Standards of Care for the Administration of Psychotropic Medications to Children and Youth Living in Licensed Residential Settings

Recommendations of the Ontario Expert Panel

July 2008

Standards of Care for the Administration of Psychotropic Medications to Children and Youth Living in Licensed Residential Settings

Summative Report
Contents

Executive Summary 1
Introduction 3
Principles, Objectives and Scope 12
Key Themes of the Expert Panel 16
Panel Recommendations: Standards, Training and Implementation 21
Membership of the Ontario Expert Panel 26

Appendix I 29
Standards of Care for the Administration of Psychotropic Medications to Children and Youth Living in Licensed Residential Settings

Appendix II 57
Advice on Training to Support the Expert Pane Standards of Care for the Administration of Psychotropic Medications to Children and Youth in Licensed Residential Settings

Appendix III 65
Advice on Implementation, Monitoring and Enforcement of the Expert Panel Standards of Care for the Administration of Psychotropic Medications to Children and Youth in Licensed Residential Settings

Executive Summary

There is nothing more important than the safety, wellbeing and health of children and youth entrusted to the care of the Government of Ontario. Many of these children have experienced chronic stress, abuse or trauma; others may be medically fragile or face physical, cognitive or mental challenges. They are among our most vulnerable citizens and they deserve nothing less than the highest level of compassion, vigilance and care.

At any time, up to half of children and youth in licensed residential settings may be prescribed and administered psychotropic prescription medications. The appropriate use of the right medication for the right child or youth can be beneficial; however, inappropriate or improper use can be detrimental. In 2007, in response to multiple incidents of concern, the Ministry of Children and Youth Services (MCYS) convened an Expert Panel to develop standards for the administration and monitoring of psychotropic medications to children and youth in licensed residential settings. The Expert Panel consisted of professionals from a broad range of disciplines and settings who work in the child welfare, youth justice or child/youth mental health systems or are familiar with these settings. All of them share a deep concern about the manner in which psychotropic medications are sometimes administered and monitored in these settings, and the potential impact these practices may have on a child's or youth's current or future well-being. As a result, all have offered their time and expertise to suggest changes that they believe will create a system that is safer and more responsive to the needs of the children and youth.

The overarching goal of the Expert Panel was to create a system that ensures that all residential settings licensed by MCYS are able to provide the right medication to the right child or youth in the right way and at the right time. Conversely, if we as a society are to promote their health, well-being and future, no child or youth in a licensed residential setting in Ontario should ever receive the wrong medication or be administered medication for the wrong reason or in an inappropriate or unsafe manner.

In its review, consultation and deliberations, the Expert Panel was guided by several key principles or themes, many of which reflect the goals outlined in the MCYS' Strategic Framework, *Realizing Potential: Our Children, Our Youth, Our Future*. These principles focused upon ensuring:

- All children and youth in licensed residential settings have fair and equitable access to high-quality, child/youth-centered, culturally-appropriate collaborative or interdisciplinary care;
- Each child or youth has appropriate opportunities to voice his or her preferences, needs and beliefs concerning psychotropic medications;
- Informed consent processes are followed by all licensed residential settings;
- Medication systems are created that promote safe medication practices;
- There is continuity of care across transitions; and
- Reporting policies and procedures are in place that support continuous quality improvement in the administration and monitoring of psychotropic medications.

Some of the practices recommended by the Expert Panel as standards are already

in place in some sectors, or may be relatively inexpensive to implement. Others, however, may require the investment of funds (e.g., for training of direct care workers, foster parents and children or youth) or regulatory or legislative changes (e.g., changes to licensing requirements). Although the Expert Panel acknowledges that not all changes can be implemented immediately, it stresses that all changes are required if we are to address current shortcomings and ensure the safety of children and youth in licensed residential settings.

Through its extensive consultative process, the Expert Panel developed for MCYS three key documents:

- Standards for the Administration of Psychotropic Medications to Children and Youth in Licensed Residential Settings: Recommendations of the Expert Panel;
- Advice on Training to Support the Expert Panel Standards of Care for the Administration of Psychotropic Medications to Children and Youth in Licensed Residential Settings; and
- Advice on Implementation, Monitoring and Enforcement of the Expert Panel Standards of Care for the Administration of Psychotropic Medications to Children and Youth in Licensed Residential Settings.

These documents outline the recommendations of the Expert Panel (the standards), its analysis of training needs and opportunities (Advice on Training) and some of the implementation, monitoring and enforcement issues raised by the standards (Advice on Implementation, Monitoring and Enforcement). These documents are summarized briefly in this paper and provided in full as appendices.

Introduction

Why an Ontario Expert Panel?

It is essential that all children and youth entrusted to the care of the Crown – whether provincial or federal – be protected against harm and their health and well-being promoted and optimized. The 2008 apology of the federal government for abuses of Aboriginal children in residential schools has brought to the attention of many Canadians what can happen if utmost vigilance is not taken to protect those placed in our collective care. Moreover, stories of many residential school survivors have shown us that if we, as a society, fail to meet that responsibility, the effects can be devastating and long-term, reverberating not only throughout life but across generations.

The Ontario Expert Panel was assembled in 2007 to address an important issue concerning children and youth living in residential settings licensed by the Ontario Ministry of Children and Youth Services (MCYS): the administration of psychotropic medications. Over the past decade, the use of psychotropic medications for children and youth has increased greatly throughout society. Given this trend, those working in children and youth mental health or the licensed residential system suspect that a substantive number of those in care are being administered psychotropic medications.

A number of media and professional reports in Canada and the United States, including several coroner's inquests in Ontario, (see *Inquests*) have raised penetrating questions concerning the safety and appropriateness of how such medications are administered and monitored in licensed residential settings.

In addition, the Expert Panel heard a number of anecdotal reports of problems or issues concerning the administration or monitoring of psychotropic medications to children and youth in licensed residential settings. They include stories of children and youth who:

- Come into care with existing prescriptions but little or no information on why the medication was prescribed or what it was supposed to treat;
- Receive prescriptions but are not told why they are being given the medication or what to expect when taking it;
- Are kept on a medication or medications for years, with no review of whether there is still a need for each medication or if the dose is appropriate;
- Are given "cocktails" or combinations of multiple medications, which can increase the risk of negative interactions and adverse reactions; and/or
- Appear to receive medication for the purpose of treating unwanted behaviour (e.g., to make them easier to manage) rather than promoting their mental health.

Two problems add to the challenge of ensuring the appropriate and safe administration and monitoring of psychotropic medications in licensed residential settings. First, those working in licensed residential settings and the child welfare system typically receive little or no formal training regarding psychotropic medications. Although most workers probably receive at least some training in medication administration (e.g., how to complete a Medication Administration

Inquests

Three Coroner's inquests in Ontario have raised serious concerns regarding the care and monitoring of children and youth in licensed residential settings who have been prescribed psychotropic medications or are dealing with psychological concerns:

- In 1998, a 17-year-old female froze to death following her release from police custody. A permanent ward of the CAS, she had been under psychiatric care for several years, with diagnoses including major depression with psychotic features, borderline personality disorder, substance abuse and post traumatic stress. At the time of her arrest, she should have been taking psychotropic prescription medications; if this had been known, the police would have been alerted to her need for psychiatric care.

- In 2001, a Coroner's inquest was held to investigate the death of an 18-year-old male of Neuroleptic Malignant Syndrome (NMS) while in care. NMS is a rare adverse reaction to some psychotropic medications that can be treated successfully if recognized early. But if unrecognized and untreated, NMS is associated with mortality rates of 20 to 40 percent.

- In 2005, an inquest released its findings regarding the suicide of a 17-year-old at a youth justice facility. Prior to and during his admission, the youth had exhibited marked signs of psychosis and although he had been treated and started on medications for treatment of depression and psychosis, expert opinion was that he had a serious mental illness requiring more substantive intervention by skilled mental health professionals.

Record or MAR), few have been taught how to monitor the effects of psychotropic medications.

Moreover, it appears that training is needed concerning the issue of consent for medical treatment. The Panel found that some Children's Aid Societies (CAS) continue to operate under a provision of the *Child and Family Services Act* (*CFSA*), which states that patient consent for medication is required only if the youth is age 16 or older. It does not appear to be widely recognized that this provision of the *CFSA* has been superseded by the *Health Care Consent Act* (*HCCA*), which does not link capacity with age.

The second problem relates to Ontario's supply of mental health specialists. In 2006, the Institute of Health Economics analyzed mental health human resources across Canada. It estimated that, per 100,000 population, there were 16.7 psychiatrists in Ontario and 18.6 psychologists. Although the supply of psychiatrists was slightly above the national average of 15.2, that of psychologists was far lower (18.6 compared to the national average of 38.8).[1] Moreover, only a proportion of all psychiatrists and psychologists have expertise or interest in child and youth mental health. A 2005 report from the Institute for Clinical Evaluative Sciences (ICES) states that there may be substantial delays in accessing mental health services for children in most regions of Ontario.[2] Province-wide, there is only one child and adolescent psychiatrist for every 6,148

[1] Institute of Health Economics. Mental Health Economic Statistics. Alberta Mental Health Board, Institute of Health Economics, 2006.
[2] Dick PT, Kavanagh L, Spalding K, McKeever, PD. Ontario's Mosaic of Children's Treatment Services. ICES Investigative Report. Toronto: Institute for Clinical Evaluative Sciences, 2005.

children and youth with mental health needs.[3]

Adding to the problem is a looming shortage of primary care physicians and specialists such as paediatricians. Ontario is currently short 2,000 physicians, leaving almost one million Ontarians without a family physician. As the current generation of practicing physicians begins to retire, the health human resource gap could widen substantively. The Ontario Medical Association predicts that if Ontarians physicians retired at age 65, the province would lose about 1,000 family physicians and 1,500 specialists within the next two years.[4] A 2005 survey by the Canadian Paediatric Society found that 11 percent of respondents said they will retire by 2010, while another 36 percent said they plan to reduce their work hours.[5]

MCYS Action Plan

The Ontario Exert Panel is an integral part of the Action Plan developed by the MCYS in 2005 for improving children and youth residential services. The Action Plan outlined four priority areas for residential services that were considered essential for long-term improvements to benefit children, youth and their families. The priorities included reviewing existing standards, improving access to information and the training of, and tools for, licensing staff, and supporting greater accountability in the funding of residential services (see *Action Plan Priority Areas*). The Expert Panel was charged with reviewing current policies and practices concerning the administration of psychotropic medications in licensed residential settings and making recommendations to ensure they are

Action Plan Priorities

1. Reviewing existing standard with a focus upon:
   - The diverse needs of children and youth, emphasizing personal choice and dignity, religious and cultural identify and supporting the development of consistent and child-centered plans of care;
   - Quality, safety and security, including issues around the administration of psychotropic medication and associated standards of care and looking at residential staff training in areas such as medication management;
   - Living environments, providing further direction on furnishings, equipment, privacy and nutrition; and
   - Support for transitioning children and youth between settings.
2. Improving the training of, and tools for, licensing staff (e.g., ongoing orientation and training and clarification of roles, responsibilities and expectations for service providers, ministry staff and placing agencies).
3. Improving access to information on residential services to agencies, ministry staff and families.
4. Supporting greater accountability in the funding of residential services.

[3] Steele M, Wolfe VV. Child psychiatry practice patterns in Ontario. *Can J Psychiatry.* 1999; 44:788-792.

[4] New OMA President Sets Recruitment and Retention as Priorities for Year. Toronto, May 4, 2008. http://www.oma.org/Media/news/pr080504.asp 26/05/08.

[5] Are We Doing Enough? A status report on Canadian public policy and child and youth health. 2007 Edition. Ottawa: Canadian Paediatric Society, 2007.

based upon best or most promising practices that promote safety, security and quality of care.

MCYS Strategic Framework

The standards developed by the Expert Panel also reflect the key principles and support the strategic goals outlined in the MCYS 2008 strategic framework, *Realizing Potential: Our Children, Our Youth, Our Future*.[6]

Goal 1: Every child and youth has a voice

A principle concern of the Expert Panel has been to ensure that mechanisms and policies are implemented to ensure children and youth in licensed residential settings are encouraged to speak about their beliefs, feelings and preferences regarding treatment with psychotropic medications. A youth focus group conducted for the Expert Panel during the spring of 2008 suggested that many children and youth in licensed residential settings who are prescribed psychotropic medications receive only limited information and education about their medication, why it is being administered or what to expect when taking it. Many of those interviewed felt that psychotropic medications were prescribed when community primary health care providers, lacking time and expertise in child and adolescent psychiatric care, failed to diagnose them properly. Moreover, the focus group participants reported that not all direct care workers they dealt with were knowledgeable about mental health issues and/or psychotropic medications, and thus able to assist them when they had questions or concerns.

The standards developed by the Expert Panel stress the need to ensure:

- An informed consent process in which children and youth are active participants and can voice their preferences; and
- Mechanisms for ensuring that the feelings, beliefs and preferences of children and youth about their medication are solicited, recorded and reflected in their plans of care.

Goal 2: Every child and youth receives personalized services

The Strategic Framework stresses that children and youth must be placed at the heart of services. Priorities for reform include:

- Strengthening service interconnectivity;
- Designing and delivering services based on a continuity; and
- Improving interactions with services.

The recommendations developed by the Expert Panel would facilitate the achievement of this goal.

As described in Chapter 4, patient-centered collaborative care that bridges transitions and covers the continuum of care were key themes in the work of the Expert Panel. It is the belief of the Expert Panel that psychotropic medications should only be administered if they are appropriate and may benefit the specific child or youth. In other words, it is critical that the right medication – and only that medication – be administered to the right child or youth at the right time and in the right dose and that there is ongoing monitoring of medication effects and side effects. Achieving this level of care will require the efforts of a collaborative team – with the child or youth at its centre.

[6] Ontario Ministry of Children and Youth Services. *Realizing Potential: Our Children, Our Youth, Our Future.* Strategic Framework 2008-12. Spring 2008.

Goal 3: Everyone involved in service delivery contributes to achieving common outcomes

One of the key themes of the work of the Expert Panel (see Standard 4) is that of promoting collaborative care and effective communications regarding the administration and monitoring of psychotropic medications to children and youth in licensed residential settings. Expert Panel members believe that MCYS can and should take a leadership role in the area of children and youth mental health, enhancing collaboration between various stakeholders (including the Ministry of Health and Long-term Care and the Ministry of Education). Currently, child and youth mental health services in Ontario are neither organized nor coordinated: rather than a system, there is a fractured web of services and programs, many of which lack accountability and transparency. Children and youth in licensed residential settings who require mental health care, particularly those who move between settings or facilities, can easily "slip between the cracks" of this fractured system. The impact of failing to receive the right care at the right time in their lives, their ability to complete their education and their futures can be severe and long-lasting.

Goal 4: Every child and youth is resilient

In the MCYS strategic framework, resilience is defined as "the capacity that allows people to adapt and persevere in the face of adversity". Resilience is viewed as the key to breaking cycles of behaviour that may led to the need for intensive services and achieving success in life.

When used appropriately, psychotropic medication may support the development of resilience in children and youth by relieving barriers that prevent them from developing essential living skills, such as emotional- and self-regulation, motivation, relationship-building, empathy and positive behaviours. But improper or inappropriate use of the same medication can hinder, rather than facilitate, these critical life skills. As the Expert Panel stressed throughout its deliberations, the use of psychotropic medication must focus upon the individual needs of the child or youth and promote his or her well-being. By encouraging the appropriate use, administration and monitoring of psychotropic medications, the standards of the Expert Panel will support the goal of promoting child and youth resilience.

Goal 5: Every young person graduates from secondary school

To succeed at school requires problem-solving skills and the ability to concentrate and focus. To have a positive educational experience also depends, in large part, upon the ability to socialize and interact appropriately with others.

Inappropriate or improper use of psychotropic medications – including the absence of such medications when they are a medical necessity – can make it difficult, if not impossible, for children and youth to develop or utilize these abilities and skills. In doing so, it can hinder children and youth from completing secondary school. It is the opinion of the Expert Panel that implementation of the standards it has developed will facilitate the appropriate use of psychotropic medications and help to reduce a potential barrier to educational success faced by a substantive proportion of children and youth in licensed residential settings.

Background

As of October 2007, approximately 19,000 children and youth were living in the care of an Ontario Children's Aid Society (CAS) and another 725 were in the custody of a youth justice facility. As some children and youth enter and leave different types of settings at different points throughout the year, the total number may be much greater. For example, in 2006, CAS provided services to approximately 44,000 Ontario families and substitute care for 29,000 children. It has been estimated that nationally, over 80,000 children and youth are in the care of the child welfare system and an additional 25,000 youth are in detention centres and youth justice facilities. In addition, an unknown number of children and youth are in mental health institutions or have fallen through the cracks of our child welfare system and are living on the streets or in shelters.[7]

Studies suggest that between 14 to 25 percent of children and youth in the general population experience mental disorders that cause clinically significant symptoms or impaired functioning.[8] Given the stresses and challenges faced by children and youth brought into licensed residential settings from abusive, neglectful or stressful environments and by pre-existing or developing cognitive, emotional or physical conditions, as well as the often traumatic impact of entering care, it is possible that mental disorders may be disproportionately represented among those in licensed residential settings. One study, for example, estimated that the rate of emotional and behavioural problems among children and youth in the Canadian child welfare system could range from as low as 48 percent to as high as 80 percent.[9] A review by the Globe and Mail of records from five Ontario CASs found that approximately half (47 percent) of Crown wards had been prescribed psychotropic medications[10] and the CAS of Toronto estimates that between 25 to 40 percent of their Crown wards are affected by Fetal Alcohol Spectrum Disorder.[11] Because of the potential for lifelong distress and disability, appropriate treatment for mental health disorders should be a priority.[12]

Although only a relatively small proportion of Crown wards come into conflict with the law (the CAS of Toronto found the rate to be only 15 percent)[13] children and youth may be subjected to frequent moves between settings, homes, schools and caregivers.

Ensuring continuity of care, quality communications and meaningful client participation in decision-making for children and youth with complex, multiple needs in an environment of frequent

[7] National Youth in Care Network. http://www.youthincare.ca/annual_report/2005.html#About Accessed 26/06/2008.
[8] Kutcher S, Davidson S. Mentally ill youth: meeting service needs. *CMAJ* 2007; 176:4-7.
[9] Stein, Mazumdar, Rae-Grant (1996). Quoted in Lambe Y. The Chemical Management of Canadian Systems Youths. Ottawa: National Youth in Care Network, 2006.
[10] Philip M. Nearly half of children in Crown care are medicated. *Globe and Mail* June 9, 2007.
[11] Children's Aid Society of Toronto. Youth in Care and the Criminal Justice System. http://www.torontocas.ca/2007/0307/youth-in-care-and-the-criminal-justice-system/ 26/05/2008.
[12] McEwan K, Waddell C, Barker Y. Bringing children's mental health "out of the shadows." *CMAJ* 2007; 176:471-2.
[13] Children's Aid Society of Toronto. Youth in Care and the Criminal Justice System. http://www.torontocas.ca/2007/03/07/youth-in-care-and-the-criminal-justice-system/ 26/05/2008.

moves, high caseloads and resource limitations can be challenging.[14]

Determining the appropriate usage of psychotropic medication among children and youth in care is difficult. A 1999 American study, for instance, found that 13 percent of children aged 6 to 12 years in foster homes had taken psychotropic medication in the previous year, compared to 4 percent of a control sample of children aged 5 to 14 enrolled in Medicaid. In this study, it was estimated that children in foster care were almost three times more likely to receive psychotropic medications. However, the same study also found that half (52 percent) of children whose clinical status merited a medication evaluation had not received medication in the previous year. For example, almost half (49 percent) of children in the study sample with attention-deficit/ hyperactivity disorder had not received any psychotropic medication.[15]

Work of the Panel

Members of the Ontario Expert Panel convened in 2007 had a broad range of experience and expertise within and outside of the children's residential service sector. Panel members include paediatricians, child and adolescent psychiatrists, child psychologists, pharmacists and individuals who work in the residential service sector (youth justice, CAS and mental health). Many members have been intimately involved with caring for and treating children and youth in care and share a deep and passionate concern for their safety and well-being.

Several members of the Expert Panel have observed issues within Ontario's children and youth residential service sector that is of concern to them. These can be categorized under the following four themes:

- ***Need for services***

  Compared to the general population, there may be an over-representation of children and youth in care with complex backgrounds and medical and/or psychiatric needs (i.e., developmental and physical challenges, medically fragile conditions, behaviour difficulties, psychiatric disorders, substance abuse problems or emotional trauma). Adequately addressing the needs of each child or youth requires up-to-date, comprehensive information about his or her needs and access to appropriate services and treatment.

- ***Tracking and monitoring medication***

  Some children and youth move in and out of the residential service system several times until they reach adulthood. Panel members indicated that as children and youth transition in and out of the residential services system, gaps can occur in their records. In other words, there is often no continuity of information. This can make it difficult to monitor the types of medication a child or youth has been prescribed.

- ***Accessibility to health care professionals***

  Children and youth in licensed residential services system may not

[14] Finlay J. Snakes and Ladders: "A Dialogue." Office of the Child and Family Service Advocacy, October 17, 2005. http://www.children.gov.on.ca/advocacy/documents/en/Snakes%20and%20Ladders%20A%20Dialogue.pdf.

[15] Zima BT, Bussing R, Crecelius GM, Kaufman A, Belin TR. Psychotropic medication use among children in foster care: relationship to severe psychiatric disorders. *AM J Public Health* 1999; 89:1732-5.

always have timely or appropriate access to different types of health or mental health professionals (i.e., family physicians, counsellors, psychologists, social workers). This inequity can be the result of financial restrictions or the reluctance by some health care professionals to work with children and youth who are deemed to be "difficult" or to have "complex needs".

- ***Education and training of direct care staff***

  Panel members report a lack of training and experience among new graduates regarding psychotropic medications, making it difficult to know for them to know when and how to seek medical services, as well as what to monitor when children and youth are administered psychotropic medications.

As well as drawing upon its extensive hands-on experience with children and youth, the Panel reviewed a number of key documents and reports. These included, but were not limited to:

- Reports and documents concerning the administration of psychotropic medications to children and youth in care developed by a number of state agencies (Illinois, Texas, Connecticut, Florida and New South Wales in Australia);
- Guidelines and statements by the American Academy for Children and Adolescent Psychiatry;
- Academic studies and publications;
- Media reports from across North America;
- MCYS licensing standards and polices;
- The Child and Parent Resource Institute's (CPRI) report on implementing international panel guidelines; and
- Consent forms and information about the consent process from the College of Physicians and Surgeons of Ontario and a sample consent form from the CAS of Haldimand and Norfolk.

Between April 2007, and June 2008, the Panel met 15 times (11 face-to-face meetings in Toronto and four teleconferences). Presentations were made to the Panel included representatives from the Office of the Public Guardian and Trustee; Legal Services Branch, Ministry of Community and Social Services; and by Panel member Marty McKay.
To ensure the work would proceed in a timely and efficient manner, members also volunteered to participate in work groups. Work groups were created to focus upon:

- Collaborative teams and patient-centered care;
- Training of direct care workers;
- How the standards would be implemented; and
- Informed consent.

Work groups were convened through a combination of in-person meetings and teleconference.

As the work groups completed their assignments, materials were combined to produce three key documents:

- Standards for the Administration of Psychotropic Medications to Children and Youth in Licensed Residential Settings: Recommendations of the Expert Panel;
- Advice on Training to Support the Expert Panel Standards of Care for the Administration of Psychotropic

Medications to Children and Youth in Licensed Residential Settings; and

- Advice on Implementation, Monitoring and Enforcement of the Expert Panel Standards of Care for the Administration of Psychotropic Medications to Children and Youth in Licensed Residential Settings.

To obtain advice and feedback on the first draft of the Standards of Care, during spring of 2008, the Expert Panel held a number of focus groups with key stakeholders: children and youth who were, or had been, in licensed residential settings; direct care workers from different regions across Ontario; and provincial and field MCYS staff. Panel members contributed to the development of focus group briefing materials and questions and helped to moderate groups.

Reports documenting the feedback and advice provided by the focus groups are provided in Appendix I. Members of the Expert Panel are deeply appreciative of the contribution made by those who participated in the focus groups. Their feedback was used to revise and improve the first draft of the standards.

Principles, Objectives and Scope

The first tasks undertaken by the Expert Panel included defining the core principles that would guide and shape its work, the objectives of the standards it had been asked to develop, and its scope.

Principles

The principal goal of the Expert Panel was to protect and promote the health and well-being of children and youth in licensed residential settings. This goal is rooted in the belief that a number of fundamental core principles are essential when psychotropic medications are prescribed and administered to children and youth in these settings.

- All children and youth living in licensed residential settings should have fair and equitable access to high-quality, person-centred, culturally-appropriate and evidence-based assessment, diagnosis and treatment of medical, psychiatric, psychological, behavioural, emotional and/or cognitive (including communication) conditions. Before psychotropic medications are administered, a reasonable attempt must be made to ensure that each child or youth has a diagnostic assessment. This assessment should include gathering adequate information on his or her:
    - Family medical, developmental and psychiatric histories;
    - Any psychological assessments, past and current psychiatric diagnoses;
    - Allergies; and
    - Full medication history (psychotropic and non-psychotropic prescription medications, over-the-counter or non-prescription medications and herbal preparations).
- In accordance with the *Health Care Consent Act* and the *Substitute Decisions Act*, there must be a full and appropriate informed consent process for diagnostic assessment at the time of the prescription of psychotropic medication.
- The use of psychotropic medication must be based on the treatment of a specific psychiatric diagnosis or to target specific symptoms. The outcome of prescribing and administering psychotropic medication should be improved functioning for the child or youth. Unless a chronic condition is identified, it should be assumed that the use of psychotropic medication will be a temporary measure.
- Procedures and processes must be in place to ensure all children and youth have culturally appropriate collaborative plans of care that include:
    - Mechanisms for ongoing monitoring of the effects and side effects of psychotropic medications;
    - Opportunities for the children and youth to voice their opinions and concerns and to have their opinions and concerns reflected in their treatment; and
    - A process by which medication incidents or errors are minimized and the safety, well-being and privacy of the children and youth are optimized.
- As children and youth in licensed residential settings may move frequently, when psychotropic

medications have been prescribed it is essential to ensure there is continuity of care and effective transition of information between settings. Given there is consent from the child or youth, there must be accurate and effective communication of information about psychotropic medications between settings and/or caregivers.

- Quality training and education of direct care workers, foster parents and caregivers on the standards and the issues of child and youth development, behaviour and psychotropic medications is essential. There is also need for education on administration of psychotropic medications to children and youth living in licensed residential settings.
- All licensed residential settings must have systems in place to ensure continuous quality improvement of policies and procedures concerning the administration and monitoring of psychotropic medications. Furthermore, as additional evidence emerges about the administration and monitoring of psychotropic medications among children and youth, the panel recommends that MCYS, with appropriate consultation, review and revise the standards to ensure the quality of care provided in licensed residential settings is continuously updated and improved.

The Expert Panel reviewed the CPRI Committee Report of 2002 and agreed with its recommendations that psychotropic medication should never be administered in licensed residential facilities under the following circumstances[16]:

- If it is not in the best interest of the child or youth (e.g., as a method of control, punishment, discipline, retaliation, or for the convenience of caregivers);
- As a substitute for appropriate and available psychosocial rehabilitative services, counselling, behavioural therapy, substance abuse counselling, psychosocial skills training, individual, group or family counselling or support programs;
- In quantities that lead to a loss of functional status; or
- When there is no clear diagnosis or reasonable expectation that the medication will address the diagnosed condition or target symptoms.

Objectives

Building upon its core principles, the Panel determined that the objectives of the standards were to:

- Promote the safe and effective use of psychotropic medications for children and youth living in licensed residential settings;
- Create a minimum expectation for the training of direct care workers; and
- Improve the communication of information to minimize or prevent the misuse and/or inappropriate use of psychotropic medications in licensed residential settings.

Scope

The standards developed by the Expert Panel are not intended to act as clinical

[16] Evans R, Frid P. "IMPLEMENTING THE International Panel Guidelines on the Use of Psychotropic Medications: in *Psychotropic Medications and Developmental Disabilities: The International Consensus Handbook.* CPRI Committee Report, August 2002.

practice guidelines, but to address areas such as procedures, policies and practices that should be in place when psychotropic medications are administered, monitored, stored, or transferred in licensed residential settings. They are to apply to all direct care workers, foster parents, caregivers and substitute decision makers working with children in licensed residential settings funded by MCYS. (In the documents produced by the panel, the term "direct care worker" is used to refer to all staff who works closely with, and has responsibility for, a child or youth in licensed residential care.) The standards are also relevant for foster parents and caregivers for children and youth in licensed residential settings.

Residential services are regulated settings for children and youth who, for a variety of reasons, cannot remain in their homes. As of March 5, 2007, there were approximately 800 providers, 9,700 regulated homes and close to 25,000 beds providing care and accommodation to children and youth. This care is provided in a number of different settings, such as foster care, group homes or institutional homes or facilities (see Table 1). Services

Types of Residential Settings				
	Child and Youth Subpopulation	**Statutory Description**	**Staffing**	**Funding**
Foster Home Agency	• Child Welfare • Children's Mental Health • Developmental Services • Complex Special Needs	• Providing care to 4 or fewer unrelated children (Agency may have several homes)	• Parent "live in" model (one or two people residing in the home care for children on a continuous basis); some variations apply	• Transfer payment agencies (TPA) • Outside paid resource (OPR)/ per diem
Group Home	• Children's Mental Health • Developmental Services • Complex Special Needs	• Staff model (3 or more unrelated children) • Parent model (5 or more unrelated children)	• Parent model • Staff model (one staff employed for a scheduled work period)	• TPA • OPR/per diem
	• Youth Justice	• Open custody • Open detention	• Staff model	• TPA • (some per diem)
Institutional	• Children's Mental Health • Developmental Services • Complex Special Needs	• Providing residential services to 10 or more children	• Staff model	• MCYS directly operated
	• Youth Justice	• Open custody • Open detention • Secure Custody • Secure Detention	• Staff model	• TPA
Respite (not licensed as a separate category)	• Children's Mental Health • Developmental Services • Complex Special Needs	• Can occur in foster or group home settings	• Parent model • Staff model	• TPA • OPR/per diem

Table 1

Note: Directly operated facilities are not formally licensed but must meet all *CFSA* licensing requirements. Developmental Services are licensed by MCYS but funded through MCSS. Per diem beds are purchased by agencies and in some cases by families.

are provided by a variety of MCYS and transfer payment agencies and fall under the mandate of Child and Youth Mental Health, CASs, Developmental Services and Youth Justice. As noted above, these children and youth may be dealing with a number of problems or challenges, such as development or physical challenges, medically fragile conditions, behaviour difficulties psychiatric disorders, conflict with the law, substance abuse problems or emotional trauma or chronic stress.

Given the age, challenges and vulnerability of these children and youth, it is essential that everything possible is done to ensure their psychological and physical heath and well-being are protected and promoted throughout their time in licensed residential care.

Key Themes of the Expert Panel

Throughout the standards developed by the Expert Panel, several key themes emerged repeatedly. They concern the issues of informed consent, collaborative care and continuity of care. All three concepts are integral to many of the recommendations developed by the Expert Panel. These key themes are closely linked to the strategic goals outlined in MCYS' strategic framework, *Realizing Potential: Our Children, Our Youth, Our Future*.[17]

Informed Consent

The issue of informed consent is strongly linked to the first goal outlined in MCYS' Strategic Framework: *every child and youth has a voice*.

One of the findings of the Expert Panel was that some CASs in Ontario have continued to operate under a provision of the original *Child and Family Services Act (CFSA)*, under which consent for medical treatment is only required for youths aged 16 and older. As the Panel discovered, this provision has been superseded by the *Health Care Consent Act (HCCA)*, in which there is no specific age cut-off or limitation. As a result, the standards developed by the Panel have emphasized the need for open and ongoing processes of informed consent when psychotropic medications are being administered to children and youth in licensed residential settings.

To conform to the *HCCA* and the Substitute Decisions Act of 1996, all children and youth in licensed residential settings should be informed that they have the right to either consent to or refuse a diagnostic assessment, treatment with psychotropic medications and communication of information about their treatment to others. Capacity to make treatment decisions is not determined by age or status of a child or youth (e.g., as a Crown ward) but is presumed. If the physician determines the child or youth lacks capacity, the Panel recommended that the reason(s) be recorded. All children and youth in licensed residential settings should also be aware that there is a mechanism by which they can appeal if they are found to lack capacity.

As part of the informed consent process, the risks and benefits of both treatment and refusing treatment must be explained to the child or youth in language they can understand. Consent may be given to a physician verbally, but in its standards the Expert Panel recommended that it also be documented by the direct care worker.

According to a briefing paper prepared by an Expert Panel member, psychologist Dr. Marty McKay, children and youth in licensed residential settings can face various barriers in terms of recognizing their rights to receive or to refuse medical treatment. These barriers may include age, the absence of family or other caregivers to support children and youth in the decision-making process or to advocate for them, the sometimes impersonal relationships with substitute decision-makers (who often carry heavy case loads), and the involuntary context of the licensed residential setting. "These conditions," writes Dr. McKay, may "create ideal conditions for perfunctory 'informed consent' to be obtained."

The potential for incorrect or incomplete employment of the informed consent process may be heightened when

[17] Ontario Ministry of Children and Youth Services. *Realizing Potential: Our Children, Our Youth, Our Future.* Strategic Framework 2008-12. Spring 2008.

psychotropic medications are involved. A psychiatric diagnosis may in itself lead caregivers to assume that the child or youth is incapable of making health care decisions – a fundamental misunderstanding of the definition of capacity.

In the past, in some settings, questionable methods have been utilized to ensure compliance with treatment, such as secreting medication in food or beverages, inducements, or threats to withdraw privileges. If not administered in a manner consistent with the principle of informed consent and for the well-being of the child and youth, there is a danger of psychotropic medications being used as a means of chemical restraint or control.

As noted by Dr. McKay, "It is simply not acceptable for 'informed consent' to be a *pro forma* exercise that is then used as a *carte blanche* permission slip to administer powerful psychotropic drugs to vulnerable children and youth."

Although clinical practices are beyond the scope of the Expert Panel, it recognizes that many psychotropic medications prescribed to children and youth have been largely developed for, and tested in, adults. As a result, there is generally only limited information on their efficacy or long-term impact on children and youth.

Collaborative Care

The theme of collaborative care, as developed by the Expert Panel, touches upon two of the goals of MCYS' Strategic Framework: *everyone involved in service delivery contributes to achieving common outcomes* and *every child and youth receives personalized services*.

In its standards, the Expert Panel frequently referred to the need to ensure that all children and youth in licensed residential settings receive personalized care that is centered upon their needs (client-focused) and delivered by collaborative teams. A collaborative or interdisciplinary team is defined as a group of professionals from different disciplines who engage in planned and interdependent collaboration.[18] The most important aspect of teamwork is that members work together in a coordinated manner, with joint ownership of decision-making and collective responsibility for outcomes.[19, 20]

The child or youth should remain the centre of his or her care team. There are two important implications of this statement. First, it speaks to the fact that care should be client-centered (i.e., tailored to the specific needs of the individual child or youth). Second, it implies that, to the greatest extent possible, given the child or youth's capacity, he or she should be involved in the decision-making process. The ability to share or transfer information about psychotropic medications should not be assumed by the care team, but requires the child's or youth's consent.

For those under the responsibility of the CAS, the guardian (e.g., the CAS worker) would be a key and integral member of the collaborative care team. If the child or youth lives in a foster home, it would also

[18] Drinka TJK. Applying Learning from Self-directed Work Teams in Business to Curriculum Development for Interdisciplinary Geriatric Teams. *Educational Gerontology* 1996; 22:433-450.

[19] Tsukuda R. Interdisciplinary collaboration: Teamwork in geriatrics. In C.K. Cassel, D. E. Riesenberg, L. B. Sorensen and J. R. Walsh (Eds.). *Geriatric Medicine, 2nd edition,* 1990; New York: Springer-Verlag, pp.668-675.

[20] Liedtka JM & Whitten E. Enhancing Care Delivery Through Cross-disciplinary Collaboration: A case study. *Journal of Healthcare Management* 1998; 43(2), 185-205.

be important to include the foster parent(s) as part of the care team, as they would be instrumental in providing key information about the child's or youth's functioning. Foster parents are also in the position to monitor behaviours, emotions, thoughts and possible side effects of the medication; they should be aware of the psychotropic medications the child or youth is taking, anticipated effects and potential side effects.

If the child or youth is in a group home setting, youth justice facility or mental health facility, those primarily responsible for him or her should be involved in the care team, for similar reasons as the foster parent(s). Ensuring that those working directly with children and youth in licensed residential settings are knowledgeable about psychotropic medications would enhance their ability to communicate with those receiving medication – as well as other members of the care team and other professionals (e.g., teachers and primary care providers).

Other members of the collaborative care team can vary according to a number of factors, such as:

- The child's or youth's circumstances (e.g., the type of problem or problems);
- The child's or youth's willingness to be involved with various members of the health care team; and
- The availability of services or professionals.

Access to a variety of medical and non-medical service providers is important. In the experience of many members of the Expert Panel, psychotropic medication may be a response to an acute crisis or when other interventions (e.g., cognitive behaviour therapy) cannot be accessed or access cannot be achieved in a timely manner. The Expert Panel believes that in some cases collaborative care could help to reduce or eliminate the need for psychotropic medications.

Some examples of the types of professionals that can make important contributions to the care team include:

- Primary health care providers (physicians, paediatricians and primary care nurse practitioners or acute care advanced practice nurses);
- Specialist physicians, such as developmental paediatricians and child and adolescent psychiatrists;
- Pharmacists;
- Psychologists;
- Social workers; and
- Mental health therapists.

Furthermore, as discussed above, the child or youth should also be considered a key member of the collaborative team. All members should recognize that he or she has a right to voice his or her preferences, beliefs and needs.

During its consultation, the Expert Panel learned that many licensed residential facilities are facing significant challenges when it comes to accessing primary care, both on an ongoing and emergency basis. Many primary health care providers see children and youth in licensed residential settings as "complex" or "difficult" and prefer not to treat them. Moreover, not all primary care providers have expertise in diagnosing and treating child and adolescent psychiatric or psychological conditions. Diagnosing and treating a child or youth in a licensed residential setting requires patience, experience and skill.

Accessibility of mental health services for children and youth is a significant challenge in many parts of Ontario. As

discussed earlier, Ontario lags behind many other provinces when it comes to its supply per population of psychiatrists and psychologists. Those with specialized training or expertise in child and youth mental health are even fewer in numbers. It has been estimated that in Ontario there is only one child and adolescent psychiatrist for every 6,148 child or youth with mental health needs.[21] Moreover, psychiatrists and psychologists are not equitably distributed throughout the province; many regions of Ontario, particularly in rural or northern areas, are acutely underserviced. As a result, children, direct care workers and caregivers may have to travel long distances in order to access services.

Access can also be challenging because of the fragmented nature of mental health services in Ontario. Services can and are delivered through the public system, privately and by service agencies. Although MCYS is the lead ministry for child and youth mental health, services may also be provided by other ministries, such as Education (school-based services), Health and Long-term Care (e.g., hospital and clinic-based services and programs), and Community and Social Services. Those working with children and youth in licensed residential settings are not necessarily familiar with all of the mental health services available in their communities or have relationships or agreements in place to facilitate access to them.

Continuity of Care

The issue of continuity of care is integral to the issue of collaborative care. As such, like collaborative care, the theme of continuity of care is strongly linked to two of the goals outlined MCYS' strategic framework: *everyone involved in service delivery contributes to achieving common outcomes* and *every child and youth receives personalized services*.

For the Expert Panel, the concept of "continuity of care" has many aspects:

- Access to coordinated, collaborative care that considers all aspects of a child's or youth's health and well-being;
- The smooth transfer of information and medications whenever there is a transition; and
- Follow-up or referral when children or youth leave care.

In the standards, the Expert Panel described a number of processes or mechanisms that can be utilized to enhance continuity of care. They included recommendations concerning:

- Gathering and communicating information about medications;
- Transferring medications between facilities or settings;
- Collaborative care teams; and
- The use of resources to educate and inform children and youth about their medications, such as the Med Ed medication passport.

In the standards, the Expert Panel recommended that all licensed residential facilities utilize the MedsCheck program of the Ministry of Health and Long-term Care for appropriate children and youth in their care. Utilization of MedsCheck would be a cost-efficient means of providing for children with multiple prescriptions an annual review of their medications and any safety issues that are identified. It would also give children and youth who consent to participate the opportunity to learn more about their

[21] Steele M, Wolfe VV. Child psychiatry practice patterns in Ontario. *Can J Psychiatry* 1999; 44: 788-792.

medications and how to take them safely (e.g., possible interactions with non-prescription or recreational medications).

Panel Recommendations: Standards, Training and Implementation

Through its deliberations and consultations, the Panel developed three key documents:

- Standards for the Administration of Psychotropic Medications to Children and Youth in Licensed Residential Settings: Recommendations of the Expert Panel;
- Advice on Training to Support the Expert Panel Standards of Care for the Administration of Psychotropic Medications to Children and Youth in Licensed Residential Settings; and
- Advice on Implementation, Monitoring and Enforcement of the Expert Panel Standards of Care for the Administration of Psychotropic Medications to Children and Youth in Licensed Residential Settings.

Standards

The standards of the Expert Panel are designed to guide the development of the policies, procedures and practices that licensed residential settings should follow when psychotropic medications are being prescribed, stored, transferred, administered and monitored. These standards represent "best" or "most promising" practices that, in the opinion of the Expert Panel, should apply to all direct care workers responsible for children and youth living in licensed residential settings, as well as, where applicable, to foster parents and other caregivers.

It is the opinion of the Expert Panel that the need to protect and promote the health and well-being of children and youth in licensed residential settings against inappropriate or improper use of psychotropic medications is urgent. Although perhaps all recommendations outlined in the proposed standards cannot be implemented in full immediately, the Expert Panel believes that implementation must begin as quickly as possible.

The Expert Panel recognizes that some of the practices may already be in place in some sectors, whereas others may require regulatory or legislative changes before they can be implemented. It also acknowledges that different licensed residential settings operate under different regulations and, based on licensing requirements and Regulation 70 of the *CFSA* many, if not most, of the 53 CASs across Ontario have developed their own forms, policies and procedures. The Expert Panel believes MCYS should encourage and support standardization and provide guidance on practices based upon its recommendations so equal quality of care is available throughout the province. This may require revision of licensing requirements. For example, members of the Expert Panel are concerned about the general level of knowledge, training and expertise among employees in group homes concerning psychotropic medications and children and youth mental health. They are also concerned that the current licensing system may inadvertently encourage group homes to use psychotropic medications as chemical restraints, as the use of physical restraint requires the completion of a Serious Occurrence Report.

If those responsible for children and youth in licensed residential settings, such as group homes, have little or no training on psychotropic medications and/or child and adolescent mental health, such workers may be unable to properly monitor the effects and side effects of the medications they are supposed to

administer and cannot knowledgeably discuss any issues that arise with the children or youth receiving them. The Expert Panel believes that licensing requirements should be modified so group homes are required to employ people with at least an agreed-upon minimum level of education/training in children and youth mental health, psychotropic medications and the new standards, and that ongoing training and educational opportunities should be provided.

The Expert Panel developed nine standards, addressing the following as they relate to the administration and/or monitoring of psychotropic medications:

1. ***Intake into the licensed residential system:*** When a child or youth enters into a licensed residential setting, a reasonable attempt should be made to document as much information as possible about all current and past medications. In addition, there should be effective communication of this information to those responsible for the child or youth's care.
2. ***Informed consent for treatment with psychotropic medications:*** Diagnostic assessment and the prescription of a psychotropic medication require informed consent of the child or youth, with capacity to give consent being presumed unless there is proof otherwise.
3. ***The diagnostic assessment process:*** All licensed residential settings should have procedures and protocols for obtaining mental health assessments in a timely manner. A direct care worker (preferably the case responsible worker) and, where appropriate, others such as the parent(s), foster parent(s) or other caregiver(s) should attend appointments as agreed to by the worker and the physician conducting the assessment. The assessment process should be fully understood by the direct care worker and there should be mechanisms by which the results are documented and explained in the child or youth's plan of care.
4. ***Collaborative care and plans of care:*** Each child and youth living in a licensed residential setting should have a child-centered plan of care developed by a collaborative care team. For children and youth prescribed psychotropic medication, the plan of care should include a record of the results of diagnostic assessments, a method for monitoring ongoing medication effectiveness and side effects, and a schedule for regular review of all psychotropic medications. Direct care workers, foster parents and caregivers should regularly, or when needed, discuss with the collaborative care team if non-pharmacologic interventions would assist the child or youth. Ongoing discussions with the child or youth, parent(s), foster parents and/or caregivers should be held about any concerns regarding the medication, with the discussions recognizing and addressing the child or youth's feelings, wishes and cultural beliefs.
5. ***Preparation and administration of psychotropic medications***: Direct care workers, foster parents and caregivers should ensure there is a safe and secure system for preparing and administrating psychotropic medications within all licensed residential settings. Specific issues that must be addressed include labeling, administration preparation, infection control, scheduling, documentation, no sharing of medication, appropriate use of PRN

(*pro re nata* or "as needed") medications, and child or youth self-administration.

6. ***Psychotropic medication storage, transfer and disposal:*** All licensed residential settings should have safe and secure methods to store, transfer and destroy psychotropic medications.
7. ***The communication of medication information:*** All parties – children, youth, direct care workers, parents, foster parents, caregivers and health care providers – should have accurate information about a child's psychotropic medications and access to educational resources about these medications, including information on PRN or emergency medications. The Expert Panel believes that a child or youth medication passport (Med Ed) could be a valuable and useful resource for the management of psychotropic medications and the education of children and youth.
8. ***Training of direct care workers, foster parents, children, youth and families:*** Educational curriculum and resources should be available to ensure that everyone who cares for children and youth in licensed residential settings receives orientation and ongoing training on the standards and issues relevant to psychotropic medications. Due to the importance of training for the implementation and ongoing utilization of the standards, the Expert Panel developed a separate document outlining their training recommendations.
9. ***Quality improvement (medication incident/error reporting and review):*** To reduce the risk of preventable harm from medication use and to promote continuous quality improvement, all residential, licensed settings where psychotropic medications are administered to children and youth should have a system to report and analyze medication incidents or errors. The objective is to ensure that direct care workers, foster parents and caregivers learn from incidences so system safeguards and enhancements can be implemented to reduce the risk of future incidents.

The full standards document is attached as Appendix I.

Advice on Training

In order to implement and carry out the practices recommended by the Expert Panel, those caring for and managing children and youth in licensed residential settings must receive education and training. As MCYS is currently reviewing training within the child welfare sector, this may be an opportune time to look at training gaps and needs in the area of psychotropic medications.

As outlined in its training paper, two broad types of training are required:

- ***On the standards:*** what they mean, how they should be implemented and how to follow the policies, practices and resources they require, such as medication passports, medication incident reports, etc.; and
- ***On topics relevant to the issue of psychotropic medications:*** examples include psychotropic medication effects and side effects, informed consent and how to communicate with others concerning psychotropic medications, broader issues of child and youth development and mental health and the impact of maltreatment, abuse, neglect trauma, chronic stress and relocation.

As described in the Advice on Training document, the Expert Panel believes that training, information and resources should be available for all those involved in the care of children and youth in licensed residential settings, including foster parents, group home staff, youth justice workers, child protection workers and relief staff. In addition, staff should be able to provide information and referral to resources for children and youth, families and other professionals who may be members of the collaborative care team.

The Expert Panel believes that training should build upon existing programs and models that have been utilized successfully in the child welfare system. It believes training should not be a "one-time" effort for staff but should be integrated into post-secondary training, job orientation and ongoing professional development. Tools and resources should be readily accessible to support and enhance learning opportunities. The Internet may provide a cost-efficient way of providing these resources throughout the province.

In the experience of the members of the Expert Panel, there is a great hunger for resources on psychotropic medications among direct care workers, foster parents and children and youth. To ensure resources are used appropriately and to full advantage, however, it is important that training in how to use them is implemented prior to the release of tools or materials.

The full Advice on Training document is attached as Appendix II.

Advice on Implementation

Focus groups conducted for the Expert Panel among MCYS staff and direct care workers suggest that some of the standards recommended by the Panel are already utilized in some settings or recognized as "best practices". Implementing such practices may require relatively simple formalization and standardization of practices across sectors. Other standards may be new but relatively easy and cost-neutral to implement (e.g., changing the Serious Occurrence Report to add a new category for medication incidents). Yet others may require more significant allocation of time and resources, or may depend upon regulatory or even legislative changes.

The Expert Panel congratulates MCYS for the significant advances it has made in addressing some of the critical issues facing children and youth in licensed residential settings, such as the Action Plan, Strategic Framework and the call for standards on the administration of psychotropic medications. However, more is required to ensure the work of the Expert Panel has a positive and lasting impact upon our licensed residential system. Although, as noted, some of the standards developed by the Expert Panel may be cost-neutral or of low cost, if we as a society are to truly protect and promote the health and wellbeing of children and youth, it is essential that the child and youth welfare and mental health systems be adequately funded. Sufficient funding must be allocated to ensure timely, efficient and effective implementation of all aspects of the standards.

The Expert Panel recognizes that MCYS is responsible for the development of an implementation plan and process for the standards. In doing so, it will probably need to work with divisions and branches within MCYS, the facilities it licenses and regulates, relevant professional bodies, centres with experience and expertise in this area (e.g., CPRI) and other ministries (e.g., Ministry of Training, Colleges and

Universities regarding post-secondary curriculum for social workers and youth justice workers and the Ministry of Health and Long-term Care in regards to health human resources). The Expert Panel believes implementation of the standards should be as flexible and positive as possible and encourages the MCYS to continue the consultation with stakeholders, such as direct care workers and youth.

The Expert Panel, both as individual members and as a group, has stated that it is willing to assist in the implementation process in whatever manner is deemed appropriate and helpful by MCYS, such as acting as a reference group or advisory committee. For example, an advisory committee could be struck consisting of members of the Expert Panel (to ensure continuity of work and integrity of the Expert Panel's intentions), as well as new representatives (e.g., direct care workers who can help identify challenges the field would face in implementing the standards, health care professionals who can comment on the medical/treatment implications of the standards, and/or representatives of bodies such as the Office of Child and Family Service Advocacy).

As part of the implementation process, a plan should be developed for further data collection and monitoring across the continuum of MCYS services in which children and youth in care may be prescribed and/or administered psychotropic medications. Standardized collection of data will enhance the ability to evaluate the implementation process and the impact of the standards and identify potential problems and opportunities for ongoing system enhancements. The desired outcome is to manage risks inherent in the system and move towards a goal of risk prevention and minimization.

The full Advice on Implementation document is attached as Appendix III.

Membership of the Ontario Expert Panel

Chair of the Panel:

Glenn R. Thompson, BA, MSW, RSW, has an extensive background in a variety of non-profit and governmental organizations in Canada and the UK, dealing with individuals, social problems and public policy. He spent one year with the Ministry of Health in the UK where he was employed as a psychiatric social worker at a therapeutic community psychiatric hospital. From 2000, he spent two years with the Government of Nunavut where he was the Executive Director, Baffin Region, Department of Health and Social Services.

In the 16 years between 1975 and 1991, Glenn served as Deputy Minister in six Ontario government ministries, including Correctional Services, Energy, Government Services, Municipal Affairs, Labour and Housing.

In 1991, Mr. Thompson joined the Canadian Mental Health Association, Ontario Division, as Executive Director where he served for 9 years. He was appointed as half time Executive Director of the Canadian Criminal Justice Association in Ottawa from 2002, for 18 months, to stabilize the organization and to assist in locating a permanent Executive Director. From the fall of 2004 he returned to the CMHA, Ontario as Interim CEO and from early 2005 has been active in a general consulting practice and in volunteer activities.

He has recently completed a nine month assignment as the Interim Chief Executive Officer of the Canadian Mental Health Association, National.

Since August 2007, Glenn has served as Interim President and CEO of the newly formed Mental Health Commission of Canada. In this role he has been assisting the Chair, Dr. Michael Kirby and the Board of Directors to establish the new organization and to situate its head office in Calgary, Alberta.

Mr. Thompson was awarded the Governor General's Centennial Medal in 1967 and in 2000 was awarded the Ontario Lieutenant Governor's Medal of Distinction in Public Administration.

Members:

Kalyna Bezchlibnyk-Butler is currently retired from her previous role as Psychiatric Pharmacist at the Centre for Addiction and Mental Health, Clark Institute of Psychiatry site. Most recently, Ms. Bezchlibnyk-Butler published a book entitled "The Clinical Handbook of Psychotropic Drugs for Children and Adolescents (2nd edition, 2007)". The handbook is a reference guide for psychiatrists, psychologists, physicians and other mental health professionals who regularly prescribe psychotropic medication to children and youth.

Dr. Simon Davidson is currently Chief of Specialized Psychiatric and Mental Health Services for Children and Youth (Children's Hospital of Eastern Ontario [CHEO]/Royal Ottawa Mental Health Centre [ROMHC]); Medical Director of the Mental Health Patient Service Unit at CHEO; and Executive Director of Planning and Development of the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO. He is Professor and Chairman of the Division of Child and Adolescent Psychiatry in the Department of Psychiatry at the University of Ottawa.

Sylvia Hyland, BScPhm, MHSc, is co-founder and Vice President of the Institute for Safe Medication Practices

Canada (ISMP Canada), an independent, non-profit agency committed to the advancement of medication safety. After receiving her pharmacy degree from the University of Toronto, she completed a clinical pharmacy residency at Women's College Hospital in Toronto. Her Master of Health Sciences in Bioethics was received from the Joint Centre for Bioethics, University of Toronto. Ms. Hyland's professional experience includes positions in clinical and administrative pharmacy in several hospitals; more recently, she has assisted with medication adverse event analyses and focused reviews of medication use systems in health care.

Lucia Lee is the Executive Director of Murray McKinnon Foundation, an organization dedicated to providing community-based supports to at-risk youth and youth in conflict with the law. Ms. Lee also volunteers with other community organizations, has counselled victims of violence and teaches suicide prevention workshops.

Dr. Marty McKay is a clinical psychologist who has practiced in Toronto since 1976. She received her Ph.D. from the University of Saskatchewan and obtained post-doctoral specialty certification from the American Board of Professional Psychology. She has assessed and treated adult and child victims of violence and abuse as well as having evaluated perpetrators of violence and abuse. Dr. McKay has worked as a consultant to public sector and governmental agencies, most notably for children's aid societies, the Ministry of Community and Social Services and in various facilities for individuals with medical and psychological disabilities.

Laurine Martyn is the Residential Director of The Hincks-Dellcrest Centre, Gail Appel Institute which was established in 1986 to respond to the challenge of improved mental health care for children by providing advanced training, research and community consultation in the area of child and youth mental health.

Dr. Ajit Ninan is a Psychiatrist at the Child and Parent Resource Institute in London, Ontario and is also an Assistant Professor in the Department of Psychiatry at the Schulich School of Medicine and Dentistry at the University of Western Ontario. His main areas of interest are in general clinical practice as well as psychiatric education.

Dr. Wendy Roberts is currently a developmental paediatrician at Bloorview Kids Rehab and the co-director for the Autism Research Unit at The Hospital for Sick Children. She is a Professor of Paediatrics at the University of Toronto. Work with a variety of developmental disorders has led Dr. Roberts to her current interest in autism, its early signs, genetic etiology and intervention, including psychopharmacological management.

Dr. Diane Sacks is past president of the Canadian Paediatric Society. She is the Chair of the Mental Health Task Force of the Canadian Paediatric Society. She sat on the Steering Committee that oversaw the development of GLAD-PC (Guidelines for Adolescent Depression in Primary Care) developed in conjunction with University of Toronto Health Network and Columbia University. She is past Chief of the Adolescent Clinic at the Hospital for Sick Children and North York General Hospital. She has been in private community paediatric and adolescent medicine practice for 35 years.

Dr. Margaret Steele is the Chair of the Division of Child and Adolescent Psychiatry, Schulich School of Medicine and Dentistry at the University of Western Ontario. Dr. Steele is an Associate

Professor in the Departments of Psychiatry, Paediatrics and Family Medicine at the Schulich School of Medicine and Dentistry. She is the Physician Lead for the Child and Adolescent Mental Health Care Program at London Health Sciences Center and conducts research in psychopharmacology and medical education. She is currently the President of the Canadian Academy of Child and Adolescent Psychiatry and a member of the Child and Youth Advisory Committee to the Board of the National Mental Health Commission.

Anne-Marie Watson is the Director of Services at the Children's Aid Society of Haldimand & Norfolk. Ms. Watson has worked on several provincial and Ministry committees advancing child welfare research and policy. Ms. Watson was also appointed to the Canadian Roster of Experts by the Child Welfare League of Canada. She holds academic credentials in psychology and social work and obtained her Master of Public Administration at Queen's University, School of Policy Studies. Ms. Watson has an interest in governance policy, regulation and the delivery of child and family services.

Standards of Care for the Administration of Psychotropic Medications to Children and Youth Living in Licensed Residential Settings

Recommendations of the Ontario Expert Panel

Appendix I

Standards of Care for the Administration of Psychotropic Medications to Children and Youth Living in Licensed Residential Settings

Contents

Introduction 31
Objectives 31
Scope 32
Core Principles 32

Recommendations of the Expert Panel 34
Standard 1: Intake 34
Standard 2: Informed Consent 36
Standard 3: Diagnostic Assessment 36
Standard 4: Collaborative Care and Plans of Care 37
Standard 5: Preparation and Administration of Psychotropic Medications 41
Standard 6: Psychotropic Medication Storage, Transfer and Disposal 42
Standard 7: Medication Information Communication 43
Standard 8: Training 44
Standard 9: Quality Improvement 45

Glossary of Terms 47

References 55

Note to Reader: When a term or word is underlined, it indicates that it is defined in the Glossary (Appendix 1). Terms and words are only underlined the first time they appear in the document.

Introduction

Each child or youth living in a licensed residential setting (facilities licensed by the Ministry of Children and Youth Services [MCYS], including foster care homes, groups homes, custody or detention facilities and residential treatment and therapeutic facilities) has basic needs for shelter, safety, nutrition, education and age-appropriate activities. These children and youth come from a variety of backgrounds and may have a spectrum of concurrent needs. Some are dealing with developmental or physical challenges, family breakdown or dysfunction, history of abuse/neglect, medically fragile conditions, emotional and behaviour difficulties, substance abuse problems, psychiatric disorders or emotional trauma.

Children or youth may enter licensed residential facilities with prescriptions for psychotropic medications or be prescribed such medications while in care. It is essential to establish minimum levels of safety, appropriate mechanisms and adequate resources to:

- Assist children and youth with decisions regarding treatment with psychotropic medication;
- Minimize the risk of harm; and
- Optimize the health and well-being of the children and youth.

The Standards of Care for the Administration of Psychotropic Medication to Children and Youth Living in Licensed Residential Settings was funded by MCYS and developed by the Ontario Expert Panel. The standards are not intended to act as clinical practice guidelines, but address areas such as: procedures that must be in place when psychotropic medications are prescribed, administered, monitored, stored, or transferred; relevant training for direct care workers, foster parents, caregivers and others responsible for children and youth in licensed residential settings; and processes to ensure effective communication of information regarding psychotropic medications. As described in the Glossary of Terms, in this document the term “direct care worker” refers to any staff who works closely with, and has responsibility for, a child or youth in licensed residential care. The standards are also relevant for foster parents and caregivers for children and youth in licensed residential settings.

The standards should apply to all licensed residential settings within Ontario where psychotropic medications may be prescribed or administered to children and youth. They will help to ensure that children and youth who could benefit from psychotropic medication receive the best possible care for their specific needs while minimizing risk and disruption to their lives. As additional evidence emerges about the prescription, administration and monitoring of psychotropic medications among children and youth, the panel recommends that MCYS, with appropriate professional consultation, review and revise the standards to ensure the quality of care provided in licensed residential settings is continuously updated and improved.

Objectives

The objectives of the standards are to:

- Promote the safe and effective use of psychotropic medications to children and youth living in licensed residential settings;
- Create a minimum expectation for the training of direct care workers; and

- Improve the communication of information to minimize or prevent the misuse and/or inappropriate use of psychotropic medications in licensed residential settings.

Scope

These standards of care will apply to all direct care workers, foster parents, caregivers and substitute decision makers working with children in licensed residential settings funded by MCYS. This includes foster care, youth justice facilities, group homes and residential mental health facilities for children and youth.

Core Principles

All standards developed by the Expert Panel are based upon a number of fundamental core principles:

- All children and youth living in licensed residential settings should have fair and equitable access to high-quality, person-centred, culturally-appropriate and evidence-based assessment, diagnosis and treatment of medical, psychiatric, psychological, behavioural, emotional and/or cognitive (including communication) conditions. Before psychotropic medications are prescribed or administered, a reasonable attempt must be made to ensure that each child or youth has a diagnostic assessment. This assessment should include gathering adequate information on his or her:
  - Family medical, developmental and psychiatric histories;
  - Any psychological assessments, past and current psychiatric diagnoses;
  - Allergies; and
  - Full medication history (psychotropic and non-psychotropic prescription medications, over-the-counter or non-prescription medications and herbal preparations).
- The use of psychotropic medication must be based on the treatment of a specific psychiatric diagnosis or to target specific symptoms. The outcome of prescribing and administering psychotropic medication should be improved functioning for the child or youth. Unless a chronic condition is identified, it should be assumed that the use of psychotropic medication will be a temporary measure.
- Procedures and processes must be in place to ensure all children and youth have culturally appropriate collaborative plans of care that include:
  - Mechanisms for ongoing monitoring of the effects and side effects of psychotropic medications;
  - Opportunities for the children and youth to voice their opinions and concerns and to have their opinions and concerns reflected in their treatment; and
  - A process by which medication incidents or errors are minimized and the safety, well-being and privacy the children and youth are optimized.
- As children and youth in licensed residential settings may move frequently, when psychotropic medications have been prescribed it is essential to ensure there is continuity of care and effective transition of information between settings. Given there is consent from the child or youth, there must be

accurate and effective communication of information about psychotropic medications between settings and/or caregivers.

- Quality training and education of direct care workers, foster parents and caregivers on the standards and the issues of child and youth development, behaviour and psychotropic medications is essential. There is also need for education on administration of psychotropic medications to children and youth living in licensed residential settings.
- All licensed residential settings must have systems in place to ensure continuous quality improvement of policies and procedures concerning the administration and monitoring of psychotropic medications. Furthermore, as additional evidence emerges about the administration and monitoring of psychotropic medications among children and youth, the panel recommends that MCYS, with appropriate consultation, review and revise the standards to ensure the quality of care provided in licensed residential settings is continuously updated and improved.

The Expert Panel reviewed the CPRI Committee Report of 2002 and agreed with its recommendations that psychotropic medication should never be administered in licensed residential facilities under the following circumstances[22]:

- If it is not in the best interest of the child or youth (e.g., as a method of control, punishment, discipline, retaliation, or for the convenience of caregivers);
- As a substitute for appropriate and available psychosocial rehabilitative services, counselling, behavioural therapy, substance abuse counselling, psychosocial skills training, individual, group or family counselling or support programs;
- In quantities that lead to a loss of functional status; or
- When there is no clear diagnosis or reasonable expectation that the medication will address the diagnosed condition or target symptoms.

[22] Evans R, Frid P. "Implementing the International Panel Guidelines on the Use of Psychotropic Medications" in *Psychotropic Medications and Developmental Disabilities: The International Consensus Handbook*. CPRI Committee Report, August 2002.

Standards of Care for the Administration of Psychotropic Medication to Children and Youth in Licensed Residential Settings

Recommendations of the Ontario Expert Panel

This document identifies the standards developed by the Expert Panel and guides the development of policies, procedures and practices licensed residential settings should follow when psychotropic medications are being prescribed, stored, transferred, administered and monitored to children or youth.

These standards apply to all direct care workers responsible for children and youth living in licensed residential settings, foster parents and caregivers. Even though different licensed residential settings operate under different regulations, all direct care workers, foster parents and caregivers should follow the same standards. Based on licensing requirements and Regulation 70 of the *Child and Family Services Act* (*CFSA*), the 53 Children's Aid Societies across Ontario have developed their own forms, policies and procedures. The ministry should support standardization and provide guidance on practice.

This document describes practices that the Expert Panel believes should be implemented by all licensed residential settings responsible for children and youth. It is recognized that some of the practices described may already be established in some sectors. The Expert Panel also recognizes that changes to current regulations and legislation may be required before all standards can be implemented in full by all sectors.

Standard 1: Intake

When a child or youth enters into a licensed residential setting, a reasonable attempt should be made to document as much information as possible about all current and past medications. In addition, there should be effective communication of this information to all responsible for the child or youth's care.

Standard 1.1: Obtaining a full medication history

A complete medication history, including prescription and over-the-counter medications, supplements and herbal remedies should be obtained for all children and youth entering a licensed residential setting. This includes standardized processes for collecting and updating:

- A "best possible" medication list which lists:
  - All the medications the child or youth is currently taking, drug name, dose, frequency, prescribing physician (where appropriate) and the target symptoms or clinical indication for each medication; and
  - Previous psychotropic medications used and their efficacy and adverse effects;
- Allergies;
- When possible, a family medication history, including allergies and response to psychotropic medication;
- Height and weight;
- Whether the child or youth has a family physician, paediatrician, community pharmacy and/or other health care provider;

- A Cumulative Medical History and a Medication Administration Record (MAR) with medication administration times and, for scheduled medications, indicating when the next dose is due;
- A "medication passport" (e.g., Med Ed) for the child or youth (see Standard 7.1);
- An inventory of medications; and
- Unless medications are dispensed in the licensed residential setting by a health care professional, ensuring that medications:
    - Are in their original containers which list drug name, prescribed dose and directions for administration; and
    - Accompany the child or youth when the admission medical is conducted, for reference and also verification of the medications.

Standard 1.2: Mechanisms for addressing questions or concerns

Direct care workers, foster parents and caregivers (e.g., guardians and parents) should have a clear and effective path to ask questions or voice concerns about psychotropic medication use. Children and youth should be instructed about resources or offices they can contact if they have questions or concerns about their medications.

Standard 1.3: Medication passport and team communications

Processes should be in place for communicating information from the Cumulative Medical History, Medication Administration Record (MAR), Medication Passport and any other information about the medications gathered or created as part of the intake process to all members of the collaborative care team, including foster parents. These processes must respect the privacy of the child or youth and conform to the principles of informed consent (see Standard 2).

Discussion

Processes for communicating information about psychotropic medication use are needed as soon as children and youth enter a licensed residential setting, as some may come with existing psychotropic prescriptions. It is recognized that it is often difficult to obtain a medical history of a child or youth if there is frequent movement between licensed residential settings. Whenever possible, information about existing medications should be obtained from the responsible adult (e.g., foster parent, parent or guardian) and child or youth, by conducting an inventory of medication containers and/or from existing medical records of the child or youth's primary physician.

Unless the direct care worker, foster parent or caregiver has concerns about the child or youth's physical or emotional well-being, or there are urgent physical or emotional concerns, medication(s) should be continued as prescribed until the child can be assessed by a physician or appropriate health care provider. If the direct care worker, foster parent or caregiver has any non-urgent concerns about the child or youth's medications, he or she should consult with a community pharmacy, the prescribing physician and/or Telehealth Ontario (1-866-797-0000; TTY 1-866-797-0007). Immediate medical attention should be sought if there are urgent concerns regarding the child or youth (e.g., stiffness, muscle weakness, unusual or repetitive motor movements, lethargy, disorientation or confusion, bizarre behaviour, severe agitation, suicidal thoughts or behaviour).

Standard 2: Informed Consent

Diagnostic assessment and the prescription of a psychotropic medication require informed consent of the child or youth, with capacity to give consent being presumed unless there is proof otherwise.

Standard 2.1: Informed consent

In accordance with the *Health Care Consent Act* and the *Substitute Decisions Act* of 1996, a process of informed consent should be followed so children and youth are aware they have the ability to either consent to or refuse a diagnostic assessment and treatment with psychotropic medications. As part of the consent process, the risks and benefits of both treatment and refusing treatment must be explained to the child or youth in language they can understand. Capacity to make treatment decisions is not determined by age but is presumed; if the physician determines the child or youth is not capable, the reasons must be recorded. Consent may be given to a physician verbally, but it is recommended that a direct care worker be present at the meeting to take notes documenting the consent process. Such notes should be initialed by the physician and child or youth. Notes regarding consent for psychotropic medication should state when the prescription will be reviewed and reassessed.

Discussion

Informed consent is an ongoing, rather than a one-time, process and should conform to the *Health Care Consent Act*. Under this *Act*, the capacity to make treatment decisions is not determined by age or status of a child or youth (e.g., as a Crown ward) but is presumed. All those who are deemed to have the capacity to understand and appreciate the risks and benefits of both treatment and refusing treatment have the right to accept or refuse treatment. Some children and youth in residential care are there involuntarily, but this has no bearing upon their ability to make health care decisions. If a child or youth is deemed to be incapable of making a treatment decision, the reasons must be established and recorded in the child or youth's plan of care.

It is essential that all those involved with the administration of psychotropic medications – direct care workers, foster parents, caregivers, physicians and children or youth – understand the informed consent process and their role within it. When a psychotropic medication is prescribed, there should be a discussion of the risks and benefits of treatment, and how to identify symptoms, treatment effects and side effects. Children and youth must be educated about the informed consent process, the fact that they can appeal decisions and the mechanism for doing so.

Standard 3: Diagnostic Assessment

All licensed residential settings should have procedures and protocols for obtaining mental health assessments in a timely manner.

Standard 3.1: Diagnostic assessment

The decision to prescribe psychotropic medication requires a diagnostic assessment by a physician, preferably with experience in children and youth mental health such as a child and adolescent psychiatrist, developmental paediatrician or a general paediatrician or family physician with mental health expertise. As described in Standard 2, the child or youth must give informed consent for a diagnostic assessment unless he/she

has been deemed to lack capacity to do so.

The assessment should identify which target symptoms the medication is intended to alleviate. When a psychiatric resource is inaccessible or unavailable in a timely manner, the direct care worker should document efforts to obtain an assessment and secure an alternate resource. If the diagnostic assessment is conducted by a professional who cannot prescribe psychotropic medications (e.g., by a psychologist), the results of the assessment should be made available to the prescribing physician.

In some cases, a child or youth may enter into a licensed residential setting, be admitted to a facility or has been in care for some time with a pre-existing prescription for psychotropic medication(s). If there is no record of an assessment within the previous twelve (12) months confirming the need for the medication, an assessment should be conducted to determine if it is still required. This assessment may be linked to the annual medical required for children and youth living in licensed residential settings.

Standard 3.2: Attendance at appointments and documentation in the plan of care

The direct care worker (preferably the case responsible worker) and, where appropriate, the parent(s), foster parent(s), caregiver(s) or guardian(s), should attend appointments as agreed by the worker and the physician conducting the assessment. The assessment process should be fully understood by the direct care worker that has primary responsibility for the child or youth. There should be mechanisms by which the results of diagnostic assessments and appointments are documented and explained in the child or youth's plan of care. The plan should also document how recommended treatments are to be obtained and treatment providers accessed.

Discussion

Unless found to lack the capacity to give consent, the child or youth must consent to a diagnostic assessment and the sharing of information about his or her medical care. If consent has been given, all members of the care team should be adequately informed regarding the results of the assessment and the treatment recommendations.

Standard 4: Collaborative Care and Plans of Care

Each child and youth living in a licensed residential setting should have a child-centered plan of care developed by a collaborative care team. For children and youth prescribed psychotropic medication, the plan of care should include a record of the results of all diagnostic assessments, a method for monitoring ongoing medication effectiveness and side effects and a schedule for regular review of all psychotropic medications.

Standard 4.1: Plan of care

Each child's or youth's individual needs should be documented and a plan of care developed and signed off by a supervisor. Any use of psychotropic medications should be a component of a collaborative, child/youth-centered plan of care.

Standard 4.2: Monitoring

The plan of care should include a process for monitoring the effectiveness and side effects of psychotropic medication on a regular and systematic basis. This process

should involve all parties (direct care workers, foster parents, child or youth, caregivers and the prescribing physician). As part of this process, verbal or written inputs from the child or youth, foster parents, caregivers and direct care workers should be sought, collected and recorded in the plan of care. Tracking of height and weight should also be included in the plan of care as this can affect medication dosage.

Standard 4.3: Scheduling reviews of psychotropic medications

The plan of care should document:

- The name and contact information of the physician or health care provider responsible for management of the child or youth's psychotropic medication(s);
- A schedule for regular review of psychotropic medications by the responsible physician that includes height and weight, discussions of dose, all medications, medication effectiveness, side effects, and impact on quality of life. It is suggested that regular reviews should occur at a minimum of three to six-month intervals (when stable) and more frequently when dose adjustments are required or emotional/ behavioural instability or cognitive effects are observed;
- The date(s) at which informed consent was given for medications (the consent process should be repeated whenever new medications are prescribed, or the most recent consent is more than twelve months old); and
- For those receiving three or more chronic prescription medications (including psychotropic and non-psychotropic medications), a schedule for an annual medication review by a pharmacist under the MedsCheck program.

Standard 4.4: Filling prescriptions

A plan should be established to ensure prescriptions are filled and refilled in a timely fashion.

Standard 4.5: Alternative interventions

Direct care workers, foster parents and caregivers should regularly or when needed, discuss with the collaborative care team if non-pharmacologic interventions would assist the child or youth. Results of these discussions should be communicated to the prescribing physician. The plan of care should document which other interventions have been implemented or considered and the rationale for interventions used, rejected or stopped.

Standard 4.6: Communications with children and youth

The plan of care developed by a licensed residential setting should include ongoing discussions with the child or youth, foster parent and caregiver about the effects of medications, a record of the child or youth's responses to these inquiries and what actions are undertaken on behalf of a child, youth or responsible adult who reports concerns about a medication. These discussions should recognize and address a child or youth's cultural beliefs.

If a child or youth refuses a medication, direct care workers should counsel him or her and review and document the reasons for the refusal. If there are concerns about non-adherence to prescription medication (e.g., several consecutive doses have been missed), the prescribing physician should be contacted, informed of the refusal and a meeting with the child or youth should be scheduled.

Discussion

Each child or youth living in licensed residential settings should have a plan of care that is specific to his or her needs, is developed and implemented by a collaborative team, signed off or approved by a supervisor, and transferred between settings to ensure continuity of care and the exchange of critical information on psychotropic medications.

A collaborative care team (also known as an interdisciplinary or inter-professional team) consists of a group of professionals from different disciplines who work with the child or youth in a planned, interdependent manner to develop and implement a plan of care. The composition and nature of the collaborative care team will vary according to the needs of the child or youth and local resources, but usually includes a number of therapists, disciplines and care providers, such as direct care workers, physicians, nurses, advanced practice nurses (e.g., Primary Care Nurses Practitioners), social workers, pharmacists, psychologists, therapists and others. Foster parents and caregivers must be part of the plan of care process.

For children and youth living in licensed residential settings, direct care workers or case managers should be integral parts of the care team. For children and youth in foster care, provided consent is given, the foster parent(s) or caregiver(s) may be included as part of the care team. Foster parents:

- Are instrumental in providing key information about the child or youth's functioning in their home;
- Can monitor behaviours, emotions, thoughts and possible effects and side effects of the medication;
- Should be able to talk with the child or youth about the medication and answer questions;
- Can facilitate communication with the child or youth's direct care worker, their physician and other members of the health care team; and
- Should attend or facilitate appointments for the child or youth with their direct care worker and other members of the health care team.

As stated in the core principles, psychotropic medication should never be used as a substitute for appropriate and available psychosocial services or counselling[23] Rather, psychotropic medication should be one part of an overall plan of care for the child or youth. Psychotropic medication should only be prescribed when it is:

- An appropriate treatment for a specific psychiatric diagnosis or behaviour; and
- Within the context of a comprehensive, collaborative plan of care.

As stated in the core principles, the use of psychotropic medication should be in the best interest of the child or youth. They should not be given in quantities that could lead to a loss of functional status.

Mental health professionals, such as psychologists, psychotherapists, counselors, etc., should be aware of the medication regime, given opportunities to

[23] Evans R, Frid P. "Implementing the International Panel Guidelines on the Use of Psychotropic Medications" in *Psychotropic Medications and Developmental Disabilities: The International Consensus Handbook*. CPRI Committee Report, August 2002.

collaborate in the development of treatment objectives and goals, and consulted on an ongoing basis. Any member of the collaborative care team has the right to discuss the diagnosis and treatment recommendations for the child and youth and to document their concerns in the plan of care. Concerns should be discussed with the responsible physician. If the issue cannot be resolved, the direct care worker may consider obtaining a second opinion from another qualified physician.

Mental health services are delivered both through the public health system and privately. Although MCYS is the lead for child and youth mental health services, other ministries, such as the Ministry of Health and Long-term Care (MOHLTC), Ministry of Community and Social Services (MCSS) and the Ministry of Education (MEDU), also provide services. Direct care workers should familiarize themselves with the range of mental health services available in their communities, such as children's mental health agencies, school-based services, community physicians, hospital-based services and other community services. Licensed residential settings may want to facilitate working relationships with a few key physicians in their community who have an interest and expertise in managing children and youth with mental health problems.

The primary care physician is a key member of the collaborative care team and will play a major role in monitoring the child or youth's symptoms, functioning and medication(s). To obtain face-to-face consultation from paediatricians and/or child or adolescent psychiatrists, direct care workers should obtain a referral from a family physician.

In communities where physicians are not readily available, such as some remote or Northern communities, direct care workers should work with the local nurse to ensure the child or youth is assessed and appropriate referrals are made. In many communities in the province, access to child or adolescent psychiatrists can be achieved through telepsychiatry. To access telepsychiatry, a referral must be made by a therapist in a local children's mental health agency. Another option is to purchase private therapist services from professionals able to offer assessment and non-pharmacological interventions.

It is also important to develop working relationships with community pharmacists. Pharmacists can identify potential problems and drug interactions, help set up medication schedules and monitoring systems, and provide education to children, youth, direct care workers, foster parents and caregivers.

Regular reviews of psychotropic medications should be integrated into the plan of care. Regular reviews will help to ensure:

- Appropriate use of medication;
- That the lowest optimal dose is used (i.e., the dose that creates the greatest efficacy balanced against tolerable side effects); and
- When appropriate, plans are made for safely stopping the medication and the appropriate parties are notified.

Additional processes for medication review and monitoring should be created for children and youth receiving three or more medications of any type on a continuous basis. This can be accomplished through involvement of local pharmacists (e.g., MedsCheck).

If possible, specific target symptoms and/or aspects of functioning should be objectively defined, quantified and

tracked using recognized empirical measurement methods, such as standardized rating scales (e.g., the Conners Rating Scales for assessment of Attention Deficit Hyperactivity Disorder). Index behaviours and quality of life outcomes can be tracked by a designated member of the collaborative care team.

Standard 5: Preparation and Administration of Psychotropic Medications

Direct care workers, foster parents and caregivers should ensure there is a safe, secure system for preparing and administrating psychotropic medications within all licensed residential settings.

Standard 5.1: Labelling

All individual medication containers should be labeled with the medication name, strength, frequency, dose, child's or youth's name and the date it was dispensed. Whenever possible, medications should be kept in their packaging up to the point of actual administration; they should not be "pre-poured" without a mechanism to ensure the correct child or youth receives the correct medication.

Standard 5.2: Administration preparation

Medications should be prepared in a physical environment that offers adequate space and lighting and allows the person preparing the medication to remain focused on the task. This includes the following considerations:

- Workspaces where medications are prepared should be orderly and free of clutter;
- Lighting should be adequate to clearly read labels and medication-related documents (e.g., the Medication Administration Record);
- The person preparing the medication for administration should be in an area that is relatively free of distractions and noise;
- Medication should be prepared for one child or youth at a time, immediately before administering; and
- Each child or youth should be observed while taking their medication.

Standard 5.3: Infection control

Appropriate hand washing procedures should be used prior to and when administering medications.

Standard 5.4: Medication Administration Records

Medication Administration Records (MARs) should be referred to at the time of medication administration and each dose administered should be immediately documented.

Standard 5.5: Scheduling

Standard times for scheduled medication administration should be established and consistently followed.

Standard 5.6: Provision of medication for administration in other settings

If medications are provided to another facility for administration (e.g., school) or home visits, the medications should be provided in labeled containers with the medication name, strength, frequency, dose, child's or youth's name and date of dispensing. There should be communication between the care providers about the proper administration and storage of the medication and all doses given should be documented on a MAR or MAR-like record.

Standard 5.7: No sharing of medications

Medication should only be used for the child or youth to whom it has been prescribed, even if it is the same drug or dose.

Standard 5.8: PRN medications

The prescription for a PRN medication (*pro re nata* or "as needed" or "as the situation arises") psychotropic medication should conform to current clinical practice guidelines. Direct care workers should ask that the prescription should clearly describe or define the specific target symptom it is to treat. The order should also state the spacing between doses (e.g., every 4 hours) and the maximum daily dose that must not be exceeded. The continuation of PRN prescriptions should be reviewed regularly by the direct care worker in consultation with the physician.[24]

Standard 5.9: Self-administration

If it is the opinion of the physician or registered nurse in the extended class that a child or youth is capable of administering his or her own medication, every effort should be made to work in cooperation with a health care provider to develop a written self-medication plan. That plan should be kept in the resident's record. Medications must still be stored and dispensed in a safe and secure manner (see Standard 6) to prevent unauthorized access and risk to others. In the case of a disagreement about a child or youth's ability to self-administer a medication, a meeting should be held among all those involved to review the situation and develop a plan. Self-administration is considered a privilege and can be discontinued if medications are shared with others or not taken as authorized.

Discussion

The administration of psychotropic medications should be conducted in a systematic way that focuses upon the safety, well-being and privacy of the child or youth. Medication administration should be part of the training of all direct care workers and foster parents and supported through policies, practices and effective communications between all parties (e.g., health care providers, direct care workers, parents, foster parents, children, youth, teachers). Any problems or issue that arises should be reported immediately (see Standard 9) so systems and practices can be improved.

Standard 6: Psychotropic Medication Storage, Transfer and Disposal

All licensed residential settings should have safe and secure methods to store, transfer and destroy psychotropic medications.

Standard 6.1: Storing medications

All licensed residential facilities, including foster care homes, should have policies and procedures in place to ensure psychotropic medications are stored securely and appropriately. Medications should be:

- Secure, locked when not in use, in child-proof containers when appropriate, and inaccessible to children and youth;
- If requiring refrigeration, stored in a locked container and segregated from food products;

[24] Evans R, Frid P. "Implementing the International Panel Guidelines on the Use of Psychotropic Medications" in *Psychotropic Medications and Developmental Disabilities: The International Consensus Handbook*. CPRI Committee Report, August 2002.

- Remote from direct sources of heat, moisture and sunlight;
- In a space for storage that is sufficient to allow them to be stored in an organized manner; and
- If discontinued or expired, kept in a separate and secure area until they can be disposed (see Standard 6.3).

Even medications that children or youth are authorized to self-administer should be stored in a secure setting and provided by an adult.

Standard 6.2: Transferring medication between settings or facilities

When a child or youth moves between residential facilities, all medication containers should be labeled with the child's or youth's name and the medication name, dose, strength and frequency of administration. Medications and the accumulative record or MAR should be transferred directly between the adults responsible for the child or youth (e.g., between direct care workers, foster parents or caregivers). Protocols must be in place to ensure the proper transfer, administration and monitoring of psychotropic medications between different licensed residential settings.

Standard 6.3: Medication disposal

All licensed residential settings, including foster care homes, should have a process for the timely, secure and safe destruction of medications. In most cases, this procedure should involve returning the medication to a community pharmacy for destruction.

Discussion

All licensed residential settings should have policies and procedures in place to ensure that psychotropic medications are stored, transferred and destroyed in a safe and secure manner. Everyone responsible for storing, transferring or destroying psychotropic medications should receive training on these policies and procedures.

Standard 7: Medication Information Communication

All parties – children, youth, direct care workers, foster parents, caregivers and health care providers – should have accurate information about a child's psychotropic medications and access to resources about these medications, including information on PRN ("as needed") or emergency medications.

Standard 7.1: Medication passports

All children and youth prescribed psychotropic medications should be given a "Medication Passport" (e.g., Med Ed) as part of the intake process (see Standard 1.3). This passport should clearly state:

- The name of medication being administered;
- Why it has been prescribed;
- How it should be administered;
- Dose and date of any dose change;
- Who should be contacted in case of emergency; and
- If possible, anticipated effects and side effects of the medication.

With the child or youth's consent, the licensed residential setting should maintain a duplicate copy of the Medication Passport. When the child or youth is moved between settings, with the consent of the child or youth the duplicate copy of the Medication Passport, like the medications themselves, should be transferred in a safe and secure manner between the direct care workers

responsible for him or her (see Standard 6.2).

Discussion

Children and youth prescribed psychotropic medications need to know why it has been prescribed and what to expect from treatment (effects and side effects). When there is informed consent to share information on psychotropic medications, direct care workers, foster parents and caregivers should also be knowledgeable about the treatment. It is important that direct care workers, foster parents and caregivers be able to discuss the treatment with the child or youth or with others (e.g., health care providers, teachers). A medication record (e.g., a record obtained from the dispensing pharmacy) facilitates the process of obtaining medication histories, medication reconciliation during transition points of care, and medication reviews. A Medication Passport (e.g. Med Ed) can help to inform and educate children and youth about their medications.

The supervisor who is responsible for the plan of care in a residential setting (or his or her delegate) should ensure that medication information, and in particular, information concerning psychotropic medications, is transferred with children or youth who move between settings (e.g., between youth justice and CAS facilities or between settings within the same system).

Standard 8: Training

Educational curriculum and resources should be available to ensure that everyone who cares for children and youth in licensed residential settings receive orientation and ongoing training on the standards and issues relevant to psychotropic medications.

Standard 8.1: Target audiences

Sectors should ensure that training and education specific to the standards and the issue of psychotropic medication reach all of those involved in delivering care to children and youth in licensed residential facilities (e.g., direct care workers, foster parents, group home staff and relief workers).

Standard 8.2: Minimum expectation

At a minimum, all those involved in the care of children and youth should receive training to support them in effectively implementing the standards, as well as on the broader issue of psychotropic medication. This training should begin during the formal education of direct care workers (e.g., during college or university), form an essential part of their workplace orientation and be reinforced by ongoing training and resources. Information on the standards and on psychotropic medications should also be incorporated into the training of foster parents.

Standard 8.3: Ongoing training

All those involved in the care of children and youth should have opportunities and resources to upgrade their knowledge of the standards and their understanding of psychotropic medications. Training should include a variety of resources that are easily accessible throughout the province (e.g., Internet or telephone-based resources), easy to understand and use, tailored to the different licensed residential settings, comprehensive and practical. For staff, the dates and type of training should be documented.

Standard 8.4: Curriculum

Training should include all issues relevant to effective implementation of the

standards, as well as those relevant to the broader issue of psychotropic medications and child and youth mental health.

Discussion

Effective implementation of the standards requires that all direct care workers, foster parents and caregivers receive training to help them understand the standards and issues relevant to the use of psychotropic medications, such as the behaviours and problems of children and youth in care. Although key issues for a province-wide curriculum will be developed by MCYS, licensed residential settings are encouraged to develop further materials if necessary. Education should include all people involved in the care of children and youth in licensed residential settings, including those who supervise or direct the work of others.

Training for direct care workers (i.e., staff) should begin during their formal education and include workplace orientation. As well, all direct care workers, foster parents and caregivers need access to resources for ongoing updating, training and education. Wherever possible, existing mechanisms, such as licensing regulations, the MCYS regional training system, orientation curriculum and mandatory child welfare curriculum, should be revised to incorporate training on the standards and psychotropic medications. It is important that both orientation and ongoing educational materials be readily accessible (e.g., a secure, MCYS-approved website that is regularly updated with relevant information and tools), appropriate to different settings, help link direct care workers and providers to community and provincial resources, and include easy-to-use and practical tools that workers can apply in their settings.

Too often, children and youth living in licensed residential settings do not fully understand why they have been prescribed psychotropic medications, their rights in respect to consenting to medication or the potential effect of psychotropic medications (i.e., medication effects and side effects). Direct care workers, foster parents and caregivers should be trained on how to communicate with children and youth about psychotropic medications. This communication should occur at the time psychotropic medications are prescribed, at regular intervals and whenever required or requested by the child or youth. Training is also needed to ensure direct care workers, foster parents and caregivers know how to communicate effectively with others involved with the care of the child or youth, such as parents, health care providers, other members of the collaborative care team, teachers, and others.

Standard 9: Quality Improvement

To reduce the risk of preventable harm from medication use and to promote continuous quality improvement, all residential, licensed settings where psychotropic medications are administered to children and youth should have a system to report and analyze medication incidents or errors.

Standard 9.1: Medication incidents/error reporting

A clear definition and examples of medication incidents that are to be reported should be established and communicated to all those administering psychotropic medications to children and youth living in licensed residential settings. Reportable events include both hazardous situations that could lead to an error and actual errors, including those

that have been detected and corrected before they reach a child or youth.

Standard 9.2: Timely review of incidents

A defined process should be in place to ensure that licensed residential settings are immediately informed of incidents with a high potential to cause harm. The process should include guidelines for timely action, including the notification of a health care practitioner.

Standard 9.3: Communications of medication errors

All medication incidents, regardless of the level of harm that result, should be honestly disclosed to the child or youth (or guardian) involved or affected.

Standard 9.4: Analysis of medication incidents/errors for system improvement

A designated, collaborative team should analyze serious or potentially serious medication incidents. Licensed residential facilities should conduct quarterly analysis of all cases for the purpose of recommending system enhancements to reduce the potential for recurrence of similar errors.

Standard 9.5: Learning from medication incidents

Direct care workers, foster parents and caregivers should receive ongoing information about medication errors that have occurred, including errors that have occurred in other facilities, as well as education about the strategies to prevent such errors.

Discussion

The system of administering and monitoring psychotropic medications should be designed with processes that ensure timely responses to, and disclosure of, medication incidents. The objective is to ensure that direct care workers, foster parents and caregivers learn from incidences and system safeguards and enhancements are implemented to reduce the risk of future incidents.

Glossary of Terms

Note: *This glossary is provided to help readers understand more about the complex issues of provincially licensed residential care and psychotropic medications; however, it is a not complete compilation. What people mean by a term may vary by context, setting and perspective. These definitions should not be read as representing the policy or legal position of the MCYS.*

Adverse Reaction[25] According to the World Health Organization, an adverse reaction is any response to a drug which is noxious and unintended, and which occurs at doses normally used in humans for the prevention, diagnosis or treatment of disease or for the modification of physiologic functioning.

"Best Possible" Medication List A list developed when a child or youth enters a provincially licensed residential setting that documents all current medications, target symptoms or clinical indications, and prescribed dose and frequency. The term "best possible" recognizes that the list is created with the information available at that point in time from the resources available. The list forms the basis for future reference and is updated when additional information emerges or new information becomes available.

Capacity[26] Everyone, regardless of age, is entitled to make their own treatment decision if they are capable of doing so. Under the *Health Care Consent Act* (*HCCA*), a person is considered to have capacity if they are capable of understanding and appreciating the relevant information and what could happen as a result of making or not making a decision. If a child or youth is found to lack capacity to make treatment decisions, the *HCCA* stipulates that the substitute decision maker has the authority to do so.

Caregiver An adult who cares for a child or youth in a provincially licensed residential setting, such as a parent, guardian or relative providing kinship care.

Child and Adolescent Psychiatrist Child and adolescent psychiatrists (CAPs) are physicians who specialize in disturbed cognition, emotions, and behavior that impact on the social, emotional, psychological, and spiritual development of children and youth in the context of their environments (i.e., home, school and community). CAPs investigate, evaluate, diagnose, treat and rehabilitate children and youth with mental health disorders, play an important role in defining and supporting interventions by mental health professionals and other physicians and have direct care responsibilities for the most severely affected, acutely ill or at-risk children and youth.[27] They may provide consultation to the child or youth's primary care provider, other members of the care team, community mental health agencies, social services, schools and correctional services.

[25] World Health Organization. *Requirements for adverse reaction reporting.* Geneva, 1975.
[26] Consent and Capacity Board. Applying for a Review of Capacity to Make Decision with Respect to Treatment (Form A). http://www.ccboard.on.ca/english/publications/documents/forma-treatment.pdf

[27] Parker Z, Steele M, June K W, Morin L, Davidson S, Fleisher W, MacLeod R, Sande T, White H, Yates T. *Child Psychiatry in Canada: Physician Resources*. Position Statement. Canadian Academy of Child Psychiatry, Physician Resource Committee, 2002.

In some situations, the CAP may be involved in a child or youth's care for a period of time until the mental health problem is stabilized or resolved or medical care is taken over by a primary care provider; in different situations, they may be involved in the child or youth's care for an extended period of time. They may assist with following and adjusting psychotropic medications as needed, as well as various aspects of treatment such as psychotherapy (e.g., cognitive-behavioural therapy, family therapy), attendance at meetings (e.g., school meetings or plan of care meetings), or psychopharmacology.

Child and Family Services Act (CFSA) The purpose of the Act is to promote the best interests, protection and well being of children and to outline the manner in which children's services (including those delivered by Children's Aid Societies) should be provided.

Child Protection Worker An employee of a Children's Aid Society (CAS) who is mandated to protect children and youth and promote the health and well-being of children, youth and families.

Children's Aid Societies There are 53 Children's Aid Societies (CASs) in Ontario, including five Aboriginal child welfare agencies designated as CASs. Each CAS is responsible for providing child welfare services in its mandated geographical area. Children and youth can come into the care of a CAS in a number of ways.

- **Temporary Care Agreement** Allows for the voluntary temporary transfer of custody of a child or youth to a CAS with the agreement of the parent and consent of a child over 12 years of age who has capacity.
- **Supervision Order** Court direction for the child or youth to be placed, remain with, or returned to the parent or a relative or other member of the child's or youth's community under the supervision of a CAS. The court may specify terms and conditions regarding the child's or youth's care.
- **Society Wardship Order** Court direction for the child or youth in need of protection; an order for the child or youth to be placed into the temporary care of the society.
- **Crown Wardship Order** Court direction for the child or youth to be made a permanent ward of the Crown.

CASs are provincially licensed to provide residential care and programs for children and youth. They can directly operate group homes, receiving homes and foster care homes, or may purchase services from provincially licensed independent private operators.[28]

Collaborative Care Team A collaborative care team (also known as an interdisciplinary or interprofessional team) consists of a group of professionals from different disciplines who work with the child or youth in a planned, interdependent manner to develop and implement the plan of care. The team may include: direct care workers, child protection workers, family physicians, specialist physicians (e.g., paediatricians, child and adolescent psychiatrists), nurses (registered nurses, nurse practitioners), pharmacists, psychologists and social workers.

[28] Human Resources and Social Development Canada. Definitions adapted from *Child Welfare in Canada 2000. Ontario. Administration and Service Delivery*. http://www.hrsdc.gc.ca/en/cs/sp/sdc/socpol/publications/reports/2000-000033/page09.shtml 1/08/07.

Consent[29] Under the *Health Care Consent Act (HCCA)*, consent must be related to the treatment in question, be informed, be voluntary and not be obtained through misrepresentation or fraud. "Informed" means the person received information about the nature of the treatment, expected benefits, material risk and side effects, as well as alternative courses of action and likely effects of not having the treatment.

Direct Care Workers In this document, "direct care worker" refers to any adult who works closely with, and has responsibility for, a child or youth in provincially licensed residential care. Different titles may be used in different settings (e.g., group homes, residential treatment centres, hospitals, institutions, and correctional facilities). Many of these workers have diverse skill sets that allow them to work in multiple roles and various contexts. They are capable of conducting a range of prevention, intervention, and treatment strategies in a number of different structured environments. These strategies may include crisis intervention, conflict management and problem-solving, counselling, activity program development and delivery, group work and psychotropic medication administration. They advocate for and guide children and youth through their daily lives, teach social and life skills, support efforts to manage behavior, and engage in counselling to facilitate better understanding of change.

Family Physician Family physicians are involved in many aspects of the health care of children and youth, including the early identification and/or diagnosis of mental health problems, initiation and monitoring of treatment, and/or referral to specialists (e.g., paediatricians and/or child and adolescent psychiatrists). Provided the child/youth has given informed consent, the family physician should be informed of any assessments which may have taken place, diagnoses and treatment recommendations, both non-pharmacological and pharmacological, and the names of the other members of the care team so they can work together and communicate when necessary.

Foster Parent[30, 31] While the legal responsibility for a child or youth in the care of a CAS remains with the CAS, foster parents play an essential role by providing a home environment. Foster parents are individuals or couples who provide care for children and youth until they can be reunited with their families or long-term plans can be made. Foster parents work with CAS staff as part of a team to develop a plan for each child in care.

Guardian A guardian is someone appointed by the Court under the *Substitute Decision Act*.

Health Care Consent Act (HCCA)[32] The legislation that applies to all regulated health professionals who treat patients in any setting. Under the *HCCA* there is no age cut-off for capacity; the health practitioner proposing the treatment determines the patient's capacity according to guidelines available from the regulatory colleges. A person is presumed to be capable to make decisions about a

[29] Government of Ontario. *Health Care Consent Act*,1996, S.O. 1996, c. 2, Sch A. Available at: http://www.canlii.org/on/laws/sta/1996c.2sch.a/20060614/whole.html 24/03/08.

[30] Foster Parents Society of Ontario. www.fosterparentssociety.org.

[31] Ontario Association of Children's Aid Societies Becoming a foster parent. http://www.oacas.org/childwelfare/foster.htm

[32] Government of Ontario. *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sch A. Available at: http://www.canlii.org/on/laws/sta/1996c.2sch.a/20060614/whole.html 24/03/08.

treatment (anything done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose) unless there are reasonable grounds to believe he or she is not.

Lowest Optimal Dose[33] The dose of a medication that creates the greatest efficacy balanced against tolerable side effects.

Med Ed Resources created by the experts at Dalhousie University and the Provincial Centre of Excellence for Child and Youth Mental Health at the Children's Hospital of Eastern Ontario. The resources include a medication education guide for young people and those who care for them, as well as a Med Ed Passport that children and youth can use to track their questions, symptoms, activities, side effects, medications and appointments. As of early 2008, the Med Ed resources were in the latter stages of development and training in how practitioners should use Med Ed was being piloted.

MedsCheck[34] A program provided by the Ontario Ministry of Health and Long-term Care which supports all Ontario residents who take three or more prescription medications for chronic conditions by funding an individual, 30-minute consultation once a year with their community pharmacist. During the review, the pharmacist verifies any patient allergies or chronic medical conditions; collects personal, lifestyle and other health information; reviews the patient's medications to help them better understand drug names, strengths, side effects and usage instructions; ensures patients are taking their medications as directed and provides tips on how to get the best results for their medication; answers any patient questions or concerns; and develops an up-to-date medication list the patient can show to their doctor, pharmacist or when admitted to hospital. After the review, the pharmacist may follow up by telephone to talk about any concerns. With permission, the pharmacist may also forward a copy of the medication list to the prescribing physician.

Medication Administration Record (MAR) A form for recording the administration of medications to children and youth in care by direct care workers.

Medication Incident[35] Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Medication incidents may include administration of the incorrect drug, an incorrect dose, administration at an incorrect time or to the wrong patient.

Medication Interaction A medication interaction can occur when different medications taken together interact with one another. Some times interactions are beneficial (e.g., using two different types of medications to lower blood pressure) but in some cases are unwanted and may be harmful (adverse interactions). Prescription medications can interact with

[33] Evans R, Frid P. "Implementing the International Panel Guidelines on the Use of Psychotropic Medications" in *Psychotropic Medications and Developmental Disabilities: The International Consensus Handbook*. Child and Parent Resource Institute (CPRI) Committee Report, August 2002.

[34] Ontario Ministry of Health and Long-term Care. MedsCheck Program Provides Better Care for Patients. Backgrounder. http://www.health.gov.on.ca/english/media/news_releases/archives/nr_07/jul/medscheck_factsheet_03_20070716.pdf

[35] Institute for Safe Medication Practices. http://www.ismp.org/

other prescription or non-prescription medications including herbal or nutritional supplements.

Medication Passport A resource or booklet for recording medication information for and by the child or youth. Please refer to "Med Ed" for more information.

Medication Reconciliation The process of verifying, clarifying and reconciling the patient's most current list of medications against the physician orders. Medication reconciliation occurs at the time of admission, transfer for consultation and discharge.

Non-prescription Medication Drugs or products sold in pharmacies and stores that do not require a prescription from a health care professional. This category also includes herbal remedies and nutritional supplements. Non-prescription medication is also referred to as over-the-counter medication.

Nurses In child and adolescent mental health, nurses provide holistic care to the identified patient and family in inpatient and outpatient settings. Components of care that the RNs may contribute to the collaborative care process include milieu management, monitoring and implementation of the treatment plan, psychotherapy (individual/family/group), medication administration and monitoring, discharge/crisis planning, patient education and advocacy.

Over-the-counter Medication Drugs or products sold in pharmacies and stores that do not require a prescription from a provincially licensed health care professional. This category also includes herbal remedies and nutritional supplements. Over-the-counter medication is also referred to as non-prescription medication.

Paediatrician (Pediatrician) Paediatricians are medical doctors with specialized training in the care of children and youth. Many paediatricians are capable of diagnosing and initiating treatment of mental health disorders in children and youth. Paediatricians may act as primary care physicians for children or youth or as consulting physicians. With the appropriate consent, they can be active members of the collaborative care team (e.g., acting as the health case manager, communicating with schools and others to implement both pharmaceutical and non-pharmaceutical treatment). Developmental paediatricians are paediatricians who have completed two additional years of training in child development, with specific training in the use of psychopharmacology.

Pharmacist The community pharmacist can be a valuable member of the child or youth's collaborative care team and as such should be aware of the indications/diagnosis for which each drug is prescribed, so as to be better involved in the care. The pharmacist can be a source of information on prescribed medication (including education/ information sheets for each newly prescribed drug). As some children and youth may have contact with several physicians (who may each prescribe medications), or may take over-the-counter drugs (e.g., vitamins, allergy preparations, herbal products), whenever possible medication records of each child or youth should be consolidated in one location. This will enable the pharmacist to monitor for drug-drug interactions for both prescribed and over-the-counter drugs. Should a child or youth move to another community, the pharmacist can also provide a medication history. A MedsCheck review can be done by the pharmacist, on an annual basis, for any child or youth prescribed three or more prescriptions for chronic conditions.

As part of the collaborative care team, the pharmacist can be involved in a number of activities, depending on needs, availability and financial considerations. These activities include regular medication reviews/evaluation of the child or youth with the team, acting as the contact person for questions that arise about medication effects and adverse effects, being involved in preparing assessment tools for monitoring effects of medication, conducting periodic medication education of the direct care workers and/or of the child or youth and helping to organize and follow medication usage and adjustments.

Prescription Medication A medication that requires a prescription from a provincially licensed health care professional, such as a physician or nurse practitioner-extended care, and is typically dispensed by a licensed pharmacist. Key elements of a prescription are:

- **Name**: the medication may have both a generic and brand name;
- **Strength**: the amount of medication in each pill or dose;
- **Dose**: what amount of the medication should be taken (e.g., how many pills) each time;
- **Frequency**: how frequently the medication should be taken (e.g., once daily, twice or four times a day); and
- **Administration**: depending upon the medication, it can be administered by mouth (oral or sublingual tablets), rectally, by inhalation, by injection or as a topical application (e.g., cream, ointment, sprays or patches). The prescription should also indicate whether the medication should be taken with or without food and may have additional, specific warning labels (e.g., do not consume alcohol).

Primary Care Nurse Practitioner or Registered Nurse in the Extended Class (RN[EC]) Primary Care Nurse Practitioners (RN[EC]) practice autonomously and offer the full scope of primary health practice, including consultation with physicians or other health professionals. They offer comprehensive health services encompassing health promotion, prevention of disease and injury, cure, rehabilitation and support services. Their scope of practice includes areas of assessment, diagnosis, prescription of drugs and treatment and health promotion. This includes controlled acts (College of Nurses of Ontario, 2005) such as: communicating a diagnosis made by the RN(EC) to a client or a client's representative; prescribing a drug from the approved drug list as per the regulations; prescribing psychotropic drugs with medical directives in an institutional setting; administering an approved drug by inhalation and injection that RN(EC)s are authorized to prescribe; and ordering the application of a form of energy as prescribed in the regulations (e.g., diagnostic ultrasound).

Provincially Licensed Residential Setting[36, 37] The *CFSA* defines a "children's residence" and "residential care", and for purposes of licensing, separates the places where children live into two streams:

- **Children's residences** (commonly called group homes) can be operated by either staff or by live-in parents. In a staff model, the staff works in shifts to care for three or more children not of common parentage. In a parent-

[36] Office of Child & Family Service Advocacy. Appendix 1: Types of Placement for Children's Residential Care. Quality of Care Review. June 2007.

[37] Office of Child and Family Service Advocacy. Cooke D, Finlay J. Open Detention and Open Custody. Review. January 2007.

model, live-in parents provide care to five or more children not of common parentage. Children's residences are individually licensed.

- **Residential care** (commonly called foster care) is provided to four or fewer unrelated children. Foster care agencies are the licensed entity, rather than individual foster homes.

The majority of children and youth in foster care homes and group homes have been placed through Children's Aid Societies (CASs) but some may come through other means, such as from mental health agencies. Some residential services offer specialized treatments and therapeutic programs.

PRN PRN is the short form of *pro re nata* and means "as needed" or "as the situation arises". These are medications that are prescribed not to be taken regularly or routinely, but as required. Some medications may be prescribed as both a routine medication and on a PRN basis.

Psychologist Psychologists are part of a diagnostic and treatment team and bring expertise in performing and interpreting standardized and other diagnostic measures and interviews. Psychologists participate in formulating and communicating diagnoses, developing treatment plans, carrying out cognitive-behavioural and other child- and youth-centered treatment interventions. Psychologists participate in supervision of qualified staff in providing services to children and youth. Psychologists consult with staff and others, such as foster parents, group home staff, kinship settings in behaviour management and collaborate in program development.

Psychotropic Medication A psychotropic medication is any drug prescribed to stabilize or improve mood, mental status or behaviour.[38]

Self-Administration When a physician or extended care nurse has authorized a child or youth to consume or apply medication in the manner prescribed, without additional assistance or direction.

Side Effects[39] Side effects are the known and frequently experienced secondary, non-intended reactions to a medication. They can vary by how frequently they occur and how serious they are.

Social Worker Social workers are employed in a variety of settings including child and family welfare agencies, mental health agencies, hospitals and correctional services institutions. Their primary responsibility is the protection and promotion of the welfare and well being of children and vulnerable youth. They offer a broad range of services from emotional support to referrals for community resources, based on psychosocial assessments of the individual child or youth's needs and the parent or caregivers capacity to respond appropriately to the child's identified needs. Social workers can provide case management (e.g., linking clients with agencies and programs that will meet their psychosocial needs) and are also skilled therapists (i.e., may provide individual, group or family therapy). Social workers can help guide professionals in their treatment, management, and interaction with a child or youth, identify and address obstacles to a successful intervention, and help children and youth

[38] Evans R, Frid P. "Implementing the International Panel Guidelines on the Use of Psychotropic Medications" in *Psychotropic Medications and Developmental Disabilities: The International Consensus Handbook*. Child and Parent Resource Institute Committee Report, August 2002.
[39] Ibid.

and their families negotiate the social services, health and mental health systems.

Substitute Decision-Maker[40] Under the *HCCA*, a substitute decision-maker can make treatment decisions for someone who is incapable of making an informed decision regarding a particular treatment. They are, in descending priority: a court appointed personal care guardian, an attorney for personal care, a representative appointed by the Consent and Capacity Board, a spouse or partner, a child, a parent with access, CAS or other lawful organization, parent with right of access, brother or sister, any other relative (through blood, marriage or adoption) or the Public Guardian and Trustee.

Substitute Decisions Act[41] The Act passed by the Ontario Legislature in 1992, enacted in 1995 and amended in 1996, which governs what may happen when someone is not mentally capable of making certain decisions about their own property or personal care.

Treatment[42] According to the *HCCA*, a treatment consists of anything done for a therapeutic, preventive, palliative, diagnostic, cosmetic or another health-related purpose. It can include:

- A course of treatment – a series or sequence of similar treatments administered to a person over a period of time for a particular health problem; and
- A plan of treatment – deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems a person is likely to have in the future given their current health condition. A plan of treatment provides for the administration of treatments and may also provide for the withholding or withdrawal of treatment in light of the person's current health condition.

---

[40] Government of Ontario. *Health Care Consent Act*,1996, S.O. 1996, c. 2, Sch A. Available at: http://www.canlii.org/on/laws/sta/1996c.2sch.a/20060614/whole.html 24/03/08.

[41] Government of Ontario. A Guide to the *Substitute Decisions Act*. Available at: http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/pgtsda.pdf

[42] Government of Ontario. *Health Care Consent Act*,1996, S.O. 1996, c. 2, Sch A. Available at: http://www.canlii.org/on/laws/sta/1996c.2sch.a/20060614/whole.html 24/03/08.

References

A Guide to the Substitute Decisions Act. Government of Ontario, no date. Available at: http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/sdaact.asp

Becoming a foster parent. Ontario Association of Children's Aid Societies.

Child Welfare in Canada 2000. Ontario. Administration and Service Delivery. Human Resources and Social Development Canada. Available at: http://www.hrsdc.gc.ca/en/cs/sp/sdc/socpol/publications/reports/2000-000033/pages09.shtml 1/08/07

Cooke D, Finlay J. Open Detention and Open Custody. Review. Office of Child and Family Service Advocacy. January 2007

Consent and Capacity Board. Applying for a Review of Capacity to Make Decision with Respect to Treatment (Form A).

Evans R, Frid P. "Implementing the International Panel Guidelines on the Use of Psychotropic Medications" in Psychotropic Medications and Developmental Disabilities: The International Consensus Handbook. CPRI Committee Report, August 2002

Foster Parents Society of Ontario. www.fosterparentssociety.org

Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch A. Available at: http://www.canlii.org/on/laws/sta/1996c.2sch.a/20060614/whole.html 24/03/08

Institute for Safe Medication Practices. http://www.ismp.org/

MedsCheck Program Provides Better Care for Patients. Backgrounder. Ontario Ministry of Health and Long-term Care.

Ministry of Children and Youth Services. Government Reforms Include Support for Grandparents to Care for Vulnerable Grandchildren. Backgrounder. January 23, 2007. Available at: http://www.gov.on.ca/children/english/news/backgrounders/STEL02_186804.html

Office of Child & Family Service Advocacy. Appendix 1: Types of Placement for Children's Residential Care. Quality of Care Review. June 2007

World Health Organization. Requirements for adverse reaction reporting. Geneva, 1975.

Advice on Training to Support the Expert Panel Standards of Care for the Administration of Psychotropic Medications to Children and Youth Living in Licensed Residential Settings

Appendix II

Advice on Training to Support the Expert Panel Standards of Care for the Administration of Psychotropic Medications to Children and Youth Living in Licensed Residential Settings

Contents

Introduction 59
Initial Assessment.....60
Who Requires Training.....60
Minimum Training Expectation.....60
When Training Should Be Delivered.....60
Curriculum.....61
Delivery 63
Tools and Resources.....63
Budget 64

Advice on Training

Introduction

The Expert Panel was established to provide advice on standards for the administration of psychotropic medications to children and youth living in licensed residential settings. This particular paper will discuss the training issues raised by the Expert Panel's standards and options for training and education to support its effective implementation.

Ensuring thoughtful and safe practices around the administration of psychotropic medications in all licensed residential settings is essential. The problem is intensified by the large number of different professions involved – and the demands made upon them. As noted in a report by the Office of the Provincial Advocate for Children and Youth:

> Human resource limitations and instability in funding has led to higher caseloads. This impinges on the ability to engage in quality interactions with children and families, encourage meaningful client participation in decision-making and relationship development with high risk youth.[43]

The Expert Panel has reason to believe that, despite current efforts, many service providers are not adequately trained in the administration and monitoring of psychotropic medication and are confused about the consent process. For example, many direct care workers are continuing to operate under Section 132 of the *Child and Family Service Act* (*CFSA*), even though it has been superseded by the *Health Care Consent Act* (*HCCA*).

It is critical that throughout the province all those involved in the care of children and youth in licensed residential settings are knowledgeable about the standards and have the skills, tools and support necessary to implement them. No matter where a child or youth lives, there must be procedures and mechanisms in place to ensure psychotropic medications are used in the safest manner possible. Achieving this objective requires that direct care workers[44] and foster parents know what to do, how to do it, when to do it, where to do it and why they are doing it. Training must be supported by accessible, practical and useful tools and resources.

Although this document focuses upon the training of direct care workers and foster parents, it is recognized that other sectors and professionals who are important members of collaborative care teams also require education, information and resources. They include health care providers, mental health specialists and others who are concerned about the health and well being of children and youth. Many parts of Ontario have significant overall shortages of health care professionals with experience or expertise in child and youth mental health issues.

It is also important that any new or additional forms of training build on

[43] Finlay J. Snakes and Ladders: "A Dialogue". Office of Child and Family Service Advocacy, October 17, 2005. http://www.children.gov.on.ca/advocacy/documents/en/Snakes%20and%20Ladders%20A%20Dialogue.pdf 24/03/08.

[44] As defined by the Expert Panel, direct care workers refers to any adult who works closely with, and has responsibility for, a child or youth in licensed residential care. Different titles may be used in different settings.

effective or promising programs and resources. Doing so would leverage existing resources and ensure that training utilizes best or most promising practices in adult education.

Initial Assessment

Before developing any training plan, it is important to investigate what sort of relevant training may already be in place, how it is delivered and how effective it is. Any training plan that is developed to support the standards should be based on preferred and/or most promising methods in adult education. Current resources that could be leveraged include the MCYS regional trainers, the "train-the-trainer" approach utilized by CAS, and resources already developed by expert bodies (e.g., the Med Ed passport and booklets, publications and training materials and CPRI resources) and professional bodies (e.g., Canadian Psychiatric Society, Canadian Psychological Association).

Who Requires Training

Training will be required for those directly responsible for the care of children and youth in licensed residential settings, including foster parents, group home staff, youth justice workers, child protection workers, as well as relief staff. In addition, whenever possible, education and resources should be available for professionals who service the children and youth in the residential system and who may be members of the collaborative care team (e.g., clinicians, mental health specialists).

A coordinated, synchronized approach to training may be helpful to reinforce correct practices (e.g., enable clinicians and direct care workers to reinforce one another in ensuring a correct consent process is followed). It is important to strategically target core groups of staff who may not have access to, or resources for, internal training, such as agencies that do not have a nurse or physician to teach direct care workers. In light of staff turnover and reliance on relief staff (backfill), it is also important that training be readily accessible and available on a continuous basis.

In the development of training programs and materials, attention must also be paid to the information and education needs of children and youth, parents and families. For example, some children and youth in licensed residential settings periodically go for home visits, during which time medication may be administered by parents or other family members.

Minimum Training Expectation

In regards to the administration and monitoring of psychotropic medication, MCYS should establish a minimum training expectation for all direct care workers who are responsible for and work with children and youth in licensed residential settings. Different expectations may be established for different types of workers and for different settings. The expectations should clearly describe the content and type of training that should be provided.

Although expectations may vary somewhat to suit the different sectors and roles of direct care workers, it is important that all sectors have minimum expectations for initial and ongoing training and education. Dates of training should be documented in the file of each direct care worker.

When Training Should Be Delivered

Training of direct care workers is not a "one-time" effort but should be integrated into various phases:

- **During university, college or other training preceding the commencement of duties:** At a minimum, the Child and Youth Worker and Community Justice Worker curriculum should be expanded to include academic and practical training on the administration of psychotropic medication. This may require collaboration with educational and professional bodies. The potential for influencing the curriculum of other disciplines at strategic points in their education (e.g., during paediatric residency) should also be explored.

- **During job orientation:** During orientation, a test should be administered to determine baseline level of knowledge about the standards and psychotropic medication administration and monitoring. This test could be part of the orientation process or conducted online (e.g., through a provincial website). This test can act as both a baseline for evaluation of knowledge of the standards, and a means of determining what sort of training is required during orientation.

- **Ongoing training:** Opportunities to undertake additional training (either self-directed or structured by the employer) and to access resources and tools must be continuously available for all direct care workers. At a minimum, direct care workers must undertake some additional training on either the standards or the administration and monitoring of psychotropic medications which should be conducted every 1-2 years. Training programs and results should be documented in the file of all direct care workers.

Curriculum

Training is required on (1) the standards and (2) the use of psychotropic medications in the child and youth population. The two topics may be combined or offered as separate modules or curricula. It is important to take into account the needs and situations of direct care workers in different settings and to tailor content to address them.

Some of the topics relevant to the training of direct care workers include, but are not limited to:

- An overview of child and youth development and mental health issues of children and youth, particularly those in care, and the impact of maltreatment, abuse, trauma, chronic stress, neglect and/or relocation on child and youth development and behaviour (e.g., differentiating normal responses from pathology);
- How to interpret and conform to the requirements set out in the standards;
- Information on the consent process and the legal rights of children and youth and resources children and youth can access if they wish (e.g., information on the Office of the Provincial Advocate for Children and Youth, how a child or youth can appeal to the Consent and Capacity Board);
- An explanation of what is meant by diagnostic assessments and medication review, and how to meet the requirement to include medication review in the plan of care;
- Helping direct care workers and foster parents develop the skill set needed for effective communications about psychotropic medications with

children and youth, families/parents, health care professionals and other members of the collaborative care team;

- The importance of establishing processes so that children and youth regularly have opportunities to discuss psychotropic medications and to express their views and preferences;
- How to identify when a child or youth needs to be assessed or examined by a clinician and what sort of review is required;
- What sort of mental health services are available and how to access them, including local mental health and emergency resources, pharmacists, and province-wide resources such as Telehealth and Telepsychiatry;
- Understanding the rationale for administering or stopping psychotropic medication, what effects and side effects to monitor, when to question the use of psychotropic medications, and situations in which they should not be used;
- Specific effects of psychotropic medications in children and youth of diverse ethnic and cultural backgrounds;
- Practices to minimize the long-term use of psychotropic medications;
- The importance of, and how the child or youth should update and use, the medication passport (e.g., Med Ed passport and booklet);[45]
- Training on the creation of and use of other medication records (e.g., Cumulative Medication Record, Medication Administration Record) for direct care workers, foster parents and others who may administer a child or youth's medication;
- How to administer psychotropic medication, including how to interpret and use PRN ("use as needed") orders and what to do if a child or youth does not want to take the medication;
- The importance of monitoring effects and side effects of medication, including "red flags" that may indicate the need for medication review;
- How to complete necessary forms and reports (including medication incident reports), the importance of reporting, what happens with reports and how to access, interpret and utilize the information produced by the monitoring and reporting system for continuous quality improvement;
- How to work in interdisciplinary teams in a collaborative manner;
- How to incorporate system safeguards into medication use that can minimize or prevent medication incidents or error;
- How to access resources for ongoing training and education; and
- The philosophic approach of physicians in prescribing psychotropic medications and other forms of programming, such as counselling or recreational activities.

Existing expert bodies such as the Provincial Centre of Excellence for Children and Youth, CPRI and the Institute for Safe Medication Practices Canada may be willing to assist in the development of training materials, including electronic

[45] As of May 2008, 20 regional MCYS offices are participating in a pilot of a "train-the-trainer" model for the MedEd passport, funded by the Provincial Centre of Excellence. To utilize learnings from this pilot and extend training, ongoing support will be required.

materials. It is critical to ensure that training materials are periodically reviewed and updated whenever necessary. A mechanism for ensuring the review and revision of materials must be developed and put into place. If there is substantive change in the standards or content of the training materials, updating of direct care workers should be undertaken.

Delivery

Logistics such as staffing limitations, distance and costs can make it difficult for agencies to send direct care workers to off-site, in-person training. It is important that agencies and workers be consulted to determine what methods have been effective in the past to provide training, as well as which have potential to improve training effectiveness. Consultation and innovative approaches will be particularly important in remote and rural communities.

Training on the Standards and psychotropic medications should utilize preferred or promising adult education practices, as evidenced in Ontario and in other jurisdictions. For example, current methods in Ontario include:

- Mandatory MCYS curriculum for foster parents (typically held in the evenings and on weekends);
- Mandatory child welfare training (classroom and train-the-trainer);
- Integration into current training requirements for direct care workers (e.g., mandatory First Aid/CPR training); and
- MCYS-funded regional trainers (youth justice facilities).

Wherever possible, existing methods should be leveraged to address the standards and psychotropic medications.

In addition, innovative methods in adult education (e.g., Internet-based courses, videoconferencing and the Ontario Telemedicine Network) that have been utilized in other areas of adult education should be examined for potential models and practices.

Tools and Resources

The first step in providing tools and resources would be a review by MCYS of all existing manuals, forms and resources and, where necessary, revision to ensure they are in keeping with the standards. Second, MCYS should provide new tools and resources to support direct care workers in implementing and meeting the standards. Some examples include:

- A template of a standard informed consent form;
- Forms and tools for recording and monitoring psychotropic medication use (e.g., regular and PRN orders) and effects (to minimize the administrative burden on staff, where feasible forms should be combined and/or deleted);
- How children and youth and direct care workers should complete and use the Med Ed resources (passport and booklet);
- Review forms with reminders of areas that must be addressed and reviewed (e.g., regular review of psychotropic medication in the plan of care, lowest optimal dose);
- Resources for education pertaining to psychotropic medications and psychiatric conditions of children and youth; and
- Resources on the broader issues of child and youth development and psychotropic medications.

As with the training materials, tools may be delivered in a number of ways, depending upon the needs of individuals and settings (e.g., print and digital resources). The Expert Panel recommends that MCYS:

- Ensure that all direct care workers have access to Internet-based resources;
- Create a provincial web site of training resources, events, etc.;
- Identify and digitize existing video training resources so they can be accessed through the provincial web site;
- Identify unmet training needs and procedure resources to address these gaps (e.g., create new online training videos).

In addition, collaboration with other bodies should be undertaken to help them develop tools and resources for their sectors (e.g., with professional colleges to ensure there are informational materials for clinicians, with universities and colleges to support the education of members of collaborative care teams).

Existing MCYS mandatory programs should be examined for opportunities to develop indicators to evaluate the effectiveness of training programs (i.e., competency indicators). In some areas, workshops have been found to be helpful by giving participants from different settings the opportunity to share both challenges and successes.

Budget

Adequate funding must be provided to support a comprehensive and effective training process. The budget must take into account the cost of:

- Curriculum development, production and distribution (e.g., minimum and optimal training expectations for different types of direct care workers);
- Updating of current regulations, manuals and reports;
- The development, production and ongoing distribution of supporting materials and resources, such as manuals, brochures, electronic training packages, and a provincial web site;
- Training trainers, transportation, training support materials, trainer fees and meeting expenses;
- Replacement staff (backfill) to cover those participating in training;
- Communications with, and training curriculum, materials and resources for, other members of the collaborative care team (e.g., training materials so physicians and nurse practitioners understand the new standards);
- Communications with, and resources for, children, youth and families affected by the new standards;
- Website development and ongoing maintenance and improvements; and
- The development and implementation of an evaluation of training activities.

Advice on Implementation, Monitoring and Enforcement of the Expert Panel Standards of Care for the Administration of Psychotropic Medications to Children and Youth Living in Licensed Residential Settings

Appendix III

Advice on Implementation, Monitoring and Enforcement of the Expert Panel Standards of Care for the Administration of Psychotropic Medications to Children and Youth Living in Licensed Residential Settings

Contents

Preface 67
Rationale 67
Consultation 68
The Implementation Process.....68
Training.....69
Monitoring and Reporting.....70
Evaluation.....70

Advice on Implementation, Monitoring and Enforcement

Preface

The Expert Panel was established to develop standards for the administration of psychotropic medications to children and youth living in licensed residential settings.

Through a review of the literature and consultations with stakeholders and experts, the Panel developed a set of standards that it believes are essential if Ontario is to protect and promote the health, well-being and safety of these children and youth. The current situation is unacceptable; implementation of these standards should begin as quickly as possible.

The Panel recognizes that flexibility will be an essential component of any implementation process. Focus groups conducted for the Expert Panel among MCYS staff and front-line workers suggest that some of the standards recommended by the Panel are already "best practice" in some settings, some may be relatively easy to put into place and yet others may require resources or legislative or licensing changes. It may take time before all standards can be consistently implemented across all sectors and continuity of care maintained even when transitions are made between settings or sectors. Regardless, it is critical that a process for implementation of the standards be initiated as quickly and as efficiently as possible.

Rationale

The health and safety of children and youth living in licensed residential settings is an important priority. Given the frequent moves and changes in caregivers experienced by the children and youth in residential settings, it is essential that those who have been prescribed psychotropic medications be given them in a safe, consistent and medically-appropriate manner.

Based on its collective experience and its consultations, the Expert Panel believes that many service providers lack access to adequate training on the issues of early childhood development, the impact of trauma on psychological health, and psychotropic medication administration and monitoring. Some may be confused about the consent process that is required (e.g., some direct care workers are continuing to operate under Section 132 of the *Child and Family Services Act* [*CFSA*] even though it has been superseded by the *Health Care Consent Act* [*HCCA*]). There is, for example, no standardized consent form or process to help guide direct care workers or to ensure compliance with the *HCCA*.

Moreover, training issues are not limited to the licensed residential sector. Many parts of Ontario face significant health human resource challenges, particularly in terms of clinicians with experience or expertise in child and youth mental health. It is important that all members of the collaborative care team – health care professionals, mental health specialists, direct care workers, parents, foster parents and children and youth – are able to participate in meaningful ways in psychotropic medication decision making. This requires training, resources and support. The standards developed by the Expert Panel are designed to promote the safe and effective use of psychotropic medication for children in care and improve the communication of information so as to minimize or prevent its misuse or inappropriate use.

Consultation

As part of its work in developing the standards, the Expert Panel reviewed the literature on the issue of psychotropic medications for children and youth in licensed residential settings and consulted with a number of key stakeholders (e.g., experts in the area of health care consent and ministry staff and legal advisors). The Expert Panel also conducted focus groups in different parts of the provinces with direct care workers, MCYS staff and youth. The Expert Panel found these focus groups an invaluable source of information on the draft standards and opportunities and challenges for their implementation.

The Expert Panel's consultations have identified that some changes may be made relatively easily and quickly (e.g., adding medication incidents to the Serious Occurrence Report so there is better data collection and analysis), whereas others may require more time and investment of resources (e.g., development of training materials and changes to post-secondary curriculum). The Expert Panel encourages the MCYS to continue to consult with stakeholders such as front-line workers and youth through the implementation process.

The Implementation Process

The MCYS is responsible for the development of an implementation plan and process. In doing so, it will probably need to liaison with divisions and branches within the MCYS, the facilities it licenses and regulates, relevant professional bodies, centres with experience and expertise in this area (e.g., CPRI) and other ministries (e.g., Ministry of Training, Colleges and Universities regarding post-secondary curriculum for social workers and youth justice workers, the Ministry of Health and Long-term Care in regards to health human resources, etc.).

The Expert Panel, both as individual members and as a group, is willing to assist in the implementation process in whatever manner is deemed appropriate and helpful by the MCYS, such as acting as a reference group or advisory committee. For example, an advisory committee could be struck consisting of members of the Expert Panel (to ensure continuity of work and integrity of the Expert Panel's intentions), as well as new representatives (e.g., direct care workers who can help identify challenges the field would face in implementing the standards, health care professionals who can comment on the medical/treatment implications of the standards, and/or representatives of bodies such as the Office of the Provincial Advocate for Children and Youth).

The Expert Panel suggests that considerations for the MCYS implementation process should include items such as:

- Identifying which standards may already be in place in some or all sectors as "best practices" or standard practice, which can be easily and quickly implemented and which may require the investment of resources or legislative or regulatory changes;
- Outlining program and policy implications of the standards and the implementation process for different sectors;
- Identifying legislative and licensing issues that must be addressed to ensure consistent implementation and utilization of the standards;
- Identifying what form or report templates are required and key elements they should include

(e.g., development of a standardized informed consent process and related template);

- Facilitating communications and coordination between programs and ministries (e.g., to facilitate smooth transition of children and youth between the child protection, youth justice and health care systems); and
- Developing and implementing a communications strategy, including a mechanism to track issues as they arise, for internal and external stakeholders.

MCYS will probably want to identify the types of resources required to ensure an effective implementation process. It should be noted that some of the standards may have little or no budgetary implications; others may require initial investment but result in greater system cost-efficiencies. For example, if the Med Ed booklets (passports) were to be given to all children and youth in licensed residential settings, resources would be required for not only production and distribution of the booklet but also for training of direct care workers, children and youth and parents in how to effectively use it.

Training

Training must be an essential element of the implementation plan and a separate paper with the Expert Panel's suggestions concerning training needs has been developed. Direct care workers cannot implement and follow standards that they are unfamiliar with or do not understand; training and education must be conducted so as to ensure that all people working in all related sectors have the knowledge, training, skills and resources necessary to meet all standards. Training may vary according to the type of facility and its needs, but all training must be comprehensive, easily accessible, practical, based on best practices in adult education, supported by resources and available at various points in time.

A plan for the training and education of direct care workers and care providers is needed. The Expert Panel believes that issues include:

- The content of training and resource materials (i.e., curriculum);
- Who requires training (e.g., direct care workers, children and youth, other members of the collaborative care team, foster parents and parents [so as to ensure continuity of medications when children or youth have home visits]);
- When training should be delivered (e.g., during formal training, at orientation or on an ongoing basis);
- How training should be delivered (e.g., as part of college/university curriculum, through existing documentation and training programs, through a comprehensive provincial website, by a train-the-trainer approach);
- Ensuring that practical tools are available that support training in the standards as well as the integration of the standards into the daily operating procedures of different facilities (e.g., consent form templates, Med Ed booklets); and
- Ensuring there is continuous quality improvement, both in terms of training and application of the standards.

It is recommended that the MCYS begin by assessing training models and resources which already exist and which could be utilized or leveraged to support implementation of the standards. For example, as of May 6, 2008, pilot testing

began of a "train-the-trainer" model for front-line workers in the use of the Med Ed passport, funded by the Provincial Centre of Excellence for Child and Youth Mental Health. There is an opportunity for the MCYS to capitalize on the findings of this pilot.

Monitoring and Reporting

As part of the implementation process, a plan should be developed for further data collection and monitoring across the continuum of MCYS services in which children and youth in care may be prescribed and/or administered psychotropic medications. Standardized collection of data will enhance the ability to identify potential problems, monitor progress in the implementation of the standards, and identify opportunities for ongoing system enhancements. The desired outcome is to manage risks inherent in the system and move towards a goal of risk prevention.

The monitoring plans could specify such things as:

- Revision of the existing Serious Occurrence form to add medication incidents (this would make possible quarterly and annual reporting);
- Budget and training needs to support a comprehensive, responsive, useful and cost-efficient system of data collection, analysis and dissemination of information and learning;
- How data will be captured, stored (data integrity, privacy and confidentiality) and analyzed;
- A system for analysis of medication incident reports/data by an expert body to detect risks, patterns and trends and communicate its findings to MCYS, care providers and other appropriate representatives (e.g., similar to the existing reporting and learning system for medication incidents provided for long-term care homes and hospitals through the Institute for Safe Medication Practices Canada);
- The type, content, focus, frequency and target audience of reports (ministry, facilities, organizations, public, children and youth in care, parents and foster parents, health care professionals, other mental health professionals, etc.); and
- Opportunities for integration with other data systems that could promote improved monitoring and reporting.

Evaluation

Evaluation is a critical component of implementing the standards. The Expert Panel recommends that evaluation experts within MCYS be consulted to develop two evaluation frameworks: one for the implementation process and another for the standards. The first framework could determine if the implementation process was proceeding effectively (e.g., whether it is meeting membership requirements, scheduled milestones) and was having the anticipated impact (e.g., achieving implementation objectives). The second framework would evaluate process indicators concerning the standards (e.g., number of direct care workers receiving training per year, number of visits to a provincial website of resource materials), as well as the impact of the standards over time (e.g., changes in psychotropic administration practices, utilization of standardized templates, understanding and utilization of the standards by facilities and direct care workers). To support the latter, the Expert Panel suggests that, prior to implementation of the standards, an investment be made to collect baseline data on knowledge,

attitudes and behaviours concerning administration of psychotropic medications to children and youth in licensed residential settings. Such data could then be repeated at intervals to determine the impact of the standards.

Evaluation activities could be conducted in a number of ways and some may require only minimal resources. For example, questions on psychotropic medications could be added to the annual questionnaire sent to Crown wards. Children Aid Societies are already attuned to the questionnaire and are known to adjust their practices according to the feedback it provides.

In developing an evaluation plan, the Expert Panel recommends that the MCYS consider such issues as:

- Identifying the evaluation questions and implementation indicators;
- Developing data collection methods (e.g., some indicators may be captured in standard MCYS reports, whereas others may require special surveys or data gathering); and
- Plans for data analysis and reporting (e.g., what types of reports are required, when they should be generated and who should receive them).