

# PSYCHOTROPIC MEDICATION AND CASSP PRINCIPLES

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## PART I: CASSP PRINCIPLES AND THE BIOPSYCHOSOCIAL PERSPECTIVE

### INTRODUCTION:

Public sector children's mental health (for children up to age 21), both in Pennsylvania and nationally, is guided by a set of ethical and pragmatic guidelines known as CASSP (Child and Adolescent Service System Program) Principles. In reality, CASSP Principles are relevant to all child-serving systems and not just mental health, since they identify the way that individuals should come together in support of the child and how services should be provided. CASSP Principles are especially relevant for those children with serious emotional disturbance (SED) – those with the most challenging mental health problems and significant functional impairment, who are often at risk for institutional placement and other adverse outcomes. Since many children with SED have physiologically based psychiatric disorders responsive to use of psychotropic medication, it is consistent with CASSP Principles that the possible indications for such medication be considered, as part of comprehensive efforts to meet the child's needs.

In Pennsylvania, there are 6 identified CASSP Principles. These are listed and described below, in the specific language agreed upon by multiple stakeholders, including families and advocates, in 1995:

- 1. Child-centered**  
Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services consider the child's family and community contexts, are developmentally appropriate and child-specific, and also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.
- 2. Family-focused**  
Services recognize that the family is the primary support system for the child. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels includes family representation.
- 3. Community-based**  
Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.

**4. Multi-system**

Services are planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems and the family collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, provide appropriate support to the child and family, and evaluate progress.

**5. Culturally competent**

Culture determines our worldview and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.

**6. Least restrictive/least intrusive**

Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.

Not only is it consistent with CASSP Principles that the potential use of psychotropic medication be considered for each child with SED and other mental health disorders. In addition, the actual use of psychotropic medication needs to be guided by CASSP Principles as well. This means that it is the responsibility of the child's entire team, not just the psychiatrist or other physician prescribing the medication (*the prescriber*), to be familiar with psychotropic medication and support its use, when clinically indicated. Consensus around medication decisions is crucial, so that the child does not experience staff splitting and treatment fragmentation. The child's prescriber, even if unable to attend interagency team meetings directly, needs to be viewed as a part of the child's team, not as an expert writing prescriptions in isolation. Each team member can play a constructive role in supporting appropriate mental health treatment for the child, including use of medication when indicated.

In what follows, we explore the relevance of each CASSP Principle to the provision of psychotropic medication for children. First, however, we consider another critical service principle – the need for child, family, and all child-serving professionals to embrace *the biopsychosocial perspective*. This latter perspective delineates the scope of information – organized into 3 domains – necessary for comprehensive understanding and treatment of the child. When the biopsychosocial perspective and CASSP Principles in combination guide information gathering and treatment planning, favorable outcomes are promoted.

**THE BIOPSYCHOSOCIAL PERSPECTIVE:**

The seminal concept of “biopsychosocial” assessment, evaluation, and treatment emerged in the late 1970's, from George Engel MD. Engel recognized that comprehensive understanding of a child, as well as the child's subsequent treatment, involves consideration of 3 core domains of

influence, involving the biological, psychological/emotional, and social context, as shown in **TABLE 1**.

**TABLE 1:** The 3 domains entailed by the “biopsychosocial perspective”:

“biological domain” = biologically based and physical health factors

“psychological/emotional domain” = unique characteristics of the individual

“social domain” = social contexts and supports

The biopsychosocial perspective, by delineating and then integrating the 3 core domains (the biopsychosocial triad), addresses both the child individually and the child’s life context. Whether the child has a medical, surgical, or mental health problem, effective treatment requires that all 3 domains be understood. It is beneficial for all those committed to the child to gain some familiarity with each domain, even if primary treatment responsibility is limited to just one or two of them.

Each domain of the biopsychosocial triad contains elements that may promote growth and development, and that may inhibit these processes. Both sets of forces need to be identified and their impact understood. Those elements that benefit the child are often referred to as protective factors, while those that limit the child’s safety and development are referred to as risk factors. From a public health perspective, the net balance of protective vs. risk factors substantially influences the child’s eventual level of stability and adaptation. When protective factors predominate, positive outcomes become more likely for the child. In contrast, when risk factors predominate, negative outcomes become more likely.

Each domain of the biopsychosocial triad needs to be understood in terms of its component parts. Thus, it is important to identify relevant components of the biological, psychological/emotional, and social domains, respectively. Although it is often tempting to think about fragments of an individual, the real task involves understanding part-whole relationships. So, once each domain is understood separately, the clinician and team can begin to appreciate the collective impact of these factors on the child and family, so that an integrated plan of treatment can be developed. In what follows, we elaborate the components of each domain individually.

*The biological domain* includes many elements. Some reflect intrinsic biological attributes of the child (e.g. genetic predispositions), while others are externally based (e.g. toxins in the environment) and may ultimately influence the child’s biology through interaction with the child over time. The full range of the biological domain, which includes both biologically based and physical health factors, can be seen in **TABLE 2**.

**TABLE 2:** “Biological domain” = biologically based & physical health factors:

General health

Nutrition

Physical illness

Temperament  
 Physical injury/limitations/disability  
 Physical environment (toxins, pollution, etc.)  
 Developmental disorders (including mental retardation, PDD)  
 Serious emotional disturbance (SED, for children and adolescents)  
 Genetic predispositions  
 Other presumed biochemical imbalances

*The psychological/emotional domain* involves those unique cognitive, emotional, and behavioral elements of the child that, as a whole, constitute the unique characteristics of the individual and help define the child's sense of self. The range of the psychological/ emotional domain is identified in **TABLE 3**. Note that, consistent with the need to maintain a strengths based focus, this domain begins by identifying the child's strengths, interests, and capabilities.

**TABLE 3:** "Psychological/emotional domain" = unique characteristics of the individual:

Strengths, interests, and capabilities  
 Personal identity  
 Beliefs and values  
 Capacity for attachment  
 Capacity for reciprocal relationships  
 Social skills/problem-solving  
 Capacity for independence  
 Areas of conflict, struggle, distress (symptoms)  
 Other areas of limitation or concern

*The social domain* includes the child's social context and supports, which influence the child both directly (e.g. the family through daily interactions) and indirectly (the role of the media and youth culture). **TABLE 4** identifies a wide range of elements that comprise the social domain, which influences both the child and the family.

**TABLE 4:** "Social domain" = social context and supports:

Nuclear family  
 Extended family  
 Neighborhood  
 School/training/work setting  
 Culture/religion  
 Informal supports/attachments  
 Formal supports/attachments  
 Economic status  
 Social environment (inc. housing, recreation, safety, access to weapons, critical events)  
 Impact of media and/or specific subculture (television, movies, music, magazines, newspapers, advertising, clothes, trends/fads)

## **PART II: USE OF PSYCHOTROPIC MEDICATION, GUIDED BY EACH CASSP PRINCIPLE:**

In what follows, we consider the relevance of each CASSP Principle to the provision of psychotropic medication for the child.

### **1. Child-centered**

The use of psychotropic medication should always be an individualized decision, based on the strengths and needs of the child and other available information, including family psychiatric history. The child's strengths may reflect a motivation to be successful, a sense of responsibility to self and others, and the ability to manage symptoms and overcome limitations. Needs typically include the child's symptoms, limitations, and specific diagnosis. With a child-centered approach, medication is not used for the convenience of teachers, parents, or professionals, but to address symptoms and behaviors that appear physiologically based and/or medication responsive. The goal of psychotropic medication use is to address symptoms and facilitate the child's optimal or near-optimal functioning, not to incapacitate the child through sedation or other significant side effects. Therefore, the prescriber carefully explains the expected therapeutic benefits and possible side effects to the child and family from the outset, and then closely monitors the child's subsequent response to the medication.

Most children can recognize the difference between a physician who inquires about side effects primarily to complete a medical checklist and one who is genuinely concerned about the impact of the medication on the child. Child-centered psychotropic practice involves the practitioner's maintaining a welcoming, non-intimidating persona, so that the child feels at ease and can comfortably ask questions and express concerns. The prescriber is sensitive to the need of some children for privacy and confidentiality related to their use of medication. Over time, the prescriber relies on the child to provide information that will influence the course of medication treatment and other practical decisions.

### **2. Family-focused**

The operant axiom here is that the child belongs to the family, not the professionals, and the family (including all relevant caregivers) needs the opportunity to collaborate with the psychiatrist and other professional members of the child's team. The child and family team (see discussion on "multi-system" below) provides a potentially valuable vehicle for family participation and for the family voice to be heard.

A family focused approach to psychotropic medication ensures that the family provides relevant information to mental health professionals, including the physician, about the child, and that the child's diagnosis is explained to the family in understandable language. When referral to a prescriber for medication evaluation is recommended, the rationale for the referral is carefully explained, including the role of psychotropic medication in mental health treatment and how the

prescriber will work with child and family. It is often beneficial for a mental health professional, and not just the family, to attend the meeting with the psychiatrist.

CASSP-oriented medication prescribers understand that they need to serve as a consultant to child and family, who ultimately make most medication decisions. Therefore, while offering information and objectively based recommendations, the prescriber recognizes that, except where the legal system has indicated otherwise, the decision to use medication needs to be voluntary. The prescriber also understands that child and family need to become experts in their own right regarding the child's diagnosis and treatment. Therefore, the prescriber offers the family written information and references to appropriate articles and books that address the diagnosis and the use of psychotropic medication. Equally if not more important, the effective prescriber understands that, beyond provision of sound medical expertise, there is need to convey a sense of caring and hopefulness, with openness to family questions and concerns and continued availability over time.

### **3. Community-based**

Since the goal is to enable the child to remain in the home and community whenever possible, medication decisions are often made with this in mind. For example, for the child with only mild to moderate symptoms, a decision may be made to provide mental health treatment without immediate use of psychotropic medication and monitor the progress. However, when a child is at high risk of psychiatric hospitalization or out-of-home placement and shows evidence of a physiologically based disorder, then it may be prudent to begin psychotropic medication early on and manage it proactively.

The concept of community-based care also involves providing services in the child and family's community, whenever possible. Therefore, every effort should be made to engage a prescriber who is geographically accessible to the family. For more complex psychiatric problems, however, geographical proximity may be sacrificed so that the child can be seen at a university or other tertiary care facility. The team as a whole should make this kind of determination, with particular reliance on the wishes of child and family. Community-based care also draws from, and is congruent with, community values. This cultural component of community-based care is addressed below, in the discussion of cultural competence (#5).

### **4. Multi-system**

Children with SED, by definition, have complex needs and are involved in multiple systems. At times, children with less severe mental health needs may also be involved in multiple systems. An important mechanism to achieve effective multi-system participation and consensus building is the child and family team, sometimes referred to in mental health as the interagency service planning team (ISPT). It is through the child and family team that all those involved with and committed to the child have a forum to meet, plan, assign tasks, and monitor outcomes. Whether or not psychotropic medication is being used, the child and family team is a key mechanism for family empowerment, and represents a way to ensure that services draw upon the knowledge and expertise of all those involved with the child, not just the professionals.

A core element of CASSP-driven provision of psychotropic medication is that the process be multi-system. This suggests the need for all team members to be familiar with psychotropic medication, so that they can understand the specific medication needs of the child in question. All team members should ideally participate in a decision to use medication, so that everyone is knowledgeable and can support the medication decision. Splitting within the team around use of medication can significantly undermine not only the use of medication but treatment in general, so efforts need to be made to maintain the consensus. All team members – including child and family, mental health staff, Children and Youth worker, Juvenile Probation Officer, school counselor, and others – should be aware of the child’s target symptoms and encouraged to report both progress and problems. Buy-in is promoted when everyone has a role.

It is important that all child-serving professionals, as well as child and family, be familiar with and committed to the biopsychosocial perspective. In this way, it is likely that all 3 domains – biological, psychological/emotional, and social – will be considered in treatment planning and implementation, and that use of psychotropic medication when indicated will not be stigmatized or otherwise devalued. The biopsychosocial perspective converges with CASSP Principles in encouraging identification of strengths and needs, as well as in supporting the integration of all available information in support of comprehensive treatment.

Whenever possible, one or more members of the professional team members should attend the child’s initial medication assessment and subsequent medication appointments. In this way, team members get to know the prescriber, which is especially important when the prescriber is unable to attend regular team meetings. When the prescriber does not attend team meetings, information needs to be shared in other ways, such as through telephone calls, letters, emails, use of rating scales, etc.

## **5. Culturally competent**

Since the subject of cultural competence is addressed separately in another training module, this discussion will offer highlights of the concept and consider its relevance to the provision of psychotropic medication for children. Culture encompasses, but extends beyond, ethnicity, religion, race, gender, and socioeconomic status. A family’s culture reflects its way of “being in the world,” whether following routines, undertaking new challenges, or confronting crisis and challenge. Family culture is the lens that organizes experience and responses to experience. Without culturally competent services, one of two outcomes becomes likely: lack of engagement from the start, leading to dropping out from treatment, or a lack of fit between family and professionals, leading to impasse and stalemate. Within the context of psychotropic medication, negative outcomes include and unwillingness to consider the potential benefits of psychotropic medication, inconsistent use of medication by the child and inconsistent monitoring by the family, and/or discontinuation of medication without prior discussion with the prescriber.

Culturally competent service provision involves more than “cultural awareness” or “cultural sensitivity” (e.g. more than just an understanding/appreciation of culture) on the part of providers and agencies. Cultural competence involves the use of cultural understanding and cultural needs in *actual service provision*. For the prescriber, this means that learning is mutual, since the perspective and experiences of child and family need to be understood and addressed. The

prescriber needs to ask questions and listen, not just provide generic information applicable to all children and their families. Areas of relevance include: family beliefs about seeking and accepting help, possible stigma related to psychiatric problems and use of medication, specific religious and cultural beliefs, prior medication-related experiences of child, siblings, parents and others, and the role of the media in promoting stigma about mental health issues.

When there is good rapport between the physician and the family, family concerns about psychotropic medication can often be addressed without the benefits of such medication being sacrificed. For example, some family concerns are based on lack of information or on misinformation, and providing accurate information may address the concerns. Information is likely to be more credible if supported by others, so the prescriber should have written information available to share and discuss. Other family concerns may involve distortions about medication conveyed by the larger culture or from other sources. Examples of the influence of stigma include the following:

A parent refuses to consider medication for the child, stating, “If my child needs medication, that would mean that I am not a good parent.”

Another parent refuses medication, stating, “Medication will change my child’s personality.”

In each instance, accurate information (e.g. parents are not responsible for a child’s needing psychotropic medication, and appropriate use of psychotropic medication does not change the child’s personality but rather enables the child to be his/her authentic self) may effectively address the family concern.

Children also may object to use of medication. Sometimes their concerns are reality based (e.g. concern about side effects, which however can often be minimized). At other times, what the child initially frames as a cultural concern may in fact be related to stigma rather than to culture per se. For example, concerns about privacy and confidentiality may be labeled in cultural terms, due to discomfort talking about stigma.

In general, it can be helpful to discuss the pervasiveness of stigma and the positive benefits of the biopsychosocial perspective, while addressing family concerns about psychotropic medication. It is also useful to assure that medication will be used as judiciously as possible, that regular monitoring will take place, and that changes will be made based on the child’s progress. It is essential that discussions between prescriber and family be respectful and non-judgmental. The physician is obliged to provide appropriate information and sound medical recommendations – whenever possible, by offering a range of possibilities. In the final analysis, however, the decision belongs to child and family.

When the family is not able to immediately reconcile use of medication with their cultural beliefs or other concerns and does not agree to use of medication, it is important to keep the medication option open, in a way that does not cause anyone to lose face. For example, all parties may reach agreement to reconsider the question at a later date, based on the child’s progress during the period in question.

An emerging area of interest involves possible ethnic and racial differences in response to psychotropic medication. It appears that some individuals and groups may metabolize certain medications differently from others, and this may require modifications in typical dosing patterns. While it is beyond the scope of this discussion to identify specific examples of such differences, it is important for psychiatrists and physicians to become familiar with this research.

## **6. Least restrictive/least intrusive**

The principle of least restrictive/least intrusive begins with the imperative to “do no harm,” and then extends to the commitment to seek positive outcomes with the least degree of restriction of, and disruption to, the life of the child and family. This means avoiding higher levels of care when community based options appear viable. As regards psychotropic medication, there is a need to consider the possible indications for psychotropic medication routinely, but to use medication only when there are clear medical indications. In some cases, use of psychotropic medication occurs only after non-pharmacological interventions have been unsuccessful or need to be augmented. In situations involving high levels of immediate risk, psychotropic medication may be indicated early on.

When psychotropic medication is used, the least restrictive and intrusive approach involves using as few medications as possible, at the lowest effective dose of each medication. The goal is to identify target symptoms and then provide sufficient medication to eliminate or ameliorate symptoms, while also minimizing side effects of concern. At times, side effects may limit the effective dose that can be used, or may require use of a different medication. Creating the appropriate balance between therapeutic effects and side effects can be quite difficult, and team members should appreciate that this reflects the challenge of individualized care, not poor medical management.

In order to avoid or minimize potential side effects, medication for children is often intentionally initiated at a low level. The dose is then gradually increased and carefully monitored over time. Such a gradualist approach is desirable and does not suggest a lack of expertise or “experimentation” with the child. It is important that child and family understand the rationale for prescribing medication for children, and the nature of “fine tuning,” prior to the inception of medication.

Unfortunately, some children with SED have more than a single disorder and require more than a single psychotropic medication. Recent clinical research with children with SED has repeatedly supported the reality that some children require more than one medication. For example, a child with ADHD might respond to psychostimulant medication, but his coexisting mood disorder remains unchanged. Since the medication treatment of ADHD does not address his mood disorder, this child might also need to receive separate medication for mood stabilization.

At times, it may be difficult for a child and family to determine if the child on more than one psychotropic medication is receiving appropriate treatment. Whenever there is question, child and family should direct questions respectfully to the prescriber. Some objective indicators of appropriate use of more than one medication include the following:

-There is clear justification for *each medication* in terms of presenting diagnoses, target symptoms, and behaviors of concern.

-All medications being used are safe in combination and do not create side effects of concern.

-Medications have been added sequentially over time, not all at once. Similarly, changes in medication (dose or change of agent) typically involve just one change at a time.

-There is close monitoring of outcomes – both therapeutic effects and side effects, through use of rating scales, observation, and direct report.

Finally, given limitations in access, primary care physicians provide medication to many children, rather than child or other psychiatrists. Regardless of the type of physician, communication between the prescriber and other members of the child's team of the child's medication remains essential. Referral to a child and adolescent psychiatrist should be considered when a child is has severe symptomatology and co-existing disorders, or is at risk of out-of-home placement.

## **CONCLUSION:**

CASSP Principles offer within children's mental health, and beyond, a set of ethical and pragmatic guidelines to effectively bring people together to meet the needs of children and their families. Rather than dictating specific treatments and interventions, CASSP Principles identify important processes that need to occur at a treatment level among involved stakeholders. These include maintaining a culture of mutual respect, collaboration, individualization, and using an active children and family team. The biopsychosocial perspective, in turn, identifies the important areas of inquiry for comprehensive assessment and treatment – the biological, psychological/emotional, and social domains. Consideration of the clinical indications for psychotropic medication is consistent with both CASSP Principles and the biopsychosocial perspective. Actual provision of psychotropic medication when clinically indicated, as with all interventions, should be guided by CASSP Principles – consistent with the strengths and needs of the child, family-focused, community based, multi-system, and culturally competent. In addition, medication should be used in the least restrictive and intrusive manner possible, so that desired outcomes are obtained while side effects are minimized.

The goal of mental health treatment, whether or not psychotropic medication is used, is to promote the child's optimal psychosocial functioning in the community, or to hasten the child's return to the community, when placement has already occurred. Ultimately, it is by conjoining CASSP Principles with the biopsychosocial perspective that the needs of child and family can most effectively be met.

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