



Children and Adolescent Behavioral Health

OBJECTIVE

The objective of this Clinical Practice Guideline (CPG) is to provide evidence-based practice recommendations the treatment of children and adolescent behavioral health. The CPG discusses medical and behavioral health implications. Side effects of psychotropic drugs, children in foster care / state custody, controversies, and future considerations are discussed. In addition, the CPG outlines the organizations that WellCare aligns with regarding child and adolescent behavioral health including relevant Measureable Health Outcomes.

OVERVIEW

The challenge of ensuring that children and adolescents receive evidence based mental health treatment requires a multi-pronged approach where children and families access and accept treatment, providers gain the necessary skills/knowledge and organizations and funding policies align to support them. Since most of mental health treatment is currently provided in primary care practices, there is a need for primary care clinicians and behavioral health specialists to forge new collaborative relationships that enhance the delivery of evidence-based care to affected children and their families. Well-designed pilot projects where primary care providers and child psychiatrist have used consultation, collaboration and co-management employing telephonic, video conferencing and on-site educational case reviews/training sessions have been lauded as model programs. Professional and consumer advocacy groups along with managed care organizations have urged state governments and health care systems to consider them as viable alternative approaches. To achieve the goal of increased personalized treatment of our young population is to be accomplished, the future direction for pediatric psychopharmacological research must provide a platform to: ¹

- Identify clinical and biological response predictors of treatment;
- Generate precise benefit and risk estimates of treatment in patient subgroups;
- Increase understanding of psychotropic drug exposure on the developing brain;
- Study the moderators, mediators, biomarkers and biosignatures of treatment outcome; and
- Test multi-stage treatment strategies utilizing dynamic/multimodal treatment regimes.

The most common BH conditions among children and adolescents include:¹

- ADHD
- Autism Spectrum Disorder
- Bipolar Disorder
- Conduct Disorder
- Depression
- Eating Disorders
- Oppositional Defiant Disorder
- Post-Traumatic Stress Disorder (PTSD)
- Substance Use Disorder

In addition, the following types of therapies are covered in this CPG:¹

- Adolescent Community Reinforcement (ACR)
- Assertive Continuing Care (ACC)
- Dialectical Behavior Therapy (DBT)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Functional Family Therapy (FFT)

- Multi-Dimensional Treatment Foster Care (MDTFC)
- Multi-Dimensional Family Therapy (MDFT)
- Multi-Systemic Therapy (MST)
- Parent-Child Interaction Therapy (PCIT)
- Play Therapy
- Seven Challenges
- Trauma-Focused Cognitive Behavioral Therapy (TFCBT)
- Trauma Informed Child-Parent Psychotherapy (TI-CPP)

Substance Use. Nearly 20 million people 12 years or older in the United States currently use illegal drugs. Vicodin is commonly abused by adolescents – one study found that 15% of seniors in high school reported use of a prescription drug for non-medical purposes in the prior year.¹

Risk-Taking Behavior. These are types of behavior that increase the chance of injury or death. Deaths among those age 10-24 years old, 72% result: motor-vehicle crashes, other unintentional injuries, homicide, and suicide. Results from the 2007 National Youth Risk Behavior Survey, 29% of high school students had been in a car with a driver who had alcohol, 18% had carried a weapon, 75% had drunk alcohol, and 48% had sexual intercourse.¹

Suicide. As the third leading cause of death among 15-to-24-year olds, suicide represents 12% of all deaths. The 2007 National Youth Risk Behavior Survey found that 7% of high school students surveyed had attempted suicide - 14.5% had seriously considered attempting suicide. The following warning signs and risk factors of suicide should be carefully monitored: depression, previous suicide attempts, recent losses, frequent thoughts about death, and the use of drugs or alcohol.¹

Medications. Antipsychotic prescribing for children has increased rapidly in recent decades, driven by new prescriptions and by longer duration of use. The frequency of prescribing antipsychotics among youth increased almost fivefold from 1996–2002, from 8.6 per 1,000 children to 39.4 per 1,000. Atypical antipsychotics doubled their share of all psychotropic medication prescriptions among privately insured youth between 1997 and 2000, from 2.4 percent of all psychotropic prescriptions to 5.1 percent. A national study of Medicaid-enrolled children found that prescribing of atypical antipsychotics increased 62 percent from 2002–2007.² Additional information can be found below under *Pharmacology*.

Psychotropic prescribing among this population has also increased. Factors include more awareness of severe behavioral health problems in children and adolescents, the development of drugs deemed safer than their previous counterparts, and an increase of behavioral expectations of very young children in settings like childcare or preschool.³ The Psychotropic Medication for Children and Adolescents Working Group (American Psychological Association) detailed estimates for the associated morbidity among child and adolescent mental disorders with prevalence rates for childhood disorders – this ranged from 17-22%. Of even greater concern is that 1 in 5 obtain mental health services.⁴ Some estimates indicate that approximately 8 million youth take multiple psychotropic medication⁵ – a trend found among various populations including those enrolled in Medicaid, foster care, preschoolers, and adolescents.^{3,6}

Additional information regarding issues on Medicaid and those in foster care can be found below.

Additional information concerning antipsychotic and psychotropic drug use in children and adolescents, are detailed in to the *Pharmacology* section below.

Hierarchy of Support

GUIDELINE HIERARCHY

CPGs are updated annually or as necessary due to updates made to guidelines or recommendations by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Psychiatric Association (APA). When there are differing opinions noted by national organizations, WellCare will default to the member's benefit structure as deemed by state contracts and Medicaid / Medicare regulations. If there is no specific language pertaining to the Children and Adolescent Behavioral Health, WellCare will default (in order) to the following:

- National Committee for Quality Assurance (NCQA);

- United States Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), Agency for Healthcare Research and Quality (AHRQ);
- Specialty associations, colleges, societies, etc. (e.g., American Academy of Family Physicians, American Congress of Obstetricians and Gynecologists, American Cancer Society, etc.).

Links to websites within the CPGs are provided for the convenience of Providers. Listings do not imply endorsement by WellCare of the information contained on these websites. NOTE: All links are current and accessible at the time of MPC approval.

WellCare aligns with AACAP and APA regarding this topic; highlights from their respective publications are below.

AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY (AACAP)

The American Academy of Child and Adolescent Psychiatry (AACAP) *Practice Parameter for the Use of Atypical Antipsychotic Medications in Children and Adolescents* recommends that “dosing of AAAs [atypical antipsychotic agents] should follow the ‘start low and go slow’ approach and seek to find the lowest effective dose.” The AACAP *Practice Parameter for the Assessment and Treatment of Children and Adolescents with Schizophrenia* calls for “adequate dosages” of antipsychotic medications and states that “instituting large dosages during the early part of treatment generally does not hasten recovery...the medication dosage should be periodically reassessed to ensure that the lowest effective dose is being used.” The full AACAP Practice Parameter is available [here](#).² For additional information regarding the AACAP’s guidance on medication use, please see the *Pharmacology* section below.

Additional Practice Parameters published by the AACAP are noted below:⁷

- [Autism](#) (2014)
- [Cultural Competency](#) (2013)
- [Child Welfare](#) (2015)
- [Eating Disorders](#) (2015)
- [Gay, Lesbian, Bisexual, Transgender Youth](#) (2012)
- [Obsessive Compulsive Disorder](#) (2012)
- [Psychodynamic Psychotherapy with Children](#) (2012)
- [Reactive Attachment Disorder and Disinhibited Social Engagement Disorder](#) (2016)
- [Schizophrenia](#) (2013)
- [Tic Disorders](#) (2013)

The AACAP has issued the following Policy Statements on the behavioral health topics below:⁸

- [Autism and Vaccines](#) (2016)
- [Children and Guns](#) (2016)
- [Coercive Interventions for Reactive Attachment Disorder](#) (2016)
- [Comorbidity Treatment in Autism Spectrum Disorders and Intellectual Disabilities](#) (2013)
- [Delivery of Child and Adolescent Psychiatry Services Through Telepsychiatry](#) (2017)
- [Family and Youth Participation in Clinical Decision-Making](#) (2009)
- [Gay, Lesbian, Bisexual, or Transgender Parents](#) (2009)
- [HIV/AIDS and Children and Adolescents](#) (2009)
- [HIV and Psychiatric Hospitalization of Children and Adolescents](#) (2009)
- [Prevention of Bullying Related Morbidity and Mortality](#) (2011)
- [Psychologists Prescribing](#) (2017)
- [Psychotherapy as a Core Competence of Child and Adolescent Psychiatrist](#) (2014)
- [Transgender Youth in Juvenile Justice and other Correctional Systems](#) (2016)
- [Pharmaceutical Benefit Management & Use of Psychotropic Medication for Children & Adolescents](#) (2009)
- [Sexual Orientation, Gender Identity, and Civil Rights](#) (2009)

AMERICAN PSYCHIATRIC ASSOCIATION

Through the American Board of Internal Medicine’s Choosing Wisely initiative, the APA published *Five Things Physicians and Patients Should Question*. The APA states that antipsychotic medications should not be routinely prescribed as a first-line intervention for children and adolescents for any diagnosis other than psychotic disorders. FDA approved and/or evidence supported indications for antipsychotic medications in children and adolescents include psychotic disorders, bipolar disorder, tic disorders, and severe irritability in children with autism spectrum disorders; there is increasing evidence that antipsychotic medication may be useful for some disruptive behavior disorders. Children and adolescents should be prescribed antipsychotic medications only after having had a careful diagnostic

assessment with attention to comorbid medical conditions and a review of the patient's prior treatments. Efforts should be made to combine both evidence-based pharmacological and psychosocial interventions and support. Limited availability of evidence based psychosocial interventions may make it difficult for every child to receive this ideal combination. Discussion of potential risks and benefits of medication treatment with the child and their guardian is critical. A short and long term treatment and monitoring plan to assess outcome, side effects, metabolic status and discontinuation, if appropriate, is also critical. The evidence base for use of atypical antipsychotics in preschool and younger children is limited and therefore further caution is warranted in prescribing in this population.⁹

Evidence Based Practice

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

The Agency for Healthcare Research and Quality (AHRQ) has published various reports on mental health conditions related to children and adolescents. Topics include:

- [Anxiety in Children](#)¹⁰
- [Child Exposure to Trauma: Interventions Addressing Maltreatment](#)¹¹
- [First- and Second-Generation Antipsychotics in Children and Young Adults](#)¹²
- [Interventions Targeting Sensory Challenges in Children with Autism Spectrum Disorder - An Update](#)¹³
- [Medical Therapies for Children with Autism Spectrum Disorder — An Update](#)¹⁴
- [Psychosocial and Pharmacologic Interventions for Disruptive Behavior in Children and Adolescents](#)¹⁵
- [Screening for Autism Spectrum Disorder in Young Children](#)¹⁶
- [Screening for Suicide Risk in Primary Care](#)¹⁷
- [Strategies to Improve Mental Health Care for Children and Adolescents](#)¹⁸
- [Therapies for Children With Autism Spectrum Disorder: Behavioral Interventions Update](#)¹⁹

To search for reports by the AHRQ, [click here](#).²⁰

MEASUREMENT OF COMPLIANCE

WellCare is committed to adhering to the measures and standards published by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). Please reference WellCare's Clinical Policy Guiding Document titled *Measures of Compliance*.

NOTE: To access Clinical Policy Guiding Documents visit www.wellcare.com – select the Provider tab, then “Tools” and “Clinical Guidelines”.

Care Management

Studies have shown that an integrated program, with families engaged in treatment and a service that is culturally competent is the most effective in managing mental health in children and adolescents. Children experiencing a mental health crisis should have a comprehensive assessment, screening and evaluation. An individual care plan is needed to meet the needs of the child. It is important to build trust, engage the family in treatment and provide the family with supports as the family is an essential piece in the treatment of mental health for children and adolescents. It is important to consider the impact of culture on mental health services and tailor services to cultural traditions if possible. Care should be taken to create a strong discharge plan when a child is transitioning from inpatient or residential back into the community. The facility should recommend necessary follow up treatment and the Care Manager should ensure the appointments and referrals are coordinated.²¹

Adjustment Disorders. **Interpersonal Psychotherapy (IPT)** has the most evidence that it helps children and adolescents address problems in their relationships leading to less depression. **Cognitive Behavioral Therapy (CBT)** can also be used to improve problem solving, communication, stress management and improved adaptation and coping. **Stress Management, Group Therapy** and **Family Therapy** are also effective treatments for Adjustment Disorders. Pharmacology alone does not provide the child assistance in learning how to cope with a stressor and therefore is not an effective treatment for Adjustment Disorders.

Anorexia Nervosa. **Nutritional Rehabilitation, Family Psychotherapy, In-patient Behavioral Programs** and **Pharmacological Treatments** (used after weight is restored to manage psychiatric comorbidities) are effective for treatment. Individual Psychotherapy, Group Psychotherapy, 12-Step Programs and Somatic Treatments have not been shown to be effective treatment options for Anorexia Nervosa.

ADHD. **Behavioral Classroom Management (BCM)** which includes rewards programs, token systems, time-outs and report cards, **Behavioral Parent Training (BPT)**, **Intensive Behavioral Peer Intervention (BPI)**, **Amphetamine, Methylphenidate**, and **Atomoxetine** are all effective treatments of ADHD. Cognitive, psychodynamic, client-centered therapies, office-based social skills training, dietary interventions and antidepressants have not been shown to be effective in managing ADHD.

Anxiety Disorders. **Behavior** and **Cognitive Behavioral Therapy (CBT)**, **SSRIs** and **Educational Support** to parents are effective in treating anxiety in children and adolescents. There is minimal to no supportive evidence that Play Therapy, Psychodynamic therapy or Biofeedback is effective in managing anxiety in children or adolescents.

Autism Spectrum Disorders (ASD). **Applied Behavior Analysis (ABA)**, Discrete Trial Teaching (DTT), **Pivotal Response Teaching (PRT)**, **Learning Experiences: An Alternative Program (LEAP)**, **Pharmacological Treatments**, **Educational and Communication-focused Interventions (TEACCH)**, **Natural Language Methods**, **Picture Exchange Communication System (PECS)**, **Other Behavioral Interventions**, **Occupational Therapy** and **Sensory Integration (SI)** all seem to be effective in managing ASD.

Bulimia Nervosa. **Cognitive Behavioral Therapy (CBT)**, **Pharmacological Treatments** (specifically SSRIs) and especially a combination of the two are the most effective for managing bulimia. Individual Psychotherapy, Behavioral Therapy and 12-step programs have not been shown to be effective in managing bulimia.

Depression/Dysthymia. For children; **Starks Cognitive Behavioral Therapy (CBT)** in a group setting with or without parents in the group, **Penn Prevention Program (PPP)**, **Self-control therapy**, and **Behavioral Therapy** have all been shown to be effective treatments. For adolescents; **Cognitive Behavioral Therapy (CBT)** in a group setting with or without parents or individually, **Interpersonal Therapy**, **Adolescent Coping with Depression (CWD-A)**, **Interpersonal Therapy for Depressed Adolescents (IPT-A)**, and **SSRIs** have all been shown to be effective.

Disruptive Behavior Disorders. **Assertiveness Training: Group Assertiveness Training, Parent Management Training (PMT) Programs, Multisystemic Therapy (MST)**, **Cognitive Behavioral Therapy (CBT)**, **Multidimensional Treatment Foster Care (MTFC)** have all been shown to be effective treatments. Pharmacological therapies, boot camps, shock incarcerations, and dramatic, short term or talk therapy has not been shown to be effective.

Early-Onset Schizophrenia. **Traditional Neuroleptics/First Generation Antipsychotics, Atypical Antipsychotics, Family Psychoeducation and Support**, and **Cognitive Behavioral Therapy (CBT)** have been shown to be effective in managing Schizophrenia in adolescents. Psychodynamic therapy has not been shown to be effective and may be harmful in this population.

Obsessive-Compulsive Disorder. **Exposure and Response Prevention (ERP)**, **Selective Reuptake Inhibitors (SRIs)**, and **SSRIs** have been shown to be effective treatments. Evidence does not support the following: cognitive therapy, psychodynamic therapy, client-centered therapy, antibiotic therapy and herbal therapy.

Pediatric Bipolar Disorder. **Mood stabilizers/Anticonvulsants, Second-generation antipsychotics, Family Focused Psychoeducational Therapy (FFT)**, **Child and family-focused Cognitive Behavioral Therapy (CFF-CBT)**, and **Multifamily Psychoeducational Groups (MFPG)** have shown to be effective. Interpersonal social rhythm therapy has not been shown to be effective in adolescents.

Substance Use Disorders. **Cognitive Behavioral Therapy (CBT)**, **Family Therapy, Multisystemic Therapy, Behavioral Therapies, Motivational Interviewing Approaches** and **some medication** may be effective. Interpersonal and Psychodynamic Therapies, Client-centered therapies, Psychoeducation, Project CARE, 12-step programs, and Process groups have not been shown to be effective in this population.

MEASURABLE HEALTH OUTCOMES

- **Symptoms:** Member's school attendance will improve by at least 20%

- **Engagement:** Member's guardian will attend >75% of meetings with teacher and school psychologist to discuss IEP/504 and modifications for member
- **Adherence:** Member will attend >75% of outpatient therapy appointments
- **Adherence:** Member will take prescribed medications >90% of the time
- **Utilization:** Member's ER admissions related to behavioral health problems will decrease by >50%

CASE MANAGEMENT GOALS

- **Symptoms:** Member will verbalize at least 3 appropriate coping skills such as yoga, art, music and/or drama.
- **Symptoms:** Member's guardian will verbalize at least 3 coping skills, soothing skills or relaxation techniques that can be used with member.
- **Engagement:** Member's guardian to obtain a journal to record daily mood, sleep, behavioral health symptoms.
- **Engagement:** Member's guardian will verbalize at least 2 people that are supportive and make a plan to connect with them.
- **Engagement:** Member will engage in at least one activity such as a new hobby.
- **Engagement:** Member's guardian connect to a caregiver training program or support/educational group.
- **Engagement:** Member will guardian will meet with teacher to discuss modifications in classroom.
- **Adherence:** Member will have a relapse prevention/crisis plan in place.
- **Utilization:** Member will attend a PCP appointment for preventative care.
- Specific for Members requiring hospitalization: The Member participates in provider follow-up visit within 7 days of hospital discharge.

CASE MANAGEMENT OBJECTIVES

- Educate member's guardian on relaxation techniques and coping skills.
- Assist member's guardian in getting IEP or 504 plan implemented for member.
- Refer member to individual therapy, psychiatric evaluation and/or psychological testing if needed.
- Refer to Targeted Case Management (TCM) if available.
- Assist member's guardian in applying for disability or any other government sponsored program member may be eligible for.
- Refer member's guardian to parent support programs such as Parent 2 Parent.
- Educate member's guardian on creating a notebook to record conversations with providers and teachers as well as recording doctors' reports and evaluations.
- Refer member to community-based services that can be provided in the home, school or community.
- Refer member to afterschool program, tutoring program or mentoring program such as Boys and Girls Club or Big Brothers, Big Sisters.
- Encourage regular communication between guardian and school.
- Educate member's guardian on how to assist member with communication and assertiveness to be able to express feelings and needs appropriately.

MEDICAL BEHAVIORAL INTEGRATION

Pediatric Primary Care is an important setting for providing behavioral health care due to the familiarity of the provider, the lack of stigma and easy access. Four out of Five children diagnosed with a behavioral health condition do not get treatment for the disorder due to various barriers such as lack of accessibility, long wait times for services, social stigma, and poor communication between behavioral health and medical professionals.²²

THERAPY TYPES

The following are types of therapy that may be used in children and adolescents:

Adolescent Community Reinforcement Approach / Assertive Continuing Care (ACRA/ACC). An outpatient program for individuals age 12-24 who have substance use and co-occurring mental health disorders. A-CRA uses behavioral and cognitive-behavioral techniques to replace environmental settings and cues that have supported alcohol or drug use with prosocial activities and new social skills that support recovery. ACRA is a main component

within ACC; this ensures that youth are provided home, school, or other community visits following residential treatment for substance use disorders. There are three sessions of ACRA: for adolescents alone; for parents/caregivers alone; and for adolescents and parents/caregivers together. Sessions are conducted by a behavioral health clinician and are tailored to the youth's needs and self-assessment of happiness in multiple areas of life functioning. Twenty-one procedures are available to select from to develop problem-solving skills to cope with day-to-day stressors and priming new prosocial activities with the goal of improving life satisfaction and eliminating alcohol and substance use problems.

Skills training for ACRA involves coaching, practice, and feedback. The emphasis is on supporting better family relationship skills, anger management, and relapse prevention skills. Homework assignments reiterate concepts between sessions. Overall ACRA is delivered for 12-14 weeks which includes 10, 1-hour individual sessions; two, 1-hour sessions with parents/caregivers; and two, 1-hour sessions with both adolescents and parents/caregivers together. ACC is a continuing care intervention specifically designed for adolescents following a period of residential, intensive outpatient, or regular outpatient treatment. It stresses rapid initiation of continuing care services after discharge to promote recovery and prevent relapse. Delivered primarily through home visits, providers offer ACRA procedures in accordance with the information the adolescent provides in terms of reinforcers, strengths, and needs. Providers also offer case-management services such as linkages to needed community services, home/community therapy sessions, and midweek telephone calls between the provider and adolescent. A-CRA/ACC has also been implemented with juvenile-justice-involved youths within a drop-in center, and with youths in residential treatment.²³

Dialectical Behavior Therapy (DBT). Therapy is a comprehensive treatment for borderline personality disorder (BPD). Most research focuses on parasuicidal women with BPD however evidence has begun to show promise for treating those with BPD with a substance use disorder (SUD) or binge-eating disorder. This therapy may also be helpful in treating depressed elderly patients. DBT is similar to other cognitive-behavioral approaches however, DBT serves the five functions of treatment; focuses on the biosocial theory and focusing on emotions in treatment; a consistent dialectical philosophy; and a mindfulness and acceptance-oriented interventions.²⁴

Eye Movement Desensitization and Reprocessing (EMDR). Cognitive behavior therapy (CBT) is often the first-line therapy for adolescent depression, data is limited regarding the efficacy of other psychotherapeutic techniques for treating adolescents with depression.²⁵ Two well-designed clinical trials of EMDR in children have shown mixed results.²⁶ EMDR is a brief, trauma-focused treatment that yielded equally large remission rates for PTSD and reductions in the severity of PTSD and comorbid difficulties in children and adolescents seeking treatment for PTSD tied to a single event. Further trials of both treatments with PTSD tied to multiple traumas are warranted.²⁷

Functional Family Therapy (FFT). FFT is a short-term, high quality intervention program with an average of 12 to 14 sessions over three to five months. This therapy is primarily used with youth ages 11 to 18 years old who have been referred for behavioral or emotional problems by the juvenile justice, mental health, school or child welfare systems. Services are conducted in both clinic and home settings as well as in schools, child welfare facilities, probation and parole offices/aftercare systems, and mental health facilities. The core of FFT is a focus on assessment and intervention to address risk and protective factors within and outside of the family that impact the adolescent and his or her adaptive development. The five major components of FFT include: engagement, motivation, relational assessment, behavior change and generalization. Each component has its own goals, focus and intervention strategies.²⁸

Multi-Dimensional Treatment Foster Care (MTFC). As a cost-effective treatment to traditional foster care (e.g., group home treatment or State facilities, incarceration), MTFC provides care to youth who have been removed from the home due to substance use and/or involvement in the juvenile justice system. MTFC usually is utilized after previous family preservation efforts have failed. Individuals are referred to care via the juvenile courts, mental health and child welfare agencies. Based on social learning theory, MTFC has four key elements that are the focus of time during foster care placement and aftercare:²⁹

- Providing a consistent, reinforcing environment where youth are mentored and encouraged to develop academic and positive living skills;
- Providing daily structure that includes clear expectations, limits, and specified consequences delivered in a teaching-oriented manner;
- Providing close supervision; and
- Helping youth to avoid deviant peer associations while providing them with the support and assistance needed to establish pro-social peer relationships.

Session length varies and depends on treatment intensity; they are created to mirror normative life. Sessions typically last for 6 to 9 months and include interventions conducted in the foster home. Continuing care also works with both the family and with the adolescent individually. MTFC is recommended for youth between the ages of 13 and 17.²⁹

Multi-Dimensional Family Therapy (MDFT). This therapy is an early intervention for youth that is integrated, comprehensive and family-centered for youth problems and disorders. MDFT prevents out-of-home placement and focuses on key areas. MDFT is suitable for youth with issues such as substance abuse, delinquency, antisocial and aggressive behaviors, school and family problems, and emotional difficulties. MDFT promotes change.³⁰

- Within the heart and mind of the adolescent
- In how parents relate to and influence their children
- In how the family solves problems and loves one another
- And in the family's interactions with school, juvenile justice, and their community

MDFT is utilized in drug abuse and mental health treatment settings (outpatient, in-home, intensive outpatient, day treatment, and residential) and with youth in juvenile justice, drug court, and child welfare settings. Therapy is culturally-responsive and gender-sensitive. Treatment objectives include:³⁰

1. Treatment Engagement and Completion
2. Family Functioning
3. Substance Abuse
4. School Performance
5. Criminal and Delinquent Behavior
6. Family Stability
7. Mental Health Symptoms

Multi-Systemic Therapy (MST). As an intensive family- and community-based treatment program, MST focuses on addressing all environmental systems that impact chronic and violent juvenile offenders (homes, families, schools, teachers, neighborhoods, friends). MST recognizes that each system plays a critical role in a youth's world and thus requires attention. MST works with the offenders ages 12 to 17 who have a very long history of arrests.³¹

Parent-Child Interaction Therapy (PCIT). Therapy places an emphasis on improving the quality of the parent-child relationship as well as changing parent-child interaction patterns for young children. Sessions include both the child and their caregiver(s) with session time spent coaching caregivers in the application of specific therapy skills. Therapists typically coach from an observation room with a one-way mirror into the playroom, using a "bug-in-the-ear" system for communicating to the parents while they interact with their child. At the end of each session, the therapist and caregiver(s) decide which skill to focus on during daily 5-minute home practice sessions the following week.³²

Play Therapy. Play therapy is the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development. The American Association for Play Therapy states that children between the ages of 3 to 12 years old should participate in play therapy as an intervention to alleviate symptoms related to behavioral and emotional problems, as well as contribute to overall wellness and healthy development. To read the *Evidence-Based Practice Statement: Play Therapy* published by the AAPT, click [here](#).³³

Seven Challenges. The Seven Challenges program is for adolescents and young adults and places emphasis on creating a climate of mutual respect within which individuals can talk openly and honestly about themselves. Young people are engaged by actively thinking about their use of alcohol and/or substance abuse, and its effect upon their lives. The program also helps individuals understand what needs they are meeting by using drugs, what harm they are causing, what risks they are taking, and what it entails to make changes. Co-occurring problems are also a focus of the program. The Seven Challenges are noted below:³⁴

1. We decided to open up and talk honestly about ourselves and about alcohol and other drugs.
2. We looked at what we liked about alcohol and other drugs, and why we were using them.
3. We looked at our use of alcohol and other drugs to see if it has caused harm or could cause harm.
4. We looked at our responsibility and the responsibility of others for our problems.
5. We thought about where we seemed to be headed, where we wanted to go, and what we wanted to accomplish.
6. We made thoughtful decisions about our lives and about our use of alcohol and other drugs.

7. We followed through on our decisions about our lives and drug use. If we saw problems, we went back to earlier challenges and mastered them.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). This form of therapy is a parallel child and parent (or primary caregiver) treatment model that encompasses cognitive-behavioral, developmental, neurobiological, attachment, family, and empowerment principles. Goals center on helping the child and parent(s) gain resiliency and coping skills, master learned and over-generalized avoidance of feared trauma memories, make more adaptive meaning of traumatic experiences, and resume optimal developmental trajectories. Children with trauma-related symptoms can benefit from trauma-focused psychotherapy whether or not they meet diagnostic criteria for PTSD.²⁶

There are three phases and components of TF-CBT; therapy is provided in each session in individual, parallel sessions to the child and the parent or caregiver and in conjoint child-parent sessions as described below:²⁶

- **Stabilization Phase** – comprised of psychoeducation, parenting skills, relaxation skills, affect modulation skills, and cognitive processing skills
- **Trauma Narration and Processing Phase** – includes trauma narration and processing
- **Integration and Consolidation Phase** – in vivo mastery, conjoint child-parent sessions, and enhancing safety

The individual components of the phases spell out the acronym "PPRACTICE" – **P**sychoeducation, **P**arenting skills, **R**elaxation skills, **A**ffect modulation skills, **C**ognitive processing skills, **T**rauma narration and processing, **I**n vivo mastery of trauma reminders, **C**onjoint child-parent sessions, and **E**nhancing safety. TF-CBT sessions are usually provided once a week for an hour over the course of 12 to 25 sessions. Additional sessions may be needed depending on the severity of the child's clinical presentation. Providers should monitor children's responses to treatment through child self-reported ratings of PTSD symptom severity (e.g., self-report instruments like the Child PTSD Symptom Scale, Young Children's PTSD Checklist).²⁶

Trauma Informed Child-Parent Psychotherapy (TI-CPP). This type of therapy is for young children (age birth to six years) who have experienced a trauma and their parent(s) or caretaking adult. CPP is very effective among children age birth to three years as well as young children who cannot express their emotions verbally but do so through play (e.g., developmental delay). The aim is to support and strengthen the parent-child relationship as a way to heal the negative impacts of interpersonal trauma. While CPP encompasses elements of CBT, CPP is based on attachment and psychodynamic theory. CPP provides more sustained interventions to the child and parent; it may be helpful for parents who are highly dysregulated due to personal experiences of domestic violence. Intervention targets include:

- Addressing parental and child maladaptive representations of self and each other
- Developing a joint trauma narrative to identify and address trauma triggers
- Developing more satisfying interpersonal relationships, activities, routines, and goals

Therapy sessions are provided in 40 to 50 weekly dyadic child-parent sessions; additional parent sessions are provided as needed. Monitoring of young children's PTSD and behavioral symptoms is systematic and a developmentally appropriate instrument should be used (e.g., YCPC). Parental symptoms may also be monitored if a subject of clinical attention.²⁶

MEMBER EDUCATIONAL RESOURCES

Currently there are no Krames/StayWell Member educational materials utilized by WellCare Case Managers. The following websites contain additional information on the topics below:

ADHD

- [Attention Deficit Disorder Resources](#)
- [Children and Adults with Attention Deficit Disorder](#)

Anxiety

- [Anxiety Disorders Association of America \(ADAA\)](#)

Autism

- [Autism Society of America](#)

Obsessive Compulsive Disorder

- [Obsessive Compulsive Foundation](#)

PTSD

- [Gateway to Post Traumatic Stress Disorder Information](#)

Suicide

- [American Foundation for Suicide Prevention](#)
- [National Suicide Prevention Lifeline](#)

- [Autism Speaks](#)

Bipolar

- [Child and Adolescent Bipolar Foundation](#)
- [Depression and Bipolar Support Alliance \(DBSA\)](#)

Eating Disorders

- [National Association of Anorexia Nervosa and Associated Disorders](#)

Violence

- [National Center for Children Exposed to Violence](#)
- [National Foundation for Abused and Neglected Children](#)
- [Prevent Child Abuse America](#)

PHARMACOLOGY

NOTE: Additional prescribing guidance is located in the Addendum.

The American Academy of Child and Adolescent Psychiatry (AACAP) published the following principles to guide treatment of children and adolescents with psychotropic drugs:³⁵

1. Before initiating pharmacotherapy, a psychiatric evaluation is completed.
2. Before initiating pharmacotherapy, a medical history is obtained, and a medical evaluation is considered when appropriate.
3. The prescriber is advised to communicate with other professionals involved with the child to obtain collateral history and set the stage for monitoring outcomes and side effects during the medication trial.
4. The prescriber develops a psychosocial and psychopharmacological treatment plan based on the best available evidence.
5. The prescriber develops a plan to monitor the patient, short and long term.
6. Prescribers should be cautious when implementing a treatment plan that cannot be appropriately monitored.
7. The prescriber provides feedback about the diagnosis and educates the patient and family regarding the child's disorder and the treatment and monitoring plan.
8. Complete and document the assent of the child and consent of the parents before initiating medication treatment and at important points during treatment.
9. The assent and consent discussion focuses on the risks and benefits of proposed and alternative treatments.
10. Implement medication trials using an adequate dose and for an adequate duration of treatment.
11. The prescriber reassesses the patient if the child does not respond to the initial medication trial as expected.
12. The prescriber needs a clear rationale for using medication combinations.
13. Discontinuing medication in children requires a specific plan.

The AACAP practice parameter also specifies that this approach is necessary for safe, effective and proactive treatment and should help decrease the stigma that some children and their parents may experience from participating in psychiatric care. This consistent and rigorous method for assessment and treatment should safeguard against the:

- Introduction of unacceptable variability into the pharmacological treatment of children;
- Underuse of established psychosocial and pharmacological treatment approaches; and
- Prescription of ineffective/outdated treatment approaches, inappropriate medications or medication combinations.

The recommended practices are implemented in an effort to eliminate demoralization experienced by patients and families receiving substandard treatment, "dropping out" of care or not seeking necessary treatment in the future.³⁶

Atypical Antipsychotic Agents (AAAs)

This type of pharmaceutical agent is sometimes referred to as second generation antipsychotics (SGAs), are currently marketed in the United States for use in adults, adolescents and children for specific indications but are often prescribed "off-label" to treat other conditions in children and adolescents. These AAAs include clozapine, risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, paliperidone, and asenapine. Safety issues surrounding the use of AAAs in youth include:²

- Weight changes, diabetes, and hyperlipidemia
- Cardiovascular
- Agranulocytosis and neutropenia
- Hepatic dysfunction
- Prolactin (in adults and youths, elevated levels may lead to symptoms such as amenorrhea, galactorrhea, and gynecomastia; the long-term significance of asymptomatic prolactin elevations remains uncertain).
- Seizures
- Extrapyrimal symptoms (EPS), tardive dyskinesia and withdrawal dyskinesias
- Neuroleptic malignant syndrome (NMS)
- Cataracts

Recent data from adult and child/adolescent studies and meta-analyses and reviews suggest that AAAs are not necessarily more effective than older antipsychotic agents. While supporting the use of some AAAs as adjunct treatment for refractory major depressive disorder (MDD), a FDA advisory panel opposed approval as stand-alone treatment for MDD and generalized anxiety disorders in adults due to cardiac, metabolic and other safety risks. While many AAAs can be sedative, there is minimal data supporting their use as hypnotics alone. No data is available for children or adolescents on asenapine, the newest AAA approved for use in adults with acute or ongoing schizophrenia or acute mania alone or with lithium. Evidence is strongest in supporting use of AAAs for children and adolescents with schizophrenia and bipolar I disorder, while evidence for use with disruptive behavior disorders is much less robust except in youth with autism. Only one study supports the use of AAAs in long-term treatment for disruptive behavior. Despite increasing evidence of these agents efficacy, a long-term safety profile has yet to be evaluated and characterized.²

Psychotropics

The Government Accountability Office (GAO) note that trends continue despite efforts by providers, advocates and other behavioral health professionals. A GAO report reviewed data from the Medical Expenditure Panel Survey (MEPS) among those age 0- 20 and enrolled in Medicaid, State Children's Health Insurance Programs (CHIP), and those in foster care. Data was compared to privately insured children. Results show that 6% of noninstitutionalized children and enrolled in Medicaid and nearly 5% of privately insured children took at least one psychotropic medication during a calendar year. Data show that utilization was twice as high in boys than in girls (8.4% vs. 3.9%). The GAO report also found that children enrolled in Medicaid were more than two times as likely to be prescribed an antipsychotic medication (1.3% vs. 0.5%).³⁷

Drugs most prescribed included those used for treating ADHD, antidepressants, antipsychotics, mood stabilizers, and sedative-hypnotics. In addition, the medical literature illustrates three major trends:⁶

- A two- to three- fold increase in the percentage of child and adolescents taking any psychotropic medication over a ten year time span
- An increase in adolescent office visits that resulted in prescribing psychopharmacological prescriptions; this was seen among child and adolescents (ages 6 – 17)
- An increase in prescribing to males (10% of all visits)

FDA indications and ages approved by the FDA for psychotropic medications can be found [here](#).³⁸

At the time of approval of the CPG, the link above was current. This link is not maintained by WellCare and may change.

CHILDREN IN FOSTER CARE / STATE CUSTODY

Antipsychotic Medication Use

According to the American Academy of Child & Adolescent Psychiatry (AACAP), approximately 85% of children in the child welfare system meet the criteria for a psychiatric diagnosis. State government public sector health systems face a trend where children in foster care have become increasingly more vulnerable to inappropriate and excessive medication use. These children have many needs related to emotional and psychological stress because they have typically experienced abuse in neglectful, serial or chaotic caretaking environments and often present with past

traumatic and reactive attachments that can mimic or complicate mental disorders.³⁵

Children in state custody* often have biological, psychological, and social risk factors that predispose them to emotional and behavioral disturbances (e.g., genetic predisposition, in utero exposure to substances of abuse, medical illnesses, cognitive deficits, a history of abuse and neglect, disrupted attachments, and multiple placements). Unfortunately, resources lack in this area and due to multiple placements, medical and psychiatric care is frequently fragmented. These factors present profound challenges to providing high quality mental health care to this unique population. Unlike mentally ill children from intact families, these children often have no consistent interested party to provide informed consent for their treatment, to coordinate treatment planning and clinical care, or to provide longitudinal oversight of their treatment.³⁵

The State has a duty to perform this protective role for children in State custody. However, the State must also take care not to reduce access to needed and appropriate services. Many children in State custody benefit from psychotropic medications as part of a comprehensive mental health treatment plan. Due to several highly publicized cases of questionable inappropriate prescribing, treating youth in State custody with psychopharmacological agents has come under increasingly intense scrutiny. Some states have implemented consent, authorization, and monitoring procedures for the use of psychotropic medications for children in state custody. However, these policies often have unintended consequences (e.g., delaying provision of or reducing access to necessary medical care).³⁵

Studies show differences in atypical antipsychotic medication use that varied by age, Medicaid eligibility, and diagnostic status. Youth in foster care diagnosed with ADHD and no other comorbid illness were three times more likely to be taking atypical antipsychotics and for an additional 100 days per year than their peers enrolled in Medicaid because of low family income. Side effects (e.g., weight gain, high cholesterol, elevated blood glucose, insulin resistance) can occur with use of antipsychotic drugs; researchers stressed the need for review of each case before prescribing as well as continued monitoring and research to assure that the benefits of these medications outweigh the risks in children and adolescents. Exposure to atypical antipsychotics in Medicaid-insured youth, in particular for children in foster care and those diagnosed with ADHD, was substantial, warranting outcomes research for long-term effectiveness, safety, and oversight for appropriate cardiometabolic monitoring.³⁹

Prescribers are defined by the scope of practice by State and Federal Law.

* The State has assumed all parental responsibilities and decision-making for the child.

Children in state custody should receive psychosocial treatment prior to prescribing of medication.

The AACAP developed the following basic principles regarding the psychiatric and pharmacologic treatment of children in state custody:³⁵

1. Every youth in state custody should be screened and monitored for emotional and/or behavioral disorders. Youth with apparent emotional disturbances should have a comprehensive psychiatric evaluation. If indicated, a biopsychosocial treatment plan should be developed.
2. Youth in state custody who require mental health services are entitled to continuity of care, effective case management, and longitudinal treatment planning.
3. Youth in state custody should have access to effective psychosocial, psychotherapeutic, and behavioral treatments, and, when indicated, pharmacotherapy.
4. Psychiatric treatment of children and adolescents requires a rational consent procedure. This is a two-staged process involving informed consent provided by a person or agency authorized by the state to act in loco parentis and assent from the youth.
5. Effective medication management requires careful identification of target symptoms at baseline, monitoring response to treatment, and screening for adverse effects.
6. States developing authorization and monitoring procedures for the use of psychotropic medications for youth in state custody should use the principles in this document as a guide and should assure that children and adolescents in state custody get the pharmacological treatment they need in a timely manner.

Studies have shown that in addition to being in foster or state care, other factors that increase the risk of improper use of psychotropic drugs in children and youth include being poor, living in group care, being hospitalized in psychiatric inpatient units, and/or being incarcerated. Children in foster care receiving any type of medication must have the consent of a caregiver. However, states differ in medication consent authority since some require biological parent permission, whereas others require a state board/panel, foster parent, the court or other designated authorities (e.g., physicians or staff in residential settings). States still report many cases where children in foster care were given psychotropic drugs without the required legal consent. Child advocates and clinicians see this as an area that needs to be rectified given the importance of the decision to use psychotropic agents in children. It is critical that the caregiver with consent authority be familiar with the specific child's needs, the therapeutic agents being prescribed and the intended impact/clinical outcomes for the specific agents. Professional second opinions are uniformly recommended in cases that may be complex (e.g., children under 6 years, pregnant teens, multiple medications), involve atypical antipsychotic medications or demonstrate treatment-resistance.

Although some evidence supports the efficacy of antipsychotics in youth for certain narrowly defined conditions, less is known about the safety and effectiveness of antipsychotic prescribing patterns in community use (e.g., combinations of medications, off-label prescribing, dosing outside of recommended ranges). Children and adolescents prescribed antipsychotics are more at risk for serious health concerns, including weight gain, extrapyramidal side effects, hyperprolactinemia and some metabolic effects.⁴⁰ In general, the field lacks high-quality research on outcomes and side effects associated with the use of higher-than-recommended doses of antipsychotics. Worrisome adverse effects of atypical antipsychotics have been documented even at low doses, including excessive weight gain, resulting in obesity, large increases in prolactin and higher risk of extrapyramidal side effects, including tardive dyskinesia. Girls treated with certain antipsychotics may also be at increased risk for gynecological problems⁴¹ and osteoporosis⁴². Studies of atypical antipsychotics in youth have demonstrated equal or worsening response when higher doses are compared with lower doses.^{43,44,45} Research has demonstrated that the pharmacokinetics of antipsychotics may vary by developmental stage.⁴⁰ This finding suggests that higher-than-recommended dosing of antipsychotics may pose differing risks for children and adolescents, compared with adults.

Atypical antipsychotics have the greatest mean prescription cost (\$132) of any psychotropic medication⁴⁶ and are the most costly drug class within the Medicaid program.⁴⁷ A review of 55 studies found no evidence that higher doses of antipsychotics were associated with better response⁴⁸; therefore, using higher than recommended doses of antipsychotics poses an increase in the cost of treatment without evidence that it is more effective for the patient. Additionally, there are substantial long-term costs of treating the health impact associated with antipsychotic medications, including treatment of obesity, diabetes and dyslipidemias. There is some evidence that these health conditions, such as new onset diabetes, do not resolve after discontinuation of the antipsychotic.⁴⁹ Although this is an understudied area, it is reasonable to assume that unresolved health impact of antipsychotics would be associated with long-term increases in health costs established for obesity and diabetes due to other causes.

Psychotropic Medication Use

Primary Care Providers (PCPs) play an important role and are in an excellent position to perform screenings of children for potential mental disorders. In addition, PCPs should be able to diagnose and treat relatively straightforward situations (e.g., uncomplicated ADHD, anxiety, or depression). Consideration should be given regarding the need for referral for counseling, psychotherapy, or behavioral therapy. Short courses and intensive skills oriented seminars may be beneficial in assisting PCPs in caring for children with mental disorders. Active liaisons with child psychiatrists who are available for phone consultation or referral can also be beneficial in assisting PCPs to meet the mental health needs of children. Multiple factors and barriers can complicate diagnosis for children in foster care. Similarly, caregivers and health providers may be faced with critical situations that require immediate decisions about the care to be delivered. Children may have:⁵⁰

- Multiple needs, including those related to emotional or psychological stress.
- Experienced abusive, neglectful, serial or chaotic care taking environments.
- Limited or no birth family history.
- Presented with a fluidity of different symptoms over time reflective of past traumatic and reactive attachment difficulties that may mimic many overlapping psychiatric disorders.
- Difficulty establishing rapport with a provider.

- A lack of access due to geographic location to mental health professionals such as child psychiatrists.

Based on the reasons listed above, a need exists for treatment guidelines and parameters regarding the appropriate use of any psychotropic medications in foster children.⁵⁰ Due to the complex issues involved in the lives of foster children, it is important that a comprehensive evaluation be performed before beginning treatment for a mental or behavioral disorder. Except in the case of an emergency, a child should receive a thorough health history, psychosocial assessment, mental status exam, and physical exam before the prescribing of any psychotropic medication. The role of non-pharmacological interventions should be considered before beginning any psychotropic medication, except in urgent situations such as suicidal ideation, psychosis, self-injurious behavior, physical aggression that is acutely dangerous to others, or severe impulsivity endangering the child or others; when there is marked disturbance of psychophysiological functioning (e.g., profound sleep disturbance), or when the child shows marked anxiety, isolation, or withdrawal. The FDA does not regulate physician and other health provider practice; the FDA has stated that it does “not limit the manner in which a practitioner may prescribe an approved drug.” Studies and expert clinical experience often support the use of a medication for an “off-label” use. Providers should utilize the available evidence, expert opinion, clinical experience, and exercise their clinical judgment in prescribing what is best for each individual.⁵⁰

Related WellCare Guidelines

In addition to the information contained in this document, please reference the following CPGs: *ADHD (HS-1020)*, *Autism Spectrum Disorder (HS-1016)*, *Depressive Disorders Adults, Children and Adolescents (HS-1022)*, and *Substance Use Disorders HS-1031*). Information related to prevention can be found in the following age-specific Preventive Health CPGs: *Adolescent (HS-1051)* and *Pediatric (HS-1019)*.

NOTE: Clinical Policies can be accessed by going to www.wellcare.com – select the Provider tab, then “Tools” and “Clinical Guidelines”.

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*Easy Choice Health Plan – Harmony Health Plan of Illinois – Missouri Care – Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona – Staywell of Florida
WellCare (Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas) – WellCare Prescription Insurance*

Medical Policy Committee Approval History

| Date | History and Revisions by the Medical Policy Committee |
|-----------|---|
| 11/2/2017 | <ul style="list-style-type: none"> Approved by MPC. Enhanced Care Management and Measures of Compliance sections. Revised with CM, DM, QI, UM, BH and the Chief Medical Directors. |

Addendum

PRESCRIBING GUIDANCE: AHCA AND THE UNIVERSITY OF SOUTH FLORIDA

The University of South Florida (USF) College of Behavioral Community Sciences and the Agency for Health Care Administration (AHCA) published the *Florida Psychotherapeutic Medication Guidelines for Children and Adolescents*. The aim of the guidelines is to provide guidance to clinicians in using psychotherapeutic medication to treat children and adolescents with behavioral health conditions. The guidelines cover a range of conditions including ADHD, anxiety disorders, severe or chronic bipolar disorder, depression, impulsive aggression, insomnia disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder in preschool-age children, early onset schizophrenia, and tic disorders.⁵⁰

*Principles of Practice Regarding the Use of Psychotropic Medication in Children under Age 6*⁵⁰

Level 0 consists of the following components:

- Conducting a comprehensive multi-informant, multi-modal, multi-disciplinary assessment for those with positive screen; and
- Using validated measures for assessing psychiatric symptoms and impairment in young children.

Recommended measures* of early childhood symptoms include:

- Ages 16 to 30 months: Modified Checklist for Autism in Toddlers (M-CHAT)
- Ages 2 to 4 years old and 4 to 11 years old: Strengths and Difficulties Questionnaire (SDQ)
- Ages 3 to 21 years old: The Child /Adolescent Psychiatry Screen (CAPS)
- Ages 4 to 11 years old: Home Situations Questionnaire (HSQ)

* Links to measures listed above are available at <http://medicaidmentalhealth.org/resourcesLinks/diagnosticTreatmentScales.cfm>

A comprehensive mental health assessment includes:

- A comprehensive assessment of the full range of psychiatric symptoms and disorders, as well as impairment from these symptoms and disorders.
- A full developmental assessment.
- A full medical history including a sleep history.
- A relevant medical work-up, physical examination, and nutritional status evaluation.
- An assessment of family psychiatric history which includes past and current history of parental psychiatric illnesses, substance abuse and treatment history of parents, parental figures (e.g., stepparent), siblings, and other relatives.
- An assessment of family structure and functioning, parent-child relationship and interaction.
- An assessment of environmental risk factors and stressors including history of abuse (physical, sexual, neglect), traumatic life events, domestic violence, economic instability, etc.

Level 1 begins with psychosocial treatment. Parental involvement is essential as well as involvement of other caregivers and/or school-based interventions as needed. In addition, Level 1 consists of the following components:

- Monitoring the child's response to treatment using reliable and valid measures of changes in targeted symptoms; and
- Except in rare cases, attempt a course of at least 12 weeks of psychosocial interventions before considering medication.

Level 2 consists of first asking if medications are being considered – the clinician should first reassess diagnosis and diagnostic formulation. If a decision is made to initiate medication:

- Initiate with monotherapy. Start low, go slow.
- Except in rare cases, use monotherapy.
- After 6 to 9 months of stabilization, plan down titration trial to determine if the medication is still needed and effective, (taper or discontinuation trial).
- Continue psychosocial treatment during treatment with medication.
- Use of psychotherapeutic medication in children under the age of 24 months is not recommended unless there are rare and extenuating circumstances.

Monitoring Parameters. Suggested monitoring parameters for baseline and regular monitoring for side effects for second generation antipsychotics include:

- BMI
- Fasting glucose
- Vital signs
- Family history of dyslipidemia or diabetes
- Screening for Involuntary Movements (AIMS)
- Lipid profile in higher risk children (obese, positive family history, etc.)

PRESCRIBING GUIDANCE: AACAP

The American Academy of Child and Adolescent Psychiatry (AACAP) discusses the current state of research based on what is currently known regarding the six AAAs that have been marketed in the United States and have pediatric data; AAAs are presented in order of marketing release. Paliperidone and asenapine were recently approved but have no data available pertaining to their use in children and adolescents; these were not considered in the AACAP parameter.²

- **Clozapine.** For pediatric patients suffering from treatment refractory schizophrenia and for those youths who require antipsychotic treatment but who have experienced severe EPS with other agents, the following applies:

Schizophrenia – ages 9 years and older (refractory that has failed with standard antipsychotic agents)

Initial dose: 6.25 – 12.5 mg orally per day

Mean effective dose (in trials): 200 – 300 mg orally per day

Maximum dose: 300 mg orally per day

- **Risperidone.** Risperidone has the most substantive amount of methodologically stringent evidence about its use in children and adolescents. Studies have found that risperidone resulted in significant improvement in serious behavioral problems in children with autism ages 5-17. In youths with disruptive behavior disorders, a study examined the impact of long-term risperidone treatment in those ages 5-17 who initially responded to a 12 week trial of medication; significant differences in relapse rates indicated that prolonged treatment with risperidone was beneficial. Prospective studies have reported the effectiveness of risperidone in the treatment of youths with schizophrenia, disruptive behaviors in autism and other PDDs, disruptive behaviors in children with sub-average intelligence, and impulsive aggression in conduct disorder/disruptive behavior disorders.

The Texas Children's Medication Algorithm project recommends the addition of an AAA for the treatment of comorbid ADHD and aggression not responsive to behavioral intervention and psychostimulants. Among child and adolescent literature, reports of worsening or new onset OCD symptoms in youths treated with risperidone have been published. The following dosing information applies:

Schizophrenia – 3 years or older

Initial dose: 0.5 mg orally once a day

Titration dose: May increase in increments of 0.5 mg to 1 mg per day at interval of 24 hours or more, as tolerated.

Target dose: 3 mg orally per day

Maximum dose: 6 mg orally per day

Autism – Ages 5 to 17 years

Weight greater than 15 kg and less than 20 kg

Initial dose: 0.25 mg orally once a day

Titration: after a minimum of 4 days, may increase to 0.5 mg per day; maintain this dose for a minimum of 14 days; subsequent dose increases may be made in increments of 0.25 mg at intervals of 2 weeks or more, as tolerated

Recommended dose: 0.5 mg orally per day

Weight 20 kg or greater

Initial dose: 0.5 mg orally once a day

Titration: After a minimum of 4 days, may increase to 1 mg per day; maintain this dose for a minimum of 14 days; subsequent dose increases in increments of 0.5 mg at intervals of 2 weeks or more, as tolerated.

Recommended dose: 1 mg orally per day

Bipolar – 10 years or older

Initial dose: 0.5 mg orally once a day

Titration dose: May increase in increments of 0.5 mg to 1 mg per day at interval of 24 hours or more, as tolerated.

Target dose: 1 to 2.5 mg orally per day

Maximum dose: 6 mg orally per day

- **Olanzapine.** Of the AAAs, olanzapine's receptor binding profile most closely matches that of clozapine. One study reported the short-term efficacy of olanzapine in the treatment of adolescents with schizophrenia. Another reported the short-term efficacy of olanzapine in the treatment of adolescents with bipolar illness suffering from a manic or mixed episode. A third study compared olanzapine, risperidone and haloperidol use in psychotic youths; the study found olanzapine's effectiveness to be comparable to both haloperidol and risperidone. A final study of olanzapine, risperidone, and molindone noted that both AAAs did not have superiority to molindone in treating early onset schizophrenia spectrum disorders. That study also found that olanzapine showed the greatest amount of weight gain. Olanzapine may provide benefit to patients suffering from PDDs, anorexia and other eating disorders, and Tourette's syndrome.

Schizophrenia – Age 6 to 13 years or older

Initial dose: 2.5 to 5 mg orally once a day

Target dose: 10 mg orally once a day; further dose adjustments, if needed, should occur at intervals of not less than 1 week in 2.5 to 5 mg increments/decrements.

Maximum dose: 20 mg orally once a day

Bipolar – Age 13 years or older (treatment of Manic or Mixed Episodes Associated with Bipolar I Disorder)

Initial dose: 2.5 to 5 mg orally once a day

Target dose: 10 mg orally once a day; dose adjustments, if needed, should occur at intervals of not less than 1 week in 2.5 to 5 mg increments/decrements.

Maximum dose: 20 mg orally once a day

- **Quetiapine.** One study found that in adolescents with mania, treatment with quetiapine plus divalproex sodium was associated with greater symptom reduction than treatment with quetiapine plus placebo. In another study quetiapine was effective in children and adolescents with bipolar mania as well as adolescent schizophrenia and OCD. Open-label trials have noted potential benefit for aggression in conduct disorder, psychosis, mania, and tic disorders.²
- **Ziprasidone.** A trial reported that low doses (20-40mg per day) of ziprasidone was superior to placebo in the treatment of 28 patients ages 7-17 years with Tourette's syndrome. Efficacy was also reported in the treatment of manic or mixed episodes in youths suffering from bipolar I disorder. However, an industry-sponsored trial of ziprasidone for early-onset schizophrenia was stopped due to concerns over lack of efficacy. Additionally, reports of improvement were found among youths with a variety of neuropsychiatric conditions, including schizophrenia, autism/PDD, major depression with psychosis, bipolar disorder, and psychosis. A small number of youths treated with intramuscular ziprasidone have described positive clinical outcomes without significant

side effects.² Ziprasidone does not have FDA approval in children and adolescents.

Bipolar – Age 10 years and older (for acute mania and maintenance therapy after stabilization)

Initial Dose: 25 mg orally twice daily (day 1)

Day 2: 50 mg orally twice daily

Day 3: 100 mg orally twice daily

Day 4: 150 mg orally twice daily

Day 5+: 200 mg orally twice daily

Target dose range: 400 to 600 mg /day based on response and tolerability

Maximum dose: 600 mg orally per day

Schizophrenia – Age 13 years and older

Initial Dose: 25 mg orally twice daily (day 1)

Day 2: 50 mg orally twice daily

Day 3: 100 mg orally twice daily

Day 4: 150 mg orally twice daily

Day 5+: 200 mg orally twice daily

Target dose range: 400 to 600 mg /day based on response and tolerability

Maximum dose: 600 mg orally per day

- **Aripiprazole.** Preliminary studies suggest that patients with mania, conduct disorder with aggression, and PDD/autism might benefit from treatment with aripiprazole. Studies describe efficacy for aripiprazole in both youths ages 10-17 suffering from manic or mixed states, adolescents ages 13-17 suffering from schizophrenia, and children with irritability associated with autistic disorder.²

Autism – Age: 6 to 17 years

Dose should be individualized according to tolerability and response.

Initial dose: 2 mg orally once a day

Dose titration: Increase dose to 5 mg orally once a day, with subsequent increases to 10 mg or 15 mg orally once a day if needed; dose adjustments in increments of up to 5 mg/day to occur at intervals of no less than 1 week.

Maximum Dose: 15 mg orally once a day

Bipolar Disorder – Age 10 years or older

As monotherapy or as adjunctive therapy with lithium or valproate.

Initial Dose: 2 mg orally once a day

After 2 days: Titrate to 5 mg orally once a day

After 4 days: Titrate to 10 mg orally once a day

Target Dose: 10 mg orally once a day; dose increases, if needed should be in 5 mg increments at 2-week intervals in order to allow time to achieve steady state

Maximum Dose: 30 mg per day

Schizophrenia – Age: 13 years or older

Initial Dose: 2 mg orally once a day

After 2 days: Titrate to 5 mg orally once a day

After 4 days: Titrate to 10 mg orally once a day

Target Dose: 10 mg orally once a day; effective dose range 10 to 30 mg per day; however, clinical trials have not found doses exceeding 10 mg per day to be more effective; dose increases, if needed should be in 5 mg increments at 2-week intervals in order to allow time to achieve steady state

Maximum Dose: 30 mg per day

The AACAP also published *A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents*. The document addresses the following areas:³⁶

- Context for Prescribing Psychotropic Medications
- Phases in Treatment

- Issues in Prescribing
- Considerations for Child Serving Agencies
- Sources of Information about Psychotropic Medications

Psychotropic medicines are taken for the purpose of improving the emotional and behavioral health of a child or adolescent diagnosed with a mental health condition. Evidence shows that psychotropic medications are both over and under-prescribed in this population. Prescribing requires a competent prescriber, optimally a child and adolescent psychiatrist, with training and qualifications in the use of these medications in this age group. Medication is one component of a comprehensive biopsychosocial treatment plan that must include other components such as a comprehensive treatment plan requires a collaborative, team effort. The term biopsychosocial recognizes the three domains that impact a youth's emotional and behavioral well-being that must be considered in creating a comprehensive treatment or service plan.³⁶

Professionals in child serving agencies can best support the treatment of youth with a mental illness by ensuring access to a comprehensive diagnostic assessment including biopsychosocial formulation conducted by a qualified licensed mental health professional in collaboration with the youth and the family. Discussions and use of psychotropic medication should recognize and address an individual's and family's cultural beliefs. A comprehensive assessment will include options for support and treatment that extend beyond just prescribing medications.³⁶

SIDE EFFECTS

The AACAP note the following significant safety issues and concerns associated at treatment initiation and even with sustained use of second generation antipsychotics (SGA):²

- Weight gain, diabetes and hyperlipidemia;
- Cardiovascular problems (e.g., prolongation of QTc interval, orthostatic hypotension, tachycardia and pericarditis and coronary artery disease associated with weight gain);
- Neutropenia and potential agranulocytosis;
- Hepatic dysfunction;
- Elevation of prolactin levels;
- Electroencephalogram (EEG) abnormalities and possible seizure activity;
- Potential for the development of extrapyramidal symptoms, tardive dyskinesia and withdrawal dyskinesias;
- Neuroleptic malignant syndrome; and
- Formation of cataracts.

The AACAP *Practice Parameter* underscores the importance of prescribers in consulting the existing scientific literature before selecting the SGA agent. Currently, SGAs clozapine, risperidone, olanzapine, quetiapine, ziprasidone, paliperidone and aripiprazole have published pediatric clinical trial data, but the more recently FDA approved SGA, asenapine, has no data pertaining to its use in the young population. Since the current FDA-approved indication for SGA use in children and adolescents includes only schizophrenia, bipolar disorder and specific symptoms of autism, the clinician is strongly urged to consider alternative pharmacological or psychosocial treatments for these other specific problems (i.e., disruptive behavior disorders and aggression). The *Practice Parameter* also discusses Pregnancy and In Utero; Bone Reduction; Cardiovascular Effects; Endocrine and Metabolic Effects; and Loss of Appetite. To review the *Practice Parameter* in its entirety, click [here](#).²

PRESCRIBING GUIDANCE: AMERICAN PSYCHIATRIC ASSOCIATION (APA)

American Psychiatric Association (APA)

The APA created a workgroup consisting of members from the Council on Research and Quality Care (CRQC). The following highlights were published to accompany the APA's recommendations noted above:⁹

- 1. Don't prescribe antipsychotic medications to patients for any indication without appropriate initial evaluation and appropriate ongoing monitoring.** Metabolic, neuromuscular and cardiovascular side effects are common in patients receiving antipsychotic medications for any indication, so thorough initial evaluation to ensure that their use is clinically warranted, and ongoing monitoring to ensure that side effects are identified, are essential. Components of an initial evaluation include:

- A thorough assessment of possible underlying causes of target symptoms including general medical, psychiatric, environmental or psychosocial problems;
- Consideration of general medical conditions; and
- Assessment of family history of general medical conditions (including metabolic, cardiovascular disorders).

Ongoing monitoring includes re-evaluation and documentation of dose, efficacy and adverse effects; and targeted assessment, including assessment of movement disorder or neurological symptoms; weight, waist circumference and/or BMI; blood pressure; heart rate; blood glucose level; and lipid profile at periodic intervals.

2. **Don't routinely prescribe two or more antipsychotic medications concurrently.** Research shows that use of two or more antipsychotic medications occurs in 4 to 35% of outpatients and 30 to 50% of inpatients. However, evidence for the efficacy and safety of using multiple antipsychotic medications is limited, and risk for drug interactions, noncompliance and medication errors is increased. Generally, the use of two or more antipsychotic medications concurrently should be avoided except in cases of three failed trials of monotherapy, which included one failed trial of Clozapine where possible, or where a second antipsychotic medication is added with a plan to cross-taper to monotherapy.
3. **Don't routinely prescribe antipsychotic medications as a first-line intervention for children and adolescents for any diagnosis other than psychotic disorders.** There are both on and off label clinical indications for antipsychotic use in children and adolescents. FDA approved and/or evidence supported indications for antipsychotic medications in children and adolescents include psychotic disorders, bipolar disorder, tic disorders, and severe irritability in children with autism spectrum disorders; there is increasing evidence that antipsychotic medication may be useful for some disruptive behavior disorders. Children and adolescents should be prescribed antipsychotic medications only after having had a careful diagnostic assessment with attention to comorbid medical conditions and a review of the patient's prior treatments. Efforts should be made to combine both evidence-based pharmacological and psychosocial interventions and support. Limited availability of evidence based psychosocial interventions may make it difficult for every child to receive this ideal combination. Discussion of potential risks and benefits of medication treatment with the child and their guardian is critical. A short and long term treatment and monitoring plan to assess outcome, side effects, metabolic status and discontinuation, if appropriate, is also critical. The evidence base for use of atypical antipsychotics in preschool and younger children is limited and therefore further caution is warranted in prescribing in this population.

Florida Medicaid Drug Therapy Management Program for Behavioral Health at the University of South Florida (USF)⁵⁰

In collaboration with the Agency for Health Care Administration (AHCA), USF developed the *Florida Psychotherapeutic Medication Guidelines for Children and Adolescents*.

Children Under 6 Years Old

The guidelines note that the use of antipsychotic medications in preschoolers (children under six years old) which is generally "off-label" is not recommended and should only be considered under the most extraordinary circumstances. Disruptive aggression in autism is one such circumstance. Adequately powered studies have not been conducted in preschoolers. Before considering pharmacological treatment, the following guidelines are strongly recommended:

- Perform a developmentally-appropriate, comprehensive psychiatric assessment with diagnoses, impairments, treatment target and treatment plans clearly identified and documented.
- Comprehensive assessment must include evaluation of parental psychopathology and treatment needs, as well as family functioning.
- Psychosocial treatments should precede the use of psychotropic medications and should continue if medications are prescribed.

Antipsychotic Dosing Information for Children under Age 6* * Should only be used under rare circumstances.

General Procedures for Monitoring Side Effects of Antipsychotic Medication in Children and Adolescents

Conduct side effect and metabolic assessments and laboratory tests that are clinically relevant, comprehensive, and

based on established guidelines.

- Monitor for metabolic syndrome criteria when prescribing atypical antipsychotics, with three of five criteria met:
 - Waist circumference greater than 90% for age
 - BP if <10 years old, then >90% for blood pressure **OR** BP if > 10 years old then >130 systolic or >85 diastolic
 - Triglycerides greater than 150 or greater than 95% for age
 - HDL <40 or <5% for age
 - Fasting blood glucose >100 (If metabolic abnormalities, refer to primary care physician)
- Monitor for extrapyramidal side effects (EPS) associated with second-generation antipsychotic use utilizing at least one of the following:
 - The Abnormal Involuntary Movement Scale (AIMS)
 - The Extrapyramidal Symptom Rating Scale (ESRS)
 - Dyskinesia Identification System: Condensed User Scale (DISCUS)

NOTE: Links to measures listed above are available at <http://medicaidmentalhealth.org/resourcesLinks/diagnosticTreatmentScales.cfm>

- Provide accessible information to parents and families about identifying and managing side effects, including lifestyle and nutritional changes, monitoring labs, etc.

For additional information on levels of care for specific behavioral health conditions, consult the USF guidelines available at <http://www.medicaidmentalhealth.org> under “Child Guidelines”.