Prescribing Psychotropic Medication to Young Children (Under age 6) under Illinois State Guardianship

January 26, 2015

Dear Illinois Providers,

The purpose of this letter is to inform you about new guidelines for prescribing psychotropic medication to young children (under age 6). These guidelines were developed for young children who are under state guardianship (IDCFS) using current literature to update the article entitled, “Psychopharmacological Treatment for Very Young Children: Contexts and Guidelines.”

The attached schematic details the process for IDCFS children. However, the principals and best practice guidelines apply broadly to young children across systems who are struggling with mental health concerns that might require psychotropic medication.

This new requirement is one of several resulting from Illinois’ participation in a three-year quality assurance initiative to improve psychotropic medication prescribing for and management of children and youth in foster care. The initiative is sponsored by the Center for Health Care Strategies, Inc. (CHCS), with funding from the Annie E. Casey Foundation (AECF). Illinois’ state team is a partnership between Healthcare and Family Services (HFS), the state Medicaid agency; Department of Human Services - Division of Mental Health (DHS-DMH), the state mental health agency; the Department of Children and Family Services (DCFS), the state child welfare agency and the University of Illinois at Chicago (UIC) Clinical Services in Psychopharmacology Program. One of the Illinois project goals is to assure the appropriateness of requests for psychotropic medication among young children under state guardianship.

Background

Concerns have been raised about the percentage of foster children on psychotropic medications, the number and dosages of medications prescribed, and the ages of the children receiving these medications. The effect of psychotropic medication on the brain development of young children has not been systematically studied, but current research suggests that early exposure, in the first 3 years of life, can permanently alter the development of neurotransmitter systems. Given the limited knowledge about the impact of psychotropic medication on young children’s developing brains, the fact that young children are more sensitive to side effects than older, larger children, and that foster children are prescribed more of these medications, new guidelines have been developed for prescribing psychotropic medication to young children. These guidelines will be used to inform consent for the prescription of psychotropic medication to young children who are under Illinois state guardianship. These guidelines can be used for prescribing psychotropic medication to any child under age 6.

Debra Dyer-Webster, Esq.

Guardian/Deputy Director

Prescribing Psychotropic Medication to Children Under 6 Years in State Guardianship Schematic Summary for Prescribers

This schematic was developed to help lead prescribers, caseworkers and therapeutic providers through the process to obtain psychotropic medication consent for a child under age six in state guardianship. The key principal that guides this process flow is that very young children require more time and information for a comprehensive clinical assessment and a trial of evidence-based psychotherapy before psychotropic medication can be considered. Because diagnosing is difficult in children ages 0-5 and the impact of psychotropic medications on brain development is largely unknown, careful consideration will be given to each consent request for this population.

If the child is 0-3 years, that child must have a comprehensive clinical assessment and a trial of evidence-based psychotherapy, before turning to psychotropic medication. If the child is 4 or 5 years old and the need is “Urgent” as defined by Box 22 at the bottom of the second page of the schematic, a time limited consent authorization can be obtained. Non-urgent cases for children ages 4 or 5 will be referred for a comprehensive clinical assessment and a trial of evidence-based psychotherapy, before psychotropic medication is considered. If significant symptoms persist despite a trial of evidence-based psychotherapy, prescribers should consider the following:

- Caution is strongly recommended in prescribing psychotropic medication given that the long term effects on brain development are poorly understood.
- Psychotropic medication should only be used with children under age 2 if there are rare extenuating circumstances.
- Has a standardized rating scale been completed in the last 90 days?
- Have the potential benefits and risks of psychopharmacology been weighed against the risks of untreated illness?
- Might the existing treatment be exacerbating the child’s behavior?

Once the prescriber has determined that psychotropic medication is still needed, (s)he should refer to the Guidelines for Prescribing Psychotropic Medication to Children Under 6 for information related to 1st line medication treatments for each disorder in this population. Some general principals to consider when prescribing to children under age 6:

- Rule of Thumb - start low, go slow
- Monotherapy options should be exhausted before considering polypharmacy
- Continue psychotherapy interventions
- For preschool aged children, 4 medications have been FDA approved for only ages 5 and up – all others are “off-label”

If the psychotropic medication is yielding the desired results, prescribers should ask:

- Is the child receiving psychosocial interventions?
- Is the parent/patient engaged in the child’s treatment?
- Have the therapeutic gains solidified?
- Do the therapeutic benefits of continued pharmacotherapy outweigh the risks?

After a successful medication trial (6-9 months), prescribers should consider whether it is the appropriate time to taper the psychotropic medication. Tapering should follow a gradual process 1) after one month, if child is stable further reduce dosage, 2) after two months, assess if medication can be discontinued 3) continue tapering until medication can be safely discontinued. Once the medication is fully discontinued, ongoing symptom monitoring is needed because symptoms may wax, wane or reemerge.
Prescribing Psychotropic Medication to Children Under 6 Years in State Guardianship

1. Considering a new psychotropic medication for a child under age 6?
   - Yes
   - No Action Needed

2. Has the child been evaluated by a preschool/infant mental health specialist or clinic?
   - Yes
   - No

3. Is the child 4 or 5 years old? (3a)
   - Yes
   - No

4. Is the medication need urgent? See Box 22
   - Yes
   - No

5. Prescriber completes a Psychotropic Medication Request Form (CFS 431-A) requesting time limited consent authorization
   - Skip to step 14

6. Caseworker Completes a Outpatient Psychiatry Request Form (CFS 431-2)
   - Contact PSYCHIATRIC REFERRAL via Outlook

7. Submit CFS 431-2 Form to the Outlook email box: PSYCHIATRIC REFERRAL

8. Was the caseworker contacted within 5 days by a Consulting Psychologist to review information and make a referral?
   - Yes
   - No

9. Therapist conducts a Comprehensive Diagnostic Assessment - including observations with caregiver(s)

   9a. Diagnostic Assessment and CFS 431-3 are sent to CW, PCP, therapist and prescriber if not the PCP

10. Does the assessment reveal symptoms and/or diagnoses that would support an intervention?
    - Yes
    - No Action Needed
    - No

11. Child is already in psychotherapy?
    - Yes
    - No

12. Trial of Evidence-Based Psychotherapy (recommend 12 weeks)
    - Yes
    - No Action Needed
    - No

13. Do significant symptoms persist despite a trial of psychotherapy?
    - Yes
    - No Action Needed
    - No

Legend
- Prescriber
- Caseworker(CW)
- Therapeutic Provider

Clinical Admin tracks assessment and therapy trial before medication

9a. Diagnostic Assessment and CFS 431-3 are sent to CW, PCP, therapist and prescriber if not the PCP

11a. Treatment progress report is sent every 90 days to CW, PCP and prescriber if not the PCP

12a. Therapist completes and submits the CFS 431-4 to PSYCH REF, CW, CSP, PCP and prescriber if not the PCP

*The consent unit will fax all psychotropic medication consultations for children under 6 to clinical 708-225-8054 to help ensure adherence to this flow chart
14. Before Prescribing to a Young Child
- Might the existing treatment be exacerbating the child’s behavior?
- Has a standardized rating scale been completed in the last 90 days?
- Have the potential benefits and risks of psycho-pharmacology been weighed against the risks of untreated illness?
- Caution is strongly recommended in prescribing psychotropic medication given the long term effects on brain development are poorly understood.
- Psychotropic medication should only be used with children under age 2 if there are rare extenuating circumstances.

15. Request Consent
- Complete the CFS 431-A
- Fax to the Consent Unit 312-814-7015 with CFS 431-3, CFS 431-4 and documentation of all previous interventions and results
- Consent will be faxed back to the prescriber and the caseworker

16. Prescribe
- Refer to the Guidelines for Prescribing Psychotropic Medication to Children Under 6
- Rule of Thumb - start low, go slow
- Use monotherapy except in rare cases
- Continue psychotherapy interventions
- For age 5 and up, only 4 medications have been FDA approved – all others are “off-label”

17. Is the psychotropic medication yielding the desired results?
- Yes
- No Consultation with CSP RN available-312 996-1927

18. Reevaluate Treatment, Efficacy and Tolerability
- Are target symptoms well controlled?
- Is the medication dose adequate?
- Has the child received psychosocial interventions?
- Is the parent/patient engaged?
- Have the therapeutic gains solidified?
- Do the therapeutic benefits outweigh the risks?

19. Is it an appropriate time to taper the psychotropic medication?
- Yes
- No

20. Tapering Process
- Begin taper after a successful medication trial (6-9 months) except for stimulants.
- After one month, if child is stable further reduce dosage.
- After two months, assess if medication can be discontinued.
- Continue tapering process until medication can be safely discontinued.

21. Ongoing Monitoring
- Needs ongoing follow-up and/or symptom monitoring by caregivers because disorders may wax, wane or reemerge.

22. Urgent Examples
- Child is chronically hyperactive, impulsive, inattentive, and/or aggressive
- Child displays an extreme change in behavior with irritable sadness, severe agitation and/or explosiveness
- Child has chronic sleep problems that are disrupting the sleep of his/her entire family or are interfering with the child’s daily functioning
- Child’s home and/or school placement might disrupt due to significant behavior problems

Revised 8/6/14
Guidelines for Prescribing Psychotropic Medication to Children Under 6 Years

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>1st Line Treatment</th>
<th>2nd Line Treatment</th>
<th>3rd Line Treatment</th>
</tr>
</thead>
</table>
| ADHD      | Psychotherapeutic Trial  
             - Parent Behavior Training (PBT) interventions (Charach 2013) | Methylphenidate/Dexmethylphenidate  
             - Initial liquid dose 1-5 mg (Gleason 2007) | Amphetamine Formulations  
             - Initial liquid dose 1-5 mg (Gleason 2007) |
|           |                    | Tapering is not recommended for stimulants | Tapering is not recommended for stimulants |
|           |                    | Side Effects  
             - Review family/child history of heart condition*  
             - Loss of appetite - severely underweight (3rd percentile)**  
             - Stomach and/or head ache  
             - Irritability/moodiness (Charach 2013)  
             - Increased blood pressure and pulse  
             - Rebound insomnia/sedation | Side Effects  
             - As effective as methylphenidate in older children but no randomized controlled trials in children under 5.  
             - Review family/child history of heart condition*  
             - Loss of appetite - severely underweight (3rd percentile)**  
             - Stomach and/or head ache  
             - Irritability/moodiness (Charach 2013)  
             - Increased blood pressure and pulse  
             - Rebound insomnia/sedation |

4th Line Treatment

Alpha-Agonists
- Careful consideration of age and body weight, initial low liquid doses  
  - Clonidine initial dosage of 0.025-0.05mg up to 0.1 mg/day at bedtime (Ming 2008) (Ingrassia 2005) maximum 0.3 mg with divided doses (Banaschewski 2004, Hirota 2014). A higher dosing range may be needed if there is significant comorbid diagnoses (Gleason 2007).  
  - Guanfacine initial dosage of 0.5 mg/day with a 0.5 mg increment every third day to a therapeutic dosage of between 1 – 3 mg/day (Hunt 1995) (Scahill 2006)  
- If planning discontinuation, these medications must be tapered  
Side Effects  
- Sedation  
- Irritability  
- Headache  
- Bradycardia  
- Hypotention – monitor blood pressure and heart rate***

Atomoxetine
- Initial liquid dose of 0.5 mg/kg/day with a maximum of 1.6 mg/kg/day (Kratochvil 2009)  
Side Effects  
- Mood Liability  
- Decreased appetite  
- Sleepiness  
- Abdominal Pain

* If there is a family history of structural heart disease or an arrhythmia, or if the patient has a heart condition, the patient should have a baseline ECG. Contact the child’s PCP to discuss safety issues. For more complicated cardiac pathology, an echocardiogram or a cardiology consultation may be indicated.
** If the patient loses weight such that his/her weight drops 2 percentile lines on a standard growth curve or if his/her weight falls below the 3rd percentile, the medication should be discontinued. The child may need a referral for a growth delay evaluation.
*** A baseline ECG is not indicated unless the patient has a pre-existing arrhythmia or cardiac disease.

Questions about diagnosis or treatment, call Illinois DocAssist 866-986-ASST (2778)  
Modified 9/29/14
### Guidelines for Prescribing Psychotropic Medication to Children Under 6 Years

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>1st Line Treatment</th>
<th>2nd Line Treatment</th>
<th>3rd Line Treatment</th>
</tr>
</thead>
</table>
| Anxiety   | Psychotherapeutic Trial  
- Behavioral therapy or preschool CBT (Geller and March 2012) for a minimum of 12 weeks  
- Parenting intervention for anxiety without mood disorder (Luby 2013) | Fluoxetine (last resort intervention)  
- Initial low dose 2.5mg – 5mg to improve tolerability of SSRI (Fanton and Gleason 2009)  
- Planned discontinuation after 6-9 months | Sertraline (last resort intervention)  
- Initial low dose of 5-10mg/day with range up to 25mg (Fanton and Gleason 2009)  
- Planned discontinuation after 6-9 months |
| Diagnostic Assessment /Screening Tool | ▪ Spence Preschool Anxiety Scale: Parent Report - free tool to help assess children ages 3-6 with anxiety.  
Anxiety | | |
▪ Ages and Stages Questionnaire: Social Emotional (ASQ-SE) | | |

### Side Effects
- Headache
- Gastric distress
- Insomnia or increased motor activity
- Behavioral activation /disinhibition may be more frequent in younger children and children with comorbid ADHD or CNS disorders (Sakolsky and Birmaher 2008)
- Black box warning: SSRIs potentiate the risk for suicidal thinking
- With use of Fluoxetine, please review cytochrome P-450 interactions with any other medications the child is taking i.e. asthma medications, antibiotics, antiepileptic medications etc.
| | Side Effects | | |
| | ▪ Headache  
▪ Gastric distress  
▪ Insomnia or increased motor activity  
▪ Behavioral activation /disinhibition may be more frequent in younger children and children with comorbid ADHD or central nervous system disorders (Sakolsky and Birmaher 2008)  
▪ Black box warning: SSRIs potentiate the risk for suicidal thinking  
▪ With use of Sertraline, please review cytochrome P-450 interactions with any other medications the child is taking i.e. asthma medications, antibiotics, antiepileptic medications etc. | | |
<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>1&lt;sup&gt;st&lt;/sup&gt; Line Treatment</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt; Line Treatment</th>
<th>3&lt;sup&gt;rd&lt;/sup&gt; Line Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism Spectrum Disorder</td>
<td>Psychotherapeutic Trial</td>
<td>Irritability and Aggression</td>
<td>Irritability and Aggression</td>
</tr>
<tr>
<td></td>
<td>• Parent psychoeducation</td>
<td>• Initial liquid dose 0.1 – 1.5mg/day with a maximum dosage of 3mg/day</td>
<td>Aripiprazole*</td>
</tr>
<tr>
<td></td>
<td>• Early intervention to address (Gleason 2007):</td>
<td>• Metabolic Syndrome (weight gain)</td>
<td>• Initial liquid dose of 0.2 - 3 mg with a maximum of 7.5mg (Leucht 2014) Using dose equivalents due to insufficient research in the preschool population.</td>
</tr>
<tr>
<td></td>
<td>• Language</td>
<td>• Elevation of serum prolactin</td>
<td>Guanfacine initial dosage of 0.5 mg/day with a 0.5 mg increment every third day to a therapeutic dosage of between 1 – 3 mg/day (Hunt 1995) (Kaplan and McCracken 2012)(Scahill 2006) or Clonidine initial dosage of 0.025-0.05mg up to 0.1 mg/day at bedtime (Ming 2008) (Ingrassia 2005)</td>
</tr>
<tr>
<td></td>
<td>• Social development</td>
<td>• FDA indication for irritability and aggression in children aged 5 to 16 years with autistic disorder and symptoms of aggression, self-injury, temper tantrums and mood swings (Kaplan and McCracken 2012)</td>
<td>Side Effects (Kaplan and McCracken 2012)</td>
</tr>
<tr>
<td></td>
<td>• Adaptive functioning</td>
<td>• Close monitoring of patients is essential</td>
<td>• FDA indication for 6-17 years</td>
</tr>
<tr>
<td></td>
<td>• Reduction in repetitive</td>
<td></td>
<td>• Good results in school aged population</td>
</tr>
<tr>
<td></td>
<td>behaviors</td>
<td></td>
<td>• Sedation</td>
</tr>
<tr>
<td></td>
<td>• Language</td>
<td></td>
<td>• Weight gain</td>
</tr>
<tr>
<td></td>
<td>• Social development</td>
<td></td>
<td>• Extrapyramidal symptoms</td>
</tr>
<tr>
<td></td>
<td>• Adaptive functioning</td>
<td></td>
<td>• Presyncope with unsteady gait (Owen 2009)</td>
</tr>
<tr>
<td></td>
<td>• Sensory sensitivity†</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Behavioral Therapy</td>
<td>Hyperactivity</td>
<td>Hyperactivity</td>
</tr>
<tr>
<td></td>
<td>(Kaplan and McCracken 2012)</td>
<td>Methylphenidate</td>
<td>Alpha-Agonists</td>
</tr>
<tr>
<td></td>
<td>Applied Behavioral Analysis</td>
<td>• Initial liquid dose 1-5mg</td>
<td>Guanfacine initial dosage of 0.5 mg/day with a 0.5 mg increment every third day to a therapeutic dosage of between 1 – 3 mg/day (Hunt 1995) (Kaplan and McCracken 2012)(Scahill 2006) or Clonidine initial dosage of 0.025-0.05mg up to 0.1 mg/day at bedtime (Ming 2008) (Ingrassia 2005). A higher dosing range may be needed if there is significant comorbid diagnoses.</td>
</tr>
<tr>
<td></td>
<td>(ABA) gold standard</td>
<td>Side Effects</td>
<td>• If discontinuation is planned, these medications must be tapered</td>
</tr>
<tr>
<td></td>
<td>† Not from Gleason 2007</td>
<td>• The rate of intolerability in children with ASD is the double (18%) that of typically developing children with ADHD (Kaplan &amp; McCracken 2012)</td>
<td>Side Effects</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Family/child history of heart condition</td>
<td>• Sedation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Loss of appetite - severely underweight (3&lt;sup&gt;rd&lt;/sup&gt; percentile)</td>
<td>• Irritability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stomach and/or head aches</td>
<td>• Bradycardia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Irritability</td>
<td>• Hypotension (Scahill et al. 2001) – monitor blood pressure and heart rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increased blood pressure and pulse</td>
<td></td>
</tr>
</tbody>
</table>
## Guidelines for Prescribing Psychotropic Medication to Children Under 6 Years

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>1st Line Treatment</th>
<th>2nd Line Treatment</th>
<th>3rd Line Treatment</th>
<th>4th Line Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Autism Spectrum Disorder</strong></td>
<td>Repetitive Behaviors</td>
<td>Repetitive Behaviors</td>
<td></td>
<td>Atomoxetine</td>
</tr>
<tr>
<td></td>
<td>Fluoxetine (last resort intervention for severe symptoms)</td>
<td></td>
<td></td>
<td>Initial liquid dose of 0.5 mg/kg/day with a maximum of 1.6 mg/kg/day (Kratochvil 2009)</td>
</tr>
<tr>
<td></td>
<td>• Initial liquid dose of 2.5 mg/day; week 2 and 3 titrated per subject’s weight, symptoms and side effects with a maximum of 0.8 mg/kg/day (Hollander 2005)</td>
<td></td>
<td></td>
<td>Side Effects</td>
</tr>
<tr>
<td></td>
<td>• Planned discontinuation after 6-12 months</td>
<td></td>
<td></td>
<td>• Mood Liability</td>
</tr>
<tr>
<td></td>
<td>• Not tested on children younger than 5 years</td>
<td></td>
<td></td>
<td>• Decreased appetite</td>
</tr>
<tr>
<td></td>
<td><strong>Side Effects</strong></td>
<td></td>
<td></td>
<td>• Sleepiness</td>
</tr>
<tr>
<td></td>
<td>• Headache</td>
<td></td>
<td></td>
<td>• Abdominal Pain</td>
</tr>
<tr>
<td></td>
<td>• Gastric distress</td>
<td></td>
<td></td>
<td><strong>Fluvoxamine and Escitalopram</strong> have evidence supporting use in children 6 years and above but there is no data supporting use in children under 6 (West 2009)</td>
</tr>
<tr>
<td></td>
<td>• Insomnia/ increased motor activity</td>
<td></td>
<td></td>
<td><strong>Black box warning for all SSRIs potentiate the risk for suicidal thinking</strong></td>
</tr>
<tr>
<td>Diagnosis</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; Line Treatment</td>
<td>2&lt;sup&gt;nd&lt;/sup&gt; Line Treatment</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt; Line Treatment</td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Bipolar</td>
<td>Psychotherapeutic Trial&lt;br&gt;▪ Parent Child Interaction Therapy (PCIT) (Luby 2013)</td>
<td>Risperidone&lt;br&gt;▪ Initial liquid dose 0.1 – 1.5mg/day (Kaplan &amp; McCracken 2012)</td>
<td>Aripiprazole (Oh et al 2013)&lt;br&gt;▪ Initial liquid dose of 0.2 - 3 mg with a maximum of 7.5mg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Note: address mania first, higher incidence of rapid cycling and mixed mania (Peruzzolo et al.</td>
<td></td>
<td>(Leucht 2014) Using dose equivalents due to insufficient research in the preschool population.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2013)</td>
<td>Side Effects&lt;br&gt;▪ Metabolic Syndrome&lt;br&gt;▪ Extrapyramidal side effects&lt;br&gt;▪ Elevation of serum prolactin</td>
<td>Side Effects&lt;br&gt;▪ Good results in school aged population but no preschool data</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>▪ Sedation</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Assessment</td>
<td></td>
<td></td>
<td>▪ Weight gain/Metabolic Syndrome</td>
<td></td>
</tr>
<tr>
<td>/Screening Tool</td>
<td></td>
<td></td>
<td>▪ Akathisia</td>
<td></td>
</tr>
<tr>
<td>Young Mania Rating Scales</td>
<td></td>
<td></td>
<td>▪ Extrapyramidal symptoms</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>▪ Good treatment effects and comparatively mild side-effects to other atypical antipsychotics (Oh et al 2013)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quetiapine</td>
<td>▪ Starting dose 2.5 mg /kg /day for a week; increase by 2.5 mg /kg /day for week 2; increase by</td>
<td>▪ Sedation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.75 mg /kg /day for week 3; increase by 5.0 mg /kg /day for week 4 – not to exceed a maximum dose</td>
<td>▪ Metabolic Syndrome/ significant weight gain</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>of 10 mg /kg /day for week 4 – not to exceed a maximum dose of 10 mg /kg /day</td>
<td>▪ No extrapyramidal side effects</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Joshi et al 2012)</td>
<td>▪ No elevation of serum prolactin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Guidelines for Prescribing Psychotropic Medication to Children Under 6 Years

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>1st Line Treatment</th>
<th>2nd Line Treatment</th>
<th>3rd Line Treatment</th>
</tr>
</thead>
</table>
| **Depression** | Psychotherapeutic Trial  
  - Psychotherapeutic Treatment modalities that address the parent-child relationship such as Parent Child Interaction Therapy-Emotion Development (PCIT-ED)(Lenze et al 2011) | Fluoxetine (last resort intervention) (Hetrick et al 2012)  
  - Suggested initial liquid dose 0.5-2mg/day to minimize side effects.  
  - 5-8mg/day effective treatment dose for this age group (Gleason 2007)  
  - Planned discontinuation after 9 months at therapeutic dose (Gleason 2007) | - Clinical experience suggests other SSRIs such as Citalapram and Escitalapram may be easier for preschool children to tolerate. However, with Citalapram prolonged QT intervals at dosages greater than 40mg need to be considered. |
| **Disruptive Behavior Disorder (DBD) and Aggression** | Psychotherapeutic Trial  
  - Preschool CBT  
  - Parent Child Interaction Therapy (PCIT), Incredible Years Program, Collaborative Problem Solving etc. (Luby 2006)  
  - Infant/Toddler Parent Programs i.e. Child Parent Interactive Therapy  
  - Classroom-Based Interventions Token Reward Systems | Disruptive/Aggressive Behavior plus any other major mental illness - see that category  
**Aggression**  
- Anti psychotics are often used to augment psychotherapy. For severe aggression in preschool age children, an atypical antipsychotic can be prescribed (Lohr and Honaker 2013) | Side Effects  
- Metabolic Syndrome  
- Extrapyramidal side effects  
- Elevation of serum prolactin |

---

Note: Treat the co-morbid disorders contributing to disruptive behavior first
- Eyberg Child Behavior Inventory (ECBI)

Questions about diagnosis or treatment, call Illinois DocAssist 866-986-ASST (2778)  
Modified 9/29/14
<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>1st Line Treatment</th>
<th>2nd Line Treatment</th>
<th>3rd Line Treatment</th>
</tr>
</thead>
</table>
| Obsessive Compulsive Disorder (OCD) | Psychotherapeutic Trial  
▪ CBT using exposure and response prevention techniques and involving parents is recommended (Whiteside et al 2012) | Fluoxetine and Sertraline (last resort interventions)  
▪ Insufficient evidence to recommend one medication over the other  
▪ Fluoxetine - initial low dose 2.5mg – 5mg to improve tolerability of SSRI (Fanton and Gleason 2009)  
▪ Sertraline – initial low dose of 5-10mg/day with range up to 25mg (Fanton and Gleason 2009)  
▪ Recommended discontinuation after 6-8 months (Coskun and Zoroglu 2009) | Side Effects  
▪ Has been approved by the Food and Drug Administration (FDA) for the treatment of OCD in children age 7 and up (Rockhill 2010)  
▪ Behavioral activation /disinhibition is a more frequent side effect in younger children and children with comorbid ADHD or central nervous system disorders. (Sakolsky and Birmaher 2008) A cautious trial of fluoxetine may be an effective treatment for severe OCD in preschool age children. Side effects, particularly behavioral activation/disinhibition, are concerning among the 0-5 population. (Coskun and Zoroglu 2009)  
▪ Decreased appetite and weight loss  
▪ Sleep disturbance  
▪ Headache  
▪ Abdominal pain  
▪ With use of Fluoxetine and Sertraline, please review cytochrome P-450 interactions with any other medications the child is taking i.e. asthma medications, antibiotics, antiepileptic medications etc.  
▪ Given the sensitivity to side effects in the young child population, tapering is recommended |

Questions about diagnosis or treatment, call Illinois DocAssist 866-986-ASST (2778)  
Modified 9/29/14
# Guidelines for Prescribing Psychotropic Medication to Children Under 6 Years

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>1&lt;sup&gt;st&lt;/sup&gt; Line Treatment</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt; Line Treatment</th>
<th>3&lt;sup&gt;rd&lt;/sup&gt; Line Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD</td>
<td>Psychotherapeutic Trial</td>
<td>Psychopharmacological</td>
<td>Alpha-agonist (Clonidine)</td>
</tr>
<tr>
<td></td>
<td>• Child-parent psychotherapy (CPP) for a 6 month trial (Gleason et al., 2007) or preschool CBT for minimum of 12 weeks (Cohen 2003)</td>
<td>interventions are not recommended for children under 6 years based on a lack of research evidence. Talk to a DCFS Psychopharmacology program consultant if symptoms are severe and therapeutic interventions are ineffective.</td>
<td>Clonidine initial dosage of 0.025-0.05mg up to 0.1mg/day at bedtime (Ming 2008) (Ingrassia 2005)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Short term use, 1 month maximum before reassessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Respiratory depression</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Bradycardia</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Anticholinergic effects (e.g. dry mouth)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Parent education about safe administration and monitoring</td>
</tr>
<tr>
<td>Sleep Disturbance</td>
<td>Parent Education</td>
<td>Melatonin</td>
<td>Alpha-agonist (Clonidine)</td>
</tr>
<tr>
<td>Sleep Log</td>
<td>• Home environment evaluation</td>
<td>• Impacting well-being and daytime functioning of child and/or caregiver</td>
<td>Clonidine initial dosage of 0.025-0.05mg up to 0.1mg/day at bedtime (Ming 2008) (Ingrassia 2005)</td>
</tr>
<tr>
<td></td>
<td>• Sleep hygiene</td>
<td>• Provide 0.25 - 3mg for preschool age children; administer 5-7 hours before bedtime (Gleason 2007)</td>
<td>Short term use, 1 month maximum before reassessment</td>
</tr>
<tr>
<td></td>
<td>• Restless leg syndrome</td>
<td>• To treat initial insomnia due to sleep phase delay, a small dose of melatonin (0.25 – 1.0 mg) given 5-7 hours before bedtime to maximize the chronobiotic effect. For use as a soporific, higher doses (3 – 9 mg) given at bedtime may be effective.</td>
<td>Side Effects (Pelayo and Yuen 2012)</td>
</tr>
<tr>
<td></td>
<td>• Sleep Apnea</td>
<td>• Over-the-counter</td>
<td>• Respiratory depression</td>
</tr>
<tr>
<td></td>
<td>• Sleep problem associated with other mental health diagnosis</td>
<td>• Short term use, 1 month maximum before reassessment</td>
<td>• Hypotension</td>
</tr>
<tr>
<td></td>
<td>• Behavior Intervention (2-4 weeks)</td>
<td></td>
<td>• Bradycardia</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Irritability</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Anticholinergic effects (e.g. dry mouth)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• REM suppression</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Parent education about safe administration and monitoring</td>
</tr>
</tbody>
</table>

Questions about diagnosis or treatment, call Illinois DocAssist 866-986-ASST (2778)  
Modified 9/29/14
Guidelines for Prescribing Psychotropic Medication to Children Under 6 Years


Lohr D and Honaker J. Atypical antipsychotics for the treatment of disruptive behavior. Pediatric Annals 42:2, February 2013


Questions about diagnosis or treatment, call Illinois DocAssist 866-986-ASST (2778)   Modified 9/29/14
Guidelines for Prescribing Psychotropic Medication to Children Under 6 Years


Sakolsky, D, Birmaher, B. Pediatric anxiety disorders: management in primary care. DOI 2008; 538-543.

