# Psychotropic Medication for Dependent Children

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## Pennsylvania HealthChoices Program

- In 1996, Pennsylvania introduced its plan for an integrated and coordinated health care model through development of HealthChoices, a mandatory managed care program for certain Medicaid recipients
- Two components of HealthChoices
  - Physical health (PH-MCO)
  - Behavioral health (BH-MCO)
- Recipients must enroll with a PH-MCO
  - Offered selection of PH-MCOs
- In all zones, recipients must enroll with the BH-MCO in operation in the recipient's county of residence

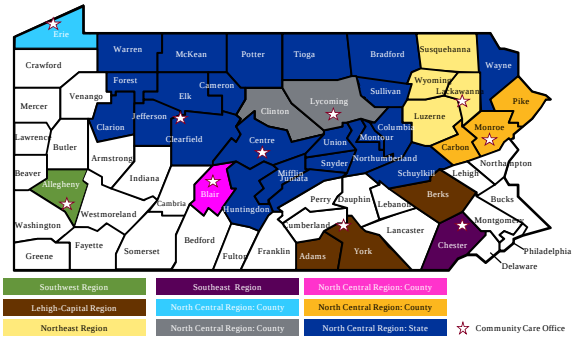
 

## Community Care

- 501(c)3 nonprofit behavioral health managed care organization
- Part of UPMC Insurance Services Division
- Manages behavioral health services for Medicaid members on behalf of DHS and 39 Pennsylvania counties
- Mission is focused on collaboration with state, counties, members, families, and others to improve the behavioral health delivery system, including shifting resources into community settings

## HealthChoices Regions Served







## Workgroup: Multidisciplinary Team

- Department of Welfare OMHSAS
- Parent representatives
- Quality Assurance Program
- Western PA Psychiatric Society Chapter
- Managed care organizations
- Support Center for Child Advocates
- PA Child Welfare Resource Center
- Children & Youth Services
- Statewide Adoption & Permanency Network
- Youth Advocacy Board
- Community Care
- Casey Family Programs
- PolicyLab, Children's Hospital of Philadelphia
- Department of Welfare Office of Medical Assistance Program
- PA Foster Parent Association
- Department of Human Services
- Administrative Office of PA Courts/Office of Child & Families in Courts Staff




## Workgroup Mission

"Recommend a system of collaborative oversight focusing on children and youth involved in the dependency system to ensure that those with mental and behavioral health needs have a plan for appropriate and effective intervention to achieve healthy development."

## Psychotropic Medication Workgroup

- Developed in August 2011
- Focus on increasing trend of psychotropic medication for children in child welfare system
- Pennsylvania leaders probed the use of psychotropic medication for dependent children and its effects on their health

## Workgroup Participants: Leadership

Honorable Kathryn Hens Greco
Court of Common Pleas of Allegheny County

David Schwille
Administrator, Department of Human Services of Venago County

## Workgroup Participants

- Four subcommittees met to complete to complete tasks recommended to PA State Roundtable
  - Local children's roundtable group
  - Psychotropic medication information card group
  - Website resource group
  - Policy group

## Workgroup Counties

- Adams County
- Allegheny County
- Bucks County
- Lehigh County
- Lycoming County
- York County

## Psychotropic Medication Workgroup

- Researched national reports
- Researched best practice guidelines
  - American Academy of Child and Adolescent Psychiatry
  - American Academy of Pediatrics
  - American Bar Association's Center on Children and the Law
- Explored other states
- Input from medical experts
- Met with parents and children
- Developed subcommittees

## Overview

- National trends
- Pennsylvania trends
- Use in children in out-of-home placement

National & State Trends

## Evidence in the Use of Antipsychotic Medications in Children



## Evidence for Use of Antipsychotics

- Evidence for the use of second-generation antipsychotics to treat disorders among 11,700 Medicaid recipients under 18 who became users between 2001-2005
  - Categories based on studies published through 2005

***Table 4***

Evidence for use of second-generation antipsychotics to treat disorders among 11,700 Medicaid recipients under age 18 who became new users of these agents between 2001 and 2005

| Level of evidence[a] | Aripiprazole (N=2,108) | | Olanzapine (N=1,147) | | Quetiapine (N=2,097) | | Risperidone (N=5,989) | | Ziprasidone (N=297) | | Multiple agents (N=62) | | Total (N=11,700) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % |
| Strong | 0 | — | 124 | 10.8 | 452 | 21.6 | 3,842 | 64.2 | 0 | — | 0 | — | 4,418 | 37.8 |
| Plausible | 0 | — | 186 | 16.2 | 0 | — | 213 | 3.6 | 0 | — | 0 | — | 399 | 3.4 |
| Weak | 482 | 22.9 | 334 | 29.1 | 962 | 45.9 | 102 | 1.7 | 169 | 56.9 | 0 | — | 2,049 | 17.5 |
| None | 1,626 | 77.1 | 503 | 43.9 | 683 | 32.6 | 1,832 | 30.6 | 128 | 43.1 | 62 | 100.0 | 4,834 | 41.3 |

[a] Evidence categories are based on studies published through 2005.



"Evidence-Based Use of Second-Generation Antipsychotics in a State Medicaid Pediatric Population, 2001–2005.", 61(2), pp. 127

## Evidence for Use of Antipsychotics

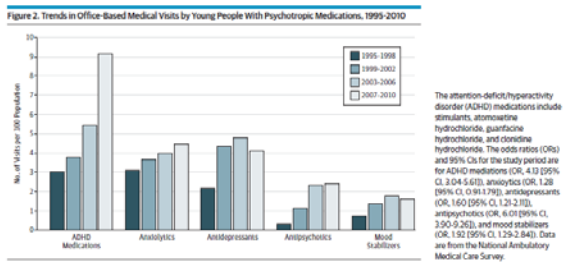
- Table 4 shows the proportion of use of the five medications in each of the evidence categories
- Among users of risperidone, 64.1% of use was in the category of strong evidence-based use—the largest percentage for any of the five medications
- Among users of aripiprazole, 77.1% of use was not supported by any published evidence
- Almost half of the children in the sample (41.3%) appeared to have received a second-generation antipsychotic without having a diagnosis associated with any supporting evidence

## Diagnoses: Non-Evidence-Based Use

- On the basis of this finding, they further investigated the diagnoses of these 4,834 participants
- Over half of the youth (N=2,790, 58%) had a diagnosis of hyperkinetic syndrome of childhood with hyperactivity
- Other frequently observed diagnoses among these 4,834 children were:
  - Oppositional defiant disorder (N=1,617, 34%)
  - Depressive disorder (N=1,354, 28%)
  - Hyperkinetic syndrome of childhood without mention of hyperactivity (N=955, 20%)
  - Unspecified disturbance of conduct (N=692, 14%)




## Trends in Office-Based Medical Visits






Olfson et al. JAMA Psychiatry.2014; 71(1):81-90.

## Trends in Office-Based Medical Visits

- Concurrent SGA use with 4 psychotropic classes
- National sample of Medicaid enrolled youth, 6-18 years between 2004-2008
- SGA use overall increased by 22%
  - 85% of such use occurred concurrently
- Highest users of concurrent SGA were in foster care, disability Medicaid programs, or with behavioral hospitalizations



Kreider A et al. 2014. JAACAP; 53(9): 960-970

## More Results

| Most Significant Increases Over Time | |
|---|---|
| Income eligible Medicaid | +13% |
| Without comorbid ADHD | +15% |
| Were not hospitalized | +13% |
| Did not have comorbid intellectual disability | +45% |

- Authors' discussion notes that earlier study found children diagnosed with ADHD account for majority of SGA use among children in Medicaid
  - However, these results point to children without ADHD driving the increase in concurrent use of SGA through 2008

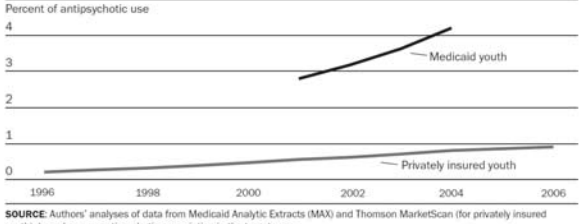



## Broadened Use of Atypical Antipsychotics: Safety, Effectiveness, and Policy Challenges



## Privately Insured vs. Medicaid Youth

**EXHIBIT 3**
**Use Of Antipsychotics Among Privately Insured And Medicaid Youth, 1996–2006**




**SOURCE**: Authors' analyses of data from Medicaid Analytic Extracts (MAX) and Thomson MarketScan (for privately insured youth), based on any antipsychotic prescription in the target year.



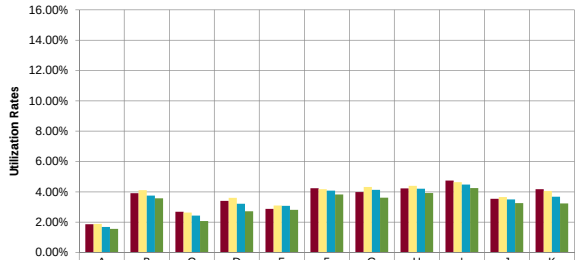
Stephen Crystal, Mark Olfson, Cecilia Huang, Harold Pincus and Tobias Gerhard. Broadened Use Of Atypical Antipsychotics: Safety, Effectiveness, And Policy Challenges. *Health Affairs*, 28, no.5 (2009):w770-w781. (published online July 21, 2009; 10.1377/hlthaff.28.5.w770)

## Privately Insured vs. Medicaid Youth

- Antipsychotic treatment rates among privately insured youth increased steadily from 1996 (0.21%) to 2006 (0.90%)
  - The rate in 2006 was 0.70% among those ages 6–12 and 1.13% among those ages 13–17
- ADHD and disruptive behavior diagnoses accounted for a much smaller proportion of privately insured (26.2%) than Medicaid (47.0%) youth treated with antipsychotics (both off label uses)
- Bipolar disorder accounted for a larger share of privately insured (22.9%) than in Medicaid-insured youth (18.7%) in 2004
  - The increase in antipsychotic treatment also appears to have been more gradual among privately insured than Medicaid children during 2001–2004



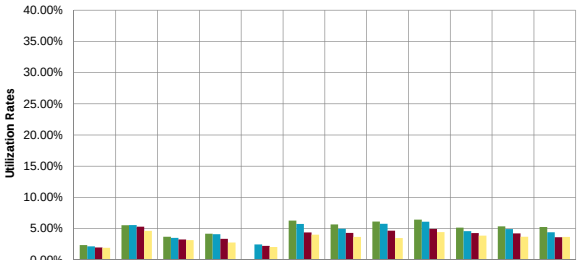

**Pediatric Medicaid Antipsychotic Utilization (ages <= 17 years) from 2008-2011 for the 35 Community Care counties in Pennsylvania**




| | A | B | C | D | E | F | G | H | I | J | K |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2008 Avg | 1.86% | 3.91% | 2.69% | 3.40% | 2.88% | 4.24% | 3.98% | 4.23% | 4.74% | 3.54% | 4.17% |
| 2009 Avg | 1.89% | 4.11% | 2.63% | 3.61% | 3.10% | 4.18% | 4.32% | 4.40% | 4.64% | 3.66% | 4.06% |
| 2010 Avg | 1.69% | 3.75% | 2.43% | 3.21% | 3.08% | 4.08% | 4.13% | 4.21% | 4.48% | 3.50% | 3.68% |
| 2011 Avg | 1.56% | 3.57% | 2.08% | 2.72% | 2.81% | 3.83% | 3.62% | 3.92% | 4.25% | 3.26% | 3.24% |




**Pediatric Medicaid Antipsychotic Utilization (ages <= 17 years) from 2010 – 2013 for all Community Care counties in Pennsylvania**




| | Region 1 | Region 2 | Region 3 | Region 4 | Region 5 | Region 6 | Region 7 | Region 8 | Region 9 | Region 10 | Region 11 | Region 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2010 | 2.35% | 5.54% | 3.70% | 4.19% | | 6.29% | 5.67% | 6.14% | 6.44% | 5.15% | 5.37% | 5.25% |
| 2011 | 2.16% | 5.56% | 3.50% | 4.10% | 2.45% | 5.74% | 4.98% | 5.78% | 6.09% | 4.59% | 4.93% | 4.42% |
| 2012 | 1.98% | 5.31% | 3.26% | 3.36% | 2.24% | 4.39% | 4.31% | 4.66% | 4.95% | 4.28% | 4.24% | 3.61% |
| 2013 | 1.92% | 4.64% | 3.14% | 2.77% | 2.05% | 4.02% | 3.68% | 3.49% | 4.45% | 3.88% | 3.71% | 3.68% |

Risks of Antipsychotic Use

## Cardiometabolic Risk of Second-Generation Antipsychotic Medications During First-Time Use in Children and Adolescents



## Demographics

| | |
|---|---|
| Total | N=272 |
| Age Mean (SD) | 13.9 (3.6) |
| Age Range | 4.3 – 19.9 |
| Male | 57% |
| White | 48.5% |
| Black | 25.9% |
| Hispanic | 8.9% |
| Asian | 4.1% |
| Mixed | 12.5% |
| SES mean | 95% CI<br>2.8 (2.6 – 2.9) |

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## Primary Psychiatric Diagnosis

- Schizophrenia spectrum disorder 30.1%
  - Psychosis NOS 19.9%
  - Schizophrenia or Schizoaffective 9.9%
- Mood disorder spectrum disorder 47.8%
  - MDD or depressive disorder NOS 18.0%
  - Bipolar I, II, or NOS 16.2%
  - Mood disorder NOS 13.6%
- Disruptive or aggressive spectrum disorder 22.1%
  - ODD, CD, IED, ICD 14.3%
- Autism spectrum disorder 7.7%

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## Second-Generation Antipsychotics

- Aripiprazole
  - Abilify®
- Olanzapine
  - Zyprexa®, Zydis®
- Quetiapine
  - Seroquel®
- Risperidone
  - Risperdal®

vs. untreated




## Weight Change

Week 0

| Range (lbs.) | Mean (lbs.) | Confidence Interval |
|---|---|---|
| 113.5 – 123.9 | 117.9 lbs. | 95% |

Change Weeks 0 – 12

| Medication | Range (lbs.) | Mean (lbs.) | P-value |
|---|---|---|---|
| Aripiprazole | 8.2 – 11.4 | 9.7 | <0.001 |
| Olanzapine | 16.3 – 21.4 | 18.8 | <0.001 |
| Quetiapine | 10.8 – 15.9 | 13.4 | <0.001 |
| Risperidone | 10.6 – 12.9 | 11.8 | <0.001 |
| Untreated | -2.3 – 3.2 | 0.42 | 0.77 |




## Glucose and Lipid Parameters

| Worsened Values | Olanzapine | Quetiapine | Risperidone |
|---|---|---|---|
| Glucose | x | | |
| Insulin | x | | |
| Ratio triglycerides to HDL | x | x | |
| Total cholesterol | x | x | |
| LDL cholesterol | x | | |
| HDL cholesterol | | | |
| Triglycerides | x | x | x |
| Non-HDL cholesterol | x | x | |

# Metabolic Monitoring of Children on Antipsychotic Medications in Pennsylvania



## 2012 Antipsychotic & Lab Monitoring Rates

| Age Group | Glucose | Lipid | # Members | Percent |
|---|---|---|---|---|
| 17 and under | 0 | 0 | 1995 | **46.47%** |
| | 0 | 1 | 153 | 3.56% |
| | 1 | 0 | 1076 | 25.06% |
| | 1 | 1 | 1069 | **24.90%** |
| **Pediatric total** | | | **4293** | |
| 18 and over | 0 | 0 | 3592 | **26.14%** |
| | 0 | 1 | 168 | 1.22% |
| | 1 | 0 | 4482 | 32.62% |
| | 1 | 1 | 5498 | **40.02%** |
| **Adult total** | | | **13740** | |

0 = no paid claims; 1 = paid claims




## Antipsychotic & Lab Monitoring

| Population | Lab | Year | | | $\chi^2_{df=2}$ | P-value |
|---|---|---|---|---|---|---|
| | | M1 | M2 | M3 | | |
| Age < 18 | Lipid = Yes | 499 (19%) | 1011 (22%) | 1222 (28%) | 79.17 | <0.0001 |
| | Glucose = Yes | 781 (30%) | 1847 (41%) | 2145 (50%) | 246.56 | <0.0001 |
| Age ≥ 18 | Lipid = Yes | 2380 (38%) | 5076 (39%) | 5666 (41%) | 15.99 | 0.0003 |
| | Glucose = Yes | 3515 (56%) | 8904 (69%) | 9980 (72%) | 526.47 | <0.0001 |

M1=2008; M2=2010; M3=2012

## Positive Findings

- Most children receiving antipsychotic medications are receiving them from psychiatrists
- Most children are receiving concurrent BH services
- The majority are receiving intensive community based services
  - Behavioral health rehabilitation or family-based mental health (BHRS or FBMH)




## Areas of Concern

- Many children receiving antipsychotic medications do not have an FDA or other indication supported in professional literature
- Antipsychotic medications may be associated with significant medical risks
- Most children receiving antipsychotic medications do not have routine monitoring of serum lipids and glucose




## Quality Initiatives: Providers

- Provider letters sent to update physicians on the current recommended guidelines for monitoring patients prescribed antipsychotics
- Articles in Community Care provider newsletters discussing pharmacy initiatives and promoting appropriate prescribing, as well as encouraging metabolic monitoring of patients on antipsychotics
- Meetings with large provider groups in Community Care counties
- Record review indicators: documented evidence that medication education (including side effects) and rationale for medication changes is provided to the consumer and their family if applicable

## Quality Initiatives: Members

- Educational articles in the member newsletter for parents discussing antipsychotic medications, appropriate follow-up while on these medications, and questions to ask your child's doctor
- Direct mailing to members' guardians highlighting the need to get appropriate monitoring while on antipsychotics and attached worksheet for members and families to fill out prior to doctor's visit to aid in medication discussion




## Guidelines

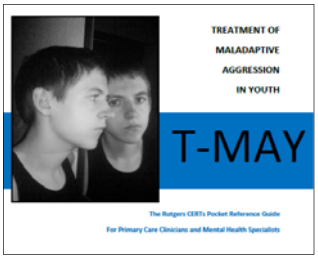
- American Academy of Child and Adolescent Psychiatry, Parameter for Use of Atypical Antipsychotic Medications in Children and Adolescents, 2011.
  *http://www.aacap.org/App_Themes/AACAP/docs/practice_parameters/Atypical_Antipsychotic_Medications_Web.pdf*
- American Academy of Child and Adolescent Psychiatry, Practice Parameter on the Use of Psychotropic Medications in Children and Adolescents, 2009.
  *http://download.journals.elsevierhealth.com/pdfs/journals/0890-8567/PIIS0890856709601568.pdf*
- Texas DFSP, 2013 Psychotropic Medication Utilization Parameters for Children and Youth in Foster Care
  *http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-psychotropic.asp*




## Community-Serving Agency Guide

- American Academy of Child and Adolescent Psychiatry, 2012. A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents
  *http://www.aacap.org/App_Themes/AACAP/docs/press/guide_for_community_child_serving_agencies_on_psychotropic_medications_for_children_and_adolescents_2012.pdf*
  - Context for prescribing psychotropic medications
  - Phases in treatment
  - Issues in prescribing
  - Considerations for child-serving agencies
  - Sources of information about medications
  - References
  - Resources for families

## T-MAY Guide






http://www.thereachinstitute.org/images/pdfs/T-MAY-final.pdf

## Foster Care & Psychotropic Medication

- Psychotropic prescribing in foster care children in 37 Community Care counties
- Compared to non-foster care children enrolled in Medicaid
- Children and adolescents age 17 and under
- Time frame: July 1, 2012 - June 30, 2013




## GAO Findings

Foster children in Florida, Mass, Michigan, Oregon, and Texas were prescribed psychotropic medications at rates 2.7-4.5 times higher than were non-foster children in Medicaid in 2008

| Percent of 0-17 year olds Prescribed a Psychotropic Medication | | | |
|---|---|---|---|
| **State** | **Foster care** | **Non-foster care** | **Care Ratio** |
| Florida | 22.0% | 8.2% | 2.7 |
| Massachusetts | 39.1% | 10.2% | 3.8 |
| Michigan | 21.0% | 7.9% | 2.7 |
| Oregon | 19.7% | 4.8% | 4.1 |
| Texas | 32.2% | 7.1% | 4.5 |

## Foster Care Group Demographics

| Race | # Children | Percent |
|---|---|---|
| African American | 1358 | 29.7% |
| White | 495 | 10.8% |
| Other | 2718 | 59.5% |

| Ages | # Children | Percent |
|---|---|---|
| <= 1 | 701 | 15.3% |
| 2-5 | 890 | 19.5% |
| 6-12 | 1056 | 23.1% |
| 13-17 | 1924 | 42.1% |




## Psychotropic Fill Rates

**Children in Foster Care**

| Class | # Unique Children | Percent (Den = 1526) |
|---|---|---|
| Stimulants | 904 | 59.2% |
| Antidepressants | 818 | 53.6% |
| Antipsychotics | 712 | 46.7% |
| Mood stabilizers | 381 | 25.0% |

1526 (33.4% of 4571 had at least 1 Rx filled

**Non-Foster Care Children**

| Class | # Unique Children | Percent (Den = 3927) |
|---|---|---|
| Stimulants | 27643 | 70.4% |
| Antidepressants | 12283 | 31.3% |
| Antipsychotics | 8971 | 22.8% |
| Mood stabilizers | 5934 | 15.1% |

39275 (14.2% of 276140 had at least 1 Rx filled




## Distribution: Foster Care Children

Based on diagnoses for foster care children

| Diagnosis Category | Therapeutic Class | # Children Prescribed (Num) | # Children w/ Diagnosis (Den) | Percent (Num/Den) |
|---|---|---|---|---|
| ADHD | Antipsychotics | 156 | 360 | 43.3% |
| Depression | | **156** | **279** | **55.9%** |
| Adjustment | | 38 | 131 | 29.0% |
| PTSD | | 44 | 109 | 40.4% |
| OOD | | **54** | **94** | **57.4%** |

## Distribution: Non-Foster Care Children

Based on diagnoses for non-foster care children

| Diagnosis Category | Therapeutic Class | # Children Prescribed (Num) | # Children w/ Diagnosis (Den) | Percent (Num/Den) |
|---|---|---|---|---|
| ADHD | Antipsychotics | 2380 | 11383 | 20.9% |
| Depression | | **1829** | **4019** | **45.5%** |
| Adjustment | | **1442** | **3895** | **37.0%** |
| PTSD | | 241 | 1750 | 13.8% |
| OOD | | 618 | 1729 | 35.7% |




## Polypharmacy Rates: Foster Care

Rates for foster care children from 07.01.2012 – 06.30.2013

| Measure | # Children | Percent (Den = 1526) |
|---|---|---|
| 3 or more medications concurrently for at least 90 days | 148 | 9.7% |
| 4 or more medications concurrently for at least 90 days | 31 | 2.0% |
| 5 or more medications concurrently for at least 90 days | 4 | 0.3% |




## Polypharmacy Rates: Non-Foster Care

Rates for non-foster care children from 07.01.2012 – 06.30.2013

| Measure | # Children | Percent (Den=39275) |
|---|---|---|
| 3 or more medications concurrently for at least 90 days | 1500 | 3.8% |
| 4 or more medications concurrently for at least 90 days | 282 | 0.7% |
| 5 or more medications concurrently for at least 90 days | 51 | 0.1% |

## GAO Report: Foster Children

- US Government Accountability Office (GAO) report *HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions*
- Foster children in the five states analyzed were prescribed psychotropic drugs at higher rates than non-foster children in Medicaid during 2008
- Could be due in part to foster children's greater mental health needs, greater exposure to traumatic experiences and the challenges of coordinating their medical care
- GAO recommended that HHS consider endorsing guidance for states on best practices for overseeing psychotropic prescriptions for foster children



*GAO-12-270T Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions, Testimony before the Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, Committee on Homeland Security and Governmental Affairs, U.S. Senate, Statement of Gregory D. Kutz, Director Forensic Audits and Investigative Service

## AACAP Best Principle Guidelines

- American Academy of Child & Adolescent Psychiatry (AACAP)
  - Consent: Each state has some practices consistent with AACAP consent guidelines, such as identifying caregivers empowered to give consent
  - Oversight: Each state has procedures consistent with some but not all oversight guidelines, which include monitoring rates of prescriptions
  - Consultation: Five states have implemented some but not all guidelines, which include providing consultations by child psychiatrists by request
  - Information: Four states have created websites about psychotropic drugs for clinicians, foster parents, and other caregivers

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## Dependent Children

- Concern: medication prescribed treats the behavior, but not the past trauma experienced
  - Many had a traumatic experience
  - Often times, these children are not identified or treated for the trauma they experienced
  - Recommendations were developed to address trauma sensitivity

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## Recommendation #1

"Collaboratively develop guidelines and/or policy regarding oversight and monitoring of psychotropic medication for the dependent children in Pennsylvania"

- Policy development:
  - Informed consent/assent
  - Screening, assessment, treatment
  - Statewide "red flag" monitoring system

 

## Recommendation #2

"Explore the possibility of providing incentives to providers who attain positive outcomes for children in the dependency system relating to mental and behavioral health treatment, including psychotropic medication"

- On hold until a standardized set of "red flags" are developed to monitor psychotropic medications for children

 

## Recommendation #3

"Facilitate the development of training on oversight of psychotropic medication to support what is expected of all partners in the child welfare system"

- Developed psychotropic medication key questions information card
  - Guidance to judges, legal representatives, caseworkers, etc.

 

## Recommendation #4

"Collaborate with the Children's Hospital of Philadelphia's PolicyLab as supported by Casey Family Programs to provide counties with data specific to the usage of psychotropic medication with their child welfare population. Provide counties a guide to assist them in discussing their county-specific data and protocols around psychotropic medication for children in the child welfare system"

- PA state analysis on psychotropic medication use for dependent children
- Data trends shared for 2002-2009
  - PA on trend nationally
- Currently looking at 3-5 year olds
- Regional analysis
- Development of psychotropic medication discussion guide for local children's roundtables




## Recommendation #5

"Develop a psychotropic medication resource section on the Office of Children and Families in the Courts website while exploring the possibility of a more comprehensive, multifunctional and multi-disciplinary website"

- Provides links and resources
- Government reports
- Reference guides
- Trauma-informed care and services




## Research

- Research demonstrates that foster children are medicated at a higher rate than other children
  - Multi-State Study on Psychotropic Medication Oversight in Foster Care (Tufts University)
  - Antipsychotic Medication Use in Medicaid Children and Adolescents: Report and Resource Guide from a 16-State Study(Rutgers University)
  - Interstate Variation in Trends of Psychotropic Medication Use among Medicaid-enrolled Children in Foster Care (PolicyLab at Children's Hospital of Philadelphia)
  - HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions (United States GAO Report to Congress)

## Research-Based National "Red Flags"

- Informed consent / assent of using psychotropic medication lacks documentation
- Off-label use of psychotropic medication
- Atypical anti-psychotic medication usage
- Poly-pharmacological treatment
- Use of psychotropic medication for young children (under 5 years old)
- Psychotropic medication prescribed by PCP for disorders other than ADHD and depression




## Best Practices and Guidelines

- Dr. David Rubin's questions to ask when a child is on psychotropic medications:
  - What is the child's diagnosis? Is it the correct diagnosis?
  - What is the medications' intended effect? Is it effective?
  - Are we monitoring for adverse effects?
  - If the child is doing well, have we thought about tapering the medication?
  - What is the opinion of the treating physician?