Chapter Four

Recommended Guidelines

The recently published *Psychotropic Medications and Developmental Disabilities: International Consensus Handbook* (1998) is widely considered to be the guideline for current best practice standards for individuals with developmental disabilities. The goal for this handbook is to promote appropriate medication use and reduce extreme, unsafe, or abusive practices. This reference text provides a compilation of viewpoints from a variety of professional disciplines in assisting consumers and caregivers with treatment planning.

**Psychotropic Medications**

*Psychotropic Medications and Developmental Disabilities: The International Consensus Handbook* [p. 51] defines psychotropic medication as any medication prescribed to stabilize or improve mood, mental status, or behavior (1998). The purpose of psychotropic medication is to improve the individual's quality of life by reducing target behaviors or psychiatric symptoms. The use of psychotropic medications is evolving rapidly with the increasing knowledge of the effects of medication on the neurochemistry of the brain. Consideration must be given to determine if the target behaviors are being influenced by internal or external factors. Sovner and Hurley (1999) reported that many individuals with developmental disabilities have neurobiochemical imbalances, which may contribute to their target behaviors and psychiatric symptoms. In many cases, psychotropic medications can improve these symptoms.

**Appropriate Use of Psychotropic Medications**

(See PMUC Part I)

The use of psychotropic medications must be based on a psychiatric diagnosis or a specific behavioral hypothesis resulting from a functional assessment (Kalachnik et al., 1998). Many psychiatric disorders such as depression, bipolar affective disorders, and psychosis, respond well to treatment with psychotropic medication (Ferron, Kern, Hanson, & Wieseler, 1999). The interdisciplinary teams function is to ensure that psychotropic medication use is appropriate for a specific consumer. The team should examine the reason the medication is being prescribed in terms of psychiatric diagnosis and specific target behaviors, along with the methods to be used when evaluating effectiveness (Rinck, 1998).

The duration of time the individual is treated with a psychotropic medication will be dependant on the presenting problem along with the individual's relapse history. Kalachnik (1999) discusses usage timelines for consumers being treated with psychotropic medications.
Acute use is generally 3-6 months or less and is intended as a short-term support while further environmental modifications are developed or additional skills are acquired to address the consumer’s circumstances. Longer-term use may be needed to treat psychiatric disorders. For example, it is recommended for a first-time episode of depression that treatment continue for a minimum of 16 – 20 weeks (American Psychiatric Association, 2000). Twelve to 24 months may be needed to treat the initial episodes of psychosis. Maintenance therapy may extend for longer than 24 months and in some cases (e.g., bipolar affective disorder) may require lifelong treatment to prevent relapse.

It is important to consider the individual’s history, symptoms, and response to medications when determining whether or not a medication should be continued. In many cases, the consumer’s target behaviors or psychiatric symptoms are not a functional response to the environment, but rather based in biological neurochemical structures and pathways. Although programmatic interventions may be supportive in order to ameliorate the symptoms, medications will likely be required (Sovner & Hurley, 1999).

**Multidisciplinary Approach**

*(See PMUC Part I)*

The interdisciplinary team is a group of people from differing professions, as well as the consumer, their family, friends, and advocates. Interdisciplinary teams serve a variety of purposes including monitoring medications, strengthening the process of treatment decision making, and implementing a treatment philosophy (Davis et al., 1998).

In consultation with mental health professionals, the team plays an important role in establishing clear parameters for the use of psychotropic medication including titration rates, dosage plans, response timelines, expected duration of usage, outcome indicators, periodic reviews, and other medication options if the current plan is not efficacious. The team members determine which alternatives to pursue in the event of side effects or adverse events. Communication among members is paramount when planning and discussing what is best for the consumer.

**Use of Diagnostic and Functional Assessments**

*(See PMUC Part I)*

Psychotropic medication use should be based on a psychiatric diagnosis or a hypothesis on what maintains the challenging behavior. This information will be useful in determining if pharmacotherapy is warranted. It should be established through a thorough diagnostic assessment using DSM IV criteria or a functional assessment.

*Psychiatric Assessment.* Ferron, Kern, Hanson, & Wieseler (1999) describe the psychiatric assessment and examination as a process including evaluating the consumer’s overall appearance, defining the behavioral
symptoms, and considering his or her cognition. In many cases, the consumer may be unable to provide a history or current manifestations of his or her mental health disorder. A therapeutic alliance between the prescriber and the consumer's guardian, family, friends, advocates, and careproviders, from both home and day program, is a key element in obtaining valuable collateral information essential to accurately diagnosing and treating the presenting symptoms.

**Functional Assessment.** Part of a functional assessment is a systematic process to help determine the motivational function a target behavior serves (i.e., to obtain a reinforcer, escape an instructional situation, or provide sensory consequences). The purpose of the functional assessment is to identify:

- the antecedents and consequences of the behavior
- if the behavior represents a deficit or excess
- if the behavior is situationally inappropriate
- whether different patterns occur in different situations
- the possible schedule of reinforcement in effect (Kalachnik et al., 1998)

Once the function of the antecedents and consequences of a target behavior are understood, interventions can be considered and tailored to fit the client's specific situation (Miltenberger, 1999; see Chapter One of the Nonaversive Manual).

**Informed Consent**

*(See PMUC Part II)*

Written informed consent must be obtained from the consumer, if competent, or the consumer's legally authorized representative before medication can be initiated. Consent for the continued use of psychotropic medication must also be renewed by the last day of the month that informed consent expires.

*(See Chapter Six for specific instruction)*

**Target Behaviors and Empirical Measurement**

*(See PMUC Part I)*

Target behaviors and psychiatric symptoms should be clearly defined. Kalachnik et al. (1998, 1999) describes these as signs (observable evidence) and symptoms (subjective observations or sensations reported by the consumer). Target behaviors and psychiatric signs and symptoms should be tracked using a measurement system agreed upon by the interdisciplinary team. Objective measurement tracking will be helpful in monitoring the psychotropic medications efficacy.

*(See Chapters Five and Seven for more detailed information)*
Side Effect and Tardive Dyskinesia Monitoring

(See PMUC Part V and Part VI)

Periodic evaluation for side effects and tardive dyskinesia using standardized assessment instruments must be completed at regular intervals. Although, standardized assessments do not diagnose, they do provide essential information for further evaluation and follow-up by the prescriber. (See Chapter Three for further discussion regarding side effect and tardive dyskinesia)

Regular and Systematic Medication Review

Periodic systematic review of psychotropic medication should be addressed in the consumer’s individual treatment plan. The review involves sharing information and reviewing: (a) data, (b) changes in significant life events, (c) quality of life indicators, and (d) possible side effects or medication effects. The consumer should meet with the prescriber at regular intervals to evaluate medication efficacy and assess for potential side effects (Kalachnik et al., 1998). (See Chapter Seven for more discussion on monitoring)

Lowest Therapeutic Dose

In the past, regulations and guidelines were often based on the assumption that challenging behaviors were functional and required an environmental intervention. Sovner and Hurley (1999) suggest that treatment be targeted at the underlying issue resulting in the behavioral manifestation. In the case of a psychiatric disorder, medications would be considered first line treatment. If the target behavior is a response to environmental factors, then psychosocial or behavioral interventions would be the treatment of choice.

At least annually, the interdisciplinary team should evaluate whether psychotropic medications are at the lowest therapeutic dose. Periodic review does not require that a psychotropic medication must be reduced for the consumer. Decisions to reduce or eliminate a medication should be based on the individual’s diagnosis, treatment response, and medication history. Gradual dose reduction is generally recommended to minimize withdrawal effects and monitor for decompensation. In situations where an extremely low dose of medication is prescribed or adverse effects are present, the medication can be decreased more rapidly (Davis et al., 1998).

Dosage reductions should be considered in situations where a consumer experiences a dramatic improvement in target behaviors or psychiatric symptoms. These changes may be the result of a significant environmental change (e.g., a new living situation) or when a new medication is added to the existing medication regime. In addition, as individual’s age, they metabolize medication more slowly and may need less medication. Another situation warranting consideration of a dosage reduction is little or no response by the consumer over the pre-established timelines. Past attempts at reductions should be evaluated to determine if medication tapering was conducted in a systematic
and planned manner. The consumer's behavioral response to the change should be considered.

A number of situations exist that would contraindicate lowering the dosage of the psychotropic medications. These include:

- the current dose has been established as the lowest effective dose through previous reductions
- a psychiatric condition has been diagnosed and a number of relapses have occurred when recommended guidelines for maintenance treatment are tapered
- a severe relapse occurred the last time the dosage was lowered
- the consumer is functioning at their highest level
- major changes have recently occurred or are anticipated in the near future (Kalachnik, 1999).

Both the consumer and the interdisciplinary team must determine if the treatment enhances or interferes with his or her quality of life. Decisions regarding psychotropic medication should reflect the team's efforts to promote an optimal quality of life for the consumer.

**Medication Adjustments**

Most medications require a period of time to reach therapeutic levels (see Chapter Two). The interdisciplinary team, in conjunction with the prescriber, should establish expected timelines for dosage adjustments. This process will help decrease the potential for overreaction to short-term fluctuations in the frequency or severity of target behaviors or psychiatric symptoms.

In general, frequent medication changes should be avoided. A proactive plan is established by the interdisciplinary team providing outcome expectations (i.e. what behavioral changes are expected), and what will be done if outcomes are met or not achieved.

**Polypharmacy**

In general, keeping medication regimes as simple as possible is considered to be the best option. By minimizing the number of psychotropic agents used, the potential for medication interactions and possible side effects are reduced.

Intraclass polypharmacy refers to the concurrent use of two or more psychotropic medications from the same therapeutic class (e.g., two antidepressants). Interclass polypharmacy refers to the use of two or more psychotropic medications from different therapeutic classes. Different medications may be used conjointly to treat: (a) multiple symptoms, (b) as augmentative treatment to another medication, or (c) in treatment resistant cases. An example of this would be using lithium to synergistically boost the effects of the first line antidepressant, or using two antidepressants, with different mechanisms, together to enhance serotonin neurotransmission (Stahl, 2000).
When interclass or intraclass polypharmacy occurs, or the dosage of the psychotropic medication exceeds the FDA maximum, the prescriber must provide written justification.

Medication additions should be closely monitored by the interdisciplinary team to avoid stacking multiple medications in an attempt to treat refractory symptoms or persistent target behaviors. Over time it is easy to forget the reason why the medication was initially prescribed. There is often a reluctance to eliminate medications or decrease dosages for fear of dramatic deterioration in the consumer’s behaviors. Unfortunately, this can result in the accumulation of a variety of medications, often at high dosages.

**PRN Use**

(See PMUC Part IV)

Pro re nata (PRN) medications, or those used intermittently, may be helpful in some situations, especially during the assessment phase or when medication adjustments are in progress. When PRN medications are used, a plan providing behavioral and procedural criteria for their administration should be in place. If PRN medications are being routinely administered over an extended period of time, they should be prescribed as a regularly scheduled medication.

**Frequently Asked Questions**

*What should be done in a situation where the practitioner and interdisciplinary team disagree on the choice of medication?*

A representative of the interdisciplinary team and the prescriber should discuss the situation and explore the reason for their disagreement. In a non-emergency situation the legally authorized representative must give his or her consent before a medication can be initiated.

*What should be done if the consumer, who is competent to make his/her own decisions, does not want to take the medication?*

The consumer cannot be forced to take the medication. The casemanager should be contacted to arrange an interdisciplinary team meeting to discuss other options and whether an alternative decision maker should be pursued.

*Is it more appropriate for the primary physician or another specialist to prescribe psychotropic medications to consumers?*

The interdisciplinary team determines which provider is the best choice to follow the consumer’s psychotropic medications. Factors that should be
considered include how well the prescriber knows the consumer, their experience and knowledge related to developmental disabilities and mental disorders, and the reason the medication is being prescribed. It is advisable to consult with a mental health practitioner to review the consumer’s medication regime.

How often should medications be evaluated by the prescriber?
The interdisciplinary team determines the frequency at which the prescriber should evaluate the consumer's medication. When medication adjustments are in progress or a consumer is experiencing increased target behaviors or psychiatric symptoms, he or she may need to be seen at more frequent intervals.

What if a medication has a dual function and can be used as a psychotropic and also for another purpose (e.g., anticonvulsant, antihypertensive or antihistamine), when does psychotropic medication monitoring apply?
Regardless of the classification, whenever a medication is being used to treat severe challenging behaviors or psychiatric symptoms it needs to monitored using the psychotropic medication monitoring guidelines.

References

