Medicaid Drug Therapy Management Program For Behavioral Health

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NEWSLETTER
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Florida Best Practice Psychotherapeutic Medication Guidelines for Children and Adolescents

In this issue we feature a newly created set of *Florida Best Practice Psychotherapeutic Guidelines for Children and Adolescents*. At a time when there is often controversy due to the lack of clear evidence about the pharmacologic treatment of mental conditions in children and adolescents, it is imperative for physicians to have access to the most current scientific evidence. The guidelines, the work of the Florida Child Experts Panel, included national and local experts who reviewed the latest available medical evidence, recommendations of several available national guidelines, and algorithms for the pharmacologic treatment of children and adolescents presenting with the following psychiatric conditions:

- ADHD
- Bipolar Mania
- Chronic Impulsive Aggression in Child and Adolescent Psychiatric Disorders
- Depression under age 6
- Depression age 7 to Adolescence
- Depression Adolescence
- Severe Tic Disorders

In addition the Panel outlined principles of practice for children, adolescents, principles regarding the use of psychotropics for children under 6, and dosing recommendations. Through a consensus process, the Panel reached agreement on several important treatment approaches firmly rooted in evidence-based medicine. However, the Panel acknowledges that due to the lack of multiple, large samples and adequately powered studies in children and adolescents for a number of psychiatric conditions, the use of these medications is largely off-label.

The guidelines in their entirety including a biography of the experts panel can be accessed on the MDTMP website **www.flmedicaidbh.com.** On the guidelines menu you will also find the adult bipolar disorder and schizophrenia medication guidelines.

These guidelines support the Institute of Medicine Six Aims of High-Quality Health Care

Safe –avoiding injuries to patients from the care that is intended to help them.

Effective—providing services based on scientific knowledge to all who could benefit and refrain from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).

Patient-centered—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

Timely—reducing waits and sometimes harmful delays for both those who receive and those who give care.

Efficient—avoiding waste, including waste of equipment, supplies, ideas, and energy.

Equitable—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Given the practice concerns today, it is more important than ever to be aware of best practices for the use of psychotherapeutic medications.

We hope that you will find these guidelines helpful in your practice and we welcome your comments and suggestions for improving their usefulness.

Special points of interest:

- *Guidelines*
- *Activities*
- *Upcoming Meeting*

Executive Committee Meeting
October 24, 2006
The Florida Agency for Healthcare Administration
2727 Mahan Drive
Tallahassee, FL 32308

The MDTMP actively seeks the input of all those interested in improving the quality of mental health services provided to Medicaid beneficiaries with a mental illness.

Email us with your comments/ suggestions at

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Florida Best Practice Psychotherapeutic Medication Guidelines For Children and Adolescents

Principles of Practice for Children and Adolescents

The expert panel agreed on a series of principles of practice statements that are consistent with other guidelines produced by national bodies in the field of child and adolescent psychiatry:

1. The use of medications should be part of a comprehensive treatment plan that includes nonbiological intervention that addresses the developmental, psychological, social and medical needs of the patient.
2. Monotherapy should be initiated before complex therapy based on the clinical condition.
3. There should be an attempt to minimize multiple medications in the same class.
4. Monitoring of target symptoms should be supported by the use of rating scales.
5. Adverse event and adherence monitoring are important aspects of addressing safety and effectiveness issues in clinical practice.

Principles Regarding the Use of Psychotropics for Children under age 6

- *Given current scientific information and clinical experience, the expert panel* agreed not to provide any recommendations for the use of antidepressants in children under the age of six.
- *Given current science and clinical experience*, the use of antipsychotics in children under the age of six is generally not recommended and should only be considered under the most extraordinary circumstances. Disruptive aggression in autism is one such circumstance.
- *Given current science and clinical experience*, the use of stimulant medications for children under age four should be rare and only after a failed behavioral intervention such as parent training.

Access the full guidelines at www.flmedicaidbh.com

Principles of Practice for the Use of Antipsychotics in Children and Adolescents

The use of antipsychotics should be restricted to the diagnosis of schizophrenia (rare in children) psychotic depression, bipolar disorder, psychotic disorder not otherwise specified, drug induced psychosis, Tourette's and tic disorders, and, to some extent bipolar disorder, aggression as a target symptom, and on rare occasions in OCD and only after treatment resistance or failure of 2 SSRI trials and extensive CBT. Antipsychotics should not be used primarily to target attention deficit and hyperactivity symptoms, should not be used to promote weight gain, and should not be used as sedatives for children. There maybe instances where antipsychotics are used for parasuicidal and severe self-injurious behaviors.

Conditions	Levels (0 through 6)
ADHD	0 - Comprehensive assessment and non-medication interventions as a critical part of care. 1 - Monotherapy with stimulants (methylphenidate or amphetamine). 2 - Stimulants not tried at level 1. If failure with a methylphenidate agent then amphetamine agents can be used. Due to possible hypersensitivity reaction to methylphenidate, the patch was not recommended as first line agents. 3 - Atomoxetine - can be used as first line in patient with severe anxiety disorders or in cases where stimulants were unacceptable due to possible side effects and patients/family preferences. 4 & 5 Bupropion or tricyclics with the exception of Desipramine. 6 – "-2 Agonist such as Guanfacine and Clonidine as monotherapy and in combination with stimulants in children with ADHD and co-occurring tic disorders.
Bipolar Disorders for Children and Adolescents	0 - Comprehensive assessment. Narrow Phenotype of classic bipolar grandiosity, elevated mood, decreased need for sleep, rapid cycling, flight of ideas, and hypersexuality (no current validity under age 6). Qualify symptoms using frequency, intensity, number, and duration prior to selecting an agent. 1 - Monotherapy with mood stabilizer like Lithium, Valproic, Carbamazepine, Olanzapine, Quetiapine, Risperidone, Aripiprazole, Ziprasidone. Two antipsychotics should not be used or could not be supported for the treatment of bipolar symptoms in this age group. 2 - Monotherapy, up to 2 iterations of any of these agents listed above. 3 - Combination treatment, 2 mood stabilizers can be used or a mood stabilizer and an atypical antipsychotic, but not 2 atypical antipsychotics. 4 - Up to 3 agents including agents like Lamotrigine, a typical antipsychotic, or Oxcarbazepine can be introduced as a third agent if previous treatments have failed. 5 - Clozapine and ECT were selected for the most complex and refractory cases. Refer to AACAP Guidelines.

Chronic Impulsive Aggression in Child and Adolescent	0 - Comprehensive assessment, diagnostic interviews with patients and parents/guardians before prescribing, changing, or discontinuing medication. 1 - May use atypical antipsychotic with multiple iterations of monotherapy consistent with TRAAY guidelines. 2 - Lithium, Valproic, Carbamazepine, typical antipsychotic as adjunctive medication. Mood stabilizers have not been shown to be successful in pervasive developmental disorders. 3 - Mood stabilizer combination with antipsychotic if not attempted in past.
Depression – Under Age 6	0 - Diagnostic assessment, caregiver and family assessment, psychosocial intervention and treatment strategy of family and/or caregiver if necessary. 1 - Psychotherapy (i.e. cognitive behavioral therapy and family therapy). No pharmacological recommendations.
Depression – Age 6 to Adolescence	0 - Diagnostic assessment, caregiver and family assessment, collateral information from school setting, psychosocial intervention and treatment strategy of family and/or caregiver if necessary. 1 - Psychotherapy, CBT, and family therapy. 2 - SSRI monotherapy for 2 iterations. 3 - Re-assessment of diagnosis and environment to ensure known biological issues are addressed and ensure that diagnosis of depression is appropriate . 4 - If failure of 2 separate trials of SSRI monotherapy, alternative antidepressants can be used if there is no contributing comorbidity or occurring disorder. 5 - Augmentation with Lithium or Buspirone. Agents other than those mentioned above can be used but multiple antidepressants should be avoided.
Depression – Adolescence	0 - Diagnostic assessment, caregiver and family assessment, collateral information from school setting, psychosocial intervention and treatment strategy of family and/or caregiver if necessary. 1 - Monotherapy – Fluoxetine. 2 - Alternative agents monotherapy – Sertraline and Citalopram. Bupropion may also be considered. 3 - Cognitive behavioral therapy if not already implemented. 4 - Augmentation with 2 agents with targeting symptoms, the use of alternative agents, stimulants for comorbid ADHD, Atomoxetine or antipsychotics for psychotics features, Buspirone, and/or Lithium are considered options but there is no need for using 2 antidepressants at the same time unless attempting a crossover strategy. 5 - Use of 3 agents but primarily using symptom targeting as the basis for co-occurring psychotic, anxiety, and/or ADHD symptoms. 6 - Electroconvulsive Therapy, refer to AACAP parameters.
Severe Tic Disorders (Chronic Tic Disorder, Tourette Syndrome)	0 - Assess duration and severity (>6 weeks) - careful assessment. Issues of social, educational, physical impairment, and contributing comorbidity need to be evaluated. 1 - Habit reversal therapy. Can also use level 2 options if severe symptoms and impairment are present. 2 - Haloperidol, Risperidone, and also Aripiprazole once emerging data are available on this agent. 3 - Options include Quetiapine, Olanzapine, Ziprasidone, and also Primozide (safety issues related to Primozide). 4 - Antipsychotics in combination with SSRIs, Clonazepam, Apha 2 agonist, and anticonvulsants depending on target symptoms. Severity of illness should drive the use of one or two agents, and that habit reversal therapy should be a mainstay.

Dosing Recommendations (off-label)

Antipsychotics

Haloperidol: 0.25-10 mg/day
Fluphenazine: 0.5-10 mg/day
Perphenazine: 2-40 mg/day
Risperidone: 0.25-6 mg/day
Olanzapine: 1.25-20 mg/day
Quetiapine: 25-800 mg/day
Ziprasidone: 20-160 mg/day
Aripiprazole: 2-30 mg/day

Antidepressants

Fluoxetine: 5-40 mg/day
Sertraline: 25-200 mg/day
Citalopram: 10-40 mg/day
Escitalopram: 5-30 mg/day
Venlafaxine: 37.5-300 mg/day
Paroxetine : 10-40 mg/day
Bupropion 50-300 mg/day

Level of Framework for Best Practice Guidelines

Instead of creating an algorithm, the Panel chose to categorize options in different levels, based upon the strength of the science and expert consensus regarding a particular agent or treatment option. The Panel weighed both safety and efficacy issues when assigning particular treatment option to a Level. Level 1 options were considered to have stronger evidence and consensus than Level 2 and below. The Panel chose this approach with an understanding that using a particular option in any level would depend upon clinical judgment and patient needs or preferences. Level 0 refers to an assessment level prior to any decisions regarding treatment options.

Principles of Practice Statement

The dosing recommendations are based on expert opinion and therefore are level C evidence. Multiple, large sample, adequately powered studies have not been conducted in children and adolescents for a number of psychiatric disorders. Therefore the use of these medications is largely off-label. Unlike other medications, stimulant dosages are not weight dependent. Clinicians should begin with a low dose of medication and titrate upward because of marked individual variability in the dose response relationship. With respect to the use of antipsychotic and antidepressants target dose, ranges are primarily based on level C evidence.

Safety issues are critical. Clinicians should review FDA alerts on all agents before prescribing.

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ACTIVITIES:

Several key activities were held during the period of July through September, 2006.

- Participated in the joint Florida Council for Community Mental Health and Florida Psychiatric Medical Directors' Advisory meeting. The medical directors provided feedback on the contents of quality improvement reports.
- Mailing of quality improvement reports to Florida physicians.
- Collaborated with the Florida Pharmacy Association on outreach activities to identify and notify physicians when patients fail to refill a mediation.

FOR MORE INFORMATION ABOUT THE MEDICAID DRUG THERAPY MANAGEMENT PROGRAM FOR BEHAVIORAL HEALTH, PLEASE CONTACT:

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Major Partners:

Florida Agency for Health Care Administration
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