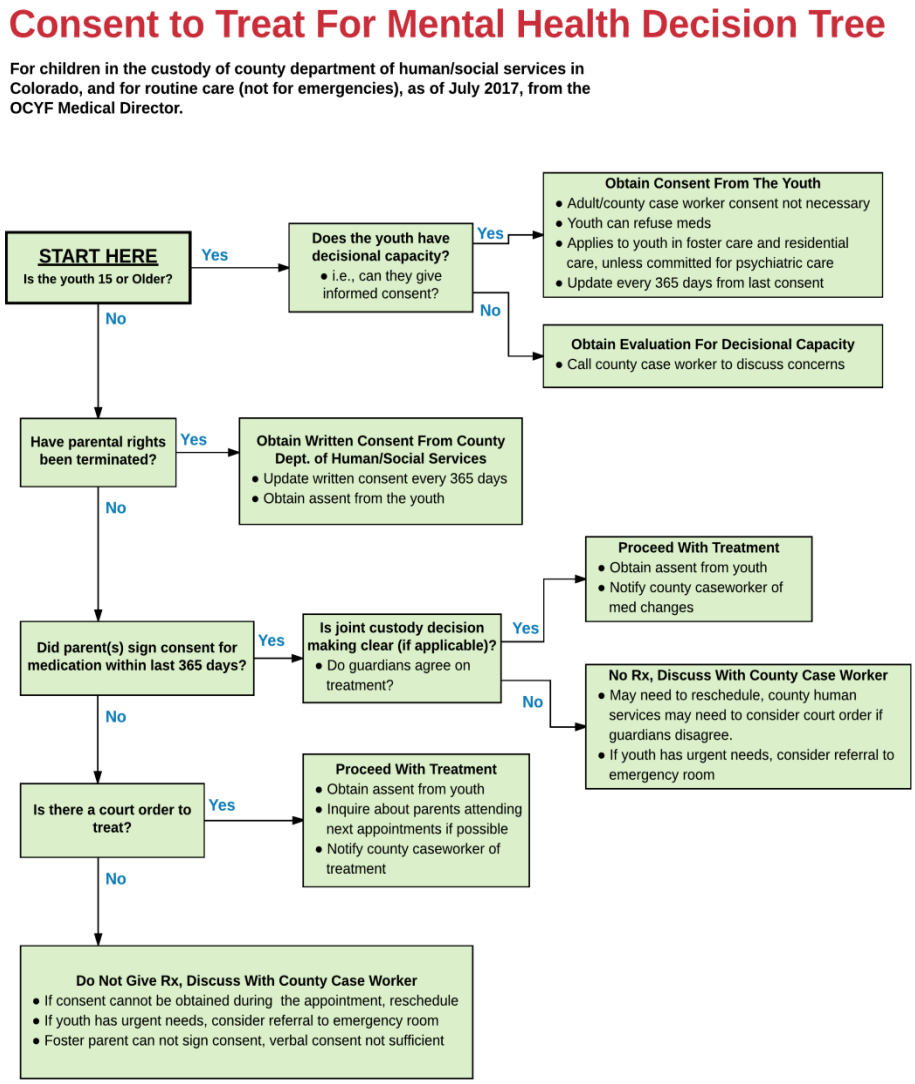
develop a clear, written procedure for whom to contact if consent is not obtained in a timely manner.

SOLUTIONS FOR CONFUSION AROUND CONSENT

Beyond having a parent or guardian simply present to sign consent for treatment, it is equally important that the person or agency providing consent be truly informed about what they are consenting to. Psychotropic medications are a challenging and sometimes controversial subject, and so it comes as no surprise that those providing consent for a foster youth might have questions. The need for truly informed consent is recognized as a concern nationally. Colorado is meeting this challenge in a couple of ways:

Consent Decision Tree

The consent process for foster youth is complicated, and could be a barrier to treatment for foster youth. To assist with making the consent process easier for caregivers and treatment providers to understand, the OCYF Medical Oversight Team and Child Welfare leadership have produced an easy-to-use decision tree to guide the consent process. A full-sized version of this consent tree can be found in **Appendix B.**



Online, Updated Q&A for Tough Consent Questions

More complicated consent issues may arise that cannot be answered by the consent decision tree. Indeed, providers have already asked the Medical Oversight Team several consent questions that were difficult to immediately answer. To address this, DCW and the Medical Oversight Team are developing an online, searchable Q&A database of difficult questions around consent that have been reviewed, and may be of use to others in the future.

In some cases, counties may have consent (or other administrative) questions that are too complex and specific to be addressed by the decision tree, or by referencing the online Q&A. To address this, the Division of Child Welfare now offers free consultation services to counties for difficult administrative issues relating to medical or psychiatric care of foster youth. This includes questions around state guidelines regarding healthcare best-practices and policies, including consent issues.

Of note, this service is not intended to deliver care or provide specific medical advice for a patient (e.g. not for recommending specific medication changes). Other consultative services beyond those mentioned are available to the counties. A full list of services available can be found here:[80]

Child Psychiatrist Telephone Consultation for Consenters

Child welfare teams may have questions about whether the treatment, including medication regimen, that a child is taking is safe and appropriate, and whether they should provide consent for that treatment. A first method to address concerns such as this is for child welfare teams to seek help with their RCCO or BHO in obtaining a second opinion from another prescriber. Note that a second opinion may generally be sought without first consulting the BHO for prior approval.

In cases where obtaining a second clinical opinion is not a realistic option, such as in a remote rural area, it would be extremely helpful for counties to be able to contact a psychiatric specialist to discuss their concerns. The American Academy of Child and Adolescent Psychiatry recommends that states should provide a "consultation by child and adolescent psychiatrists to the persons or agency that is responsible for consenting for treatment with psychotropic medications.[81]" A few states, such as Oregon and Massachusetts, have already developed this kind of program (referenced in [4]). These kinds of programs have typically been implemented in states that have a consent process based at the state level, rather than at the county level as found in Colorado.[82] In Colorado, counties would need to contract with these consultation services individually, rather than relying on a single state-level contract.

The Medical Oversight Team is currently developing technical assistance for counties when they adopt child psychiatry consultation programs for case workers. Specifically, the Medical Oversight Team is helping identifying some potential service providers with high quality child psychiatrists on staff, and is also developing forms and process suggestions to aid counties in working with these consultative services. These child psychiatrist consultative services are most likely to be delivered on fee-per-use basis, in which counties pay for the consultative services that they need. Discussion around specific potential consultation service options is expected to begin by early 2017.

Treatment Algorithms and Psychoeducational Materials For Youth and Caregivers

Medical practitioners often benefit from using treatment algorithms when treating mental illnesses. County child welfare agencies that must provide consent for treatment may similarly benefit from having easy access to algorithms that are specifically designed with them in mind. Such algorithms could provide the team with generally accepted guidelines for treatment with psychotropic medications, and thus empower the team to ask more informed questions about the current treatment. CDHS anticipates a series of algorithms adapted from those made for prescribers, and intended for caseworkers and foster parents, to be available in late 2017. These

Guidelines also offer guidance on what constitutes a generally acceptable psychiatric evaluation, including for prescribing of psychotropic medications. Caregivers are encouraged to peruse this guidance as a part of making informed decisions around consent for treatment and any medications.

Adverse Effect Rating Forms

Psychotropic medications can cause a number of potential side effects, and it can be difficult to cover all of these with a provider during a short clinic visit. Often, the youth may not even be aware that the symptoms they are experiencing are related to the medication. To aid youth and caregivers in exploring potential adverse effects, AACAP calls for the implementation of adverse effect rating scales[73] that are available to caregivers on the web.

The Ontario Child and Parent Resource Institute (CPRI) has developed a series of adverse/side effect rating forms, and has kindly granted CDHS permission to reprint them here (see **Appendix F**). They can also be accessed here:

These rating forms can be extremely useful in helping youth and caregivers know what side effects to watch for, and how to report them in a clear manner.

The CPRI has also been developing a smartphone-based app to administer these rating scales, which would allow them to be tracked over time, and more easily reported back to clinicians. CPRI is also considering using this app to gather data on the frequency of side effects that youth experience with different medications. The Medical Oversight Team is collaborating with CPRI to beta-test their adverse effects app and ensure that it is user-friendly. The app is expected to be freely available in 2017.

Training Caseworkers, Foster Parents, and Court Personnel About Psychotropic Medications, and How To Ask Questions About Treatment:

Caseworkers, foster parents, and court staff are critically important in caring for foster youth, and are often asked to comment or even make decisions regarding their mental health care. The American Academy of Child and Adolescent Psychiatry suggests that states establish "training requirements for child welfare workers, court personnel, and/or foster parents to promote more effective advocacy for youth in their custody regarding behavioral health care, psychiatric medications, and monitoring."[83]

Non-medical caregivers can sometimes have difficulty communicating their opinions regarding treatment to prescribers and feeling appropriately listened to. Prescribers, on the other hand, can sometimes feel as if non-medical staff are "telling them how to do their job" when they express their concerns. To address this, the Division of Child Welfare and Medical Oversight Team are collaborating to design training modules intended for non-medical staff on how to discuss these concerns with their prescriber.

One method to improve communication around psychotropic medications is to clearly and concretely report symptoms and behaviors exhibited by the youth, rather than attempting to use vague or diagnostic wording in the discussion. Consider the following two examples regarding the same hypothetical patient:

> #1: "Doctor, his bipolar disorder is really out of control. He probably needs to go up on his risperidone. The last doctor thought it was ADHD and gave him something else and he became very aggressive."
>
> #2: "Doctor, he has been sleeping only about 4 hours per night for the last week rather than his usual 9 hours, and has been talking much faster than normal. He is also talking about big ideas he has to save the world, which is very different than his usual conversation about video games. Over the past 3 days he has been punching his siblings when they don't do what he says. This same type of behavior happened last year, and he stopped sleeping when his doctor prescribed a different medication that was supposed to be for ADHD."

The first example uses vague, leading, diagnostic terms that do not convey a clear picture of what is actually happening with this boy and seem to jump to the treatment conclusions. For instance, what does "bipolar disorder" really mean here in terms of behavior and symptoms? Using this kind of wording does not give the prescriber a clear idea of what symptoms to target, and makes it harder to assess whether the diagnosis is even accurate. It can also easily convey to the prescriber the impression that the layperson has already made up their mind about what the diagnosis is, and that the caregiver wishes to ensure that the prescriber conforms with their thoughts on the diagnosis (even if that was not really the intent).

This kind of interaction can quickly lead to defensiveness on both sides as the caregiver is fully aware of a serious situation but feels unable to express this and get the help they are seeking, while the prescriber feels that the caregiver is attempting to prescribe the diagnosis and treatment course.

The second description, on the other hand, is very clear and concrete, and gives a sense for what the youth is doing, how long it has been happening, and what the practical consequences are. It also conveys a clear description of what the last medication treatment did to the youth. Use of this kind of concrete symptom and behavior reporting is far more likely to aid in achieving a helpful outcome with the prescriber, and is also far less likely to inspire a defensive reaction.

Improving effective communication with prescribers, such as in the example shown above, is a topic being integrated in case worker training. Use of mock interactions with prescribers in addition to didactic teaching is being considered as a way to illustrate this complex topic. The Division of Child Welfare anticipates some of these elements to be incorporated into training starting in the fall of 2017.

NFORMATION SHARING AROUND PSYCHOTROPIC PRESCRIBING

A consulting report[12] conducted by PCG and HCPF in 2016 interviewed several dozen child welfare staff, and found that 55% disagreed with the statement "information is generally shared effectively between mental/behavioral health providers in your community(ies)." Youth and families have also expressed significant concerns around information sharing, expressing frustration with having to answer duplicate questions, and wondering where and how their responses will be shared.[84]

Communication between providers and different systems in the state is an ongoing concern that was noted by the Committee in the 2013 version of these Guidelines. Since then, new initiatives are developing to improve information sharing around the care of foster youth.

Health Information Exchanges

Youth in foster care often receive health care in a variety of different settings over. Clinicians caring for these youth often have difficulty locating prior medical records. The Colorado Regional Health Information Organization (CORHIO) and the Quality Health Network (QHN) are public-private partnerships that have been tasked with facilitating health information exchange (HIE) between different medical records systems in Colorado. They collaborate with all health care stakeholders including physicians, hospitals, clinics, behavioral health, public health, long-term care, laboratories, imaging centers, health plans and patients to ensure that records can be transferred. To date, more than 4000 physicians in Colorado are able to use this system to access patient medical records contained in other EHR systems.

Data Sharing With HCPF

Tracking the psychotropic medication actually taken by children and youth while they are in foster care can be difficult. Currently, it is not a mandatory field in the State's Statewide Automated Child Welfare Information System (SACWIS, aka Trails), and therefore, the information is often missing or inaccurate.

To address this, CDHS and HCPF collaborated on a method to automatically import data from the HCPF claims database into Trails, in order to give caseworkers and other caregivers more accurate information regarding what medications a foster youth is actually taking. This project was completed in June 2016, and data is loaded from HCPF on a monthly basis into a Trails report for all children and adolescents in the Child Welfare and DYS systems. The data not only lists all of the Psychotropic Medication prescriptions per youth, but lists other behavioral treatment services and types of placement. The next phase of the project will take place likely in 2017 to determine whether the county caseworkers find this useful to their case management and whether there is a subsequent reduction in polypharmacy.

Trails

The state of Colorado's Statewide Automated Child Welfare Information System (SACWIS), more commonly known as Trails, is an electronic record system used by caseworkers, Division of Youth Services Staff, and various administrative human services personnel, to document a wide range of activities pertaining to foster youth. Examples include intake paperwork, Colorado Health First eligibility, court documents, financial management, and administrative matters. It also handles many payment services to health care providers. It also links with the court data system called the Family Justice Information System (FAMJIS).

Trails was not originally designed to be an electronic medical record, however, it has often served as the *de facto* medical record system for youth in foster care. While it is advantageous from an information-sharing standpoint to have one system used by all of the counties, Trails generally lags behind in its ability to document medical and psychiatric information compared to most other current electronic medical records. This can result in frustration and time lost as caseworkers and some clinicians use it for this purpose.

Trails can also be difficult for outside providers to access if they need copies of records, and similarly, it can be cumbersome to incorporate outside medical records into the Trails system.

Because Trails serves functions far beyond medical record keeping, transition to a new medical record system presents enormous logistics challenges as each county would need to adopt a new system, train their staff to it, and the new EMR would need to seamlessly integrate with the existing Trails database. This hurdle has, so far, made transition to a new system less immediately appealing, although it continues to be discussed.

In the meantime, CDHS has secured funding for a three-year Trails modernization project, begun in 2015. While not solely focused on the medical records keeping aspect of Trails, the modernization project main requirements are:

- mobile device compatibility and support to provide secure systems that meet industry standards;
- data integration to help promote the effective use and availability of data across multiple systems that influence child welfare, including the ability to add unstructured or external data; and
- profile-driven capabilities for data administration and ease of use by providing user-appropriate interfaces (agency-specific and/or job function related).[85]

Colorado Client Information Sharing System' or CCISS

In July 2012, CDHS's Office of Children, Youth and Families applied for grant funding from the federal Administration of Children and Families to examine interoperability between record systems and information sharing within the agency, and look for ways to improve. The resulting ACF Interoperability Planning Grant has since allowed CDHS to create the Colorado Client Information Sharing System (CCISS) to address interoperability concerns.

The overarching goal is to allow for efficient data sharing about a client in the human services system, such as a foster youth. Any direct services worker (e.g. case workers, school counselors, mental health therapists and prescribers) should therefore have access to all needed client information in order to provide effective services, and this grant aims to make that a reality. The eventual goal is an 'interoperable human service record' for any client (e.g. foster youth) receiving services through the Department of Human Services within state.

CCISS is also working with COHRIO (see section above to make communication with their database more efficient (e.g. helping the health passport talk to COHRIO). This will allow providers outside of human services to access needed records within the system, and vice-versa.[86]

Office of Behavioral Health Data Integration Initiative

The Office of Behavioral Health (OBH) has two older data systems: Colorado Client Assessment Record and Drug/Alcohol Coordinated Data System, (CCAR, DACODS), that make it difficult to track clients, including foster youth, who are receiving behavioral health care services, and ensure that they are receiving the appropriate care. To address this, since 2013 OBH has been designing a modern, web-based data collection system called the Colorado Integrated Behavioral Health Services Data Collection System (IBHS), which will consolidate the State's mental health and substance use disorder data, and will also include physical health data. The IBHS will span the entire behavioral health system and better integrate with health care professionals, and other government agencies (e.g., CDHS, HCPF, CDPHE, CO Health Information Exchange, and the All Payer Claims Database).[87]

Colorado Health First, RCCOs and Better Data Sharing

Several Colorado Health First Regional Care Collaborative Organizations (RCCOs) have been concerned about deficiencies in information sharing, and are exploring ways to data share for improved care coordination of foster youth and the various agencies serving them. For example, RCCO 7 currently has an agreement in place with their county department of human/social services to share data on foster care youth. It has allowed RCCO 7 to accurately identify and stratify foster care youth and coordinate among the local agencies serving these youths. Additionally, this agreement has resulted in cross-referencing data, which allows both the RCCO and the county department of human/social services access to a more complete picture of the medical and behavioral health services utilized to ensure foster care youth are receiving appropriate services.

Transitioning Youth

Youth who are transitioning from foster care to adulthood are still finding it especially difficult to obtain or transfer their mental health records to new providers, as well as transfer important items such as prescriptions. One challenge had been widespread confusion and disagreement on consent forms, in order to authorize transfer of information. To address this, the Colorado Children and Youth Information Sharing (CCYIS) Initiative developed a common consent form for use across agencies. Caregivers and providers assisting transitioning youth should be aware of this form, which is freely available here:

Transitioning youth are also entitled to receive a copy of their Health Passport, in order to have a centralized record and summary of their treatment. In reality, case workers have complained that the Health Passport is difficult to use, and thus often does not get filled out. In some cases, case workers will even resort to attaching paper copies of relevant youth information when transferring records to a new PCP, rather than attempting to fill out the very cumbersome online forms. Foster youth also do not currently have the ability to electronically access their own Health Passport records directly in the Trails system (if any information is even entered in it), and so case workers often resort to printing copies of it to hand to the youth.

To address these concerns, CDHS is currently engaged in a Trails Modernization Project (see section above) to make the Health Passport much easier to use, and more accessible to the transitioning youth.

Youth Discharging from Youth Services

Youth exiting DYS may have difficulty connecting with treatment in the community. Records from treatment in DYS facilities are not always available to outside providers, and appointments with outside providers are sometimes not set up in a timely manner. Underlying much of this is a gap in communication between providers within DYS, and the community.

Behavioral Health Organizations are tasked with providing a specific "discharge liaison" who helps coordinate community care before the youth is discharged. Anecdotally, many facilities have reported that they have

not interacted with a person in this role. The Committee thus recommends that HCPF, DYS and OBH review the availability of these personnel, and ensure that they are being utilized efficiently.

Discharge documents, such as a discharge summary, medication list, and list of future appointments, is also often not available in a timely manner. To address this, DYS is collaborating with the Medical Oversight Team to develop a common discharge document that will contain all needed information for a youth exiting the system. The aim is to produce a smart document that tracks all required elements, and notifies the responsible individuals if an element is missing. A system devised in this manner can also collect statistics on areas of discharge that may need more systematic attention.

The common discharge document is most likely to succeed if implemented in the new electronic medical record for DYS, as the current Trails system is likely to have difficulty implementing this. This effort is thus expected to gain new traction with the adoption of the new DYS medical record (see below), expected to occur in early 2018.

New Electronic Medical Record for the Division of Youth Services

The current medical record for DYS, Trails, was not originally built to serve as an Electronic Medical Record (EMR). Because of this, the software for this program is often inefficient and hard for clinicians to use when documenting care. This reduces the time that clinicians have available for direct treatment of youth, and also reduces job satisfaction. In 2016, DYS secured an agreement with Fusion to begin using their electronic medical record, Centricity.[88]

This new medical record will be far more efficient than the current system. Not only will it reduce documentation time, but it will also make it far easier to communicate clinical information within DYS, and with outside providers. It will also allow for more efficient data analysis to look for trends in prescribing, medication side effects, and behavioral outcomes as a result of treatment. The new EMR is expected to go live by early 2018.

OVERSIGHT OF PSYCHOTROPIC PRESCRIBING

Concern about excessive prescribing of psychotropic medications to youth in foster care has been ongoing for over a decade. The use of psychotropic medications in foster youth grew considerably during this time, although notably appears to have leveled off in recent years[7].

A core problem in conducting oversight of psychotropic prescribing trends is determining the "right" amount of medication. This is a complex assessment process just for an individual child. Determining the "right" amount of psychotropic medication for an entire group of people (e.g. all foster youth), is vastly more complicated.

The likely best approach to this complex problem will be in 1) ensuring on a case-by-case basis that psychotropic prescribing for a youth has a clear, evidence-based rationale and 2) better understanding the approach to "deprescribing" for youth taking multiple psychotropic medications.

Most randomized, controlled studies of psychotropic medications have examined the effects of starting a medication vs not starting one (i.e. instead taking a placebo). Much less effort has been devoted to studying the cessation of an existing medication, i.e. deprescribing. This is changing, however, and interest in the topic of deprescribing has grown[89]. Indeed, assigning a description to an evidence-based process of stopping medications (deprescibing) within the past couple of years is symbolic of the attention now being paid to it. Nationally, discussions about thoughtful deprescribing are increasing, and the American Academy of Child and Adolescent Psychiatry is likely to being producing formal guidance on this subject in the coming years.

When discussing the oversight of psychotropic prescribing, it is worth noting that the vast majority of providers who care for foster youth truly seek their best interest, and want to help as best they can. Thus, most cases of highly unusual psychotropic prescribing represent a response to a difficult situation, rather than provider mal-intent. Solutions to polypharmacy will do well, then, to remember this and focus on providing helpful assistance for difficult cases, rather than being adversarial and punitive in nature, which would be more appropriate of mal-intent was the core issue.

Prescribers for foster youth often encounter situations in which the youth's mental health affects their wellbeing, in addition to their ability to live at home or with a foster family. Medications may be desired, but there is often little evidence-base to prescribe from[90-92] particularly in cases of polypharmacy.[93] Prescribers are then additionally often ill-equipped to provide or find other evidence-based services such as psychotherapy, or worse yet, those services may not exist in their area. Thus, the prescriber may be left with the unpleasant task of deciding whether to prescribe unusual amounts or combinations of medications in hope that it will help, versus the potential for the youth to continue to act in a harmful manner.

Oversight of psychotropic prescribing for foster youth is thus a delicate balance between minimizing truly unsafe prescribing patterns, versus the realization that foster youth are often in highly complex situations in which the risks and benefits of such medications may not be as straight-forward as it seems.

The state of Colorado is currently involved in multiple efforts to provide oversight for psychotropic prescribing to foster youth. The overall intent it to provide supportive assistance to providers, while ensuring that appropriate practices are followed.

Drug Utilization Review (DUR)

Research literature indicates that drug utilization review (DUR) has a modest but measurable impact on psychotropic prescribing patterns[94-96]. This oversight tool has now been adopted in most states[97] specifically to monitor psychotropic polypharmacy in youth.

Colorado Health First already has a well-established DUR process for medications across all specialties. It blends cost concerns (e.g. using generic vs brand) with concerns about safety and efficacy. For instance, Colorado Health First will seek to question and potentially limit drugs being used outside of their established indications, and/or at higher doses than generally deemed appropriate. Attempts to use an antipsychotic medication for sleep (not an accepted indication), or psychotropic medications prescribed at an unusually high dose may thus be denied through this process, or may request further supporting documentation for their continuance.

The Criteria for psychotropic polypharmacy, and DUR review, are found in The Preferred Drug List[98] for Colorado Health First, which can be found here:

HCPF and the DUR board have been collaborating with CDHS and the Medical Oversight team to devise evidence-based criteria for "red flagging" cases of psychotropic polypharmacy in youth. Among the new criteria being considered is youth who are taking 3 or more psychotropic medications (with > 60 day overlap of each), or 2 or more psychotropic medications from the same class. HCPF will be employing a new electronic monitoring system that can reliably track these situations. This has not been possible under the current billing system, and has thus limited the ability of DUR to review these cases until now. This new system was operational in February 2017.

In the meantime, the DUR has only put a "hard stop" on payment for polypharmacy cases for prescriptions to children under 5 years of age. The rest of the concerning prescription patterns are reviewed retrospectively (i.e. after they have been prescribed). The DUR team is examining ways to intelligently roll out hard-stops on other red flags, but in a manner that does not unnecessarily inhibit foster youth from getting the medications that they need.

Refinement of DUR Physician Review Hotline

In recent years, HCPF has sought to refine what constitutes unusual or unsafe psychotropic medication prescribing. "Red flagging" these unusual instances would trigger a clinical review process to ensure that the rationale for use is well-supported, and that alternatives have been considered.

One specific method to accomplish this has been through establishing a physician review hotline attached to the DUR process. If a case of unusual psychotropic prescribing is red-flagged, the DUR team now refers the case to the physician call-line for a clinical review. The review committee is comprised of a board certified child psychiatrist(s), who call the prescriber to discuss the case and review the rationale for prescribing. This kind of program has already been successfully adopted in other states, and resulted in clear reduction in polypharmacy.

Prior to 2016, the DUR and physician call-line were not able to share specific health information about cases being referred, due to HIPPA concerns. In early 2016, a business agreement was reached that allowed the DUR to share specific clinical information about a case with the child psychiatrist doing the clinical review. This has enabled a much richer review experience, and feedback from providers has been mostly

positive. In many cases, the consultation with the child psychiatrist has led to true benefit for the case, and has provided real consultative aid to the prescriber.

HCPF and the DUR team also recognize that requiring a prescriber to discuss the case with the physician, and then also requiring them to speak with the pharmacist about a prior authorization of those same medications, would be burdensome. Therefore, if treatment of a patient is red flagged for polypharmacy reasons, and the case is referred to physician call line, that review process will now, in most cases, also take care of any prior authorization request.

Lastly, a review line is likely to be received best when criteria for being reviewed are known, and stable. To address this, the DUR Committee, HCPF, and Medical Oversight Team are collaborating to set specific criteria to trigger a review process, such as if a youth is on a certain number of psychotropic medications, or taking above a certain dose of medication.

Retrospective DUR Letters

For the past couple of years, Colorado Health First has been mailing out letters to providers to inform them of potentially unusual cases of prescribing in their practice. The purpose of these letters is educational, and not punitive. It is hoped that these notifications can alert physicians to cases that may need reconsideration.

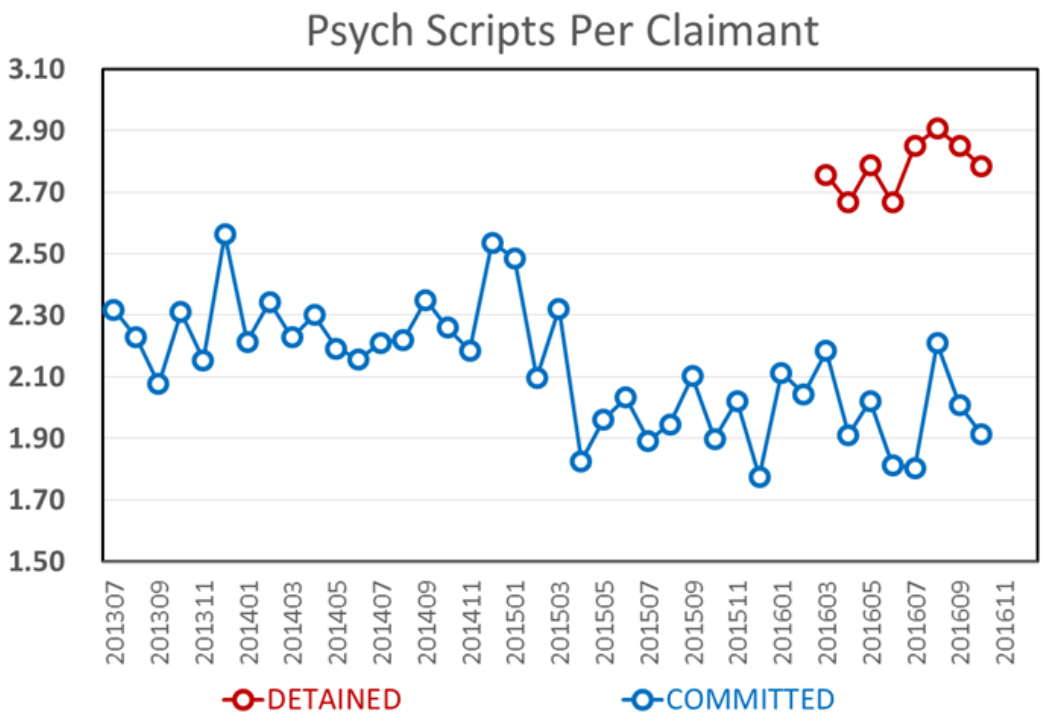
The impact of these letters on psychotropic polypharmacy in Colorado remains to be fully examined. Research literature regarding the effectiveness of review letters in general suggests that they can be effective in changing physician prescribing patterns,[99] although most studies have not focused on foster youth and/or psychotropic polypharmacy.

One complicating factor in accurately assessing the impact of review letters is ruling out potential study confounders, as simply observing the effect of a letter implemented statewide is unlikely to yield clear results. To address this, the DUR team is currently collaborating with the Medical Oversight Team to devise ways to rule out confounding factors and measure which specific elements of review letters are most effective.

Oversight of Polypharmacy in the Division of Youth Services

In 2014, an audit conducted by Health Management Associates[100] identified a greater need for oversight of psychotropic prescribing to youth in the custody of the Division of Youth Services. To address this, the Medical Oversight Team began collaborating with the DYS contractor(s) providing medical care beginning in 2015 to review psychotropic prescribing patterns. Specifically, statistical data about all prescriptions is analyzed and reported monthly to the Division of Youth Services leadership and Medical Oversight Team, and trends in prescribing (e.g. any changes in psychotropic polypharmacy) are discussed in detail, so that any needed administrative changes can be made.

Notably, the number of psychotropic meds per committed youth (see **"Psych Scripts Per Claimant"** (figure below) appears to have decreased since the HMA audit and formation of the Medical Oversight Team (approximately starting 201503 in the chart, or March 2015). Also, detained youth in DYS who are taking any psychotropic medications appear to be taking more of them (about 2.8 on average), concurrently, than those committed to DYS (about 2 on average). This is consistent with the hypothesis that youth in DYS for longer stays (i.e. committed youth) have a net reduction of polypharmacy, although this will need to be analyzed further before firm conclusions can be made.



The Medical Oversight Team reviews individual cases of psychotropic polypharmacy for youth detained or committed to DYS. Polypharmacy is defined currently as taking 3 or more concurrent psychotropic medications, or two or more from the same class. Clinical notes from these cases are reviewed to ensure appropriate rationale exists for such polypharmacy, and clinical teams are contacted when this is uncertain.

New DYS-wide protocols are also being developed to guide medication prescribing in DYS and further reduce unnecessary polypharmacy. To date, protocols for insomnia and ADHD are now being implemented as of October 2016. ADHD and insomnia were the first mental health areas chosen for new policy development as they have a notably high potential for both polypharmacy and diversion of medications (e.g. stimulants and sleep medications). These new protocols draw on best practice guidelines from national organizations in order to make sure that youth are accurately diagnosed, treated in a manner that carefully assesses the need for psychotropic medication, monitored for response in an ongoing way, and that the role of non-pharmacological interventions is thoroughly considered.

Improved Error Reporting for the Division of Youth Services

The Department of Human Services has sought to standardize medical error reporting across DYS facilities. Doing so will allow for more accurate identification of systematic areas for improvement in the various facilities. To help accomplish this, the Medical Oversight Team and Division of Youth Services have updated the error reporting process for all DYS facilities to a national best-practice standard, known as Medication Error Reporting and Prevention program (MERP).[101] Under this system, medication errors are logged within the DYS system to help with feedback and process improvement, but are also logged anonymously in a national database, which allows for nationwide data gathering around medication errors. The MERP process began at DYS in November 2016.

Measuring Unintended Consequences of Oversight

Oversight methods such as DUR and physician phone hotlines are often effective in reducing polypharmacy. However, this reduction in prescribing may have unintended consequences on health and provider availability. Research literature in adults has examined the impact of new psychotropic prescribing oversight policies on various

health metrics and found mixed results. In many cases, strong restrictions on psychotropic medications led to increased emergency room and hospital utilization[78, 102, 103], suggesting that unintended harm was caused by some of these strong policies. Other indirect methods of restricting access to medications, such as changes in co-pays, have similarly resulted in adverse health outcomes in some cases[104].

The impact on the health of foster youth after new restrictions on psychotropic polypharmacy is still poorly understood, despite the fact that the majority of states have implemented new oversight methods in the past decade. The Committee therefore recommends that CDHS and HCPF collaborate to examine whether new oversight methods in the state associate with changes in emergency room visits, psychiatric hospitalizations, and foster home placements, for example.

National Collaboration for Psychotropic Polypharmacy

Over the past few years, national organizations such as the American Academy of Child and Adolescent Psychiatry have become very interested in finding ways to reduce unnecessary polypharmacy. For instance, the AACAP Adoption and Foster Care Committee has been considering working on potential ways to develop guidelines around "deprescribing" psychotropic medication. In this case, "deprescribing" simply means reducing or stopping medications that might no longer be needed, or may be more harmful than good. The overall intent is to develop a sensible, evidence-based approach to reducing medications when needed.

The Medical Oversight Team has attended some of these meetings and offered input and support about developing any guidelines around deprescribing, and agrees that this is much needed conversation for foster care. The Medical Oversight Team continues to be involved in online and in-person conversations with these national thought leaders as these topics develop.

CONCLUSION

Foster youth deserve high quality care at least on par with children not in the foster system. Psychotropic medications play a positive role in the wellbeing of many of these youth, and can help alleviate mental health suffering and dysfunction. That said, psychotropic medications are powerful drugs, and must be given judiciously, and with caution.

Providing cutting edge psychotropic prescribing for our foster youth requires the collaboration among the foster youth, their caregivers, health providers, the courts, schools, and state agencies. The Committee remains deeply appreciative of all of those who devote their time and energy towards achieving this goal. We hope that these Guidelines are informative for you regarding best practices for prescribing these medications, and that it also provides you with tools and updates to assist you in doing so.

The Committee itself continues to evolve and will continue to provide updated Guidelines as laws and rules change, and as new initiatives are developed (or completed) to help make psychiatric care and administration of psychotropic medications to youth in foster care ever safer and more effective. Based on the progress so far, we eagerly look forward to seeing what the future holds.

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Additional Materials

NATIONAL PUBLICATIONS:

AACAP Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline

https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/FosterCare_BestPrinciples_FINAL.pdf

A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents (AACAP)

http://www.aacap.org/App_Themes/AACAP/docs/press/guide_for_community_child_serving_agencies_on_psychotropic_medications_for_children_and_adolescents_2012.pdf

2015 Practice Parameter for the Assessment and Management of Youth Involved With the Child Welfare System (AACAP)

http://www.jaacap.com/article/S0890-8567(15)00148-3/pdf

Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents (AACAP)

http://www.jaacap.com/article/S0890-8567(09)60156-8/pdf

Promoting the Safe, Appropriate, and Effective Use of Psychotropic Medication for Children in Foster Care (ACF publication)

https://www.acf.hhs.gov/sites/default/files/cb/im1203.pdf

Promoting Social and Emotional Well-Being for Children and Youth Receiving

Child Welfare Services (ACF)

http://www.acf.hhs.gov/sites/default/files/cb/im1204.pdf

Primary Care Principles for Child Mental Health, written by Dr. Hilt, and a template for our own treatment algorithms in these Guidelines:

http://www.seattlechildrens.org/pdf/PAL/WA/WA-care-guide.pdf

Minnesota database of treatment algorithms for all major mental health disorders.
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_158267

STATE GUIDELINES:

Psychotropic Medication Use in the Foster Care Population in Arizona

http://www.azdhs.gov/bhs/documents/children/psychotropic-medication-use-foster-care-az.pdf

2014 Connecticut Guidelines

http://www.ct.gov/dcf/lib/dcf/ccmu/pdf/guidelines_for_psychotropic_medication_use_in_children_and_adolescents_draft_4_24_14.pdf

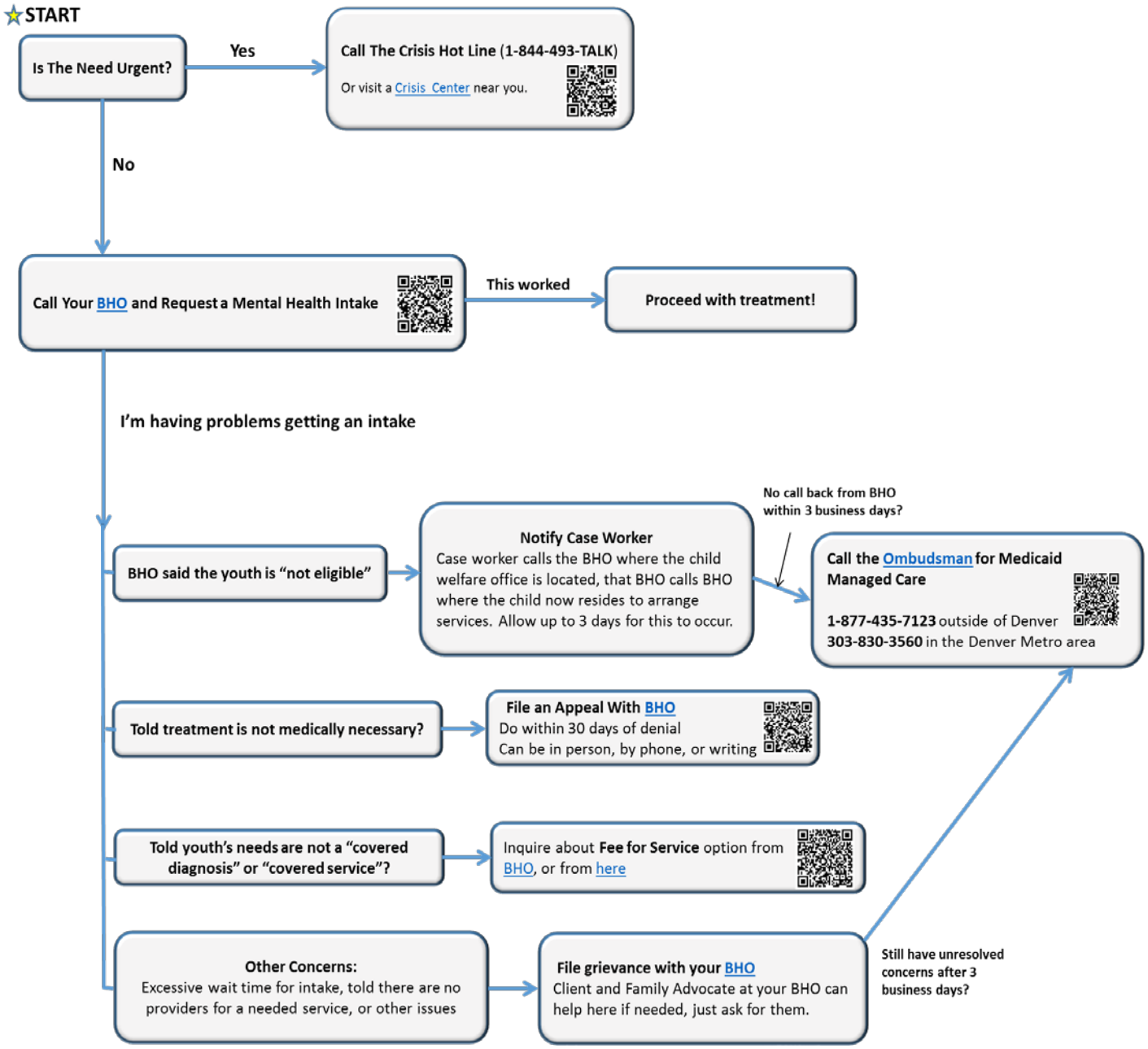
California Guidelines
http://youthlaw.org/wp-content/uploads/2015/05/Guidelines.pdf

Indiana 2016 Guidelines
http://www.in.gov/dcs/files/INPsychotropicMedicationGuide4YouthnCareDCSUpdate.pdf

New Jersey 2011 Psychotropic Medication Policy
http://www.state.nj.us/dcf/documents/behavioral/providers/PsychotropicMeds.pdf

2016 Texas Psychotropic Medication Guidelines
https://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-psychotropic.asp

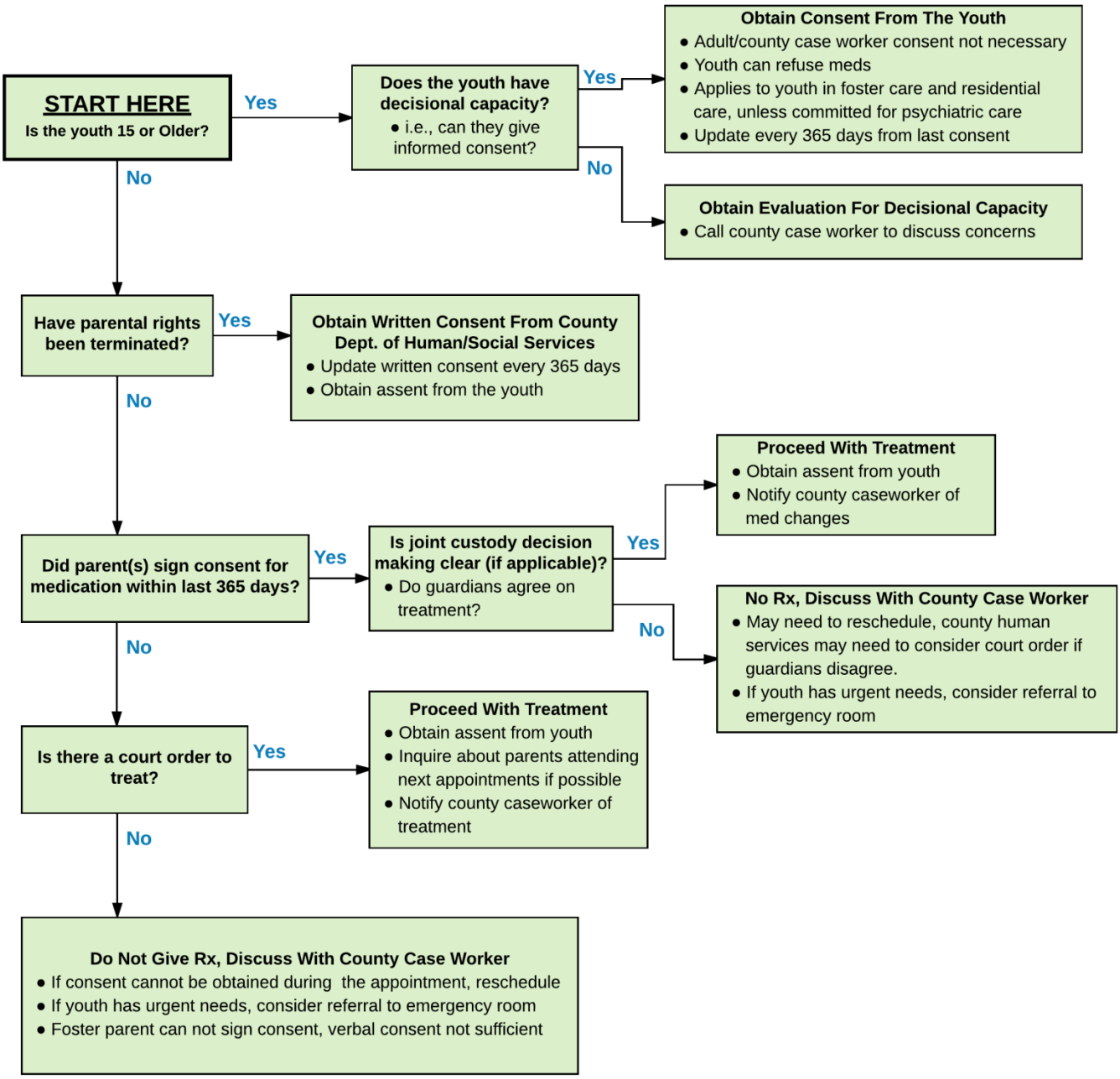
APPENDIX A
Decision Tree for Obtaining Mental Health Services for Foster Youth



APPENDIX B

Consent to Treat For Mental Health Decision Tree

For children in the custody of county department of human/social services in Colorado, and for routine care (not for emergencies), as of July 2017, from the OCYF Medical Director.



APPENDIX C
Child Welfare Process for Gathering Consent For Psychotropic Medications

When a child involved with the child welfare system is referred for psychotropic medications, the following process should be followed:

1. In compliance with Code of Colorado Regulations 12 CCR 2509-8, 7.702.52, and 7.710.45, before referring a child/youth to a provider, the child welfare caseworker shall make reasonable efforts to engage the parent or caregiver in determining the appropriateness of assessing for psychotropic medication need and solicit consent for the assessment and potential initiation of psychotropic medication.
2. When the parental rights to the child have been terminated and there is no identified remaining parent or caregiver, the child welfare caseworker shall determine who may consent to medical care, including the potential initiation of psychotropic medication.
3. The child welfare caseworker shall also identify individuals that may have relevant information about the child/youth's medical and psychiatric history.
4. The contact information for the parent or caregiver, and any other individual that may have relevant information, shall be provided to the psychotropic medication prescriber.
5. The child welfare caseworker shall ensure that the child/youth is sent to the medical appointment with the "Consent Form for Psychotropic Medication."
6. The child welfare caseworker and psychotropic medication prescriber shall facilitate the attendance or participation of the parent or caregiver, or other individual providing consent to medical.

APPENDIX D

Colorado Health First Drug Utilization Review Standards for Colorado:

Within Colorado Health First, the following situations are under review for being subject to Drug Utilization Review and/or review by clinician oversight intervention. Some of these measures already trigger a DUR process:

1. Clients taking three or more psychotropic medications within 60 days of each other (to screen out cross tapers).

2. Clients taking two or more medications in the same psychotropic class at the same time or within 60 days of each other (to screen out cross tapers).

3. Clients under age five who are prescribed antipsychotic agents.

4. Clients taking antipsychotic agents with no diagnosis of psychosis, bipolar disorder, schizophrenia, or autism.

5. Clients that are prescribed psychotropic agents at doses that exceed their published recommended daily maximum dose.

Note: this does not include red flags for more traditional DUR review processes, such as those generated when brand is used instead of generic, or when a non-preferred drug is tried before preferred. Also, these requirements and oversight refer only to medications prescribed for children which are payable under Colorado Health First. Prescription coverage policies through other plans may or may not have such policies in place.

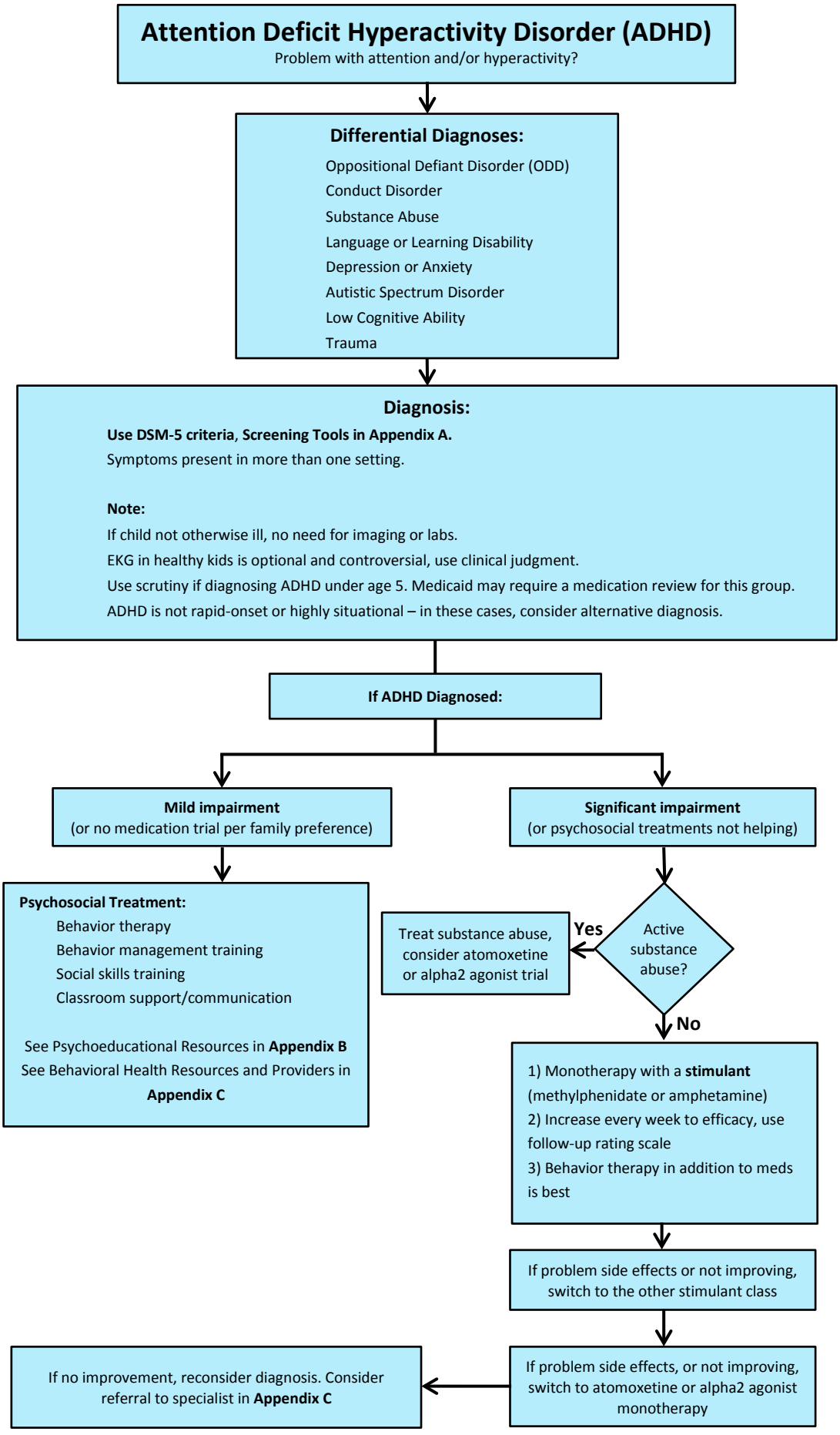
For additional information on Colorado Health First drug coverage policies, please see the Colorado Health First Preferred Drug List here.

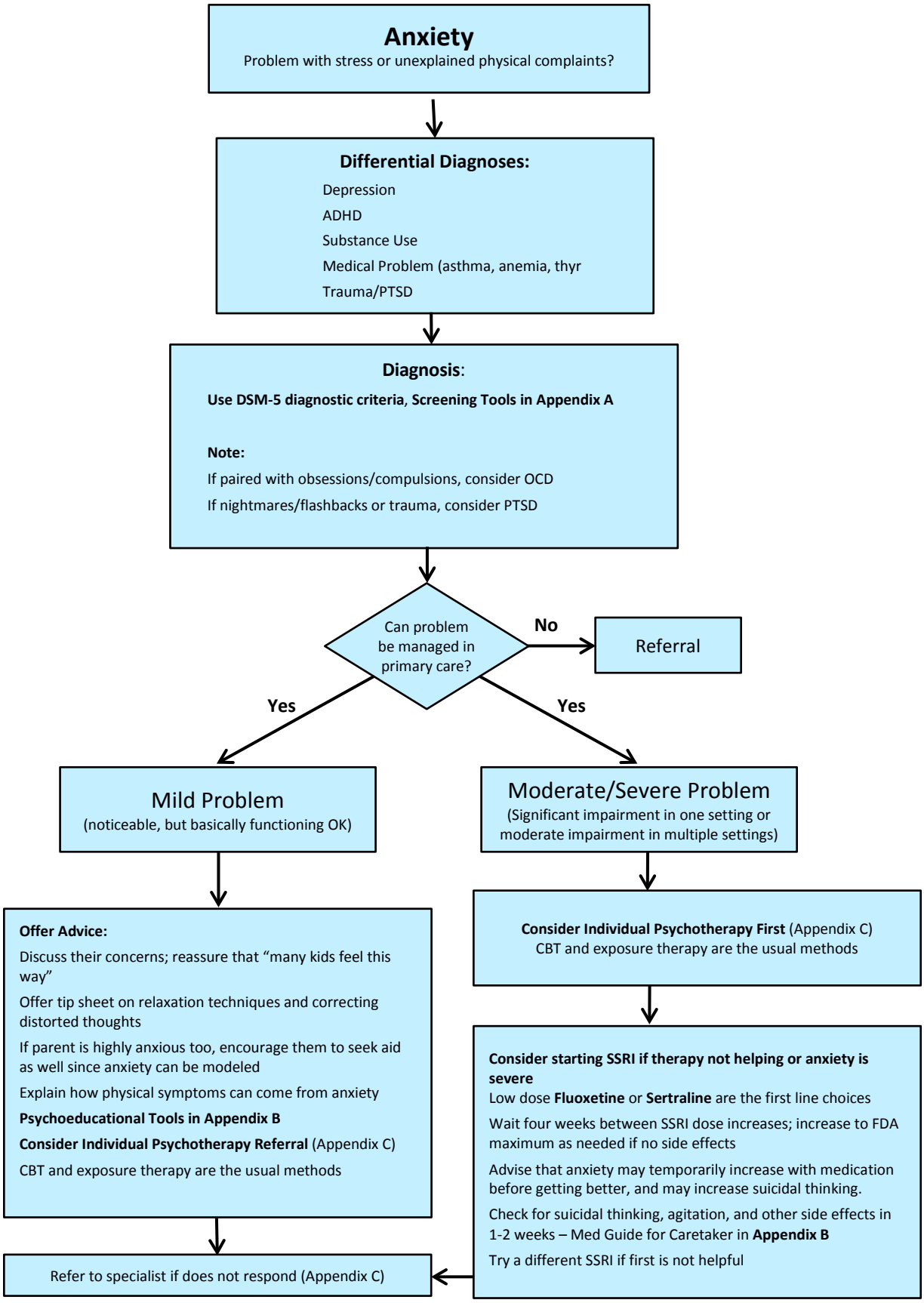
APPENDIX E

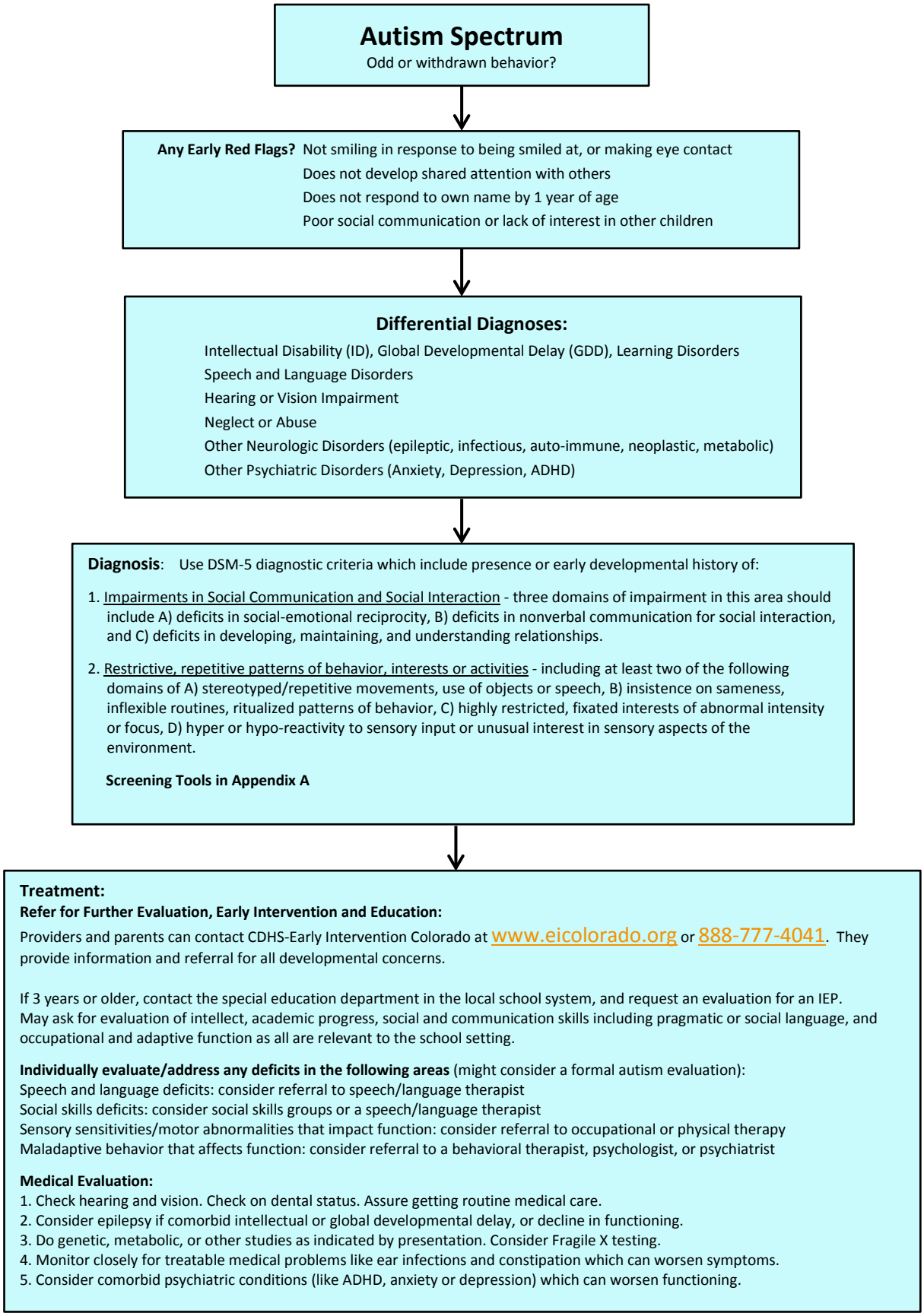
Treatment Algorithms for Common Mental Illness Concerns

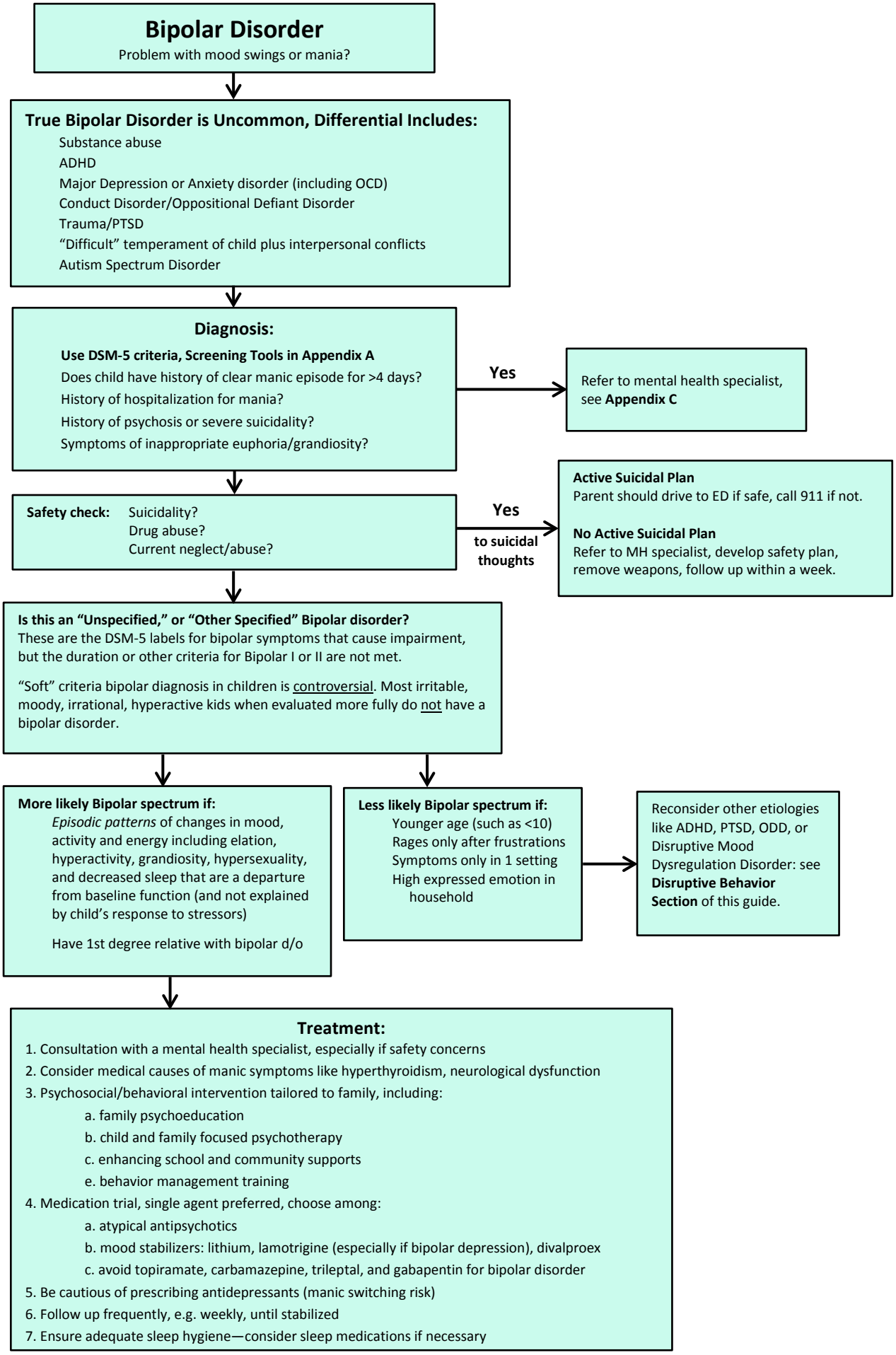
Please see the following pages for algorithms regarding ADHD, anxiety, autism, bipolar disorder, depression, and disruptive behavior and aggression. These are adaptations of algorithms developed by Robert Hilt at Seattle Children's, which can be found here:

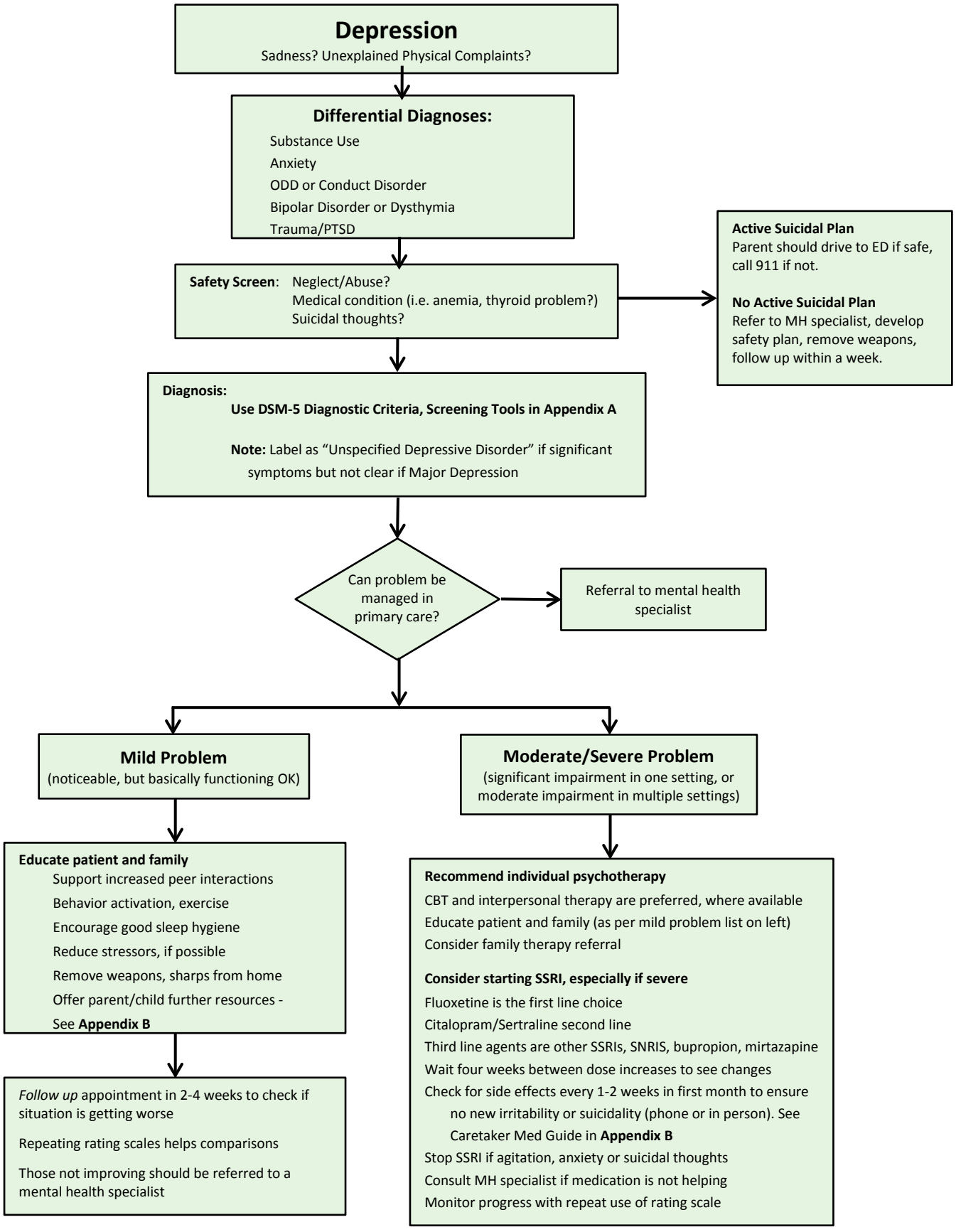
(See Below)

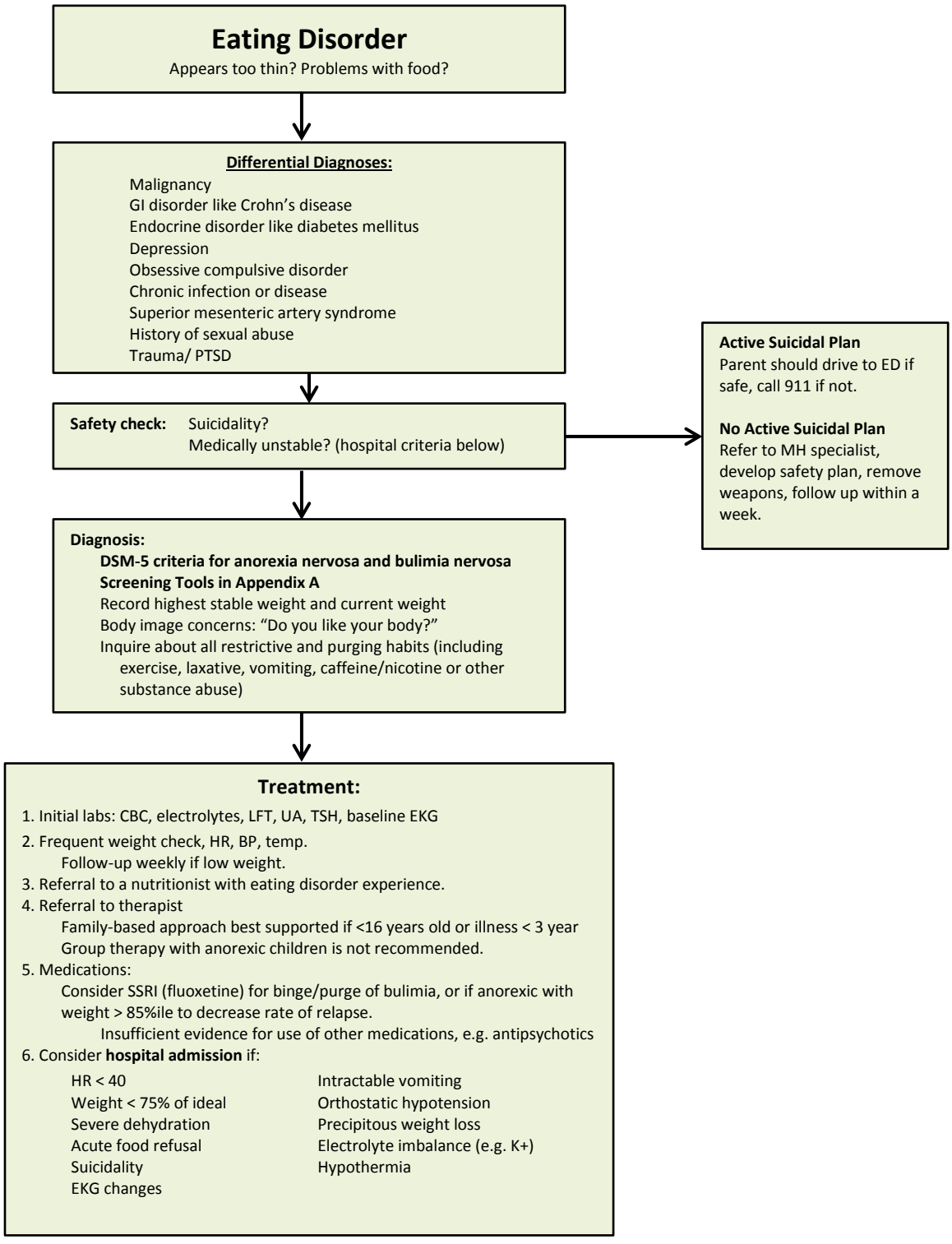

Attention Deficit Hyperactivity Disorder (ADHD)
Problem with attention and/or hyperactivity?
Differential Diagnoses:
Oppositional Defiant Disorder (ODD)
Conduct Disorder
Substance Abuse
Language or Learning Disability
Depression or Anxiety
Autistic Spectrum Disorder
Low Cognitive Ability
Trauma
Diagnosis:
Use DSM-5 criteria, Screening Tools in Appendix A.
Symptoms present in more than one setting.
Note:
If child not otherwise ill, no need for imaging or labs.
EKG in healthy kids is optional and controversial, use clinical judgment.
Use scrutiny if diagnosing ADHD under age 5. Medicaid may require a medication review for this group.
ADHD is not rapid-onset or highly situational – in these cases, consider alternative diagnosis.
If ADHD Diagnosed:
Mild impairment
(or no medication trial per family preference)
Significant impairment
(or psychosocial treatments not helping)
Psychosocial Treatment:
Behavior therapy
Behavior management training
Social skills training
Classroom support/communication
See Psychoeducational Resources in Appendix B
See Behavioral Health Resources and Providers in Appendix C
Active substance abuse?
Yes
Treat substance abuse, consider atomoxetine or alpha2 agonist trial
No
1) Monotherapy with a stimulant (methylphenidate or amphetamine)
2) Increase every week to efficacy, use follow-up rating scale
3) Behavior therapy in addition to meds is best
If problem side effects or not improving, switch to the other stimulant class
If problem side effects, or not improving, switch to atomoxetine or alpha2 agonist monotherapy
If no improvement, reconsider diagnosis. Consider referral to specialist in Appendix C

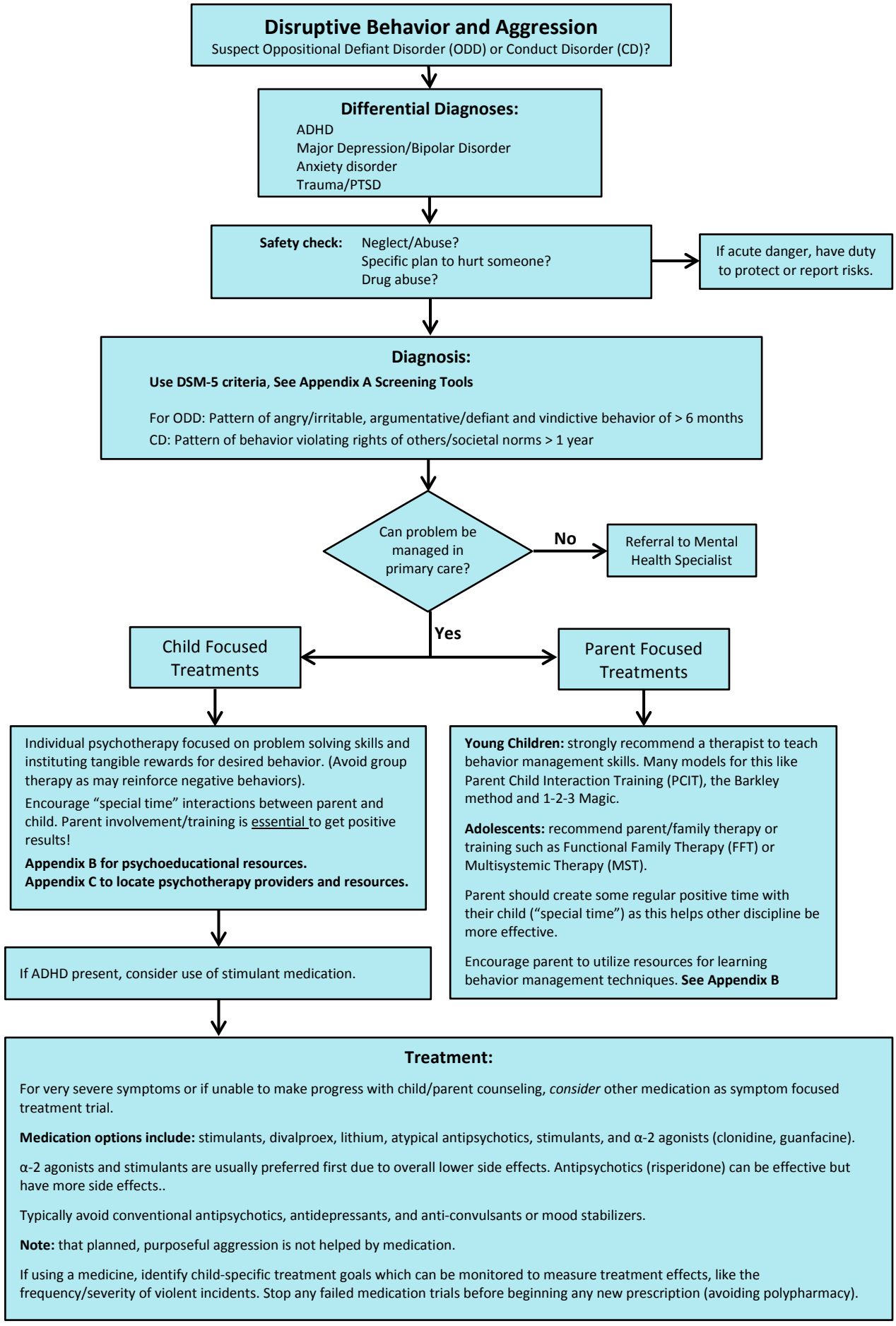

Anxiety
Problem with stress or unexplained physical complaints?
Differential Diagnoses:
Depression
ADHD
Substance Use
Medical Problem (asthma, anemia, thyr
Trauma/PTSD
Diagnosis:
Use DSM-5 diagnostic criteria, Screening Tools in Appendix A
Note:
If paired with obsessions/compulsions, consider OCD
If nightmares/flashbacks or trauma, consider PTSD
Can problem be managed in primary care?
No
Referral
Yes
Yes
Mild Problem
(noticeable, but basically functioning OK)
Moderate/Severe Problem
(Significant impairment in one setting or moderate impairment in multiple settings)
Offer Advice:
Discuss their concerns; reassure that "many kids feel this way"
Offer tip sheet on relaxation techniques and correcting distorted thoughts
If parent is highly anxious too, encourage them to seek aid as well since anxiety can be modeled
Explain how physical symptoms can come from anxiety
Psychoeducational Tools in Appendix B
Consider Individual Psychotherapy Referral (Appendix C)
CBT and exposure therapy are the usual methods
Consider Individual Psychotherapy First (Appendix C)
CBT and exposure therapy are the usual methods
Consider starting SSRI if therapy not helping or anxiety is severe
Low dose Fluoxetine or Sertraline are the first line choices
Wait four weeks between SSRI dose increases; increase to FDA maximum as needed if no side effects
Advise that anxiety may temporarily increase with medication before getting better, and may increase suicidal thinking.
Check for suicidal thinking, agitation, and other side effects in 1-2 weeks – Med Guide for Caretaker in Appendix B
Try a different SSRI if first is not helpful
Refer to specialist if does not respond (Appendix C)


Autism Spectrum
Odd or withdrawn behavior?
Any Early Red Flags? Not smiling in response to being smiled at, or making eye contact
Does not develop shared attention with others
Does not respond to own name by 1 year of age
Poor social communication or lack of interest in other children
Differential Diagnoses:
Intellectual Disability (ID), Global Developmental Delay (GDD), Learning Disorders
Speech and Language Disorders
Hearing or Vision Impairment
Neglect or Abuse
Other Neurologic Disorders (epileptic, infectious, auto-immune, neoplastic, metabolic)
Other Psychiatric Disorders (Anxiety, Depression, ADHD)
Diagnosis: Use DSM-5 diagnostic criteria which include presence or early developmental history of:
1. Impairments in Social Communication and Social Interaction - three domains of impairment in this area should include A) deficits in social-emotional reciprocity, B) deficits in nonverbal communication for social interaction, and C) deficits in developing, maintaining, and understanding relationships.
2. Restrictive, repetitive patterns of behavior, interests or activities - including at least two of the following domains of A) stereotyped/repetitive movements, use of objects or speech, B) insistence on sameness, inflexible routines, ritualized patterns of behavior, C) highly restricted, fixated interests of abnormal intensity or focus, D) hyper or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment.
Screening Tools in Appendix A
Treatment:
Refer for Further Evaluation, Early Intervention and Education:
Providers and parents can contact CDHS-Early Intervention Colorado at www.eicolorado.org or 888-777-4041. They provide information and referral for all developmental concerns.
If 3 years or older, contact the special education department in the local school system, and request an evaluation for an IEP. May ask for evaluation of intellect, academic progress, social and communication skills including pragmatic or social language, and occupational and adaptive function as all are relevant to the school setting.
Individually evaluate/address any deficits in the following areas (might consider a formal autism evaluation):
Speech and language deficits: consider referral to speech/language therapist
Social skills deficits: consider social skills groups or a speech/language therapist
Sensory sensitivities/motor abnormalities that impact function: consider referral to occupational or physical therapy
Maladaptive behavior that affects function: consider referral to a behavioral therapist, psychologist, or psychiatrist
Medical Evaluation:
1. Check hearing and vision. Check on dental status. Assure getting routine medical care.
2. Consider epilepsy if comorbid intellectual or global developmental delay, or decline in functioning.
3. Do genetic, metabolic, or other studies as indicated by presentation. Consider Fragile X testing.
4. Monitor closely for treatable medical problems like ear infections and constipation which can worsen symptoms.
5. Consider comorbid psychiatric conditions (like ADHD, anxiety or depression) which can worsen functioning.


Bipolar Disorder
Problem with mood swings or mania?
True Bipolar Disorder is Uncommon, Differential Includes:
Substance abuse
ADHD
Major Depression or Anxiety disorder (including OCD)
Conduct Disorder/Oppositional Defiant Disorder
Trauma/PTSD
"Difficult" temperament of child plus interpersonal conflicts
Autism Spectrum Disorder
Diagnosis:
Use DSM-5 criteria, Screening Tools in Appendix A
Does child have history of clear manic episode for >4 days?
History of hospitalization for mania?
History of psychosis or severe suicidality?
Symptoms of inappropriate euphoria/grandiosity?
Yes
Refer to mental health specialist, see Appendix C
Safety check: Suicidality?
Drug abuse?
Current neglect/abuse?
Yes
to suicidal thoughts
Active Suicidal Plan
Parent should drive to ED if safe, call 911 if not.
No Active Suicidal Plan
Refer to MH specialist, develop safety plan, remove weapons, follow up within a week.
Is this an "Unspecified," or "Other Specified" Bipolar disorder?
These are the DSM-5 labels for bipolar symptoms that cause impairment, but the duration or other criteria for Bipolar I or II are not met.
"Soft" criteria bipolar diagnosis in children is controversial. Most irritable, moody, irrational, hyperactive kids when evaluated more fully do not have a bipolar disorder.
More likely Bipolar spectrum if:
Episodic patterns of changes in mood, activity and energy including elation, hyperactivity, grandiosity, hypersexuality, and decreased sleep that are a departure from baseline function (and not explained by child's response to stressors)
Have 1st degree relative with bipolar d/o
Less likely Bipolar spectrum if:
Younger age (such as <10)
Rages only after frustrations
Symptoms only in 1 setting
High expressed emotion in household
Reconsider other etiologies like ADHD, PTSD, ODD, or Disruptive Mood Dysregulation Disorder: see Disruptive Behavior Section of this guide.
Treatment:
1. Consultation with a mental health specialist, especially if safety concerns
2. Consider medical causes of manic symptoms like hyperthyroidism, neurological dysfunction
3. Psychosocial/behavioral intervention tailored to family, including:
a. family psychoeducation
b. child and family focused psychotherapy
c. enhancing school and community supports
e. behavior management training
4. Medication trial, single agent preferred, choose among:
a. atypical antipsychotics
b. mood stabilizers: lithium, lamotrigine (especially if bipolar depression), divalproex
c. avoid topiramate, carbamazepine, trileptal, and gabapentin for bipolar disorder
5. Be cautious of prescribing antidepressants (manic switching risk)
6. Follow up frequently, e.g. weekly, until stabilized
7. Ensure adequate sleep hygiene—consider sleep medications if necessary


Depression
Sadness? Unexplained Physical Complaints?
Differential Diagnoses:
Substance Use
Anxiety
ODD or Conduct Disorder
Bipolar Disorder or Dysthymia
Trauma/PTSD
Safety Screen: Neglect/Abuse?
Medical condition (i.e. anemia, thyroid problem?)
Suicidal thoughts?
Active Suicidal Plan
Parent should drive to ED if safe, call 911 if not.
No Active Suicidal Plan
Refer to MH specialist, develop safety plan, remove weapons, follow up within a week.
Diagnosis:
Use DSM-5 Diagnostic Criteria, Screening Tools in Appendix A
Note: Label as "Unspecified Depressive Disorder" if significant symptoms but not clear if Major Depression
Can problem be managed in primary care?
Referral to mental health specialist
Mild Problem
(noticeable, but basically functioning OK)
Moderate/Severe Problem
(significant impairment in one setting, or moderate impairment in multiple settings)
Educate patient and family
Support increased peer interactions
Behavior activation, exercise
Encourage good sleep hygiene
Reduce stressors, if possible
Remove weapons, sharps from home
Offer parent/child further resources - See Appendix B
Follow up appointment in 2-4 weeks to check if situation is getting worse
Repeating rating scales helps comparisons
Those not improving should be referred to a mental health specialist
Recommend individual psychotherapy
CBT and interpersonal therapy are preferred, where available
Educate patient and family (as per mild problem list on left)
Consider family therapy referral
Consider starting SSRI, especially if severe
Fluoxetine is the first line choice
Citalopram/Sertraline second line
Third line agents are other SSRIs, SNRIS, bupropion, mirtazapine
Wait four weeks between dose increases to see changes
Check for side effects every 1-2 weeks in first month to ensure no new irritability or suicidality (phone or in person). See Caretaker Med Guide in Appendix B
Stop SSRI if agitation, anxiety or suicidal thoughts
Consult MH specialist if medication is not helping
Monitor progress with repeat use of rating scale


Eating Disorder
Appears too thin? Problems with food?
Differential Diagnoses:
Malignancy
GI disorder like Crohn's disease
Endocrine disorder like diabetes mellitus
Depression
Obsessive compulsive disorder
Chronic infection or disease
Superior mesenteric artery syndrome
History of sexual abuse
Trauma/ PTSD
Safety check: Suicidality?
Medically unstable? (hospital criteria below)
Active Suicidal Plan
Parent should drive to ED if safe, call 911 if not.
No Active Suicidal Plan
Refer to MH specialist, develop safety plan, remove weapons, follow up within a week.
Diagnosis:
DSM-5 criteria for anorexia nervosa and bulimia nervosa
Screening Tools in Appendix A
Record highest stable weight and current weight
Body image concerns: "Do you like your body?"
Inquire about all restrictive and purging habits (including exercise, laxative, vomiting, caffeine/nicotine or other substance abuse)
Treatment:
1. Initial labs: CBC, electrolytes, LFT, UA, TSH, baseline EKG
2. Frequent weight check, HR, BP, temp.
Follow-up weekly if low weight.
3. Referral to a nutritionist with eating disorder experience.
4. Referral to therapist
Family-based approach best supported if <16 years old or illness < 3 year
Group therapy with anorexic children is not recommended.
5. Medications:
Consider SSRI (fluoxetine) for binge/purge of bulimia, or if anorexic with weight > 85%ile to decrease rate of relapse.
Insufficient evidence for use of other medications, e.g. antipsychotics
6. Consider hospital admission if:
HR < 40
Weight < 75% of ideal
Severe dehydration
Acute food refusal
Suicidality
EKG changes
Intractable vomiting
Orthostatic hypotension
Precipitous weight loss
Electrolyte imbalance (e.g. K+)
Hypothermia


Disruptive Behavior and Aggression
Suspect Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD)?
Differential Diagnoses:
ADHD
Major Depression/Bipolar Disorder
Anxiety disorder
Trauma/PTSD
Safety check: Neglect/Abuse?
Specific plan to hurt someone?
Drug abuse?
If acute danger, have duty to protect or report risks.
Diagnosis:
Use DSM-5 criteria, See Appendix A Screening Tools
For ODD: Pattern of angry/irritable, argumentative/defiant and vindictive behavior of > 6 months
CD: Pattern of behavior violating rights of others/societal norms > 1 year
Can problem be managed in primary care?
No
Referral to Mental Health Specialist
Yes
Child Focused Treatments
Parent Focused Treatments
Individual psychotherapy focused on problem solving skills and instituting tangible rewards for desired behavior. (Avoid group therapy as may reinforce negative behaviors).
Encourage "special time" interactions between parent and child. Parent involvement/training is essential to get positive results!
Appendix B for psychoeducational resources.
Appendix C to locate psychotherapy providers and resources.
Young Children: strongly recommend a therapist to teach behavior management skills. Many models for this like Parent Child Interaction Training (PCIT), the Barkley method and 1-2-3 Magic.
Adolescents: recommend parent/family therapy or training such as Functional Family Therapy (FFT) or Multisystemic Therapy (MST).
Parent should create some regular positive time with their child ("special time") as this helps other discipline be more effective.
Encourage parent to utilize resources for learning behavior management techniques. See Appendix B
If ADHD present, consider use of stimulant medication.
Treatment:
For very severe symptoms or if unable to make progress with child/parent counseling, consider other medication as symptom focused treatment trial.
Medication options include: stimulants, divalproex, lithium, atypical antipsychotics, stimulants, and α-2 agonists (clonidine, guanfacine).
α-2 agonists and stimulants are usually preferred first due to overall lower side effects. Antipsychotics (risperidone) can be effective but have more side effects..
Typically avoid conventional antipsychotics, antidepressants, and anti-convulsants or mood stabilizers.
Note: that planned, purposeful aggression is not helped by medication.
If using a medicine, identify child-specific treatment goals which can be monitored to measure treatment effects, like the frequency/severity of violent incidents. Stop any failed medication trials before beginning any new prescription (avoiding polypharmacy).

APPENDIX E (continued)
Supplement for Treatment Algorithms for Common Mental Illness Concerns

Screening and Assessment Tools (Appendix A)

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)
https://www.psychiatry.org/psychiatrists/practice/dsm/dsm-5

Attention-Deficit/Hyperactivity

Free Screening Tools

Vanderbilt Assessment Scale (note, latest edition may no longer be free)
Parent- http://www.uwmedicine.org/neighborhood-clinics/Documents/03VanAssesScaleParent%20Infor.pdf
Teacher- http://www.uwmedicine.org/neighborhood-clinics/Documents/04VanAssesScaleTeachInfor.pdf
Scoring- https://depts.washington.edu/dbpeds/07ScoringInstructions.pdf
ADHD Rating Scale IV
Home version- https://www.samhealth.org/-/media/SHS/Documents/English/323-Mental-Health/ADHD-Home-Version-323.ashx?la=en
School version- https://www.samhealth.org/-/media/SHS/Documents/English/323-Mental-Health/ADHD-School-323.ashx?la=en
Self-Report- https://www.samhealth.org/-/media/SHS/Documents/English/323-Mental-Health/ADHD-Self-Report-323.ashx?la=en
Is It ADHD?
http://www.cdc.gov/ncbddd/adhd/documents/adhd-symptom-checklist.pdf

Screening Tools for Purchase

Child Behavior Checklist (Parent & Teacher)
http://store.aseba.org/CHILD-BEHAVIOR-CHECKLIST_6-18/productinfo/201/
http://store.aseba.org/TEACHERS-REPORT-FORM_6-18/productinfo/301/
Connors 3 (Parent & Teacher)
http://www.mhs.com/product.aspx?gr=cli&id=overview&prod=conners3
ADD-H Comprehensive teacher's Rating Scale, Second Edition (ACTeRS)
http://www.wpspublish.com/store/p/2639/add-h-comprehensive-teachers-rating-scale-second-edition-acters

Anxiety

Free Screening Tools

Screen for Child Anxiety Related Disorders (SCARED)
http://psychiatry.pitt.edu/sites/default/files/Documents/assessments/SCARED%20Child.pdf
Spence Children's Anxiety Scale
http://www.scaswebsite.com/1_1_.html
Anxiety Disorders in Children: A Test for (Parents)

https://www.adaa.org/living-with-anxiety/ask-and-learn/screenings/screening-anxiety-disorder-children

Screening Tools for Purchase

Revised Children's Manifest Anxiety Scale: Second Edition
http://www.mhs.com/product.aspx?gr=edu&prod=rcmas2&id=overview
Beck Youth Inventories™ - Second Edition, Anxiety Inventory
http://www.pearsonclinical.com/psychology/products/100000153/beck-youth-inventories-second-edition-byi-ii.html?origsearchtext=byi-2#tab-details
State-Trait Anxiety Inventory for Children
http://www.mindgarden.com/146-state-trait-anxiety-inventory-for-children

Autism Spectrum Disorders

Free Screening Tools

Child Autism Spectrum Test
https://psychology-tools.com/cast/
Communication and Symbolic Behavior Scales (CSBS) Toddler Checklist
http://firstwords.fsu.edu/pdf/checklist.pdf
Modified Checklist for Autism in Toddlers (MCHAT)
http://mchatscreen.com/

Screening Tools for Purchase

Ages and Stages Questionnaires (ASQ)
http://agesandstages.com/products-services/
Parents' Evaluation of Developmental Status (PEDS)
http://www.pedstest.com/default.aspx
Screening Tool for Autism in Toddlers and Young Children (STAT)
http://vkc.mc.vanderbilt.edu/vkc/triad/training/stat/

Bipolar Disorders

Free Screening Tools

Mood Disorder Questionnaire for Parents of Adolescents
http://bipolarnews.org/wp-content/uploads/2012/08/Mood-Disorder-Questionnaire-for-Parents-of-Adolescents.pdf
Parent General Behavior Inventory, Short Form (Mania)
http://www.moodychildtherapy.com/wp-content/uploads/2011/01/PGBI-10M-2-wks.pdf
Mania Screening Questionnaire (self-report developed for adults, but can be used by adolescents)
http://www.dbsalliance.org/site/PageServer?pagename=education_screeningcenter_mania
Child Mania Rating Scale – Parent Version
http://www.dbsalliance.org/pdfs/ChildManiaSurvey.pdf
Young Mania Rating Scale – Parent Version
http://www.healthyplace.com/images/stories/bipolar/p-ymrs.pdf
Children's Bipolar Mood Charting
http://www.bpchildren.com/kids

Screening Tools for Purchase

Child Behavior Checklist (Parent & Teacher)
http://store.aseba.org/CHILD-BEHAVIOR-CHECKLIST_6-18/productinfo/201/
http://store.aseba.org/TEACHERS-REPORT-FORM_6-18/productinfo/301/

Depression

Free Screening Tools

Center for Epidemiological Studies, Depression Scale for Children (CES-DC)
https://www.brightfutures.org/mentalhealth/pdf/professionals/bridges/ces_dc.pdf
Mood and Feelings Questionnaire (MFQ) self-report & parent report forms
http://devepi.mc.duke.edu/mfq.html
Severity Measure for Depression—Child Age 11–17 (adapted from PHQ-9)
http://www.ohsu.edu/xd/education/schools/school-of-medicine/departments/clinical-departments/psychiatry/divisions-and-clinics/child-and-adolescent-psychiatry/opal-k/upload/PHQ-A-Severity-Measure-for-Depression.pdf
or
https://www.aacap.org/App_Themes/AACAP/docs/member_resources/toolbox_for_clinical_practice_and_outcomes/symptoms/GLAD-PC_PHQ-9.pdf

Screening Tools for Purchase

Children's Depression Rating Scale™, Revised (CDRS™-R)
http://www.wpspublish.com/store/p/2703/childrens-depression-rating-scale-revised-cdrs-r
Beck Youth Inventories™ - Second Edition, Depression Inventory
http://www.pearsonclinical.com/psychology/products/100000153/beck-youth-inventories-second-edition-byi-ii.html?origsearchtext=byi-2#tab-details
Beck Depression Inventory®-II (BDI®-II) for adolescents
http://www.pearsonclinical.com/psychology/products/100000159/beck-depression-inventoryii-bdi-ii.html?Pid=015-8018-370&Mode=summary#tab-details
Reynolds Child Depression Scale™–2nd Edition and Reynolds Child Depression Scale™–2nd Edition: Short Form
http://www4.parinc.com/Products/Product.aspx?ProductID=RCDS-2

Eating Disorder

Free Screening Tools

The SCOFF Questionnaire
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1070794/
Eating Disorder Screen for Primary Care (ESP)
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1494802/#b12
Eating Attitudes Test (EAT-26)
http://eat-26.com/Form/index.php
Compulsive Exercise Test - self-report
http://www.jennischaefer.com/cet/

Psychoeducational Resources (Appendix B)

Attention-Deficit/Hyperactivity

Information - http://www.nimh.nih.gov/health/publications/adhd-listing.shtml
Understanding and Managing ADHD Children - http://connect.additudemag.com/videos/watch/128/
Behavior Management - http://psychcentral.com/lib/setting-up-a-behavior-management-plan-for-an-adhd-child/
Parenting Tips - http://www.helpguide.org/articles/add-adhd/attention-deficit-disorder-adhd-parenting-tips.htm
ADHD Apps - http://www.additudemag.com/adhd/article/11161.html
Teaching Strategies - http://accessproject.colostate.edu/disability/modules/ADHD/tut_ADHD.php?display=pg_1
ADHD Videos - http://connect.additudemag.com/videos
ADHD Videos - http://www.healthline.com/health/adhd/best-videos-adhd#1

ANXIETY

Information - https://www.anxietybc.com/parenting/childhood-anxiety
Parenting Tips - http://www.todaysparent.com/family/family-health/anxiety-disorders-in-children/
Anxiety Apps for Kids - https://www.anxiety.org/gift-apps-children-anxiety
SSRI/SNRI Medication Guide for Caretakers:
http://www.fda.gov/downloads/Drugs/DrugSafety/InformationbyDrugClass/ucm100211.pdf

Autism Spectrum

Information - https://www.autismspeaks.org/what-autism
Guide for Parents - http://www.helpguide.org/articles/autism/helping-children-with-autism.htm
Seattle Children's Autism Videos - https://www.youtube.com/playlist?list=PLjvfRtcMhn4PB0NTW0RIvsMJGu1Csnn5s
Autism TED Talks - http://www.educatorstechnology.com/2014/05/7-great-ted-talks-on-autism-teachers.html
Autism Apps - http://www.parenting.com/gallery/autism-apps

Bipolar

Parent Information and Resources - http://www.bpchildren.com
Parent Information and Resources -
https://education.ucsb.edu/sites/default/files/hosford_clinic/docs/Bipolar.Children.pdf
Bipolar Apps - https://www.pinterest.com/bipolarbandit/apps-for-bipolar-disorder/

Depression

Parent Information on Child Depression - https://www.healthychildren.org/English/health-issues/conditions/emotional-problems/Pages/Childhood-Depression-What-Parents-Can-Do-To-Help.aspx
Parent Information on Teen Depression - http://www.helpguide.org/articles/depression/teen-depression-signs-help.htm
Depression Apps for Teens and Adults - http://www.healthline.com/health/depression/top-iphone-android-apps#2
SSRI/SNRI Medication Guide for Caretakers:
http://www.fda.gov/downloads/Drugs/DrugSafety/InformationbyDrugClass/ucm100211.pdf

Eating Disorder

Parent Toolkit - https://www.nationaleatingdisorders.org/sites/default/files/Toolkits/ParentToolkit.pdf
Eating Disorder Videos - http://www.healthline.com/health/eating-disorders/best-videos-of-the-year#1
Eating Disorder Videos - http://www.aedweb.org/index.php/education/eating-disorder-information/eating-disorder-information-8

Eating Disorder Apps - http://www.healthline.com/health/eating-disorders/top-iphone-android-apps#1

Disruptive Behavior

ADHD vs Disruptive Behavior Disorder - https://www.understood.org/en/learning-attention-issues/getting-started/what-you-need-to-know/the-difference-between-disruptive-behavior-disorders-and-adhd?gclid=CPD7hs-g-84CFQcoaQodKIkLFQ
Information for Parents - http://www.healthline.com/health/conduct-disorder#Symptoms3
Information for Parents - https://childdevelopmentinfo.com/child-psychology/oppositional-defiant-disorder/
Parenting Tips - http://www.parents.com/health/mental/dealing-with-disruptive-behavior
Parenting Tips - http://www.boystown.org/parenting/guides/Pages/behavioral-disorders.aspx
Parenting Tool Handouts - http://www.boystown.org/parenting/Pages/parenting-tools.aspx
Disruptive Behavior Videos for Parents - http://www.howcast.com/videos/507698-what-is-a-disruptive-behavior-disorder-child-psychology/

Locating Behavioral Health Resources and Specialists (Appendix C)

Behavioral Health and Substance Use Disorder services for Colorado Health First (Colorado's Medicaid Program) members:
https://www.colorado.gov/pacific/hcpf/behavioral-health-organizations
Colorado Department of Human Resources
https://sites.google.com/a/state.co.us/cdhs-behavioral-health/home-old/find-help
State of Colorado Programs for Children
https://www.colorado.gov/pacific/hcpf/programs-children
Colorado Behavioral Healthcare Council
http://www.cbhc.org/#help
Substance Abuse and Mental Health Services Administration (SAMHSA)
https://findtreatment.samhsa.gov/

Professional Locator Services

American Academy of Child and Adolescent Psychiatry – Psychiatrist Finder
http://www.aacap.org/AACAP/Families_and_Youth/Resources/CAP_Finder.aspx
American Psychiatric Association
http://finder.psychiatry.org/
Colorado Psychological Association
http://www.coloradopsych.org/directory
American Association of Marriage & Family Therapists
https://www.therapistlocator.net/iMIS15/therapistlocator/Content/Directories/Locator_Terms_of_Use.aspx
National Association of Social Workers
http://www.helpstartshere.org/find-a-social-worker
American Counseling Association
https://www.counseling.org/membership/member-directory
American Psychological Association
http://locator.apa.org/?_ga=1.22079867.1369250853.1472832828

Behavioral Health Provider Directories

Contact your healthcare provider for their provider list,
Or access an online provider directory, sample directories below:
Healthgrove Treatment Center Locator
http://www.healthgrove.com/

Psychology Today Therapist Finder
https://therapists.psychologytoday.com
Network Therapy Therapist Finder
http://www.networktherapy.com/directory/

Primary References for Algorithms (Appendix D)

Attention-Deficit/Hyperactivity

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AACAP: Practice Parameter for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders, JAACAP; 46(2): 267-283

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Johnson C, Myers S, Council on Children with Disabilities, "Identification and Evaluation of Children with Autism Spectrum Disorders," Pediatrics 120(5): November 2007: 1183-1215.

Myers S, Johnson C, Council on Children with Disabilities, "Management of Children with Autism Spectrum Disorders," Pediatrics 120 (5), November 2007: 1162-1182.

Bipolar Disorders

AACAP "Practice Parameter for the Assessment and Treatment of Adolescents and Children with Bipolar Disorder" JAACAP 2007, 46(1), 107-125

DSM-5 (2013) American Psychiatric Publishing, Inc.

Depressive Disorders

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Marek JS, Silva S, Vitiello B, TADS team (2006): "The treatment for adolescents with depression study (TADS): methods and message at 12 weeks." JAACAP 45:1393-1403

AACAP (in press): "Practice parameter for the assessment and treatment of children and adolescents with depressive disorders." Accessed 2/08 on www.aacap.org

Zuckerbrot R ed.: "Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit." Columbia University: Center for the Advancement of Children's Mental Health

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Jellinek M, Patel BP, Froehle MC eds. (2002): Bright Futures in Practice: Mental Health-Volume I. Practice Guide. Arlington, VA: National Center for Education in Maternal and Child Health: 203-211

AAP Committee on Adolescence (2003): "Policy statement: identifying and treating eating disorders." Pediatrics 111(1):204-211

Disruptive Behavior or Aggression

AACAP (2007): Practice parameter for the assessment and treatment of children and adolescents with oppositional defiant disorder. JAACAP 46(1):126-141

Pappadopulos E, Woolston S, Chait A, et al. (2006): Pharmacotherapy of aggression in children and adolescents: efficacy and effect size. J Canadian Acad Child Adolesc Psychiatry 15(1):27-39

Cheng K and Myers KM. Child and Adolescent Psychiatry: The Essentials, LWW, Inc. 2011.

APPENDIX F

Adverse Effect Rating Scales, and the PMMC: Psychotropic Medication Monitoring Checklists User Manual

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Disclaimer

The authors do not intend that the PPMC should be used in lieu of comprehensive, appropriate care. Every reasonable effort has been made to ensure that the information provided in the PMMC is accurate and up to date. The potential side effects listed in the PMMC should be reviewed against current information relevant to each medication. The physician or prescriber should ensure through comprehensive assessment that medication is appropriate for the individual child before prescribing. Health professionals are responsible for providing appropriate clinical oversight and care subject to the professional practice regulations where the child receives care. Caregivers should tell their child's doctor about all potential side effects that the child experiences. Some of the side effects on the PMMC require urgent medical attention, and these are indicated with the words "NOTIFY MEDICAL". If the caregiver is unsure whether urgent medical attention is needed for a side effect that the child is experiencing, the caregiver should contact the child's appropriate health professional for advice.

Note to Physicians

Purpose of the PMMC

The PMMC are used to track potential side effects that children may experience from psychotropic medication. These tools were designed to streamline the documentation and communication of potential side effects associated with the pediatric use of psychotropic medications. As you know, psychotropic medications have been used increasingly over the last few decades with children without comprehensive knowledge of safety, risks and adverse effects. This significantly amplifies the need to vigilantly monitor for such concerns. Tracking symptoms and interpreting the likelihood of side effects can be useful in directing and monitoring treatment, as well as preventing serious and seminal events related to medication use. Use of the PMMC has been demonstrated to improve various elements of side effect monitoring for children in residential care.

Completing the PMMC

Each PMMC accommodates a full week of daily side effect monitoring. Supply the family with copies of the PMMC relevant to which medication is prescribed. The caregiver (or other responsible individual) is to indicate if a potential side effect was observed in the course of each day with a check mark. A "Baseline" column is also included for the caregiver to indicate if a potential side effect was present before beginning the medication. The next page provides notes to caregivers on using the PMMC.

The PMMC as a Tool in Comprehensive Clinical Care

Side effects listed on the PMMC are separated into the categories: **Common, Infrequent, and Rare but Serious**. Some of the side effect symptoms listed as common and infrequent may also pose a serious risk to the child. When providing the PMMC to the family, you may wish to review the potential side effects with the caregiver and child, and instruct on which symptoms represent an urgent concern requiring immediate medical attention, and which potential side effects can be communicated to you in the course of regular follow up appointments if observed.

Note to Caregivers

What is the PMMC?

The PMMC are sheets that list possible side effects that children might experience when taking certain types of medication. The PMMC are a tool to help you to be aware of what possible side effects to watch for in your child. The PMMC are also a way for you to document observed side effects to help you communicate these to your child's doctor.

The possible side effects are organized into 3 sections on each PMMC according to how likely each are to occur: Common, Infrequent, and Rare but Serious. It is important to keep in mind that even some of the side effects in the Common and Infrequent sections might be a serious medical concern for your child requiring urgent care. Talk to your child's doctor to find out which potential side effects would require an emergency response.

How do I use the PMMC?

Make side effect monitoring part of your daily routine. For example, at the end of each day read the list of potential side effects and think about if you noticed any that day with your child. You can also talk to your child about how he/she is feeling, and get other family members involved in monitoring as well.

- Use each PMMC sheet for a full week of monitoring for side effects. In the spaces provided at the top of the sheet, write the child's name, prescriber's name, and the date that the week starts.
- Place a check mark ☑ next to the name of each medication that your child is taking that week and record the dosage.
- There is a column labeled "Baseline" on each PMMC. If your child had one or more of the symptoms listed on the PMMC before beginning the medication then place a check mark in the baseline column for the row that corresponds with the side effect symptom.
- When you notice a possible side effect, place a check mark in the space that corresponds to the row for the potential side effect you observed and column for the day(s) of the week that your child experienced it.
- Each day, be sure to check the last two rows on each sheet:
- Check for each day that medication was administered
- Check for each day if NO side effects observed
- There is a space at the bottom of each PMMC for your comments. You can write in this space any questions or concerns you have to help you remember when you talk to your child's doctor. You can also write here if you think there may be another reason for the observed side effect symptom that is not related to medication (for example, the child had contact with poison ivy and that may be the cause of the observed rash).

What should I do if my child has one of the side effects listed?

You should tell your child's doctor about all potential side effects that your child experiences. Some of the side effects on the PMMC require urgent medical attention, and these are indicated with the words "NOTIFY MEDICAL". Your child's doctor may tell you if other potential side effects listed would also require urgent medical attention for your child.

Side effects that do not require an urgent medical response can be communicated to the doctor during a regular follow up appointment. If you are unsure whether urgent medical attention is needed for a side effect that your child is experiencing, contact your child's doctor.

Brief Definitions of Potential Side Effects

Abnormal Eye Movements: Side to side, up and down or rotatory movements of eyes, or both eyes looking in different directions.

Abdominal Pain: Lower belly ache.

Agitation: Confused, restless and excited, extreme emotional disturbance, extreme worry or anxiety that is reflected in someone's behavior, movements or voice.

Appetite Change: Change in desire to eat food.

Bedwetting: Urination at night in bed.

Blurred Vision: Not seeing sharp outlines clearly, hazy appearance.

Bruising: Areas of reddish purple discoloration of skin.

Chest Pain: Discomfort in the chest.

Clumsy: Poor balance and coordination, accident prone.

Confusion: Inability to think clearly.

Constipation: When bowel movements occur less often than usual or consist of hard, dry stools that are painful or difficult to pass. Although bowel habits vary, 3 or less bowel movements a week may be an indicator of constipation.

Depressed Affect: Feeling low or down.

Diarrhea: Increased frequency or unusual frequency of bowel movements and/or decreased consistency/increased liquidity or looseness of stools.

Dizziness: Light-headedness.

Drooling: Excessive salivation.

Drowsiness: Difficulty staying awake.

Dry Eyes: Decreased tears.

Dry Mouth: Decreased saliva in mouth.

Dry Nose: Decreased mucus in nose, possibly with nose bleeding.

Dry Skin: Decreased skin moisture and itchiness.

Euphoria: Exaggerated, unrealistic and intense feeling of well-being or happiness.

Excessive Sweating: Increased perspiration or wet skin.

Eye Pain: Burning, throbbing, aching or stabbing sensation in or around the eye.

Fast Heart Rate/Heart Palpitations: Feeling the heart is racing.

Feeling Cold: Feeling an uncomfortable lack of warmth may include shivering or chills.

Fever: High temperature or very warm body.

Focusing Problems: Difficulty concentrating or paying attention.

Hair Loss: Hair falling out

Hallucinations: Seeing, hearing, smelling, tasting or feeling things that do not exist.

Headache: Pain in head.

Heart Burn: Painful burning in chest or throat.

Inability to Breathe or Swallow: Choking or gagging sensation.

Insomnia: Trouble falling or staying sleep.

Irregular Pulse Rate: Variation in heart rate and rhythm.

Irritability: More excitable or bad tempered than normal.

Lack of Movement: Being still or stiff.

Metallic Taste: Abnormal salty or rancid taste in mouth.

Mood Swings: Extreme and rapid highs and lows in mood.

Mouth Ulcers: Canker sores in mouth.

Muscle Stiffness: Muscle tightness or soreness.

Nausea: Uneasiness in the stomach with urge to vomit.

Nervousness: Apprehensiveness in conjunction with being scared and/or highly excitable.

Rash or Hives: Welts or flat-topped bumps.

Restless: Always in motion, not calm.

Sedation: The bringing about of calmness, of mental and physical relaxation.

Seizures: Convulsion or part of the body shaking rapidly and uncontrollably, or losing the ability to control a part of the body temporarily.

Serotonin Syndrome: A group of symptoms caused by too much serotonin in the body, can be extremely serious. *Symptoms include at least some of the following:* Agitation, confusion, sweating, dilated pupils rapid heart rate, shivering, tremor, eyelid spasms, muscle twitches, muscle stiffness.

Severe Rash: Change in color or texture of a large area of skin generally with itching.

Sleep Disturbance: Over arousal or increased sleepiness.

Sleepiness: Feeling the need for sleep.

Slowed Movements: Sluggish or lethargic.

Slurred Speech: Decreased clarity of spoken words.

Sore Throat: Painful redness of the throat.

Stiffness of Tongue: Weakness in the tongue or feeling unable to move the tongue.

Stomach Pain: Upper belly ache.

Sudden Stiffness: Rigidity or decreased flexibility.

Suicidal Ideation: Having thoughts and/or intent to kill oneself.

Sustained Involuntary Muscle Contraction: Spasm.

Swelling: Enlargement or increase in size of an area.

Thirsty: Cravings for fluids.

Tics: Sudden repetitive movement of an area of the body.

Tingling in Fingers or Toes: Tickling or pricking sensation in fingers or toes.

Tiredness: Fatigue, exhaustion, feeling depleted of strength and/or energy.

Tremor: Trembling or quivering.

Twitching: Jerky or spasmodic movement.

Unable to Sit Still: On the move always.

Unsteady: Unable to firmly remain upright.

Unsteady Gait: Abnormal walk.

Urination – Burning: Pain while urinating.

Urination – Frequent: Need to pass urine more than usual.

Urinating Trouble: Dribbling, or difficulty starting urination and weak urine stream.

Urine Dark or Feces Pale: Change in color of urine or feces.

Vomiting: Throwing up or puking.

Weight Gain: Increase in body weight.

Weakness: Lack of strength.

Worsened Suicidal Ideation: An increased preoccupation of killing oneself that has become more regular or consistent.

Yellow Skin/ Eyes: Jaundice, changing color of the skin or whites of the eyes.

Psychotropic Medication Monitoring Checklist (PMMC)ALPHA AGONISTS

Child's Name:	Prescriber:	Week Start Date:

Check all meds given this week and record dosage.

- ☐ CLONIDINE (CATAPRES) _____
- ☐ GUANFACINE XR (INTUNIVE_____

Instructions: Place a check mark in the correct space for observed side effects. To indicate days when no monitoring took place (i.e., child was away) place a line down the length of the column(s).

COMMON:	BASELINE	MON	TUE	WED	THUR	FRI	SAT	SUN
Constipation								
Dry Mouth								
Drowsiness								
Sedation								
INFREQUENT:	BASELINE	MON	TUES	WED	THUR	FRI	SAT	SUN
Agitation								
Headache								
Nervousness								
RARE BUT SERIOUS (NOTIFY MEDICAL):	BASELINE	MON	TUES	WED	THUR	FRI	SAT	SUN
Seizure								
Check for each day that medication was administered								
Check for each day if NO side effects observed:								

COMMENTS:

CSW or Medical Initials:_____Date:_____

Psychotropic Medication Monitoring Checklist (PMMC)ANTICONVULSANTS

Child's Name:	Prescriber:	Week Start Date:

Check all meds given this week and record dosage:

☐ CARBAMAZEPINE (TEGRETOL) _____ ☐ LAMOTRIGINE (LAMICTAL) _____

☐ DIVALPROEX (EPIVAL) _____ ☐ TOPIRAMATE (TOPAMAX) _____

Instructions: Place a check mark in the correct space for observed side effects. To indicate days when no monitoring took place (i.e., child was away) place a line down the length of the column(s).

COMMON:	BASELINE	MON	TUE	WED	THUR	FRI	SAT	SUN
Abnormal Eye Movements								
Appetite Change								
Blurred Vision								
Dizziness								
Focusing Problems								
Nausea								
Stomach Pain								
Tiredness								
Vomiting								
INFREQUENT:	BASELINE	MON	TUES	WED	THUR	FRI	SAT	SUN
Abdominal Pain								
Bruising								
Constipation								
Depressed Affect								
Diarrhea								
Hair Loss								
Hallucinations								
Headache								
Insomnia								
Nervousness								
Rash or hives (NOTIFY MEDICAL)								
Restless								
Sore Throat								
Swelling								
Tingling in Fingers or Toes								
Tremor								
Unsteady Gait								
Urination - Burning								
Urination - Frequent								
Urine Dark or Feces Pale								
Weakness								
RARE BUT SERIOUS (NOTIFY MEDICAL):	BASELINE	MON	TUES	WED	THUR	FRI	SAT	SUN
Mouth Ulcers								
Severe Rash								
Yellow Skin/ Eyes								
Check for each day that medication was administered:								
Check for each day if NO side effects observed:								
COMMENTS (continue on back of page if needed):								

CSW or Medical Initials:_____Date:_____

Psychotropic Medication Monitoring Checklist (PMMC)ANTIPSYCHOTICS

Child's Name:	Prescriber:	Week Start Date:

Check all meds given this week and record dosage:

- ☐ ARIPIPRAZOLE (ABILIFY) _____
- ☐ ASENAPINE (SAPHRIS) _____
- ☐ CHLORPROMAZINE (LARGACTIL)_____
- ☐ HALOPERIDOL (HALDOL)
- ☐ OLANZAPINE (ZYPREXA) _____
- ☐ QUETIAPINE (SEROQUEL) _____
- ☐ RISPERIDONE (RISPERDAL) _____
- ☐ ZIPRASIDONE (ZELDOX)

Instructions: Place a check mark in the correct space for observed side effects. To indicate days when no monitoring took place (i.e., child was away) place a line down the length of the column(s).

COMMON:	BASELINE	MON	TUE	WED	THUR	FRI	SAT	SUN
Blurred Vision								
Constipation								
Dizziness								
Drooling								
Dry mouth								
Muscle Stiffness								
Nervousness								
Skin – Itchy								
Skin Rash								
Sleepiness/ Tiredness								
Tremors/ Slowed Movements								
Unable to Sit Still								
Urinating Trouble								
Weight Gain								
RARE BUT SERIOUS (NOTIFY MEDICAL):	BASELINE	MON	TUES	WED	THUR	FRI	SAT	SUN
Extreme stiffness or lack of movement, very high fever, mental confusion, irregular pulse rate, eye pain **(EMERGENCY RESPONSE)**								
Fever, sore throat, yellowing of eyes/skin, easy bruising								
Seizure								
Stiffness of Tongue								
Sustained involuntary muscle contraction								
Sudden stiffness and inability to breathe or swallow **(EMERGENCY RESPONSE)**								
Check for each day that medication was administered:								
Check for each day if NO side effects observed:								

COMMENTS:

CSW or Medical Initials:_____Date:_____

Psychotropic Medication Monitoring Checklist (PMMC) ATOMOXETINE (STRATTERA)

Child's Name:	Prescriber	Week Week Start Date:
Check if med is given this week and record dosage: ☐	ATOMOXETINE (STRATTERA) _____ **Contraindicated in Glaucoma**	

Instructions: Place a check mark in the correct space for observed side effects. To indicate days when no monitoring took place (i.e., child was away) place a line down the length of the column(s).

COMMON:	BASELINE	MON	TUE	WED	THUR	FRI	SAT	SUN
Abdominal Pain								
Appetite Loss								
Dizziness								
Mood Swings								
Nausea								
Tiredness								
Vomiting								
INFREQUENT:	BASELINE	MON	TUES	WED	THUR	FRI	SAT	SUN
Insomnia								
Sedation								
Tremors								
RARE BUT SERIOUS (NOTIFY MEDICAL):	BASELINE	MON	TUES	WED	THUR	FRI	SAT	SUN
Jaundice (Yellow Skin or Eyes)								
Suicidal Ideation								
Check for each day that medication was administered:								
Check for each day if NO side effects observed:								

COMMENTS:

CSW or Medical Initials:_____Date:_____

Psychotropic Medication Monitoring Checklist (PMMC) LITHIUM

Child's Name:	Prescriber:	Week Start Date:
Check if med is given this week & record dosage:	☐ LITHIUM (LITHANE, CARBOLITH, APO-LITHIUM, PMS-LITHIUM, DURALITH, LITHMAX)	

Instructions: Place a check mark in the correct space for observed side effects. To indicate days when no monitoring took place (i.e., child was away) place a line down the length of the column(s).

COMMON:	BASELINE	MON	TUE	WED	THUR	FRI	SAT	SUN
Diarrhea								
Nausea								
Stomach Pain								
Thirsty								
Tremor								
Urination - Frequent								
Vomiting								
INFREQUENT:	BASELINE	MON	TUES	WED	THUR	FRI	SAT	SUN
Acne								
Appetite Change								
Bedwetting								
Blurred Vision								
Clumsy								
Confusion								
Dizziness								
Dry Skin								
Feeling Cold								
Hair Loss								
Headache								
Metallic Taste								
Swelling - General								
Rash or Hives								
Sleepiness or Tiredness								
Tingling in Fingers/ Toes								
Weakness								
RARE BUT SERIOUS (NOTIFY MEDICAL):	BASELINE	MON	TUES	WED	THUR	FRI	SAT	SUN
Hallucinations								
Seizures								
Slurred Speech								
Unsteady								
Check for each day that medication was administered:								
Check for each day if NO side effects observed:								

COMMENTS:

CSW or Medical Initials:_____Date:_____

Psychotropic Medication Monitoring Checklist (PMMC) SSRI – SELECTIVE SEROTONIN REUPTAKE INHIBITORS

Child's Name:	Prescriber:	Week Start Date:

Check all meds given this week and record dosage:

- ☐ CITALOPRAM (CELEXA) _____
- ☐ ESCITALOPRAM (CIPRALEX) _____
- ☐ FLUOXETINE (PROZAC) _____
- ☐ FLUVOXAMINE (LUVOX) _____
- ☐ PAROXETINE (PAXIL) _____
- ☐ SERTRALINE (ZOLOFT) _____

Instructions: Place a check mark in the correct space for observed side effects. To indicate days when no monitoring took place (i.e., child was away) place a line down the length of the column(s).

COMMON:	BASELINE	MON	TUE	WED	THUR	FRI	SAT	SUN
Appetite Change								
Constipation								
Diarrhea								
Dizziness								
Dry Mouth / Eyes / Nose								
Headache								
Nausea								
Nervousness								
Heart Burn								
Sleepiness / Tiredness								
Twitching								
Weakness								
INFREQUENT:	BASELINE	MON	TUES	WED	THUR	FRI	SAT	SUN
Agitation								
Blurred Vision								
Euphoria								
Insomnia								
Irritability								
Rash or Hives								
Restlessness								
Excessive Sweating								
Tremor								
Urination Trouble								
RARE BUT SERIOUS (NOTIFY MEDICAL):	BASELINE	MON	TUES	WED	THUR	FRI	SAT	SUN
Symptoms of Serotonin Syndrome: Confusion, Sweating, Seizure, Agitation, Diarrhea, Tremors, Chest Pain								
Worsened Suicidal Ideation								
Check for each day that medication was administered:								
Check for each day if NO side effects observed:								

COMMENTS:

CSW or Medical Initials:_____Date:_____

Psychotropic Medication Monitoring Checklist (PMMC)
STIMULANTS

Child's Name: ☐	Prescriber:	Week Start Date:

Check all meds given this week and record dosage:

☐ DEXTROAMPHETAMINE:
DEXEDRINE _____

☐ DEXTROAMPHETAMINE + AMPHETAMINE: ADDERALL XR _

☐ LISDEXAMFETAMINE:
VYVANSE _____

METHYLPHENIDATE:

☐ BIPHENTIN _____
☐ CONCERTA _____
☐ RITALIN _____
☐ RITALIN-SR _____

Instructions: Place a check mark in the correct space for observed side effects. To indicate days when no monitoring took place (i.e., child was away) place a line down the length of the column(s).

COMMON:	BASELINE	MON	TUE	WED	THUR	FRI	SAT	SUN
Appetite Decrease								
Mood Swings								
Sleep Disturbance								
INFREQUENT:	BASELINE	MON	TUES	WED	THUR	FRI	SAT	SUN
Abdominal Pain								
Fast Heart Rate / Heart Palpitations								
Hallucinations								
Headache								
Skin Rash								
Tics								
Tremor								
RARE BUT SERIOUS (NOTIFY	BASELINE	MON	TUES	WED	THUR	FRI	SAT	SUN
Seizure								
Check for each day that medication was								
Check for each day if NO side effects								

COMMENTS:

CSW or Medical Initials:_____Date:_____

deprescribing.org | Antipsychotic (AP) Deprescribing Algorithm

October 2016

Why is patient taking an antipsychotic?

- Psychosis, aggression, agitation (behavioural and psychological symptoms of dementia - BPSD) treated ≥ 3 months (symptoms controlled, or no response to therapy).
- Primary insomnia treated for any duration or secondary insomnia where underlying comorbidities are managed
- Schizophrenia
- Schizo-affective disorder
- Bipolar disorder
- Acute delirium
- Tourette's syndrome
- Tic disorders
- Autism
- Less than 3 months duration of psychosis in dementia
- Mental retardation
- Developmental delay
- Obsessive-compulsive disorder
- Alcoholism
- Cocaine abuse
- Parkinson's disease psychosis
- Adjunct for treatment of Major Depressive Disorder

Recommend Deprescribing

Strong Recommendation (from Systematic Review and GRADE approach)

Taper and stop AP (slowly in collaboration with patient and/or caregiver; e.g. 25%-50% dose reduction every 1–2 weeks)

Stop AP

Good practice recommendation

Continue AP

or consult psychiatrist if considering deprescribing

Monitor every 1-2 weeks for duration of tapering

Expected benefits:

- May improve alertness, gait, reduce falls, or extrapyramidal symptoms

Adverse drug withdrawal events (closer monitoring for those with more severe baseline symptoms):

- Psychosis, aggression, agitation, delusions, hallucinations

If BPSD relapses:

Consider:

- Non-drug approaches (e.g. music therapy, behavioural management strategies)

Restart AP drug:

- Restart AP at lowest dose possible if resurgence of BPSD with re-trial of deprescribing in 3 months
- At least 2 attempts to stop should be made

Alternate drugs:

- Consider change to risperidone, olanzapine, or aripiprazole

If insomnia relapses:

Consider

- Minimize use of substances that worsen insomnia (e.g. caffeine, alcohol)
- Non-drug behavioural approaches (see reverse)

Alternate drugs

- Other medications have been used to manage insomnia. Assessment of their safety and effectiveness is beyond the scope of this deprescribing algorithm. See AP deprescribing guideline for details.

Bjerre LM, Farrell B, Hogel M, Graham L, Lemay G, McCarthy L, Raman Wilms L, Rojas-Fernandez C, Sinha S, Thompson W, Welch V, Wiens A. (2015) Deprescribing antipsychotics for behavioural and psychological symptoms of dementia (BPSD) and insomnia: an evidence-based clinical practice guideline.

deprescribing.org | Bruyère Research Institute | OPEN

deprescribing.org | Antipsychotic (AP) Deprescribing Notes

October 2016

Commonly Prescribed Antipsychotics

Antipsychotic	Form	Strength
Chlorpromazine	T IM, IV	25, 50, 100 mg l25 mg/mL
Haloperidol (Haldol®)	T L IR, IM, IV LA IM	0.5, 1, 2, 5, 10, 20 mg 2 mg/mL 5 mg/mL 50, 100 mg/mL
Loxapine (Xylac®, Loxapac®)	T L IM	2.5, 5, 10, 25, 50 mg 25 mg/L 25, 50 mg/mL
Aripiprazole (Abilify®)	T IM	2, 5, 10, 15, 20, 30 mg 300, 400 mg
Clozapine (Clozaril®)	T	25, 100 mg
Olanzapine (Zyprexa®)	T D IM	2.5, 5, 7.5, 10, 15, 20 mg 5, 10, 15, 20 mg 10mg per vial
Paliperidone (Invega®)	ER T PR IM	3, 6, 9 mg 50mg/0.5mL, 75mg/0.75mL, 100mg/1mL, 150mg/1.5mL
Quetiapine (Seroquel®)	IR T ER T	25, 100, 200, 300 mg 50, 150, 200, 300, 400 mg
Risperidone (Risperdal®)	T S D PR IM	0.25, 0.5, 1, 2, 3, 4 mg 1 mg/mL 0.5, 1, 2, 3, 4 mg 12.5, 25, 37.5, 50 mg

IM = intramuscular, IV = intravenous, L = liquid, S = suppository, SL = sublingual, T = tablet, D = disintegrating tablet, ER = extended release, IR = immediate release, LA = long-acting, PR = prolonged release

Antipsychotic side effects

- **APs associated with increased risk of**:
  - Metabolic disturbances, weight gain, dry mouth, dizziness
  - Somnolence, drowsiness, injury or falls, hip fractures, EPS, abnormal gait, urinary tract infections, cardiovascular adverse events, death
- **Risk factors**: higher dose, older age, Parkinsons', Lewy Body Dementia

Engaging patients and caregivers

Patients and caregivers should understand:

- The rationale for deprescribing (risk of side effects of continued AP use)
- Withdrawal symptoms, including BPSD symptom relapse, may occur
- They are part of the tapering plan, and can control tapering rate and duration

Tapering doses

- No evidence that one tapering approach is better than another
- Consider:
  - Reduce to 75%, 50%, 25% of original dose on a weekly or bi-weekly basis and then stop; **or**
- Consider slower tapering and frequent monitoring in those with severe baseline BPSD
- Tapering may not be needed if low dose for insomnia only

Sleep management

Primary care:

1. Go to bed only when sleepy
2. Do not use your bed or bedroom for anything but sleep (or intimacy)
3. If you do not fall asleep within about 20-30 min at the beginning of the night or after an awakening, exit the bedroom
4. If you do not fall asleep within 20-30 min on returning to bed, repeat #3
5. Use your alarm to awaken at the same time every morning
6. Do not nap
7. Avoid caffeine after noon
8. Avoid exercise, nicotine, alcohol, and big meals within 2 hrs of bedtime

Institutional care:

1. Pull up curtains during the day to obtain bright light exposure
2. Keep alarm noises to a minimum
3. Increase daytime activity and discourage daytime sleeping
4. Reduce number of naps (no more than 30 mins and no naps after 2pm)
5. Offer warm decaf drink, warm milk at night
6. Restrict food, caffeine, smoking before bedtime
7. Have the resident toilet before going to bed
8. Encourage regular bedtime and rising times
9. Avoid waking at night to provide direct care
10. Offer backrub, gentle massage

BPSD management

- Consider interventions such as: relaxation, social contact, sensory (music or aroma-therapy), structured activities and behavioural therapy
- Address physical and other disease factors: e.g. pain, infection, constipation, depression
- Consider environment: e.g. light, noise
- Review medications that might be worsening symptoms

Bjerre LM, Farrell B, Hogel M, Graham L, Lemay G, McCarthy L, Raman Wilms L, Rojas-Fernandez C, Sinha S, Thompson W, Welch V, Wiens A. (2015) Deprescribing antipsychotics for behavioural and psychological symptoms of dementia (BPSD) and insomnia: an evidence-based clinical practice guideline.

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COLORADO CONSENT FORM FOR PSYCHOTROPIC MEDICATIONS

Youth Name:_____ **DOB**:_____ **ID#**:_____

THIS SECTION IS TO BE COMPLETED BY A MEDICAL PROFESSIONAL

Current medications:	Dosing:	Reason Prescribed:	Continue?
_____	_____	_____	Yes No
_____	_____	_____	Yes No
_____	_____	_____	Yes No
_____	_____	_____	Yes No
_____	_____	_____	Yes No

New medications prescribed:	Dosing instructions:	Reason Prescribed:
_____	_____	_____
_____	_____	_____

Prescriber's name and credentials:_____

I, _____ have been informed of:
(consenter's name)

- Why the medications are being given, including for what feelings and behaviors. I also understand these medications are sometimes given for uses not approved by the FDA, and we discussed this.
- The possible benefits of the medications, as well as the common, serious, and long-term side effects that may happen because of them
- The possible consequences of not taking the medications or suddenly stopping them. We have also discussed other treatment options besides these medications.
- The consequences for misusing a medication, such as by taking it in a non-prescribed way, or by trading, giving, or selling it to another person
- My right to obtain a second opinion
- Printed information about the medications was provided on: _____ (date)

By signing this consent, I confirm that I:

- Understand everything written above, and had enough time to discuss all questions and concerns I had about the medications
- Am legally competent and have the authority to consent to treatment
- Have given consent voluntarily, and know I can take back my consent at any time by letting my provider know in writing
- Understand taking back consent will not harm my relationship with my provider
- Understand that there are no guaranteed results of these medications

For a Child or Adolescent <u>Under</u> Age 15:

- I understand the child cannot be forced to take medications because of signing this consent, and as parent/legal guardian I may request that the medications be stopped.

For an Adolescent Age <u>15 Years or Older</u>:

- I understand that I may give consent for my own treatment, but cannot be forced to take medications because of signing this consent. I may ask that the medications be stopped.

Based on the above information, I voluntarily give consent for the medication(s) to be administered as prescribed:

_____ _____

Signature of Parent or Legal Guardian(s) (if applicable) Relationship

_____ _____

Signature of Youth Indicating Informed Consent or Assent Date Signed

_____

Signature(s) of Health Care Staff Administering this Consent Form

This consent for psychotropic medications will expire one year from the date the consent is signed. It may be revoked in writing at any time for all future actions. The consent may not be retroactively revoked as action has been taken in reliance on it.