



DIVISION OF DEVELOPMENTAL DISABILITIES  
Olympia, Washington

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TITLE: USE OF PSYCHOACTIVE MEDICATIONS POLICY 5.16

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Authority: Chapters 71A.12, 71A.18 RCW

### **BACKGROUND**

Psychoactive medications are primarily used for persons who have a mental illness. They have proven to be a very effective form of treatment for major forms of mental illnesses. Psychoactive medications may also be helpful for persons with developmental disabilities in whom it is more difficult to make a clear diagnosis of mental illness but may nonetheless be suffering from mental illness. Some people may express their mental illness through severe problem behaviors.

Psychoactive medications have potential side effects that range from mild to severe. Regular monitoring for side effects and evaluation of medication effectiveness is especially important for individuals who have a reduced capacity to communicate symptoms of potential side effects. Psychoactive medications are not necessarily the first treatment of choice. Positive behavior support approaches may be equally or more effective and treatment decisions should always be made on an individual basis.

### **SCOPE**

This policy applies to all persons who receive residential services contracted by the Division of Developmental Disabilities (DDD) and services through DDD State Operated Living Alternatives (SOLA).

### **DEFINITIONS**

"**Psychoactive medications**" means medications prescribed for the purpose of enabling a person to function better, reducing problem behavior, or treating a mental illness. Psychoactive medications possess the ability to alter mood, anxiety level, behavior, cognitive processes, or mental tension. Common groups of psychoactive medications are antipsychotic or neuroleptic medications, antidepressants, antianxiety medications, sedative/hypnotics, psychostimulants, and mood stabilizers.

**POLICY**

Persons with developmental disabilities and mental illness and/or serious behavior problems shall have adequate access to treatment with psychoactive medications and reasonable protection from serious side effects or the inappropriate use of these medications.

**PROCEDURES****A. Assessment and Treatment Plan**

1. If the person appears to be displaying symptoms of mental illness and might benefit from taking a psychoactive medication, the person should be referred for an assessment. It is recommended a psychiatrist, or a physician's assistant or nurse practitioner working under the supervision of a psychiatrist, conduct this assessment, if available.
2. Prior to the assessment, staff should prepare a psychiatric referral summary and send or take this to the professional conducting the assessment. The summary should briefly describe the frequency and severity of the person's symptoms or behaviors and what has been tried previously. See Attachment A for sample form, *Psychiatric Referral Summary*.
3. After the assessment, if the professional recommends psychoactive medication, the prescribing professional or agency staff should document the professional's treatment plan. See Attachment B for sample form, *Psychoactive Medication Treatment Plan: Introduction of New Medication*. The plan should address the following:
  - a. A mental health diagnosis or a description of the behaviors for which the medication is prescribed;
  - b. The name(s) and purpose(s) of the medication(s);
  - c. The length of time considered sufficient to determine if the medication is effective; and
  - d. The behavioral criteria to determine whether the medication is effective (i.e., what changes in behavior, mood, thought, or functioning are considered evidence that the medication is effective).
4. Informed consent by the person and/or their guardian for administration of the medication should be obtained and documented on a form that lists justification for the use of the medication. See Attachment C for sample form, *Consent for Use of Psychoactive Medication*. An information sheet on the medication,

including potential side effects, should be attached to the consent form. It is acceptable to use the written information supplied by the dispensing pharmacy.

5. Plans to support the person in positive ways that will assist in the treatment or reduction of the person's symptoms/behaviors should be documented in a written plan such as the behavior support plan (BSP), individual service plan (ISP), or the Individual Instruction and Support Plan (IISP).

## **B. Monitoring Psychoactive Medications**

1. The agency must monitor the person to help determine if the medication is being effective based on criteria identified in the treatment plan. If the medication appears not to have the desired effects, the agency must communicate this to the prescribing professional.
2. The agency must observe the person for any changes in behavior and/or health, which might be side effects of the medication, and inform the prescribing professional of any concerns.
3. The agency should request that the prescribing professional see the person at least every three (3) months unless a different schedule has been recommended by the prescribing professional.
4. Continued need for the medication should be assessed at least annually by the prescribing professional. See Attachment D for sample form, *Psychoactive Medication Treatment Plan: Annual Continuation of Medication*.

## **EXCEPTIONS**

Any exceptions to this policy must be reviewed and approved in writing by the DDD regional administrator.

## **SUPERSESSON**

DDD Policy 5.16  
Issued January 30, 1996

Approved:     /s/ Timothy R. Brown      
Director, Division of Developmental Disabilities

Date:     5/26/99

**ATTACHMENT A**

**PSYCHIATRIC REFERRAL SUMMARY**

Name \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Sex: male \_\_\_ female \_\_\_  
Address \_\_\_\_\_ Supporting Agency \_\_\_\_\_  
\_\_\_\_\_ Contact Person \_\_\_\_\_ Phone \_\_\_\_\_  
Phone \_\_\_\_\_ Legal Guardian? \_\_\_\_\_ Phone \_\_\_\_\_  
Primary M.D. \_\_\_\_\_ Phone \_\_\_\_\_ Other M.D. \_\_\_\_\_ Phone \_\_\_\_\_  
Disability(ies): \_\_\_\_\_  
DDD Case/Resource Manager \_\_\_\_\_ Phone \_\_\_\_\_  
Form completed by: \_\_\_\_\_ Date \_\_\_\_\_ Relationship \_\_\_\_\_

**Briefly describe why this person is being referred for a psychiatric evaluation:**

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**Symptom(s)/Behavior(s) of Concern (define, state frequency and severity of each symptom or behavior):**

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**Previous Mental Health Involvement (list past counseling, behavioral interventions, diagnoses, medications, psychiatric hospitalizations, crisis team contact, etc.):**

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**List Other Agency Contacts and Phone Numbers (vocational, mental health, other therapists, etc.):**

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**ATTACHMENT B**

**Psychoactive Medication Treatment Plan  
Introduction of New Medication**

**Client Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Supporting Agency:** \_\_\_\_\_

**Diagnosis and/or Description of Behavior for Which Medication is Prescribed:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medication:** \_\_\_\_\_ **Dosage:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Length of Treatment Trial (considered sufficient to determine if medication is effective):**

\_\_\_\_\_  
\_\_\_\_\_

**Behavioral Criteria to Evaluate Effectiveness of Medication (what changes in behavior, mood, thought or functioning should be expected):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Prescribing Physician**

\_\_\_\_\_  
**Agency Staff**

ATTACHMENT C

Consent for Use of Psychoactive Medication

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Medication for Which Consent is Requested: \_\_\_\_\_

Purpose for Which Medication is Prescribed:

Information on Medication: See attached information sheet that describes the medication, dosage ranges, and possible side effects.

Questions regarding the use of this medication should be addressed to the prescribing physician listed below.

Name of Physician: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Consent Statement:

I have received information on this medication, the reasons for its use, and I have had the opportunity to get my questions about it answered. I consent to the use of this medication. I understand that failure to consent to this medication will not result in loss of services from the Division of Developmental Disabilities (DDD). I also understand that I may withdraw my consent at any time, without loss of services from the Division of Developmental Disabilities.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Guardian

\_\_\_\_\_  
Date

**ATTACHMENT D**

**Psychoactive Medication Treatment Plan  
Annual Continuation of Medication**

**Client Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Supporting Agency:** \_\_\_\_\_

**Diagnosis and/or Description of Behavior for Which Medication is Prescribed:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medication:** \_\_\_\_\_ **Dosage:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Positive Results of this Medication and Justification for Continuation:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Plan to Continue Use of This Medication:**

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Prescribing Physician**

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**Agency Staff**