



DIVISION OF DEVELOPMENTAL DISABILITIES  
Olympia, Washington

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TITLE: USE OF PSYCHOACTIVE MEDICATIONS POLICY 5.16

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Authority: Chapter 71A RCW Developmental Disabilities  
Chapter 388-820 WAC Community Residential Services and Supports

**BACKGROUND:**

Psychoactive medications have proven to be a very effective treatment for many forms of mental illness. For person with developmental disabilities in whom it is more difficult to make a clear diagnosis of mental illness, but who may nonetheless be suffering from mental illness and/or severe problem behaviors, psychoactive medications can be helpful. This class of medications has potential side effects ranging 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. Refer to Division of Developmental Disabilities (DDD) Policy 5.14, *Positive Behavior Support*, for more information on positive behavior support.

**PURPOSE:**

This policy establishes guidelines for assisting a person with mental health issues or severe problem behavior to access accurate information about psychoactive medications and treatment, and to make fully informed choices.

**SCOPE:**

This policy applies to all persons who receive DDD certified and contracted residential services 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 are prescribed 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 problem behavior, shall have adequate access to information and 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. If one is available, it is recommended that a psychiatrist, physician's assistant, or nurse practitioner (ARNP) with experience in treating people with developmental disabilities, conduct this assessment.
2. Prior to the assessment, staff should prepare a psychiatric referral summary and send or take this to the treatment 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*.

Note: Some individuals may prefer to visit their treatment professional independently and without the assistance of residential agency staff. In such cases, the person's choice should be respected and documented in the person's file.

3. After the assessment, if the treatment professional recommends psychoactive medication, the prescribing professional or agency staff should document the person'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 for administration of the medication by the person, or his or her legal guardian, 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*.
- a. An information sheet on the medication(s), including potential side effects, should be attached to the consent form. It is acceptable to use the written information supplied by the dispensing pharmacy.
  - b. Agencies should retain a copy of the consent form that is mailed to the person's guardian in the person's file.
  - c. If the person's guardian refuses to give consent, the agency should encourage the guardian to meet with the treatment professional to discuss the medication issue.
5. There may be situations in which a person's guardian is unavailable to provide consent and the treatment professional wants the person to begin taking the medication immediately. Where the physician believes the medication will alleviate the person's physical or emotional distress, and no significant risks are associated with the medication, the agency should act in the person's best interests and assist them in obtaining and taking their medication. Attempts to gain consent from the guardian must still be actively pursued and documented.
6. 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), Psychoactive Medication Treatment Plan (PMTP), 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 the prescribing professional has recommended a different schedule.
4. The continued need for the medication should be assessed 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.

**SUPERSESSION:**

DDD Policy 5.16  
Issued May 26, 1999

DDD Policy 5.16  
Issued January 30, 1996

Approved: /s/ Linda Rolfe  
Director, Division of Developmental Disabilities

Date: July 1, 2001

**ATTACHMENT A**

**PSYCHIATRIC REFERRAL SUMMARY**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F

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

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

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Legal Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

DDD Case Manager: \_\_\_\_\_ Phone: \_\_\_\_\_

Form completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

\_\_\_\_\_

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

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

Symptom(s) or behavior(s) of concern (define and state frequency and severity of each symptom or behavior):

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

Previous mental health involvement (list past counseling, behavioral interventions, diagnoses, medications, psychiatric hospitalizations, crisis team contact, etc.):

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

\_\_\_\_\_

\_\_\_\_\_

**ATTACHMENT A**

**PSYCHIATRIC REFERRAL SUMMARY (continued)**

List other agency contacts and phone numbers (employment, vocational, mental health, other therapists, etc.):

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What has been tried previously (list intervention and results, if known):

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List diagnoses/medical concerns:

Current medications and daily dose:

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List any known unusual or adverse reactions to medications:

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Describe the following characteristics of the person (if not already listed):

Sleep pattern \_\_\_\_\_

Mood/affect \_\_\_\_\_

Eating/appetite \_\_\_\_\_

Thinking/cognition \_\_\_\_\_

Memory \_\_\_\_\_

Anxiety level \_\_\_\_\_

Hyperactivity \_\_\_\_\_

**ATTACHMENT A**

**PSYCHIATRIC REFERRAL SUMMARY (continued)**

Sensory impairments \_\_\_\_\_

Allergies \_\_\_\_\_

Gynecological problems \_\_\_\_\_

Urinary problems \_\_\_\_\_

Communication impairment \_\_\_\_\_

Other Information that may be pertinent:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ATTACHMENT B**

**PSYCHOACTIVE MEDICATION TREATMENT PLAN  
INTRODUCTION OF NEW MEDICATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

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

Supporting Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

Diagnosis and/or description of behavior for which medication is prescribed:

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

Medication(s):

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**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ 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.

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**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**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Address:

\_\_\_\_\_

Supporting Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

Diagnosis and/or description of behavior for which medication is prescribed:

\_\_\_\_\_

\_\_\_\_\_

Medication(s):

Dosage:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Positive results of this medication and justification for continuation:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Plan to continue use of this medication:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_