Recommendations for Best Practice

The American Academy of Child & Adolescent Psychiatry[37] makes the following recommendations for the use of psychotropic medication with children and teens:

1. **Before initiating pharmacotherapy, a psychiatric evaluation is completed.**
   Understand the child as fully as possible. A psychiatric evaluation should include a family background, therapies already tried, current medications, the child's ability to function in multiple places, i.e., home, school, social circles, and mental health status. This information provides a baseline for starting any kind of treatment.

2. **Before starting pharmacotherapy, a medical history is obtained, and a medical evaluation is considered when appropriate.**
   A medical history is critical to understanding any health issues that could relate to the child's symptoms. For example, a history of a head injury might relate to the development of aggressive behavior, or a seizure disorder history might relate to a decreased ability to focus. A medical evaluation would help establish baselines on such issues as growth (height and weight), cardiac function, and elimination patterns (particularly important in diagnosing encopresis and enuresis).

3. **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 trial.**
   Children act differently depending on their environments; their behaviors and emotional states can vary with different caregivers or other people. For example, a child can function well at school and thrive in a structured environment, but act out at home due to the presence of domestic violence. Gathering baseline information will help understand the impact of the medication over time.

4. **The prescriber develops a psychosocial and psychopharmacological treatment plan based on the best available evidence.**
   A treatment plan is important to think through all necessary potential treatments as well as medication options. The evidence supporting these choices should be addressed as well.

5. **The prescriber develops a plan to monitor the patient, short and long term.**
   Short-term monitoring helps to assess for any developments or increases in suicidal ideation as well as initial side effects, such as stomachaches or drowsiness. Long-term monitoring helps assess the continued impact and potential changes over time.

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

   Treatment plans should be followed and evaluated over time. Treatment modalities or requirements that cannot be monitored should be reconsidered.

7. **Prescriber provides feedback about the diagnosis and educates the patient and family about the child's disorder, and the treatment and monitoring plan.**

   The patient and caregivers should be kept updated and educated about the diagnosis, what it means, the treatment of the disorder, and the monitoring of the treatment plans.

8. **Complete and document the assent of the child and the consent of the caregivers before initiating medication treatment and at important points during treatment.**

   Assent and consent needs to be given before treatment starts. Both children and caregivers should be given easy-to-understand information and have the risks and benefits of medication explained to them.

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

   The risks and benefits of medication and of alternative treatments, such as psychotherapy, should be discussed.

10. **Implement medication trials using an adequate dose and for an adequate treatment period.**

    If medications are tried, the dosage needs to reach therapeutic levels and the medication needs to be tried for an adequate period to reach a therapeutic stage. Some medications work quickly, and leave the system quickly. Other medications need to reach certain levels to work well, and then those levels need to remain stable. For example, Zoloft is often used to treat obsessive-compulsive disorder with doses as high as 200 mg./day. With depression, the basic dose is 50 mg./day. Lithium is a medication that needs to reach a therapeutic level and be kept stable to be effective.

11. **The prescriber reassesses the patient if the child does not respond to the initial medication trial as expected.**

    Finding the right or best medication might take time; some children do better on one medication than another, just like adults. At times, several medications might be tried before the best medication for that individual is found. For example, certain stimulant medications can have no effect on some children but work extremely well in others. The same phenomena

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can happen with antidepressants. The underlying reasons for specific symptoms may differ from person to person and the medications used to treat those symptoms can differ as well.

12. The prescriber needs a clear rationale for using medication combinations.

Combining medications increases the risk to the child; understanding what is needed and what medications compliment one another is key. For example, combining an antidepressant for depression and a stimulant for ADHD might be warranted. Placing a child on two antidepressants at the same time or two antipsychotics does not make sense in most cases.

13. Discontinuing medication in children requires a specific plan.

Most medications should not be stopped abruptly. They should be tapered off. Discontinuing medication should be part of a plan within the overall treatment goals.