University of South Florida
Louis de la Parte Florida Mental Health Institute
Department of Mental Health Law and Policy

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid Drug Therapy Management Program for Behavioral Health

FLORIDA BEST PRACTICE PSYCHOTHERAPEUTIC MEDICATION GUIDELINES FOR CHILDREN AND ADOLESCENTS

Conditions	Levels (0 through 6)
ADHD	0 — Comprehensive assessment 1 — Psychostimulant (methylphenidate or amphetamine) *Due to the possibility of a hypersensitivity reaction to oral methylphenidate, the patch was not recommended as a level one option* 2 — Psychostimulant not tried at level 1 3 — Atomoxetine 4 — Bupropion or tricyclic antidepressants. *Desipramine not recommended due to safety issues* 5 — Antidepressant class not tried at level 4 6 — α-2 Agonist – *May be useful as an adjunctive medication in children with co-morbid tics, or in children with partial response to stimulant medication. The Expert Panel made no recommendations regarding the use of selegiline and modafinil in ADHD*
Bipolar Disorders in Children and Adolescents	0 — Comprehensive assessment. Narrow phenotype, classic bipolar grandiosity, elevated mood, decreased need for sleep, cycling, flight of ideas (no current validity under age 6) qualify symptoms using frequency, intensity, number and duration **1 — Monotherapy with mood stabilizer or atypical antipsychotic**. If partial response use augmentation with mood stabilizers, or atypical antipsychotics but not two atypical antipsychotics: Lithium, Valproate, Carbamazepine, Olanzapine, Quetiapine, Risperidone, Aripiprazole, Ziprasidone 2 — Monotherapy, up to two iterations of any agents listed in level 1 3 — Combination treatment, two mood stabilizers can be used or a mood stabilizer and an atypical antipsychotic, but not two atypical antipsychotics 4 — Up to three 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 Psychiatric Disorders	0 — Comprehensive assessment 1 — May use atypical antipsychotic as adjunctive treatment if not attempted in past with multiple iterations 2 — Lithium, Valproate, Carbamazepine, typical antipsychotic as adjunctive treatment *Mood stabilizers not shown to be successful in pervasive developmental disorder, autism* 3 — Mood stabilizer 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 — Emerging best practices in psychosocial 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 — Emerging best practices in psychotherapy. CBT, family therapy 2 — SSRI monotherapy, two iterations 3 — Re-assessment of diagnosis and environment 4 — *If no contributing co-morbidity, alternative antidepressant* 5 — Augmentation with Lithium or Buspirone – two iterations. *Additional agent other than antidepressants or above based on target symptoms and co-morbid disorders*
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, Citalopram, SNRI, Bupropion, Escitalopram 3 — Augmentation with cognitive behavioral therapy if not already implemented 4 — Augmentation with two agents with targeting symptoms. Bupropion, stimulants, Lithium, Atomoxetine, atypical antipsychotics, Buspirone, or others 5 — Augmenting with three agents based on targeting symptoms 6 — Electro Convulsive Therapy – refer to AACAP parameters

Access the full guidelines at www.flmedicaidbh.com

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Florida Best Practice Psychotherapeutic Medication Guidelines for Children and Adolescents

I. Level of Framework for Florida Best Practice Guidelines

The different options are categorized 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 options to a Level. Level 1 options are 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 or family needs or preferences. Level 0 refers to an assessment level prior to any decisions regarding treatment options.

II. 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 can 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.

III. 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 two SSRI trials and extensive CBT. Antipsychotics should not be used primarily to target ADHD 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.

Note: The Guidelines were developed by the Center for Mental Healthcare Improvement.

Dosing Recommendations (off-label)			
Antipsychotics	**Range**	**Antidepressants**	**Range**
Haloperidol	0.25-10mg/day	Fluoxetine	5-40mg/day
Fluphenazine	0.5-10mg/day	Sertraline	25-200mg/day
Perphenazine	2-40mg/day	Citalopram	10-40mg/day
*Risperidone	0.25-6mg/day	Escitalopram	5-30mg/day
Olanzapine	1.25-20mg/day	Venlafaxine	37.5-300mg/day
Quetiapine	25-800mg/day	Paroxetine	10-40mg/day
Ziprasidone	20-160mg/day	Bupropion	50-300mg/day
Aripiprazole	2-30mg/day		

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

* On October 6, 2006 the FDA approved Risperidone for the treatment of irritability associated with autism disorder in pediatric patients aged 5 to 16 years.

IV. Principles Regarding the Use of Psychotropics for Children under Age 6

Given current science and clinical experience:

- No recommendations for the use of antidepressants in children under the age of six.
- 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.
- The use of stimulant medications for children under age four should be rare and only after a failed behavioral intervention such as parent training.

V. Principles of Practice Statement For Dosing Recommendations

1. 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.
2. Unlike other medications, stimulant dosages are not weight dependent. Clinicians should begin with a low dose and titrate upward because of marked individual variability in the dose response relationship.
3. With respect to the use of antipsychotics and antidepressants target dose ranges are primarily based on Level B and C evidence.

Access the full guidelines at www.flmedicaidbh.com