7.2.22 GENERAL PSYCHOACTIVE MEDICATION ULITLIZATION GUIDELINES

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References:	California Business & Professions Code Sections 2725-2836 American College of Obstetricians and Gynecologists (ACOG) Guidelines on Psychiatric Medication Use During Pregnancy and Lactation, American Family Physician: 2008; Sep 15; 78(6):772-778 Lanterman-Petris-Short Act, California Welfare and Institution Code, Section 5000 California Welfare & Institutions Code (WIC) § 5328
Policy Owner:	Behavioral Health Division, Quality Assessment and Performance Improvement (QAPI), Quality Assurance Manager
Director Signature:	**Signature on File**

I. Policy Statement

This policy establishes guidelines for the appropriate prescribing of psychotropic medications within the Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD), Mental Health Services (MHS). It ensures that prescribing practices are consistent across the Division and adhere to relevant state and federal standards, providing a framework for safe and effective client care.

II. Scope

This policy applies to all DHS-BHD Covered Persons including employees (full-time, part-time, extra-help), unpaid interns, paid interns, temporary agency workers, registered volunteers, and all individual providers contractually designated as Covered Persons. Covered Persons do not include Community Based Organization (CBOs) staff.

III. Definitions

Not Applicable

IV. Policy

The DHS-BHD, MHS maintains a policy to ensure that the practices of prescribing psychotropic medications are consistent within the Division and are aligned with state and federal guidelines. These guidelines serve as a point of reference or norm by which psychiatric providers prescribe psychotropic medications in the treatment of psychiatric disorders.

V. Procedures

The following guidelines are not intended to replace prescribers' clinical judgment. For example, the dosage required for long-term maintenance may be lower than the minimal range. Prescribers should document the rationale for prescribing practices that deviate from these guidelines.

A. Use of Psychotropic Medications

1. General Principles: Any decision to prescribe a psychotropic medication needs to be clearly documented in the client's medical records. This documentation should include the anticipated risks and benefits of the medication, as well as specific case characteristics that may impact the use of the medication. Refer to Section C, "Documentation", below.

2. Doses and Duration: The doses and duration of psychotropic medication administration should be the least amount necessary to achieve the best possible results.

3. Dosage Application: In general, standard dosages apply to physically healthy adults of ordinary size. Dosages should be decreased and/or adjusted when applied to children, the elderly, or to any clients with complicating medical issues (See guideline 10, "Pregnancy", below).

4. Geriatric Upper Limits: For geriatric clients, the starting dose should be low and raised slowly, due to decreased tolerance.

5. Children and Adolescents: For clients under 18 years of age, refer to BHD Policy No. 7.2.23, "Psychoactive Medication Utilization Policy for Children and Adolescents".

6. Exceeding Usual Range Limits: When the upper limits of psychotropic medication dosages need to be exceeded, the treating prescriber must explicitly note indications for such exceptions in the client's chart. A

consultation with a peer psychiatrist or DHS-BHD Medical Director is recommended, and must be noted in the client's medical record. Because of individual variation, some clients may be treated with medication doses either below or above the usual range.

7. Single Dose of Medications: If a single dose of medication in a 24-hour period is considered medically feasible by the prescriber, a single dose may be preferred to ease adherence to the recommended treatment.

8. Adverse Medication Reaction: Staff should be familiar with potential adverse effects and report them to the prescribing provider or designated clinician if the prescribing provider is unavailable.

9. Polypharmacy: Prescribers should seek to minimize the use of multiple psychoactive medications in client care whenever possible. Generally, only one medication within a psychotropic class should be prescribed at a time. In cases of refractory depression, two (2) antidepressants may be concurrently prescribed. In cases of refractory or unstable bipolar disorder, up to three (3) mood stabilizers may be prescribed. Multiple medications should not be initiated simultaneously, unless the client has a history of previous benefit and tolerability to that combination of medications. Five (5) or more psychotropic medications for one client calls for a consultation with a psychiatrist colleague.

10. Pregnancy: There are important medication side-effects and/or toxicities that can occur to babies who are exposed to psychotropic medication either in utero or post-partum via breast milk. As a result, any decision to utilize psychiatric medication for a pregnant or breast-feeding woman needs to be carefully analyzed in consultation with the mother's primary care and/or obstetric providers. Individual prescribers are urged to consult the American College of Obstetrics and Gynecology "Guidelines on Psychiatric Medication Use During Pregnancy and Lactation."

11. Individual Variation: Variations in age, sex, body weight, ethnicity, allergy potential, individual tolerance, concurrent medications, and metabolism of drugs, as well as the severity and type of illness, must all be considered as individualized regimens are designed.

12. Use of Long-Acting Injectable (LAI) Antipsychotics: LAIs may be considered as first-line treatment in schizophrenia, delusional disorder, and schizoaffective disorder, and as second-line treatment in bipolar disorder. Use of an LAI should follow an initial course of the short-acting version of the LAI for the length of time required to determine the effective dose, tolerability, and general safety of the antipsychotic medication.

B. Use of Analgesic Agents

1. In general, physically painful conditions requiring ongoing prescription analgesic medication should be referred to the clinical care of a general practitioner (GP). Repeated prescribing by a psychiatrist of controlled medications for the purpose of analgesia is contraindicated.

C. Documentation

1. Psychiatric Evaluation: Prior to initiating a psychiatric medication, an evaluation should be performed and documented in a service note format. This evaluation should include the symptoms that are targeted for treatment, as well as the risks and the benefits of the medication.

2. Informed Consent: Prescribers must inform the client/parent/caretakers of the purpose for the medication, possible side effects, and any special precautions, and must document the evidence of informed consent. Special concerns and discussions of risks and benefits should be documented in the prescriber's service notes.

3. Medication Changes: Must have an accompanying service note explaining the reasoning for the change. Any change in the prescription that exceeds the parameters specified in the original consent form for the use of that same medication requires a new consent form.

4. Medication Orders and Reconciliation: All new medication orders should be clearly documented in the medical record, utilizing CalMHSA Rx through SmartCare for outpatient medication orders, or client orders for Crisis Stabilization Unit (CSU) medication orders that need to populate the Client Medication Administration Record (MAR) or form MHS 208, "Medication Administration Record for Crisis Stabilization Unit." All previous medication orders should be reviewed at each visit, and the medication record should indicate which medication orders are to be continued, changed, or discontinued.

5. Service Notes: Prescriber should address progress, symptoms, medication response, side effects, and rationale for prescribing medications. Refer to BHD Policy No. 7.1.17, "Documentation Requirements for all Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) Services" for further requirements.

6. Medication History: Whenever possible, a comprehensive medication history shall be obtained to support effective treatment. This should include a history of previous medication use and response. It should also include current use and the need for other medications prescribed for non-psychiatric conditions, to avoid potential adverse medication interactions.

7. Frequency of Follow-Up Appointments: It is the Division's expectation that when prescribed a new medication, the client should be seen within 30 days. For routine medication follow-up visits, the interval of time between visits should not exceed four months.

8. Medication Administration: Under clinical direction of the supervising physician, the Registered Nurse (RN), Licensed Vocational Nurse (LVN), or Licensed Psychiatric Technician (LPT) will, when indicated, administer the psychotropic medication orally (PO) or intramuscularly (IM). The RN, LVN, or LPT will write a service note to document the medication administration. Documentation will be reviewed by the psychiatric provider on, or before the next medication appointment date.

D. Client Participation

1. The client shall be an informed and active partner in any decision to use or not use psychiatric medication for the treatment of a mental health condition.

2. Clients shall be informed about the targeted symptoms, benefits, side effects, and adverse reactions related to the use of psychiatric medication. They shall also be informed of alternatives to the use of medication for any mental health condition. The client's medical record shall specifically document this informed consent. There are occasions when the use of a medication may be required on an emergency basis without informed consent to prevent serious injury or death to the client or others. In these cases, short-acting medications will be utilized to address only the emergency condition.

3. All use of involuntary medication under the Lanterman-Petris-Short (LPS) Act will adhere to federal and state guidelines for due process.

E. Integrated Care

1. All prescribers of psychotropic medications are encouraged to coordinate care with primary care providers and other medical specialists. This coordination should involve medication reconciliation and consultation around mental health issues that impact the medical wellbeing of our clients. This coordination is strongly recommended for all pregnant or breast-feeding women who are taking psychotropic medications.

F. Medication Consultations

1. Consultations with a psychiatrist are recommended in the following circumstances:

   a. When the standard upper dosage limits of psychotropic medications are exceeded.

b. When a conventional neuroleptic or amoxapine is prescribed for a client with diagnosed or suspected Tardive Dyskinesia (TD).

c. A client receives more than two drugs in a class.

d. A client receives five (5) or more psychotropic medications.

e. When dosing quantities or frequency diverge for youth and adolescent parameters indicated in BHD Policy No. 7.2.23, “Psychoactive Medication Utilization Policy for Children and Adolescents.”

G. History and Physical Examination Requirements

1. New outpatients who have not had a history and physical examination within the past six (6) months, and who are being considered for medication treatment, should be encouraged (and referred) to have a medical history and physical examination.

H. Metabolic Monitoring

1. All clients placed on antipsychotics need to be managed according to the DHS-BHD protocol for metabolic monitoring.

I. TD Screening and Monitoring

1. Screening is intended to facilitate early detection of TD.

2. Screening is conducted for all clients placed on psychotropic medication.

3. At the initial evaluation, and at all subsequent medication appointments, TD will be monitored and documented in the service notes.

4. Abnormal findings require documentation of efforts to reduce, discontinue, or change psychotropics, or the rationale for continuing the same psychotropic regimen.

5. In the presence of TD, the Abnormal Involuntary Movement Scale (AIMS) form MHS 404 will be completed and updated at least annually, or more frequently, as clinically indicated.

6. **Who May Conduct Screening:** In addition to physicians, registered nurses may screen clients for TD. In this case, any new abnormal findings or an intensification of previously observed symptoms require immediate consultation with a prescriber and documentation in the service notes. This consultation must be documented in the client's mental health record.

VI. Forms

A. MHS 208 Medication Administration Record for Crisis Stabilization Unit

B. MHS 404 Abnormal Involuntary Movement Scale (AIMS)

VII. Attachments

None