7.2.23 PSYCHOACTIVE MEDICATION UTILIZATION POLICY FOR CHILDREN AND ADOLESCENTS

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Revision History: 10/20/2026, 09/13/2016

References: Welfare & Institutions Code, Section 369.5(d) California

California Welfare & Institutions Code (WIC) § 5328, Confidential Information and Records; Disclosure; Consent

Psychotropic Medications, 2016 California Rules of Court, Rule 5.640

California Department of Social Services (CDSS) Foster Care Quality Improvement Project, California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care, Including Appendices A, B, C, D

Los Angeles Department of Mental Health, Parameters 3.8 For Use of Psychotropic Medication in Children and Adolescents, March 15, 2023

Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents, Journal of American Academy of Child and Adolescent Psychiatry, September 2009, 48:9

Policy Owner: Behavioral Health, Quality Assessment and Performance Improvement (QAPI), Quality Assurance Manager

Director Signature: **Signature on File**

I. Policy Statement

This policy establishes consistent practices and mandatory parameters for the prescribing and utilization review of psychotropic medications by Sonoma County Department of Health Services - Behavioral Health Division (DHS-BHD) psychiatric providers for children and adolescents, including foster youth, in keeping with generally accepted community and applicable standards.

II. Scope

This policy applies to all DHS-BHD Covered Persons including employees (full-time, part-time, extra-help), unpaid interns, paid interns, temporary agency workers, registered volunteers, and all individual providers contractually designated as covered persons. Covered Persons do not include Community Based Organization (CBO) staff.

III. Definitions

A. Pronoun Usage: Throughout this policy, the singular "they/their" is used as a gender-neutral pronoun to promote clarity, readability, and inclusivity.

IV. Policy

A. This policy contains the internal requirements and guidelines that all psychiatric providers employed by DHS-BHD are expected to follow. This policy is consistent with, and indexed to, two additional external documents:

   1. California Department of Social Services (CDSS) Foster Care Quality Improvement Project, California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care.

   2. Los Angeles Department of Mental Health, Parameters 3.8 For Use of Psychotropic Medication in Children and Adolescents, March 15, 2023.

B. The purpose of this policy is to ensure consistent practices in the prescribing of psychotropic medications in keeping with generally accepted community standards. It also ensures consistent practices in the evaluation of Form JV-220 (Application for Psychotropic Medication) requests for psychotropic utilization by foster youth in Sonoma County. This policy establishes mandatory parameters as well as recommended guidelines for psychotropic utilization that reflect local, state, and federal standards for the psychiatric care of children and adolescents.

V. Procedures

The guidelines are not designed to replace psychiatric prescribers' clinical judgment; however, prescribers should document rationale for prescribing practices that deviate from the guidelines.

A. Policy Guidelines for Children and Adolescents:

   1. Evaluation Components: The psychiatric evaluation includes a thorough mental status exam, review of current psychiatric symptoms and psychiatric clinical history, including pertinent collateral documents when available, and a recent physical examination. The evaluation should also include a summary

assessment of the risks and benefits of proposed psychotropic medication, and a summary of the psychosocial interventions that have been implemented to date to resolve the psychiatric conditions that warrant current use of psychotropic medication. The following components need to be included in the overall evaluation:

a. Review of Collateral Documents: This includes physical health and psychiatric clinical records, including prior psychological evaluations, treatment plans, medication trials, educational testing or Individualized Education Plan (IEP), developmental records, admission and discharge summaries, and medical history and physical reports from all psychiatric hospitalizations. For foster children, the following additional documentation reports are recommended for review:

    i. The Detention Hearing Report

    ii. The Jurisdiction/Disposition Report

    iii. Copies of significant additional court reports

    iv. Order Authorizing Health Assessments, Routine Health Care and Release of Information (ROI) (Blanket Court Order) or case-specific forms signed by the court

    v. History of Child Placement Report

    vi. Current Health and Education Passport (HEP)

    vii. Prior JV-220 forms, including attached medication logs

b. Physical Examination: As part of the decision to initiate a medication trial, the results of the most recent physical examination conducted within the past year are reviewed. If no documentation is available or an examination was not completed, a brief physical examination is indicated. If the client does not have a primary care provider, staff should urge the client to establish primary care with an appropriate primary care institution such as a community health center. When indicated by history, physical examination, or psychiatric evaluation, the child may require medical specialty consultation and testing.

c. Mental Status Examination: A full mental status exam must be sensitive to the child's age, developmental stage, and current clinical status. Multiple sessions may be required to gain an accurate profile of the child's mental status. When indicated, the child is interviewed both with and without parents or caregivers present.

d. Diagnosis: A diagnosis should incorporate findings from the current mental status exam, clinical history, and collateral reports. Diagnostic impressions should reflect balanced assessments of biological, psychological, and social dimensions, including reference to pertinent traumatic experiences in the child's life. The diagnosis should reflect the most current federal and state standards for nomenclature (e.g., current Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or International Classification of Diseases (ICD).

e. Goals and Target Symptoms: Medications are prescribed to target specific symptoms based on biological, psychological, and social assessments. Realistic goals for the amelioration and/or resolution of these symptoms should be defined. These target symptoms and goals should be documented and shared with the child, family, caregiver, and the child and family's support network, as permitted according to all pertinent policies governing the release of personal health information (PHI).

2. Choice of Medication: Medication decisions are driven by case considerations that reflect the child's clinical history, collateral documents, physical health exam, mental status exam, and biopsychosocial evaluation. The choice of medication is also influenced by available research that addresses pharmacological risks and benefits of available medication options. Medication is prescribed as part of a comprehensive treatment strategy that includes other non-pharmacological interventions, and is not prescribed in lieu of non-pharmacological treatments that the individual child needs.

3. Informed Consent: Children and adolescent clients are included in the informed consent process to the extent that is feasible and appropriate. All rights to privacy and confidentiality for the child are to be respected as per WIC Section 5328. Informed consent is based on a dialogue that addresses the reasons for the use of medication, the relative benefits and the risks regarding the use of medication, and the available alternative options to the use of the medication. The dialogue also addresses whether available psychosocial interventions can be a substitute for the use of medication. Clients and their legally defined decision makers are to be apprised as to the dose range, frequency, duration, and route of administration for each proposed medication. All informed consent procedures should be consistent with the ‘Informed Consent’ guidelines specified in DHS-BHD Policy No. 7.2.22, *General Psychoactive Medication Utilization Guidelines*.

4. JV-220 Application for Psychotropic Medication Form Process: Psychotropic medication utilization for foster children and adolescents is subject to Rule 5.640 of the California Rules of Court, Psychotropic Medications, which specifies the use of Form JV-220 Application for Psychotropic Medication, and other applicable forms such as the Prescribing Physician's Statement—Attachment (Form JV-220(A)) and the Prescribing

Physician's Request to Continue Medication—Attachment (Form JV-220(B)). Sonoma County Behavioral Health Psychiatrists are involved in the review and evaluation of JV-220 requests. The same psychoactive medication utilization guidelines employed in the prescribing of medications are to be employed in the review of JV-220 requests for the treatment of foster youth in Sonoma County.

B. Guidelines for Prescribers of Psychotropic Medications:

1. To ensure that prescribing standards represent the current state of best practices and incorporate current evidence-based research, DHS-BHD establishes the following guidelines and linked references. These guidelines and references are intended to suppress symptoms and ameliorate maladaptive behaviors. Medications should be considered as one element in a comprehensive treatment plan along with other psychosocial and environmental interventions. The potentially serious adverse effects of medications must be considered and a plan for ongoing close monitoring of potential adverse effects be established based on monitoring parameters. If the following prescribing guidelines are not met, or if medications are prescribed outside the recommended parameters, the prescribers will be urged to seek peer consultation and/or clinical review with the DHS-BHD Medical Director. For additional information refer to Attachment #1: CDSS Foster Care Quality Improvement Project, California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care, Including Appendices A, B, C, D, and Attachment #2: Los Angeles Department of Mental Health, Parameters 3.8 For Use of Psychotropic Medication in Children and Adolescents, March 15, 2023.

   a. Summary of allowable number of psychotropic medications by age group. (Refer to Attachment #1: CDSS Foster Care Quality Improvement Project, Appendix A). Exceptions to the guidelines may be granted for cross-tapering in which certain medications are taken away gradually while other medications are added. Exceptions may also be granted on the basis of individual case characteristics. Regardless, any plan to exceed the recommended number of psychotropic meds should trigger consultation with a peer provider and/or DHS-BHD Medical Director.

Age (Years)	Number of Psychotropic Medications Allowed
0-5	<2 (allows no more than 1)
6-11	<3 (allows no more than 2)
12-17	<4 (allows no more than 3)

   b. Summary of allowable number of psychotropic medications per medication class.

i. For children aged 12-17 years: Fewer than 4 psychotropic medications are recommended per the following guidelines:

(1) <2 antipsychotics (any combination of typical and atypical).

(2) <2 mood stabilizers (antipsychotics not included).

(3) <2 antidepressants (trazodone as hypnotic excepted).

(4) <2 stimulants. Stimulants of the same chemical type, varying only in compound formulation for time of release (e.g. extended release, immediate release) are counted as the same type.

(5) <2 hypnotics (including trazodone, diphenhydramine, zolpidem, zaleplon, eszopiclone, melatonin, and benzodiazepines. This does not include clonidine, guanfacine, and prazosin).

(6) Medication doses(s) within the usual recommended doses as defined in the most recent version of the Los Angeles County Department of Mental Health Parameters.

ii. For children aged 6-11 years: Fewer than 3 psychotropic medications are recommended per the above restrictions.

iii. For children aged 0-5 years: Fewer than 2 psychotropic medications are recommended per the above restrictions.

c. Pregnancy: There are important medication side-effects and/or toxicities that can occur to babies who are exposed to psychotropic medication either in utero or post-partum via breast milk. As a result, any decision to utilize psychiatric medication for a pregnant or breast-feeding woman needs to be carefully analyzed in consultation with the mother's primary care and/or obstetric providers. Individual prescribers are urged to consult the American College of Obstetrics and Gynecology 'Guidelines on Psychiatric Medication Use During Pregnancy and Lactation.'

d. Use of Long Acting Injectable (LAI) Antipsychotics: There is insufficient data to support the safe use of LAI's for individuals under the age of 18. Prior to initiation of an LAI for a minor, it is mandatory to seek consultation with a peer and/or the DHS-BHD Medical Director. Evidence of this consultation should be documented in the client's medical record. Prior to use of an LAI, clients must demonstrate positive response and tolerability to the short-acting form of the medication.

e. Monitoring and Follow Up: Prescribers should follow up with clients ideally within two weeks, but at least within 30 days, after they start psychotropic medications. Ongoing monitoring should adhere to American Academy of

Child and Adolescent Psychiatry parameters according to the following consideration:

i. "Many factors are involved in determining a monitoring strategy for children on psychotropic medications including the type of medication, the risk of and timing of onset of side effects, the patient's need for ongoing psychological support, the patient's and family's risk for non-adherence, and the phase of treatment. Discussion of the monitoring plan with the patient and family includes the frequency of visits and methods used to assess outcome and side effects. The frequency of visits is determined by the need for dose titration, by the timing of onset of side effects, and to maintain the doctor-patient relationship." (Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents, Journal of American Academy of Child and Adolescent Psychiatry, September 2009, 48:9).

VI. Documentation

A. Medication Orders and Reconciliation: All new medication orders should be clearly documented in the medical record, utilizing the medication log system, as specified on Forms MHS 130, Medication Record, or MHS 208, CSU (Crisis Stabilization Unit) Medication Administration Record. All previous medication orders should be reviewed at each visit, and the medication record should indicate which medication orders are to be continued, changed, or discontinued.

B. Service Notes: Prescriber should address progress, symptoms, medication response, side effects, and rationale for prescribing medications. Refer to DHS-BHD Policy No. 7.1.17, *Documentation Requirements for All Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) Services* for further requirements.

C. Informed Consent: Prescribers must inform the member/parent/caretakers of the purpose for the medication, possible side effects, and any special precautions, and must document evidence of informed consent. Special concerns and discussions of risks and benefits should be documented in the prescriber's progress notes.

VII. Forms

A. MHS 130 Medication Records

B. MHS 208 CSU Medication Administration Record

C. Application for Psychotropic Medication (JV-220)

D. Physician's Statement—Attachment (form JV-220(A))

E. Physician's Request to Continue Medication—Attachment (form JV-220(B))

VIII. Attachments

Attachment #1: California Department of Social Services (CDSS), Foster Care Quality Improvement Project, California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care, including Appendices A, B, C, D

Attachment #2: Los Angeles Department of Mental Health, Parameters 3.8 for Use of Psychotropic Medication in Children and Adolescents, March 15, 2023