Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

DIVISION OF DEVELOPMENTAL DISABILITIES
Olympia, Washington

TITLE: USE OF PSYCHOACTIVE MEDICATIONS POLICY 5.16

Authority: Chapter 71A RCW Developmental Disabilities
Chapter 388-101 WAC Certified Community Residential Services and Supports

BACKGROUND

Psychoactive medications have proven to be a very effective treatment for many forms of mental illness. As with other prescription medications, psychoactive medications have the potential for unwanted side effects. 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 or only treatment of choice, particularly for challenging behaviors. 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) Policies 5.14, *Positive Behavior Support,* and 5.15, *Use of Restrictive Procedures* for additional information and requirements.

PURPOSE

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

SCOPE

This policy applies to the use of psychoactive medications by persons who receive medication services through DDD certified and contracted residential services, including State Operated Living Alternatives (SOLA).

DEFINITIONS

Medication administration is the direct application of a prescribed medication whether by injection, inhalation, ingestion, or other means, to the body of the client by an individual legally authorized to do so.

Medication assistance is assistance with self-administration of medication rendered by a nonpractitioner to a client receiving certified community residential services and supports in accordance with RCW 69.41 and chapter 246-888 WAC.

Medication service is any service provided by a certified community residential services and support provider related to medication administration or medication assistance provided through nurse delegation and medication assistance.

Psychoactive means possessing the ability to alter mood, anxiety level, behavior, cognitive processes, or mental tension, usually applied to pharmacological agents.

Psychoactive medications means medications prescribed to improve or stabilize mood, mental status or behavior. Psychoactive medications include antipsychotics/neuroleptics, atypical anti-psychotics, antidepressants, stimulants, sedatives/hypnotics, and anti-mania and anti-anxiety drugs.

POLICY

Psychoactive medications are prescribed to enable a person to function better, reduce challenging behavior, or treat a mental illness. Persons with developmental disabilities and mental illness, and/or persistent challenging behavior shall have appropriate access to information and treatment with psychoactive medications, and reasonable protection from serious side effects or the inappropriate use of these medications.

If a psychoactive medication is used to treat a physical condition (e.g., sleep or seizure disorder), the requirements of this policy do not apply. Positive behavior support strategies, if warranted, should be integrated in the person's overall support plan.

PROCEDURES

A. Assessment

1. If the person appears to be displaying symptoms of mental illness and/or persistent challenging behavior, refer the person for a professional assessment. It is important to rule out any physical or medical conditions that may be causing or contributing to the behavior. It is recommended that a psychiatrist, physician's assistant, general practitioner, or nurse practitioner (ARNP) with experience in treating people with developmental disabilities conduct this assessment.

2. Prior to the assessment, staff will 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, respect the person's choice and document this in the person's record and Plan of Care (POC). Also document in the service plan/POC whether the person is assessed as capable of self-monitoring his/her medications or requires assistance.

B. Treatment Plan

1. After the assessment, if the treatment professional recommends psychoactive medication, the prescribing professional or agency staff will document this in a Psychoactive Medication Treatment Plan. See Attachment B for sample form, *Psychoactive Medication Treatment Plan.* The plan must include the following:

   a. A description of the behaviors, symptoms or conditions for which the medication is prescribed and a mental health diagnosis, if available;

   b. The name, dosage, and frequency of the medication (subsequent changes in dosage may be documented in the person's medical record);

   c. The length of time considered sufficient to determine if the medication is effective (i.e., treatment trial);

   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); and

   e. The anticipated schedule of visits with the prescribing professional.

2. The PMTP must be updated whenever there is a change in medication.

3. The prescribing professional is responsible for obtaining informed consent when necessary from the person or, if applicable, his/her legal representative. Agencies must retain a copy of the signed consent form, if available, in the person's record. If the person's legal representative refuses to give consent, the agency should encourage the legal representative to meet with the treatment professional to discuss the medication issue.

4. Agency staff will review with the person and his/her legal representative the name, purpose, potential side effects and any known potential drug interactions of the medication. Agency staff should base such discussion on the written information supplied by the dispensing pharmacy whenever possible. See Attachment C for sample form, *Information Regarding Psychoactive Medication*.

5. Agencies must have available to staff and clients an information sheet for each psychoactive medication that is being used by persons served by the agency. This information sheet should describe potential side effects and potential adverse drug interactions that may occur from use of the medication. This information sheet should be one provided by the dispensing pharmacy or based on information provided by the dispensing pharmacy whenever possible.

6. There may be situations in which a person's legal representative is unavailable or unwilling to provide consent. Where, in the physician's opinion, no significant risks are associated with the medication, the agency should act in the person's best interest and assist the person in obtaining and taking the medication.

7. If positive supports have been identified that will assist in the treatment, reduction, or elimination of the person's symptoms or behaviors, document these in a written plan.

C. 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 PMTP. If the medication does not appear 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 or health that 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 recommends a different schedule. Document the visitation schedule in the person's treatment plan.

4. Continued need for the medication and possible reduction 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 have the prior written approval of the division director.

SUPERSESSION

DDD Policy 5.16
Issued November 1, 2003

DDD Policy 5.16
Issued July 1, 2001

DDD Policy 5.16
Issued May 26, 1999

DDD Policy 5.16
Issued January 30, 1996

Approved: */s/ Linda Rolfe* Date: 9/1/2005
Director, Division of Developmental Disabilities

ATTACHMENT A

PSYCHIATRIC REFERRAL SUMMARY

Client Name: _____ DOB: _____ Age: ____ Gender: M F

Address: _____

Supporting Agency: _____

Contact Person: _____ Phone: _____

Legal Representative: _____ 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.):

_____

_____

_____

_____

PSYCHIATRIC REFERRAL SUMMARY (continued)

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

_____

_____

_____

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

_____

_____

_____

_____

_____

List diagnoses/medical concerns:

_____

_____

_____

_____

_____

Current medications and daily dose:

_____

_____

_____

_____

_____

List any known unusual or adverse reactions to medications:

_____

_____

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

Sleep pattern _____

Mood/affect _____

Eating/appetite _____

Thinking/cognition _____

Memory _____

Anxiety level _____

Hyperactivity _____

Sensory impairments _____

PSYCHIATRIC REFERRAL SUMMARY (continued)

Allergies _____

Gynecological problems _____

Urinary problems _____

Communication impairment _____

Other Information that may be pertinent:

_____

_____

_____

_____

_____

_____

ATTACHMENT B

PSYCHOACTIVE MEDICATION TREATMENT PLAN

Name: _____ DOB: _____ Date: _____

Supporting Agency: _____ Phone: _____

Description of behavior(s) for which medication is prescribed and a mental health diagnosis, if available:

_____

_____

_____

Medication(s):	Dosage and Frequency:
_____	_____
_____	_____
_____	_____
_____	_____

Trial period (how long before an effect should be noticed):

_____

Behavioral criteria to evaluate effectiveness of medication (what changes in behavior, mood, thought or functioning should be expected):

_____

_____

_____

_____

Potential interactions with other drugs/food:

_____

_____

Prescribing Professional:_____ Phone: _____

Return for medication monitoring: ☐ 1 month ☐ 3 months ☐ 6 months ☐ Other: _____

_____
Name of Person Completing Form

ATTACHMENT C

INFORMATION REGARDING PSYCHOACTIVE MEDICATION

Name: _____ DOB: _____ Date: _____

Description of behavior for which medication is prescribed and mental health diagnosis, if available:

_____

_____

Medication(s):	Dosage and Frequency:
_____	_____
_____	_____
_____	_____
_____	_____

Information on medication: attach information sheet(s) that describe the medication, dosage ranges, possible side effects and potential adverse drug interactions.

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

Name: _____ Phone: _____

Information reviewed with the client/legal representative on: _____.

_____
Name of Person Completing Form

To be completed by client/legal representative:

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.

_____ _____
Signature of Client Date

_____ _____
Signature of Client's Legal Representative Date

ATTACHMENT D

PSYCHOACTIVE MEDICATION TREATMENT PLAN
ANNUAL CONTINUATION OF MEDICATION

Name: _____ DOB: _____ Date: _____

Address: _____

Supporting Agency: _____ Phone: _____

Description of behavior for which medication is prescribed and mental health diagnosis, if available:

_____

_____

Medication(s):	Dosage and Frequency:
_____	_____
_____	_____
_____	_____
_____	_____

Positive results of this medication and justification for continuation:

_____

_____

_____

Plan to continue use of this medication:

_____

_____

_____

Schedule return visit in:

_____

_____

Name of Person Completing Form