*Behavioral Health Services (BHS)*

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# Children and Youth Services Physician Manual and Practice Guidelines

# Quick Guide: Prescribing Practices for Psychotropic Medication in Children and Youth

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| **Approval** | **Signature** | **Date** |
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# Quick Guide

## I. Parameters for Psychotropic Medication in Children and Youth

This summary is limited to principles and pharmacokinetics. It was determined that medication-specific recommendations would be both beyond the scope and too extensive to review in this context.

## II. Principles for Prescribing Practices

A. Before initiating pharmacotherapy, a psychiatric evaluation is completed.

B. Before initiating pharmacotherapy, a medical history is obtained, and a medical evaluation is considered when appropriate.

C. The prescriber is advised to communicate with other professionals involved with the child to obtain collateral history and set the stage for monitoring outcome and side effects during the medication treatment.

D. The prescriber develops a psychosocial and psychopharmacological treatment plan based on the best available evidence.

E. The prescriber develops a plan to monitor the patient, short and long term.

F. Prescribers should be cautious when implementing a treatment plan that cannot be appropriately monitored.

G. The prescriber provides feedback about the diagnosis and educates the patient and family regarding the child's diagnosis and the treatment and monitoring plan.

H. Complete and document the assent of the child and consent of the parents before initiating medication treatment and at important points during treatment.

I. The assent and consent discussion focuses on the risks and benefits of the proposed and alternative treatments.

J. Implement medication treatment with a recommended (or evidence-based) starting dosage and titrate to a dosage to adequately treat symptoms. Medication is continued for a duration appropriate to the expected course of illness.

K. The prescriber reassesses the patient if he/she/they does/do not respond to the initial medication treatment as expected.

L. The prescriber needs a clear rationale for using medication combinations and discusses any increased risks with the child and parent.
M. Discontinuing medication in children requires a specific plan.

## III. Pharmacokinetics

A. For most children, by age 2, body systems are functioning at adult levels as related to drug disposition, metabolism, and elimination.
B. Then, between 2 and 12 years of age, drug clearance changes. It increases and functions faster than adults' bodies do. As a result, shorter half-lives are seen, and children often have greater dosing requirements than adults do for many medications.
    1. Common strategies to address this circumstance include once-daily medications dosed twice a day (in age groups: in elementary, middle school-aged children, and adolescents).
C. Children have greater hepatic capacity, more glomerular filtration, and less fatty tissue when compared to their adult counterparts.
    1. Some medication classes that are more rapidly eliminated by children (versus adults). These are: stimulants, antipsychotics, and tricyclic drugs.
    2. Another medication class that may be more rapidly eliminated is Lithium.

## IV. References

Child and Adolescent Psychiatry: The Essentials. Cheng, Keith & Kathleen M. Myers. Lippincott Williams & Wilkins. Philadelphia, PA. 2005.

Kaplan & Sadock's Concise Textbook of Child and Adolescent Psychiatry. Sadock, M.D., Benjamin James & Virginia Alcott Sadock, M.D. Lippincott Williams & Wilkins. Philadelphia, PA. 2009.

Walkup, J. (2009). Practice Parameter on the use of psychotropic medication in children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry, 48(9)*, 961-973.