About Minds Matter
Minds Matter is a statewide project with lots of professionals that care about your health. The goal is to improve the prescribing of mental health (psychotropic) medications to youth. This toolkit was made to help kids and teenagers like you! This toolkit is for you and your parents, caregivers or guardians to help make good choices about your mental health. It can help you speak with a doctor and give you a voice in your treatment.

Minds Matter has resources for you on its website: www.ohiomindsmatter.org

How to use this toolkit

**Personal Decision Guide**

*Use this before, during, and after your doctor visit to:*

- Prepare for a doctor’s visit.
- Think through your options.
- Make good choices and share them with others.

**Additional Information**

**Medication Side Effects Watch List**
- Check this list if you take medications or if your doctor suggests them.

**Youth Substitute Care**
- Check these pages for helpful tips about post-emancipation.
## Challenges:

It can be difficult for youths and caregivers in foster care to:

- Get a second opinion.
- Request to lower the dose of medication or not take medication.

## What you can do:

- Decide what to share and double check if it will be kept private.
- Keep a journal.
- Ask questions and do your own research.
- Speak up until you get the help you need.
- Share any concerns you have about your treatment with someone you trust.
- Ask about help for any trauma or stressful event that you have experienced.
- Check the Minds Matter website. (ohiomindsmatter.org)

## It’s ok to ask:

- The reasons for treatment and what it will do.
- A doctor to slow down and repeat when you don’t understand.
- For a list of your prescriptions.
- The long term effects of treatment.
NOTES:

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Your Decision Team: Makes the best choices together

School
Supports your learning and situation.

Health Professional
Listens to your needs and helps make a care plan.

Judicial
Help you make choices for your best interests.

Social Services Agency
Provides approval for your care choices.

Other Important Adults
Mentor/help you.

Other Family Members
Provide support.

Youth and Caregiver
Shares needs and concerns. Follows through on what they agree to do.

Prepare for visit:

Be ready to describe: (take notes on back)

- A typical day.
- Any blood relatives with mental health problems.
- Any alcohol/drug use during your mother’s pregnancy.
- Things you have already tried or want to try.
- Anyone who is important in your life.
- Sickness or disability.
- Stressful or traumatic events.

What behaviors concern you or others the most?

- Poor attention
- Poor listening
- Hyper
- Moody
- Depressed or sad
- Worried or stressed
- Angry
- Acts out
- Other _____________________

What do you want to get out of your doctor’s visit? ____________________
Information for Foster Care

Social Service Agency
Makes informed decision about treatment approval.

Judicial
Gathers information.
Makes legal decisions.

Youth and Caregiver
Shares needs, questions, and concerns. Follows through on what they agree to do.

Health professional
Shares information.
Listens to patients’ needs.

School
Helps student learn.

Your Family Can:
Challenges?

Your Decision Team: Makes the best decision together.

There is no system for foster youths/parents to:
• Get a second opinion.
• Request to lower the dose of medication or not take medication.

Decide what to share and double check it will be kept private.

Keep a journal.

Ask questions and do your own research.

Speak up until you get the help you need.

Consent or refuse medication.

Ask about care for any trauma or stressful event that you have experienced.

Before Your Visit

Personal Decision Guide

Who is in your decision team?

Mentors Contact Info

Regular doctor Contact Info

Other doctors Contact Info

Teachers/school staff Contact Info

Therapist/counselor Contact Info

Court service officer Contact Info

Others Contact Info

NOTES :

Mentors Contact Info

Regular doctor Contact Info

Other doctors Contact Info

Teachers/school staff Contact Info

Therapist/counselor Contact Info

Court service officer Contact Info

Others Contact Info
## Personal Decision Guide

### Have you had a complete evaluation?  □ Yes  □ No

### Is there a diagnosis?  □ Yes  □ No

**If yes, what is it?** _______________________________________________________________________

### Discuss Options

<table>
<thead>
<tr>
<th>Discuss Options</th>
<th>Treatment Option 1</th>
<th>Treatment Option 2</th>
<th>Treatment Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Is there a big benefit?

<table>
<thead>
<tr>
<th>Is there a big benefit?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Option 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Option 2</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Treatment Option 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Are the side effects/risks small?

<table>
<thead>
<tr>
<th>Are the side effects/risks small?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Option 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Option 2</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Treatment Option 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Will it help meet your goals?

<table>
<thead>
<tr>
<th>Will it help meet your goals?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Option 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Option 2</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Treatment Option 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### How much do you like this option?

<table>
<thead>
<tr>
<th>How much do you like this option?</th>
<th>A lot</th>
<th>Some</th>
<th>Not much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Option 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Option 2</td>
<td>A lot</td>
<td>Some</td>
<td>Not much</td>
</tr>
<tr>
<td>Treatment Option 3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### During Your Visit

- Check if you and the doctor have the same understanding. _______________________________________________________________________
- Other treatment options. _______________________________________________________________________
- Will the medications interact with (or affect) each other? _______________________________________________________________________
- Where can you get more information or help? _______________________________________________________________________
- Issues with getting the option you like (travel, cost, time). _______________________________________________________________________
Evaluation/diagnosis: ____________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

Treatment Options: ______________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

NOTES: __________________________________________________________
________________________________________________________________
________________________________________________________________
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________________________________________________________________
Step 1: Think
Are you ready to make choices?

☐ Yes
Discuss how to begin with the doctor.

☐ No
That’s okay.
Take some more time to think. Make a follow-up appointment today.
To ask questions or tell the doctor your choices over the phone, call:

Step 2: Choose
Treatment

Step 3: Set Goals
How will you know you are making progress?

How long will it take to see results?

How often will you have check-ups?

What should you do to get good results?

When should I call my doctor?

Step 4: Evaluate
During or After Your Visit
Use the next page to keep track of how the treatment is working out.
Take it to your next appointment.

Date ____________

Time ____________
During or After Your Visit

Treatment:

Goals:

NOTES:
How are you doing?  □ ☺ □ 😊 □ ☹ □ 😞
Describe ____________________________

How is it going since your last visit?

Medication
□ ☺ □ 😊 □ ☹ □ 😞
How many doses were missed?
□ 0–4 □ 5–10 □ More than 10
Why? ____________________________
Describe ____________________________

Counseling
□ ☺ □ 😊 □ ☹ □ 😞
How many times did you go?
□ 0–1 □ 2–4 □ More than 4
Describe ____________________________

School
□ ☺ □ 😊 □ ☹ □ 😞
How many days have you missed?
□ 0–1 □ 2–4 □ More than 4
Describe ____________________________

Other (like diet or exercise)
□ ☺ □ 😊 □ ☹ □ 😞
Were you able to follow the plan?
□ Yes □ No □ Somewhat
Describe ____________________________

Is there anything else you would like to talk about today?
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
What changes are you seeing? 

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

When did you notice those changes? Time Date

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Questions you have for the doctor:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Anything going on at home?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

NOTES:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
### Personal Decision Guide

**Who knows?**
Ask your caseworker who gets information about your treatment.

**Why share?**
Professionals might be able to help you if they know basic information about treatment.

**Who to share with?**
Choose people you trust to share with.
Consider teachers, counselors, caseworkers, family members, doctors, court service officers, and others.

**How to share?**
1. Decide who to share with and what to share.
2. Complete this checklist and make copies.
3. The doctor or nurse can help you fill it in.

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### Child’s Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of birth</th>
</tr>
</thead>
</table>

### Diagnosis

<table>
<thead>
<tr>
<th>Current treatments (include frequency/dose of medications)</th>
</tr>
</thead>
</table>

### Treatment

<table>
<thead>
<tr>
<th>Goals:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goals:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goals:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### Needs

How my team can help me succeed:

- [ ] School
- [ ] Caseworker/care manager
- [ ] Counselor
- [ ] Caregivers
- [ ] Doctors
- [ ] Court service officer
- [ ] Others

### Who to contact about this child.

Parent/legal guardian/authorized caregiver and/or you

Relationship to child

Best way/time to contact

Email

Cell phone
Personal Decision Guide

Share Your Choices

Treatment:

________________________________________________________________________________________
________________________________________________________________________________________
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________________________________________________________________________________________
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________________________________________________________________________________________

Needs:

________________________________________________________________________________________
________________________________________________________________________________________
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NOTES:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
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________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
If you are turning 18:

Keep your health insurance:
- You can still get free Medicaid. Apply at medicaid.ohio.gov/forohioans/programs/fostercare.aspx
- Know your social security number.
- Keep the phone number for your health plan.

If you have to change doctors:
- Get your medical records.
- Keep a list of your past doctors and your prescriptions.
- Call your health plan to get a new doctor.
- Visit your new doctor for regular check-ups and to discuss any health issues.

Understand your care:
- Make sure you understand how to take your medications.
  - Talk to a doctor or pharmacist.
- Check the medication section of this toolkit.
Do get help:

- Talk to your caseworker
- Programs to pay for medications
  - NeedyMeds (needymeds.org)
  - Partnership for Prescription Assistance (pparx.org)
  - Prescription Hope (prescriptionhope.org)
- Free health clinics

Do not get help:

- Keep taking your medications and going to counseling.
- If you stop without talking to a doctor, it can disrupt your school, work, personal relationships, and housing.

NOTES:

____________________________________________________________________________________
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____________________________________________________________________________________
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____________________________________________________________________________________
____________________________________________________________________________________
Any medications may cause common, general side effects such as:

### About this watch list
Common side effects are listed, but there may be others you want to discuss with your doctor.

### Tips about medications
- Medications treat the symptoms of mental conditions.
- They cannot cure the condition, but they can help you feel and function better.
- Medications work differently for different people.
- Use caution, medications can react with each other.
- There may be other uses for medications which is called "off-label."
- You should have therapy along with your medication.
- Don’t take street drugs or medicines not prescribed to you.

### About side effects
Some side effects go away with time. If they happen right after starting medication, they might be side effects.
<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Potential Conditions</th>
<th>Medications</th>
<th>Common Side Effects</th>
<th>Rare Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyper</td>
<td>Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD)</td>
<td><strong>Stimulants</strong>&lt;sup&gt;1&lt;/sup&gt; such as methylphenidate or amphetamines</td>
<td>Loss of appetite</td>
<td>High blood pressure and heart rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Brands</strong>: Ritalin, Adderall</td>
<td>Difficulty falling asleep</td>
<td>Strange feelings on skin or seeing/hearing things that aren’t there</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Non-Stimulant</strong>: Atomoxetine, Strattera</td>
<td></td>
<td>Mania (super hyper or moody)</td>
</tr>
<tr>
<td>Hyper</td>
<td>ADHD and ADD</td>
<td><strong>Alpha-agonist</strong> such as clonidine, guanfacine</td>
<td>Light headed</td>
<td>Trouble with liver or kidneys</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Brands</strong>: Kapvay, Intuniv</td>
<td>Dry mouth/eyes</td>
<td>Changes in blood pressure</td>
</tr>
<tr>
<td>Depressed or sad</td>
<td>Depression, Anxiety, PTSD, and Obsessive-Compulsive Disorder (OCD)</td>
<td><strong>Antidepressants</strong> such as fluoxetine, sertraline and escitalopram</td>
<td>Dizziness</td>
<td>Depression worsens or suicidal thoughts</td>
</tr>
<tr>
<td>Moody</td>
<td></td>
<td><strong>Brands</strong>: Prozac, Zoloft, Lexapro</td>
<td>Sweating</td>
<td>Changes in heartbeat, body temperature or muscle tone</td>
</tr>
<tr>
<td>Worries a lot</td>
<td></td>
<td></td>
<td>Sleeping problems</td>
<td>Activation (repeated physical actions)</td>
</tr>
<tr>
<td>Crying</td>
<td>Seizure disorders, certain cases of severe anxiety (like panic attacks)</td>
<td><strong>Benzodiazepines</strong>&lt;sup&gt;1&lt;/sup&gt; such as alprazolam or clonazepam</td>
<td>Dizziness</td>
<td>Memory problems</td>
</tr>
<tr>
<td>Cranky</td>
<td></td>
<td><strong>Brands</strong>: Xanax, Klonopin, Ativan</td>
<td>Gets annoyed easily</td>
<td>Seizures (might happen if you suddenly stop taking it)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Not usually recommended for children</td>
<td></td>
<td>Dependency (body becomes used to medicine)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extreme moods or behavior changes</td>
<td>Bipolar disorder</td>
<td><strong>Mood Stabilizers</strong>&lt;sup&gt;1&lt;/sup&gt; such as lithium</td>
<td>Tremors</td>
<td>Trouble with kidneys and/or thyroid</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Brands</strong>: Eskalith</td>
<td>Thirsty</td>
<td>Easy to bruise/bleed</td>
</tr>
<tr>
<td>Racing thoughts</td>
<td></td>
<td>such as valproic acid</td>
<td>Urinate a lot</td>
<td></td>
</tr>
<tr>
<td>Changes in sleep habits</td>
<td></td>
<td><strong>Brands</strong>: Depakote</td>
<td>Nausea</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Regular blood work is needed</td>
<td>Tremors</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Weight gain</td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup> High abuse potential
### Atypical Antipsychotics

<table>
<thead>
<tr>
<th>Medication Type</th>
<th>Potential Conditions</th>
<th>Common Side Effects</th>
<th>Rare Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aripiprazole like Abilify&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Schizophrenia</td>
<td>Weight gain</td>
<td>Muscle stiffness</td>
</tr>
<tr>
<td>Asenapine like Saphris&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Bipolar</td>
<td>Feeling sleepy</td>
<td>Unusual movement like jerking or twitching</td>
</tr>
<tr>
<td>Clozapine like Clozaril&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Irritability with autism</td>
<td>Dry mouth</td>
<td>Changes in blood sugar and cholesterol</td>
</tr>
<tr>
<td>Lurasidone like Latuda&lt;sup&gt;®&lt;/sup&gt;</td>
<td></td>
<td>Constipation</td>
<td>Delay or changes in your period</td>
</tr>
<tr>
<td>Olanzapine like Zyprexa&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Other ♦</td>
<td>Blurred vision</td>
<td>Breast enlargement in boys or girls</td>
</tr>
<tr>
<td>Quetiapine like Seroquel&lt;sup&gt;®&lt;/sup&gt;</td>
<td></td>
<td>Restless</td>
<td>Sudden high fever with confusion</td>
</tr>
<tr>
<td>Risperidone like Risperdal&lt;sup&gt;®&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ziprasidone like Geodon&lt;sup&gt;®&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

♦ There may be other uses for medications which is called “off-label.”

### Key

- **Light blue** = Tell a nurse or doctor.
- **Dark red** = See a nurse or doctor right away and take your medication with you.

### Medication Legend

- **bid** = twice a day
- **tid** = three times a day
- **qid** = four times a day
- **I** = one
- **ii** = two
- **iii** = three
- **prn** = as needed
- **hs** = bedtime
- **po** = by mouth