Disclaimer

The Kansas Psychotropic Medication Utilization Parameters for Children and Youth in Foster Care is intended to provide principles to guide prescriptive practices. Children in the child welfare system often present with complicated clinical pictures. The formation of treatment algorithms that clinicians must rigidly adhere to is unrealistic and is not in the best interest of the child. The Kansas PMUR is meant to inform the practice of pediatric psychopharmacology in this population and to provide a framework to promote the provision of quality psychiatric services to children in foster care in the state of Kansas. These guidelines are not meant to supersede the clinical judgment of providers working closely with foster children and their caregivers.

Committee:

Kansas Department for Aging and Disability Services Psychotropic Medication Workshop

Psychotropic Medication Utilization Parameters for Children and Youth in Foster Care  
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***Psychotropic Medication Utilization Parameters***

***for Children and Youth in Foster Care***

***Introduction and General Principles***

The use of psychotropic medications by children and youth is an issue confronting parents, other caregivers, and health care professionals across the United States. Children and youth in foster care, in particular, have multiple needs, including those related to emotional or psychological stress. They typically have experienced abusive, neglectful, serial or chaotic caretaking environments. Birth family history is often not available. These children often present with a fluidity of different symptoms over time reflective of past traumatic events that may mimic many psychiatric disorders and result in difficulties with attachment, mood regulation, behavioral control, and other areas of functioning.

**Because of 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 prescribing a psychotropic medication.** The physical assessment should be performed by a physician or another healthcare professional qualified to perform such an assessment. It is recognized that in some emergency situations, it may be in the best interest of the child to prescribe psychotropic medications before a physical exam can actually be performed. In these situations, a thorough health history should be performed to assess for significant medical disorders and past response to medications, and a physical evaluation should be performed as soon as possible. A thorough psychosocial assessment should be performed by an appropriately qualified mental health clinician (masters or doctoral level), a psychiatrist/child psychiatrist, or a primary care physician with experience in providing mental health care to children and youth. The child’s symptoms and functioning should be assessed across multiple domains, and the assessment should be developmentally age appropriate. It is very important that information about the child’s history, including history of trauma and current functioning be made available to the treating physician in a timely manner, either through an adult who is well-informed about the child or through a comprehensive medical record. It is critical to meet the individual needs of patients and their families in a culturally competent manner. This indicates a need to address communication issues as well as differences in perspective on issues such as behavior and mental functioning. Interpretation of clinical symptoms and decisions concerning treatment should, whenever possible, be informed by the child’s developmental history of trauma, neglect or abuse and the timing of these stressors. In general, optimal outcomes are achieved with well-coordinated team based care with members of different professions (e.g., child psychiatrist, child psychologist, social worker, primary care physician, etc.) each contributing their particular expertise to the treatment plan and follow-up. Additionally, at present there are no biomarkers to assist with the diagnosis of mental disorders, and imaging (e.g., MRI) and other tests (e.g., EEG) are not generally helpful in making a clinical diagnosis of a mental disorder.

**The role of non-pharmacological interventions should be considered before beginning a 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 or psychophysiological functioning (such as profound sleep disturbance), or when the child shows marked anxiety, isolation, or withdrawal.** Given the history of trauma, unusual stress and change in environmental circumstances associated with being a child in foster care, psychotherapy should generally begin before or concurrent with prescription of a psychotropic medication. Referral for trauma-informed, evidence-based psychotherapy should be considered when available and appropriate. Equally important, the role of the health care providers and the health care environment’s potential to exacerbate a child’s symptoms, given their respective trauma history, should be considered and minimized. Patient and caregiver education should be provided about the condition to be treated, treatment options (non-pharmacological and pharmacological), treatment expectations, and potential side effects that may occur during the prescription of psychotropic medications.

**It is recognized that many psychotropic medications do not have Food and Drug Administration (FDA) approved labeling for use in children.** The FDA has a statutory mandate to determine whether pharmaceutical company sponsored research indicates that medication is safe and effective for those indications that are listed in the approved product labeling. The FDA assures that information in the approved product labeling is accurate, and limits the manufacturer’s marketing to the information contained in the approved labeling. The FDA does not regulate physician and other health provider practice. In fact, 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. Physicians should utilize the available evidence, expert opinion, their own clinical experience, and exercise their clinical judgment in prescribing what is best for each individual patient. To that end, clear documentation of the physician’s rationale in the medical record facilitates continuity of care and minimizes misinterpretation.

***Role of Primary Care Providers***

Primary care providers play a valuable role in the care of youth with mental disorders. Not only are they the clinicians most likely to initially interact with children who are in distress due to an emotional or psychiatric disorder, but also an inadequate number of child psychiatrists are available to meet all children’s mental health needs. Primary care clinicians are in an excellent position to perform screenings of children for potential mental disorders, and they should be able to diagnosis and treat relatively straightforward situations such as uncomplicated ADHD, anxiety, or depression. Primary care providers should provide advice to youth in foster care and their caregivers about handling feelings and behaviors, recognizing the need for help, making decisions regarding healthy lifestyles, and the available treatments for childhood mental disorders. As always, consideration should be given regarding the need for referral for counseling psychotherapy, or behavioral therapy. Primary care providers vary in their training, clinical experience, and confidence to address mental disorders in children. Short courses and intensive skills oriented seminars may be beneficial in assisting primary care clinicians in caring for children with mental disorders. Active liaisons with child psychiatrists who are available for phone consultation or referral can be beneficial in assisting primary care clinicians to meet the mental health needs of children. “The management of common presentations of ADHD, depression and anxiety, psychotherapy referral, psychopharmacology and appropriate child psychiatry referral are within the scope of general pediatric practice” (Southammakosane 2015). In addition, the American Academy of Pediatrics has recently provided a policy statement (“Health Care Issues for Children and Adolescents in Foster Care and Kinship Care”) which can be found at:

<http://pediatrics.aapublications.org/content/136/4/e1131>

***General principles regarding the use of psychotropic medications in children include:***

* A DSM-5 psychiatric diagnosis should be made before the prescribing of psychotropic medications.
* A comprehensive physical exam such as the annual well child exam should be considered prior to starting psychotropic medications to identify medical problems or issues that may impact treatment.
* Clearly defined target symptoms and treatment goals for the use of psychotropic medications should be identified and documented in the medical record at the time of or before beginning treatment with a psychotropic medication. These target symptoms and treatment goals should be assessed at each clinic visit with the child and caregiver in a culturally and linguistically appropriate manner. Whenever possible, standardized clinical rating scales (clinician, patient, primary caregiver, teachers, and other care providers) or other measures should be used to quantify the response of the child’s target symptoms to treatment and the progress made toward treatment goals.
* In making a decision regarding whether to prescribe a psychotropic medication in a specific child, the clinician should carefully consider potential side effects, including those that are uncommon but potentially severe, and evaluate the overall benefit to risk ratio of pharmacotherapy.
* Except in the care of an emergency, informed consent should be obtained from the appropriate party(s) before beginning psychotropic medication. Informed consent to treatment with psychotropic medication entails diagnosis, expected benefits and risks of treatment, including common side effects, discussion of laboratory findings, and uncommon but potentially severe adverse events. Alternative treatments, the risks associated with no treatment, and the overall potential benefit to risk ratio of treatment should be discussed.
* Whenever possible, trauma-informed, evidence-based psychotherapy, should begin before or concurrent with the prescription of psychotropic medication.
* Before starting psychopharmacological treatment in preschool-aged children even more emphasis should be placed on treatment with non-psychopharmacological interventions. Assessment of parent functioning and mental health needs, in addition to training parents in evidence-based behavior management can also reduce the need for the use of medication.
* Medication management should be collaborative. Youth, as well as caregivers, should be involved in decision-making about treatment, in accordance with their developmental level. Parents providing informed consent should be engaged, and where applicable, other caregivers, family, and child related agencies should be involved.
* During the prescription of psychotropic medication, the presence or absence of medication side effects should be documented in the child’s medical record at each visit.
* Appropriate monitoring of indices such as height, weight, blood pressure, or laboratory findings should be documented.
* Monotherapy regimens for a given disorder or specific target symptoms should usually be tried before polypharmacy regimens. While the goal is to use as few psychotropic medications as can be used to appropriately address the child’s clinical status, it is recognized that the presence of psychiatric comorbidities may affect the number of psychotropic medications that are prescribed. When combined psychotropic medication regimens are needed, addition of each medication should occur in a systematic orderly process, accompanied by on-going monitoring, evaluation, and documentation. The goal remains to minimize the number of drugs while maximizing therapeutic outcomes. There is a lack of evidence for prescribing multiple medications within the same class, but, the practice has some support in specific clinical situations such as: Temporary use of two drugs when cross-tapering from one drug to another, combining a short-acting and long-acting stimulant, and the addition of trazodone to an SSRI to target insomnia.
* Medications should be initiated at the lower end of the recommended dose range and titrated carefully as needed.
* Only one medication should be changed at a time, unless a clinically appropriate reason to do otherwise is documented in the medical record. (Note: starting a new medication and beginning the dose taper of a current medication is considered one medication change.)
* The frequency of clinician follow-up should be appropriate for the severity of the child’s condition and adequate to monitor response to treatment, including: symptoms, behavior, function, and potential medication side effects. At a minimum, a child receiving psychotropic medication should be seen by the clinician at least once every ninety days.
* The potential for emergent suicidality should be carefully evaluated and monitored, particularly in depressed children and adolescents as well as those initiating antidepressants, those having a history of suicidal behavior or deliberate self-harm and those with a history of anxiety or substance abuse disorders.
* If the prescribing clinician is not a child psychiatrist, referral to or consultation with a child psychiatrist, or a general psychiatrist with significant experience in treatment children, should occur if the child’s clinical status has not shown meaningful improvement within a timeframe that is appropriate for the child’s diagnosis and the medication regimen being used.
* Before adding additional psychotropic medications to a regimen, the child should be assessed for adequate medication adherence, appropriateness of medication daily dosage, accuracy of the diagnosis, the occurrence of comorbid disorders (including substance abuse and general medical disorders), and the influence of psychosocial stressors.
* If a medication has not resulted in improvement in a child’s target symptoms (or rating scale score), discontinue that medication rather than adding a second medication.
* If a medication is being used in a child for a primary target symptom of aggression associated with a DSM-5 non-psychotic diagnosis (e.g., conduct disorder, oppositional defiant disorder, intermittent explosive disorder), and the behavior disturbance has been in remission for six months, then serious consideration should be given to slow tapering and discontinuation of the medication. If the medication is continued in this situation, the necessity for continued treatment should be evaluated and documented in the medical record at a minimum of every six months.
* The clinician should clearly document care provided in the child’s medical record, including history, mental status assessment, physical findings (when relevant), impressions, rationale for medications prescribed, adequate laboratory monitoring specific to the drug(s) prescribed at intervals required specific to the prescribed drug and potential known risks, medication response, presence or absence of side effects, treatment plan, and intended use of prescribed medications.

***Use of PRN Medication***

* The use of “PRN” or as needed medication is generally discouraged. However, when deemed appropriate, such as a prn dose of antihistamine for anxiety or medication adverse effect, it is important to clearly document the medication that is used, the situation indicating need for the administration of a prn medication, as well as the maximum dosage in a 24-hour period and in a week. The frequency of administration should be monitored over time to assure that these do not become regularly scheduled medications unless clinically indicated.
* Psychotropic medications are not to be used in place of psychosocial and behavioral interventions for Kansas youth in DCF custody. A standing order for the use of pro re nata (PRN) medications for behavioral dysregulation outside of a treatment facility or without appropriate supervision by medical staff is strongly discouraged.

***Use of Psychotropic Medication in Preschool Age Children***

The use of psychotropic medication in young children of preschool ages is a practice that is limited by the lack of evidence available for use of these agents in this age group. The Preschool Psychopharmacology Working Group (PPWG) published guidelines (Gleason 2007) summarizing available evidence for use of psychotropic medications in this age group. The PPWG was established in response to the clinical needs of preschoolers being treated with psychopharmacological agents and the absence of systematic practice guidelines for this age group, with its central purpose to attempt to promote an evidence-based, informed, and clinically sound approach when considering medications in preschool-aged children.

The PPWG guidelines emphasize consideration of multiple different factors when deciding on whether to prescribe psychotropic medications to preschool-aged children. Such factors include the assessment and diagnostic methods utilized in evaluating the child for psychiatric symptoms/illness, the current state of knowledge regarding the impact of psychotropic medication use on childhood neurodevelopmental processes, the regulatory and ethical contexts of use of psychotropic medications in small children (including available safety information and FDA status), and the existing evidence base for use of psychotropic medication in preschool aged children.

The publication includes specific guidelines and algorithms schematics developed by the PPWG to help guide treatment decisions for a number of psychiatric disorders that may present in preschool-aged children, including Attention-Deficit Hyperactivity Disorder, Disruptive Behavioral Disorders, Major Depressive Disorder, Bipolar Disorder, Anxiety Disorders, Post-Traumatic Stress Disorder, Obsessive-Compulsive Disorder, Pervasive Developmental Disorders, and Primary Sleep Disorders. The working group’s key points and guidelines are similar to the general principles regarding the use of psychotropic medication in children already detailed in this paper. However, the working group’s algorithms put more emphasis on treating preschool-aged children with non-psychopharmacological interventions (for up to 12 weeks) before starting psychopharmacological treatment, in an effort to be very cautious in introducing psychopharmacological interventions to rapidly developing preschoolers.

The working group also emphasizes the need to assess parent functioning and mental health needs, in addition to training parents in evidence-based behavior management, since parent behavior and functioning can have a large impact on behavior and symptoms in preschool-aged children.

***Distinguishing between Levels of Warning Associated with Medication Adverse Effects***

Psychotropic medications have the potential for adverse effects, some that are treatment limiting. Some adverse effects are detected prior to marketing, and are included in the FDA approved product labeling provided by the manufacturers. When looking at product labeling, these adverse effects will be listed in the “Warnings and Precautions” section. As well, the “Adverse Reactions” section of the product labeling will outline those adverse effects reported during clinical trials, as well as those discovered during post-marketing evaluation. Many tertiary drug information resources also list common adverse effects and precautions for use with psychotropic medications.

***Black Box Warnings***

At times, post-marketing evaluation may detect critical adverse effects associated with significant morbidity and mortality. The Food and Drug Administration (FDA) may require manufacturers to revise product labeling to indicate these critical adverse effects. If found to be particularly significant, these effects are demarcated by a box outlining the information at the very beginning of the product labeling, and have, in turn, been named boxed warnings. Boxed warnings are the strongest warning required by the FDA. One example, is the black box warning about the increased risk of suicidal thoughts and behavior for children, adolescents and young adults taking antidepressants. This includes multiple classes of medications taken for any indication and necessitates close monitoring and communication with the prescriber. It is important for clinicians to be familiar with all medication adverse effects, including boxed warnings, in order to appropriately monitor patients and minimize the risk of their occurrence. The medication tables include two columns that outline this important information – one for “Black Box Warning” and the other for “Warnings and Precautions.” The medication tables include boxed warnings as well as other potential adverse effects. The list of potential adverse effects in the tables should not be considered exhaustive, and the clinician should consult the FDA approved product labeling and other reliable sources for information regarding medication adverse effects.

The FDA has in recent years taken additional measures to try to help patients avoid serious adverse events. New guides called Medication Guides have been developed, and are specific to particular medication and medication classes. Medication Guides advise patients and caregivers regarding possible adverse effects associated with classes of medications, and include precautions that they or healthcare providers may take while taking/prescribing certain classes of medications. The FDA requires that Medication Guides be issued with certain prescribed medications and biological products when the Agency determines that certain information is necessary to prevent serious adverse effects, that patient decision-making should be informed by information about a known serious side effect with a product, or when patient adherence to directions for the use of a product are essential to its effectiveness. During the drug distribution process, if a Medication Guide has been developed for a certain class of medications, then one must be provided with every new prescription and refill of that medication.

Copies of the Medication Guides for psychotropic medications can be accessed on the FDA website at:

<http://www.fda.gov/Drugs/DrugSafety/ucm085729.htm>

***Usual Recommended Doses of Common Psychotropic Medications***

The attached medication charts are intended to reflect usual doses and brief medication information for commonly used psychotropic medications. The tables contain two columns for maximum recommended doses in children and adolescents—the maximum recommended in the FDA approved product labeling, and the maximum recommended in medical and pharmacological literature sources. The preferred drug list of medications potentially prescribed for foster children is the same as for all other Kansas Medicaid recipients.

The tables are intended to serve as a resource for clinicians. The tables are not intended to serve as comprehensive drug information references or a substitute for sound clinical judgment in the care of individual patients. Circumstances may dictate the need for the use of higher doses in specific patients. In these cases, careful documentation of the rationale for the higher dose should occur, and careful monitoring and documentation of response to treatment should be performed. If the use of higher medication doses does not result in improvement in the patient’s clinical status within a reasonable time period (e.g., 2-4 weeks), then the dosage should be decreased and other treatment options considered.

Not all medications prescribed by clinicians for psychiatric diagnoses in children and adolescents are included in the following tables. However, in general, medications not listed do not have adequate efficacy and safety information available to support a usual maximum dose recommendation.

**See Psychotropic Medication Tables.**

***References***

Aman, MG, Bukstein OG, Gadow KD, et al., What does risperidone add to parent training and stimulant for severe aggression in child attention-deficit/hyperactivity disorder? J Am Acad Child Adolesc Psych 2014;53:47-60.

Biederman et al. A prospective open-label trial of lamotrigine monotherapy in children and adolescents with bipolar disorder. CNS Neurosci Ther Apr 2010;16(2):91-102.

Blader JC, Pliszka SR, Kafantaris V, et al. Prevalence and treatment outcomes of persistent negative mood among children with attention-deficit/hyperactivity disorder and aggressive behavior. J Child Adolesc Psychopharmacol. 2016;26(2)164-173.

Bobo WV, Cooper, WO, Stein CM, et al. Antipsychotics and the risk of type 2 diabetes mellitus in children and youth. JAMA Psychiatry 2013:70;1067-75.

Bridge JA, Iyengar S, Salary CB, et al. Clinical response and risk for reported suicidal ideal and suicide attempts in pediatric antidepressant treatment. JAMA 2007;297:1683-96.

Correll CU. Monitoring and management of antipsychotic-related metabolic and endocrine adverse events in pediatric patients. Int Rev Psychiatry 2008;20(2):195-201.

Correll CU, Kratochvil CJ, March JS. Developments in pediatric psychopharmacology: focus on stimulants, antidepressants, and antipsychotics. J Clin Psychiatry 2011;722:655-70.

Cooper WO, Habel LA, Sox CM et al. ADHD drugs and serious cardiovascular events in children and young adults. N Engl J 2011;365:1896904.

Crismon ML, Argo T. The use of psychotropic medication of children for children in foster care. Child Welfare 2009;88:71-100.

Cutler AJ, Brams M, Bukstein O, et al. Response/remission with guanfacine extended-release and psychostimulants in children and adolescents with attention-deficit/hyperactivity disorder. J Am Acad Child Adolesc Psych 2014;53:1092-1101.

De Hert M, Bobbelaere M, Sheridan EM, et al. Metabolic and endocrine adverse effects of second-generation antipsychotics in children and adolescents: A systematic review of randomized, placebo controlled trials and guidelines for clinical practice. European Psychiatry 2011;26:144-58.

Detke HC, DelBello MP, Landry J, Usher RW. Olanzapine/fluoxetine combination in children and adolescents with bipolar I depression: a randomized, double-blind placebo controlled trial. J Am Acad Child Adolesc Psyc 2015;54:217-224.

Dopheide JA, Pliszka SR. Attention-Deficit-Hyperactivity Disorder: An Update. Pharmacotherapy 2009;29(6)656-79.

Elbe D, et al. Clinical Handbook of Psychotropic Drugs for Children and Adolescents. Hogrefe Publishing, 2015.

Emslie GJ, et al. Escalopram in the treatment of adolescent depression: a randomized placebo-controlled ultisite trial. J Am Acad Child Adolesc Psychiatry 2006;48(7)721-9.

Etminan M, Carleton B and Brophy JM. Risperidone and Risk of Gynecomastia in Young Men. J Child Adolesc Psychopharm 2015;25(9)671-673.

Fanton J, Gleason M. Psychopharmacology and preschoolers: a critical review of current conditions. Child Adolesc Psychiatr Clin N Am 2009;18(3)753071.

Findling RL. Efficacy, long-term safety, and tolerability of ziprasidone in children and adolescents with bipolar disorder. J Child Adolesc Psychopharm 2013;23(8)545-57.

Findling RL, Drury SS, Jensen PS, AACAP Committee on Quality Issues. Practice parameter for the use of atypical antipsychotic medication in children and adolescents. American Academy of Child and Adolescent Psychiatry. Approved by the AACAP Council on August 2, 2011.

***References (continued)***

Findling RL, Johnson JL, McClellan J, et al. Double-blind maintenance safety and effectiveness findings from the treatment of early-onset schizophrenia spectrum (TEOSS) study. J Am Acad Child Adolesc Psychiatry 2010;49:583-94.

Findling RL, Reed MD, O’Riordan MA, Demeter CA, Stansbery RJ, McNamara NK. Effectiveness, safety, and pharmacokinetics of quetiapine in aggression children with conduct disorder. J Am Acad Child Adolesc Psychiatry 2006;45:792-800.

Findling RL, Robb A, McNamara NK, et al. Lithium in the acute treatment of bipolar I disorder: a double-blind placebo-controlled study. Pediatrics 2015;13:885-894.

Gadow KD, Arnold LG, Molina BSG, et al. Risperidone added to parent training and stimulant medication: Effects on attention-deficit/hyperactivity disorder, conduct disorder, and peer aggression. J Am Acad Child Adolesc Psych 2014;53:948-959.

Galling B et al. Type 2 Diabetes Mellitus in Youth Exposed to Antipsychotics: A Systematic Review and Meta-analysis. JAMA psychiatry. Online Jan 20, 2016:el-e13.

Gandelman K, Alderman JA, Glue P, et al. The impact of calories and fat content of meals on oral ziprasidone absorption: A randomized, open-label, crossover trial. J Clin Psychiatry 2009;70:58-62.

Geller B, Luby JL, Joshi P, et al. A randomized controlled trial of risperidone, lithium, or divalproex sodium for initial treatment of bipolar I disorder, manic or mixed phase, in children and adolescents. Arch Gen Psych 2012;69:515-528.

Gibbons RD, Brown H, Hur K, Davis JM, Mann JJ. Suicidal thoughts and behavior with antidepressant treatment: Reanalysis of the randomized placebo-controlled studies of fluoxetine and venlafaxine. Arch Gen Psych 2012;69:580-587.

Ghanizadeh A et al. A head-to-head comparison of aripiprazole and risperidone for safety and treating autistic disorders. Child Psychitry Hum Dev 2014;45(2):185-192. Geller B, Luby JL, Joshi P, et al. A randomized controlled trial of risperidone, lithium, or divalproex sodium for initial treatment of bipolar I disorder, manic or mixed phase, in children and adolescents (TEAM Study). Arch Gen Psych 2012;69:515-528.

Gleason MM, Egger HL, Emslie GJ, et al. Psychopharmacological treatment for very young children: contexts and guidelines. J Am Acad Child Adolesc Psychiatry 2007;46:1532-1572.

Greenhill L, Kollins S, Abikoff H, et al. Efficacy and safety of immediate-release methylphenidate treatment for preschoolers with ADHD. J Am Acad Child Adolesc Psychiatry 2006;45(11):1284-1293.

Groenman AP, Oosterlaan NN, et al. Stimulant therapy for attention-deficit hyperactivity disorder and risk of developing substance abuse disorder. Pediatrics 2014;204:494-501.

Hammond TA, Laughren T, Racoosin J. Suicidality in pediatric patients treated with antidepressant drugs. Arch Gen Psychiatry. 2006;63:332-339.

Hastard EB et al. ADHD, stimulant treatment, and growth: a longitudinal study. Pediatrics 2014;134(4):e935-944.

Hay W, Levin M, Deterding R, et al. Current diagnosis and treatment pediatrics. 20th ed. McGraw-Hill Professional Publishers 2010.

Hirota T, Schwartz S, Carrell CU. Alpha-2 agonists for attention-deficit/hyperactivity disorder in youth: systematic review and meta-analysis of monotherapy and add-on trials to stimulant therapy. Jour Am Acad Child Adolesc Psych 2014;53:153-173.

Jensen KG, Juul K, Fink-Jensen A, Correll CU, Pagsberg AK. Corrected QT changes during antipsychotic treatment of children and adolescents: asystematic review and meta-analysis of clinical trials. J Am Acad Child Adolesc Psych 2015;54:25-36.

Johns Hopkins Hospital, Arcara K, Tschudy M. The Harriet Lane Handbook: A Manual for Pediatric House Officers. 19th Ed. Philadelphia, PA: Mosby/Elsevier 2012.

Kennard BD, Emslie GJ, Mayes TL, et al. Sequential treatment with fluoxetine and relapse-prevention CBT to improve outcomes in pediatric depression. Am J Psych 2014;171:1083-1090.

Keller MB et al. Efficacy of paroxetine in the treatment of adolescent major depression: a randomized, controlled trial. J Am Acad Child Adolesc Psychiatry 2001;40(7):762-72.

Knapp P, Chait A, Pappadopulos E, Crystal S, Jensen PS, T-MAY Steering Committee. Treatment of maladaptive aggression in youth. CERT Guidelines I. Engagement, assessment, and management. Pediatrics 2012;129(6):e-1562-76.

Kliegman RM, Stanton B, Gene J, et al. Nelson textbook of pediatrics. 19th ed. Saunders Publishers; 2011.

Kowatch RA, Scheffer RE, Monroe E, et al. Placebo-controlled trial of valproic acid versus risperidone in children 3-7 yrs. of age with bipolar I disorder. Jour Child Adolesc Psychopharm 2015;25:306-313.

Lam RW. Antidepressants and QTc prolongation. J Psychiatry Neurosci 2013;38:E5-6.

***References (continued)***

Le Noury J, et al. Restoring Study 329: efficacy and harms of paroxetine and imipramine in treatment major depression in adolescence. BMJ 2015;351:h4320.

March JS. The preschool ADHD treatment study (PATS) as the culmination of twenty yrs. of clinical trials in pediatric psychopharmacology. J Am Acad Child Adolesc Psychiatry 2011;50(5):427-30.

McVoy M, Findling RL, eds. Clinical manual of child and adolescent psychopharmacology, 2nd ed. American Psychiatric Publishing Washington, DC. 2013.

Miller M, Swanson SA, Azrael D, Pate V, Styrmer T. Antidepressant dose, age, and the risk of deliberate self-harm. JAMA Intern Med 2014;174:899-909.

Nagy P, Nagy A, et al. Functional outcomes form a head-to-head trial of lisdexamfetamine dimesylate and atomoxetine in children and adolescents with attention-deficit/hyperactivity disorder and an inadequate response to methylphenidate. Eur Chld Adolesc Psychiatry; online May 22, 2015.

Lelayo R, Yuen K. Pediatric sleep pharmacology Child Adolesc Psychiatr Clin N Am 2012;21:861-83.

Papadopulos, E. The Treatment Recommendations for the use of Antipsychotics for Aggressive Youth (TRAAY). J Am Acad Child Adolesc Psychiatry. 2003, Vol 42, 2:145-61.

Perrin JM, Friedman RA, Knilans TK, et al. Cardiovascular monitoring and stimulant drugs for Attention Deficit/Hyperactivity Disorder. Pediatrics 2008;122:451-453.

Peukens J. The effects of novel and newly approved antipsychotics on serum prolactin levels: a comprehensive review. CNS Drugs 2014;28(5):421-53.

Pliszka SR, AACAP Work Group on Quality Issues. Practice parameter for the assessment and treatment of children and adolescents with attention-deficit/hyperactivity disorder. J Am Acad Child Adolesc Psychiatry 2007;46:894-921.

Rahman A, et al. Evaluating the incidence of leukopenia and neutropenic with valproate, quetiapine, or the combination in children and adolescents. Ann Pharmacother 2009;43(5):822-30.

Rosato NS, Correll CU, Pappadopulos E, Chait A, Crystal S, Jensen PS, T-MAY Steering Committee. Treatment of maladaptive aggression in youth. CERT guidelines II. Treatments and ongoing management. Pediatrics 2012;129(6):e1577-86

Scahill L, Oesterheld JR, Martin A. Pediatric psychopharmacology II. General principles, specific drug treatments, and clinical practice. In: Lewis M (ed.). Child and adolescent psychiatry: A comprehensive textbook. Lippincott Williams & Wilkins, Philadelphia 2007 754-788.

Scheeringa MS, Weems CF, Cohen JA, et al. Trauma-focused cognitive-behavioral therapy for posttraumatic stress disorder in 3 through 6 year-old children: a randomized clinical trial. J Child Psychol Psychiatry 2011;52:853-860.

Schelleman H, Bilker WB, Strom BL, et al. Cardiovascular events and death in children exposed and unexposed to ADHD agents. Pediatrics 2011;127(6):1102-1110.

Seida JC, Schouten JR, Boylan K, et al. Antipsychotics for children and young adults: a comparative effectiveness review. Pediatrics 2012;129:e771-e784.

Sikich L, Frazier JA, McCelellan J, et al. Double-Blind Comparison of First- and Second-Generation Antipsychotics in Early-Onset Schizophrenia and Schizoaffective Disorder: Findings from the Treatment of Early-Onset Schizophrenia Spectrum Disorders (TEOSS) Study. Am J Psychiatry 2008;165(11):1420-31.

Southammakosane C, Schmitz K. Pediatric Psychopharmacology for Treatment of ADHD, Depression, and Anxiety. Pediatrics 2015;136(2):351-59.

Sporn AL, et al. Clozapine treatment of childhood-onset schizophrenia: evaluation of effectiveness, adverse effects, and long-term outcome. J Am Acad Child Adolesc Psychiatry 2007;46(10):1349-56.

Stigler KA, et al. Paliperidone for irritability in adolescents and young adults with autistic disorder. Psychopharmacology (Berl) 2012;223(2):237-45.

Subcommittee on Attention-Deficit Hyperactivity Disorder, Steering Committee on Quality Improvement and Management. ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. Pediatrics 2011;128:1007-22.

van Geijlswijk IM, van der Heijden KB, Egberts ACG, et al. Dose finding of melatonin for chronic idiopathic childhood sleep onset insomnia: an RCT. Psychopharmacology 2010;212:379-391.

***References (continued)***

Varigonada AL, Jukubovski E, Taylor MJ, et al. Systematic review and meta-analysis: early treatment responses of selective serotonin reuptake inhibitors in pediatric major depressive disorder. J Am Acad Child Adolesc Psych 2015;54:557-564.

Vaughan B, Kratochvil CJ. Pharmacotherapy of pediatric attention-deficit/hyperactivity disorder. Child Adolesc Psychiatric Clin N Am 2012;21:941-55.

Vetter VL, et al. Cardiovascular monitoring of children and adolescents receiving medications for ADHD-Scientific Statement. Admerican Heart Assoc Circulation 2008;117:2407-2423.

Wagner KD. A double blind, randomized placebo-controlled trial of escitalopram in the treatment of pediatric depression. J Am Acad Child Adolesc Psychiatry 2006;45(3):280-288.

Wagner KD, Pliszka SR. Treatment of child and adolescent disorders. In: Schaztzberg AF, Nemeroff CB (eds). Textbook of psychopharmacology, 4th. Ed. American Psychiatric Publishing, Washington, DC, 2009;1309-1371.

Walkup J, Work Group on Quality Issues. Practice parameter on the use of psychotropic medication in children and adolescents. J Am Acad Child Adolesc Psychiatry 2009;48:961-73.

Wilens TE, Robertson B, Sikirca V, et al. A randomized, placebo-controlled trial of guanfacine extended release in adolescents with attention-deficit/hyperactivity disorder. J Am Acad Child Adolesc Psychiatry 2015;54:916-25.

Wozniak J, Mick E, Waxmonsky J, et al. Comparison of Open-Label, 8-Week Trials of Olanzapine Monotherapy and Topiramate Augmentation of Olanzapine for the Treatment of Pediatric Bipolar. J Child Adolesc Psychopharmacol 2009;19(5):539-45.

Zolaly MA. Histamine H1 antagonists and clinical characteristics of febrile seizures. Int J Gen Med 2012;5:277-281.

Zuddas A, Zanni R, Usala T. Second generation antipsychotics (SGAs) for non-psychotic disorders in children and adolescents: a review of the randomized controlled studies. Eur Neuropsyschopharmacol 2011;21:600-20.

***Web Link References***

21 CFR Part 201. Specific Requirements on Content and Format of Labeling for Human Prescription Drugs: Revision of “Pediatric Use” Subsection in the Labeling; Final Rule, Federal Register Volume 59, Number 238, December 13, 1994. <http://www.gpo.gov/fdsys/pkg/ER-1994-12-13/html/94-30238.htm>

Advisory Committee on Psychotropic Medications. The use of psychotropic medications for children and youth in the Texas foster care system. Texas Department of Family and Protective Services, September 1, 2004. Archived at: <http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-psychotropic.asp>

Children and Adolescents’ Psychoactive Medication Workgroup. Psychoactive medication for children and adolescents: Orientation for Parents, Guardians, and Others. Massachusetts Department of Mental Health, Boston, July 2007. <http://www.mass.gov/eohhs/docs/dmh/publications/psychoactive-booklet.pdf>

Child Exposure to Trauma: Comparative Effectiveness of Interventions Addressing Maltreatment (Review Number 89). Goldman FJ, Lloyd SW, et al., April 15, 2013. <http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=1463>

Child Welfare Trauma Training Toolkit (2013). The National Child Traumatic Stress Network. <http://learn.nctsn.org/login/index.php>

Facts and Comparisons Drug Information. Clin-eguide [database online]. St. Louis, MO: Wolters Kluwer Health, Inc., 2012. <http://cline-guide.ovid.com.ezproxy.lib.utexas.edu/>

FDA Drug Safety Communications: Revised recommendations for Celexa (citalopram hydrobromide) related to a potential risk of abnormal heart rhythms with high doses, August 24, 2011. <http://www.fda.gov/Drugs/DrugSafety/ucm297391.htm>

Health Care Issues for Children and Adolescents in Foster Care and Kinship Care. American Academy of Pediatrics Policy Statement, October 2015. <http://pediatrics.aappublications.org/content/136/4/e1131>

Making Healthy Choices: A Guide on Psychotropic Medication for Youth in Foster Care. Administration on Children, Youth and Families Children’s Bureau, U.S. Department of Health and Human Services, 2012. <https://www.childwelfare.gov/pubs/makinghealthy-choices/>

Natural Medicines Comprehensive Database [database online]. Stockton, CA: Therapeutic Research Faculty, 2011. <http://naturaldatabase.therapeuticresearch.com>

Pediatric and Neonatal Lexi-Drugs. Lexi-Comp OnlineTM [database online]. Hudson, OH: Lexi-Comp, Inc., 2012. <http://online.lexi.com.ezproxy.lib.utexas.edu>

Recommendations about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems. System of Care Resource from the American Academy of Child and Adolescent Psychiatry 2015. <http://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/AACAP_Psychotropic_Medication_Recommendations_2015_FINAL.pdf>

When to seek referral or consultation with a child or adolescent psychiatrist. American Academy of Child and Adolescent Psychiatry, 2003. <http://www.aacap.org/AACAP/Member_Resources/Practice_Information/When_to_Seek_Referral_or_Consultation_with_a_CAP.aspx>