POLICY: Psychiatry Services

PURPOSE: The purpose of this policy is to ensure that the individuals served receive psychiatric care consistent with generally accepted practice standards at State Supported Living Centers (SSLCs) and the ICF component of the Rio Grande State Center (“state centers”).

APPROVED BY: Joe Vesowate
Assistant Commissioner
State Supported Living Centers

APPLIES TO: State center employees, volunteers, contractors, and subcontractors. The provisions of this policy may not apply to prescribing practice in research projects that have been approved in accordance with DADS policies and procedures concerning the review and approval of research involving human subjects.

DISTRIBUTION: The state center must ensure the policy, all exhibits, and forms are distributed to applicable staff, contractors, agents, and any individual requesting a copy.

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EXHIBIT AND FORM:

Exhibit:
- Exhibit A – Psychotropic Medication List
- Exhibit B – Appendix B of the SA, with information added

REFERENCES:
- Settlement Agreement (SA), Section J and Health Care Guidelines
- 40 Texas Administrative Code, Chapter 5, Subchapter A and Chapter 8, Subchapter I
- Medication Audit Criteria and Guidelines: https://www.dshs.state.tx.us/mhprogra.ms/MedAudCriteria.shtm
I. State Center Responsibilities

A. The state center must ensure that individuals receive needed integrated clinical services, including psychiatry.

B. The state center must provide psychiatric services only by persons who are qualified professionals.

C. The state center must ensure that psychiatric consultation is available and that sufficient numbers of staff or contract psychiatrists, board certified/eligible psychiatrists, psychiatric advanced practice registered nurses (APRNs), and/or psychiatric physician assistants are available to provide appropriate psychiatric care to all individuals who reside in the State Centers.

D. The state center must ensure that individuals are evaluated and diagnosed by a psychiatrist prior to administration of psychotropic medications. The documentation of the psychiatric evaluation must follow the format in Exhibit A to this policy.

E. The state center must develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through disciplinary assessments and combined formulation.

F. Psychotropic medication must not be used as punishment, for convenience of staff, as a substitute for appropriate psychosocial treatments, or in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis.

G. The state center must promulgate procedures governing the scope of practice regarding prescription of psychotropic medications when the prescribing professional is not a psychiatrist.

H. The state center must provide education about psychotropic medications when appropriate to individuals, their families, and/or their legally authorized representatives (LARs) according to accepted guidelines.

1. If accepted guidelines do not exist, the education must address characteristics of the medication, including expected benefits, potential adverse or side effects, dosage, standard alternative treatments, legal rights, and any questions the individual, the family, and/or LAR may have.

2. Education should also address significant changes in the individual's medication regimen.

I. The state center must obtain informed consent (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures.
J. Prescription of psychotropic medications must comply with all relevant ICF/IID conditions of participation.

K. The prescribing professional must practice within the scope of the person’s license with supervision as appropriate to that license.

II. Pre-Treatment Sedation

A. Appropriate staff (i.e., psychiatry, pharmacy, medical, nursing, and psychology) reviews Pre-Treatment Sedation (PTS) orders for both routine dental and/or medical treatment for all individuals on psychotropic medication.

B. The IDT documents PTS, noting current treatments, strategies or programming, including desensitization plans, to minimize or eliminate the need for PTS. The IDT must confirm individuals who receive PTS have ongoing assessment and monitoring of effectiveness of strategies or programming to eliminate or reduce the reliance on PTS.

C. The IDT must coordinate PTS with other medications, supports and services, and as appropriate psychiatric, pharmacy and medical services.

D. Nursing staff assesses and monitors individuals pre- and post-treatment, including for side effects.

III. Assessment and Diagnosis

A. A psychiatrist may use evidence-based clinical practice guidelines promulgated by national and international organizations and from the federal and Texas governments to guide practice. In the absence of evidence-based clinical practice guidelines applicable to a specific situation, the psychiatrist uses clinical judgment and applies current generally accepted standards of practice.

B. The state center must conduct an initial Reiss screen:

1. Within 30 days of admission for all newly admitted individuals who are not on any psychotropic medication for a psychiatric diagnosis; and

2. For individuals residing at the state center who do not have a current psychiatric assessment and thereafter, as clinically indicated and recommended by the IDT.

C. The state center must complete a comprehensive psychiatric evaluation for:

1. Any individual identified as needing a comprehensive psychiatric evaluation based on a Reiss screen; and
2. Any newly admitted individual who has a psychiatric diagnosis or is receiving psychotropic medication.

D. The psychiatrist must diagnose and document the psychiatric disorder in accordance with the current Diagnostic and Statistical Manual (DSM) and/or the current clinical modification of the International Statistical Classification of Diseases and Related Health Problems.

E. The psychiatrist’s assessment and diagnosis must be consistent with current generally accepted professional standards of care as described in Exhibit B to this policy (Appendix B of the Settlement Agreement.)

F. All individuals must receive an annual psychiatric update/addendum for the comprehensive psychiatric evaluation (CPE), completed annually from the date of the last CPE or last CPE addendum.

IV. Treatment Management

A. All individuals must receive an assessment, a diagnosis, and a case formulation consistent with current, generally accepted professional standards of care (see Exhibit B).

B. Treatment plans must integrate pharmacological treatments with behavioral and other interventions.

C. Prior to implementing a proposed discipline-specific non-pharmaceutical plan or plans, the IDT, including a psychiatrist, must determine that the plan or plans:

1. Includes the least intrusive and most positive intervention;

2. Addresses whether the individual will be best served primarily through behavioral, pharmacological, or other interventions, in combination or alone; and

3. Identifies non-pharmaceutical treatments, interventions, and supports that are being used to address the signs and symptoms of the disorder in order to minimize the need for psychotropic medication to the degree possible.

D. The determination of the plan or plans addressed in C.1. – 3. above, may occur in person or through a telephonic communication, including during the psychiatric clinic, and the determination of these items must be documented in writing.

E. When medications are prescribed to treat both seizures and a mental health disorder, the neurologist and psychiatrist must coordinate the use of medications through the IDT process.
V. Psychotropic Medications

A. Prior to prescribing psychotropic medications known to cause movement disorders, a trained and competent staff member must screen the individual for abnormal involuntary movements using the MOSES and DISCUS as determined necessary by the psychiatrist and document the result of the examination.

B. The psychiatrist must indicate psychotropic medications used to treat specific target behaviors with an appropriate psychiatric diagnosis or a specific behavioral-pharmacological hypothesis.

C. Before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse must determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications. This determination may occur in person or through a telephonic communication, including during the psychiatric clinic, and the determination must be documented in writing.

D. The psychiatrist must solicit input from and discuss with the IDT any proposed alternative treatment, incorporating behavioral and other interventions to minimize the need for psychotropic medication to the degree possible.

E. For every individual receiving psychotropic medication, the IDT, including the psychiatrist, must:

1. Ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis;

2. Determine the expected timeline for the therapeutic effects of the medication to occur;

3. Determine the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment’s efficacy;

4. Determine by whom, when, and how this monitoring will occur; and

5. Provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual’s current status and/or changing needs, but no less often than quarterly.

F. The psychiatrist, in conjunction with the pharmacist and appropriate staff, must conduct quarterly reviews of the risk versus benefit of continued psychotropic medication therapy as well as the appropriateness of drug selection, effectiveness,
dosage, and presence or absence of side effects. The psychiatrist documents the review in the active record. The pharmacist’s input must include the written quarterly Drug Regimen Review, but may also include participation in the discussion.

G. The prescribing professional must document quarterly the rationale for initiating, continuing or discontinuing psychotropic medication in the active record.

H. Each month, the psychiatrist and designated staff must review and monitor individuals who are prescribed two or more psychotropic medications from the same class, or three or more psychotropic medications, regardless of the class. The pharmacist must develop a plan to eliminate polypharmacy that are not clinically justified.

I. The prescribing professional must monitor required parameters using the state monitoring guidelines. The guidelines can be found online at: https://www.dshs.state.tx.us/mhprograms/MedAudCriteria.shtm

J. Psychotropic Medications Ordered for Emergencies

1. The prescribing professional may order the immediate administration of psychotropic medication for a psychiatric emergency. State centers must have procedures for emergency use of psychotropic medications. The procedures for emergency use must address:

   a. Indications;

   b. Appropriate medication classes and dosing, including maximum dose in 24 hours;

   c. Assessment of effectiveness;

   d. Staff monitoring of individual for adverse reactions;

   e. Individual education as appropriate;

   f. Review with consideration of changing the current plan of care if a pattern of use of psychiatric emergency orders emerges; and

   g. Documentation of time frames and standards that address the incident, the use of medications, and the outcome.

K. The psychiatrist must assess and document a psychiatric emergency in the psychiatry notes as soon as feasible after the emergency.

VI. Monitoring for Medication Side Effects
A. All staff providing care for individuals who are receiving psychotropic medications must be aware of the side effects and must regularly monitor those individuals for the side effects.

B. The nursing staff must complete the Monitoring of Side Effects Scale (MOSES) every six months and the Dyskinesia Identification System—Condensed User Scale (DISCUS) every three months for all individuals receiving psychoactive medications. (See Exhibit A, Psychotropic Medication List for MOSES/DISCUS requirements.) In addition, nursing staff must complete:

1. a MOSES and DISCUS when a new psychotropic medication is initiated (only for specific medications as listed on the Psychotropic Medication List, unless specified by prescriber);

2. a DISCUS once a month for three months after an antipsychotic or metoclopramide is discontinued and every three months until symptoms are resolved; and

3. a MOSES and DISCUS within 30 days of a psychoactive medication dose change, as clinically determined necessary by the psychiatrist.

C. The psychiatrist must review the results of these scales to monitor the side effects of psychotropic medications.

VII. Dyskinesia

A. A psychiatrist, neurologist, or primary care provider must verify the diagnosis of movement disorder, including tardive dyskinesia.

B. The professional who diagnoses the dyskinesia must document the duration and severity of dyskinesia in the individual's individual progress notes (IPN).

C. The prescribing professional must document the diagnosis in the CPE/updated CPE and include relevant information and justification for continued antipsychotic use.

D. State centers must provide the individual and LAR with relevant education about the diagnosis and its implications for psychotropic medication use.

E. The prescribing professional must assess the risks and benefits of continued psychotropic medication use and communicate these to the individual and LAR.

F. The prescribing professional, if not a psychiatrist or neurologist, must obtain and document consultation from a psychiatrist or neurologist if continued use of psychotropic medication is considered after the diagnosis of tardive dyskinesia.

VIII. Documentation
A. All clinical documentation must be accurate and legible and must include date, time, and signature.

B. Psychiatric assessments must be typed or transcribed.

C. Progress notes may be handwritten, typed, or transcribed. If handwritten, notes must be legible. Progress notes must use the SOAP (subjective, objective, assessment, and plan) format.

D. Documentation of Acute Psychiatric Problems

1. When documenting the assessment of an individual with an acute psychiatric problem, include:
   a. A comprehensive history of the problem, including relevant past medical history and, in an emergent situation, a complete review of the relevant history;
   b. The source of the information (e.g., direct support professional, licensed vocational nurse, registered nurse, qualified developmental disability professional, psychologist, past medical history);
   c. All pertinent physical examination findings;
   d. Results of diagnostic tests;
   e. A differential diagnosis based on current DSM and, if needed, DM-ID nomenclature; and
   f. A plan for treatment, as well as further evaluation, treatments, and monitoring.

2. Document follow-up assessments until the problem is resolved or has stabilized.

3. Specific medical orders include instructions for the monitoring that the psychiatrist expects from the nursing, psychology, direct support professionals, and/or any other staff for ongoing assessment of the acute problem.

E. Orders

1. List indication(s) for each medication on all orders.

2. Document the rationale for medical orders representing a significant change in therapy in a progress note.

3. Orders may be typed, transcribed, or handwritten.
4. Orders only include abbreviations approved by the state center.

5. Ensure that results of laboratory tests are reviewed and critical lab values are addressed and documented.

**IX. Quality Assurance**

A. State centers must monitor and address quality of psychotropic medication-related services. The review must include the following per the psychiatric monitoring tool:

1. Clinically justifiable evaluation/diagnosis;

2. Use of psychotropic medication;

3. Pre-treatment sedation;

4. Procedure for psychiatric assessment;

5. Reiss Screen, if positive for maladaptive behavior;

6. Non-pharmacological treatments, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible;

7. Risk versus benefit;

8. Psychotropic polypharmacy;

9. MOSES and DISCUS;

10. Treatment plans for psychotropic medications;

11. Informed consent; and

12. Collaboration with neurology.

B. State centers must establish a system to review and monitor individuals who are prescribed two or more psychotropic medications from the same class, or three or more psychotropic medications, regardless of the class. The monitoring system must track and trend prescribing information by individual, by prescriber, and by medication.

C. State centers must establish a tracking system for using the MOSES or DISCUS to monitor, detect, report, and respond to side effects of psychotropic medications at least quarterly or as needed.
D. State centers may develop tracking systems as needed for other areas.

X. **Data Collection**

A. Each state center tracks, trends, and analyzes the number of:

1. Individuals on psychotropic medications;

2. Individuals who are prescribed two or more psychotropic medications from the same class, or three or more psychotropic medications, regardless of the class;

3. Completed comprehensive psychiatric assessments;

4. Individuals for whom a MOSES or DISCUS was completed; and

5. Individuals who have tardive dyskinesia.

B. The state center psychiatrist or designee submits data to the State Office data analyst at the end of each quarter of the fiscal year.
**DRAFT Definitions (to be added to the Definitions Dictionary)**

**Case formulation**: A process of review and integration of the information obtained from clinical assessments to identify factors that are hypothesized to influence an individual’s condition, functional abilities, and quality of life. The process involves the participation of various clinical disciplines, including psychology, applied behavior analysis, and psychiatry. The result of case formulation should aid the IDT in making decisions regarding the support and services needed for individuals with a behavioral disturbance or psychopathology. (See Sections I.E. and IV.A. and Exhibit B of this policy for more information).

**Contractor**: A person who contracts with a facility to provide services to an individual, including an independent school district that provides educational services at the facility. (40 TAC §3.101)

**DM-ID**: *Diagnostic Manual-Intellectual Disability: A Clinical Guide for Diagnosis of Mental Disorders in Persons with Intellectual Disability*, a joint publication of the National Association for the Dually Diagnosed and the American Psychiatric Association which provides information relevant to making accurate diagnosis in persons with intellectual disability and addresses the limitations in applying DSM-IV-TR criteria to persons with intellectual disability.

**DSM**: The current edition of *The Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Press. (40 TAC §5.3(3))

**Emergency**: A situation which, in the opinion of the treating physician or other appropriate professional, the immediate use of medication is necessary for acute treatment or essential to interrupt imminent danger to the individual served or others. (40 TAC §8.203(4))

**Individual support plan (ISP)**: An integrated, coherent, person-directed plan that reflects an individual's preferences, strengths, needs, and personal vision, as well as the protections, supports, and services the individual will receive to accomplish identified goals and objectives. (40 TAC §3.101)

**Interdisciplinary team (IDT)**: An interdisciplinary team, with the active participation of the individual and legally authorized representative (LAR), that is responsible for assessing the individual's treatment, training, and habilitation needs and making recommendations for services based on the personal goals and preferences of the individual using a person-directed planning process, including recommendations on whether the individual is best served in a facility or community setting. (40 TAC §3.101)

**Legally authorized representative (LAR)**: A person authorized by law to act on behalf of an individual, including a parent, guardian, or managing conservator of a minor individual, or a guardian of an adult individual. (40 TAC §3.101)
**Polypharmacy**: The prescription of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual. (Settlement Agreement, Part II, Section J11)

**Positive behavior support plan (PBSP)**: A comprehensive, individualized plan that contains intervention strategies designed to modify the environment, teach or increase adaptive skills, and reduce or prevent the occurrence of target behaviors through interventions that build on an individual's strengths and preferences, without using aversive or punishment contingencies. The PBSP is a component of the Individual Support Plan (ISP). (40 TAC §3.101 and Settlement Agreement, Part II, Section A.3.)

**Prescribing professional**: A physician or other health care professional who, as authorized by statute, may prescribe under the supervision of a physician. (40 TAC §5.3(10))

**Primary care provider (PCP)**: A physician, advanced practice registered nurse, or physician assistant who provides primary care to a defined population of patients. The PCP is involved in health promotion, disease prevention, health maintenance, and diagnosis and treatment of acute and chronic illnesses. (40 TAC §3.101)

**Psychiatric Emergency**: A situation in which, in the opinion of the physician, it is immediately necessary to administer medication to an individual to ameliorate the signs and symptoms of mental illness and to prevent:

a. Imminent probable death or substantial bodily harm to the individual because the individual:
   i. Overtly or continually is threatening or attempting to commit suicide or serious bodily harm; or
   ii. Is behaving in a manner that indicates that the individual is unable to satisfy the individual’s need for nourishment, essential medical care, or self-protection; or

b. Imminent physical or emotional harm to others, because of threats, attempts, or other acts the individual makes or commits. (40 TAC §5.3(12))

**Psychiatrist**: A physician who is certified by the American Board of Psychiatry and Neurology, or who is board-eligible (has completed a residency training program in psychiatry approved by the Residency Review Committee of the American Council on Graduate Medical Education).

**Psychotropic medication**: A medication prescribed for the treatment of symptoms of psychosis or other severe mental or emotional disorders and that is used to exercise an effect on the central nervous system to influence and modify behavior, cognition, or
affective state. Psychotropic medications include antipsychotics and neuroleptics; antidepressants; agents for the control of mania or depression; antianxiety agents; sedatives, hypnotics or other sleep-promoting drugs; psychomotor stimulants, and medications used for treatment of dementia.
## Classes of Medications Frequently Used for Psychiatric Indications

Consent is required for any medication that is used in the treatment of a psychiatric diagnosis or symptom, whether or not the medication is included in this list. Refer to physician order for determination of indication for use.

The classification of psychotropic medication is fairly standard but medications can be used for treatment of illnesses that would be considered listed under a different classification. For example, some medications listed under antipsychotics may be used as a mood stabilizer. MOSES and/or DISCUS requirement in red.

### Antidepressants (MOSES)
- amitriptyline (Elavil)
- amoxapine (Asendin)
- bupropion (Wellbutrin, Wellbutrin SR)
- bupropion (Wellbutrin XL)
- citalopram (Celexa)
- desipramine (Norpramin)
- desvenlafaxine (Pristiq) nonformulary
- doxepin (Sinequan)
- duloxetine (Cymbalta)
- escitalopram (Lexapro)
- fluoxetine (Prozac)
- imipramine (Tofranil)
- maprotiline (Ludiomil)
- mirtazapine (Remeron, Remeron SolTab)
- nefazodone (Serzone) nonformulary
- nortriptyline (Pamelor, Aventyl)
- paroxetine (Paxil, Paxil CR)
- protriptyline (Vivactil)
- sertraline (Zoloft)
- trazodone (Desyrel)
- trimipramine (Surmontil)
- venlafaxine (Effexor, Effexor XR)

### Antipsychotics (MOSES and DISCUS)
- aripiprazole (Abilify)
- asenapine (Saphris)
- chlorpromazine (Thorazine)
- clozapine (Clozaril, Fazaclol) Reserve
droperidol (Inaprine) nonformulary
- fluphenazine (Prolixin)
- fluphenazine decanoate (Prolixin D)
- haloperidol (Haldol)
- haloperidol decanoate (Haldol D)
- iloperidone (Fanapt) Reserve
- loxapine (Loxitane)
- lurasidone (Ludata)
- olanzapine (Zyprexa, Zyprexa Zydis)
- olanzapine pamoate (Zyprexa Relprevv) Reserve
- paliperidone (Invega)
- paliperidone palmitate (Invega Sustenna)
- perphenazine (Trilafon)
- pimozide (Orap) nonformulary
- quetiapine (Seroquel)
- quetiapine (Seroquel XR) nonformulary
- risperidone (Risperdal, Risperdal M-Tab)
risperidone (Risperdal Consta)
- thioridazine (Mellaril)
- thiothixene (Navane)

### Anxiolytics/Sedatives/Hypnotics (MOSES)
- alprazolam (Xanax, Xanax XR)
- buspirone (BuSpar)
- chloral hydrate (Noctec)
- chlordiazepoxide (Librium)
- clonazepam (Klonopin)
- clorazepate (Tranxene)
- diazepam (Valium)
- diphenhydramine (Benadryl)
- eszopiclone (Lunesta) nonformulary
- flurazepam (Dalmene) nonformulary
- hydroxyzine (Atarax, Vistaril)
- lorazepam (Ativan)
- oxazepam (Serax)
- pentobarbital (Nembutal) nonformulary
- ramelteon (Rozerem) nonformulary
- temazepam (Restoril)
- triazolam (Halcion)
- zaleplon (Sonata)
- zolpidem (Ambien)

### Mood Stabilizers (MOSES)
- carbamazepine (Tegretol, Tegretol XR, Carbatrol, Equetro)
divalproex sodium (Depakote, Depakote ER)
lithium (Eskalith, Eskalith CR, Lithobid)
- valproic acid (Depakene)
oxcarbazepine (Trileptal)
lamotrigine (Lamictal)

### Stimulants (MOSES)
- amphetamine/dextroamphetamine mixture (Adderall, Adderall XR)
dexamfetamine (Dexedrine)
lisdexamfetamine (Vyvanse) nonformulary
methamphetamine (Desoxyn) nonformulary
methylphenidate (Ritalin, Ritalin SR, Concerta, Metadate, Metadate CD)
methylphenidate patch (Daytrana) nonformulary

### Chemical Dependency Adjuncts (MOSES)
- acamprosate (Campral) nonformulary
- disulfiram (Antabuse)
naltrexone (ReVia, Vivitrol)
topiramate (Topamax)
trifluoperazine (Stelazine)
ziprasidone (Geodon)

Monoamine Oxidase Inhibitors (MOSES)
- isocarboxazid (Marplan)
- phenelzine (Nardil)
- selegiline (Emsam) nonformulary
- tranylcypromine (Parnate)

Miscellaneous Drugs (per provider)
- atomoxetine (Strattera)
- atenolol (Tenormin)
- clomipramine (Anafranil)
- clonidine (Catapres)
- clonidine ER (Kapvay) nonformulary
- fluvoxamine (Luvox)
- gabapentin (Neurontin)
- guanfacine (Tenex)
- guanfacine ER (Intuniv) nonformulary
- metoprolol (Lopressor)
- nadolol (Corgard)
- propranolol (Inderal)
- reserpine (Serpasil) nonformulary
- naltrexone (ReVia)
- olanzapine/fluoxetine (Symbyax) nonformulary
- pindolol (Visken) nonformulary

Other Medications requiring MOSES and DISCUS)
Metoclopramide (Reglan)
Anticholinergics
STATE CENTERS
Psychiatric Evaluations/Assessments

I. Identifying Information
   a. Name
   b. Age
   c. Gender
   d. Ethnicity
   e. Housing
   f. Marital status

II. History of Present Illness
   a. Behavioral concerns: antecedents, frequency, intensity, duration
   b. Substance use
   c. Suicidal/homicidal ideation
   d. Current medications, pattern of use, efficacy
   e. Psychiatric symptoms
   f. Neuro-vegetative symptoms

III. Past Psychiatric History
   a. Inpatient treatment
   b. Outpatient treatment
   c. Medication history
   d. Previous diagnosis
   e. Trauma history
   f. History of self-injury, suicide, aggression to others

IV. Family History
   a. Psychiatric disorders
   b. Medical disorders, especially diabetes, cardiovascular disease, CVA, HTN
   c. Neurological syndromes

V. Substance Use History
   a. Alcohol: first drink, DUI, blackouts, current pattern
   b. Drugs of abuse, including IVDU
   c. Tobacco
   d. Caffeine

VI. Medical History
   a. Active conditions
   b. Past history
   c. Current medications
   d. Allergies
   e. Diet
   f. Exercise habits
VII. Developmental History
   a. Prenatal and birth history
   b. Early development
   c. Family relationships
   d. Educational history

VIII. Social History
   a. Relationship history (marriage, partner, children)
   b. Work history
   c. Legal history
   d. Sexual history

IX. Physical Examination
   a. Pertinent positives and negatives
   b. Neurological findings

X. Labs
   a. Urine drug screen
   b. Pertinent positives and negatives

XI. Mental Status Examination
   a. General observations
      i. Appearance (jewelry, scars, tattoos)
      ii. Behavior (eye contact/calm/agitated, psychomotor slowing/pressure/agitation)
      iii. Speech
      iv. Cooperativeness
   b. Thinking
      i. Thought process (logical, goal-directed, loose, tangential, circumstantial, over-inclusive)
      ii. Thought content (preoccupations, delusions, suicidal ideation, homicidal ideation)
      iii. Perception (auditory, tactile, visual, olfactory, gustatory hallucinations)
   c. Emotion
      i. Affect
      ii. Mood
   d. Cognition
      i. Orientation
      ii. Attention and concentration
      iii. Memory
      iv. Insight
      v. Judgment

XII. Diagnostic Assessment (five axes)
   a. Provide clinically justifiable diagnoses for each individual. All diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review.
   b. The documented justification of diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist).
c. Differential diagnoses, “deferred,” or “rule-out” diagnoses, and a diagnoses as listed as “NOS” (“Not Otherwise Specified”) are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner.
d. If the determination is “no diagnoses” this is considered to be clinically justified and documented.

XIII. Bio-Psycho-Social-Spiritual Formulation (Case Formulation)
Case formulation consists of the following sequential tasks, undertaken to channel distinct disciplinary assessments into the creation of an integrated treatment plan:
a. Review and integration of information from the disciplinary assessments;
b. Identification of important factors, in a biological psychological social and spiritual hierarchy, that affect the individual's condition, functional abilities, and quality of life;
c. Creation of clinically based predictions about the individual's needs; and
d. Design of integrated treatment, habilitation, and enrichment interventions, through the interdisciplinary treatment process, to meet the individual's needs.
e. Identification of concerns related to individual’s preferences, strengths, and needs

XIV. Treatment Recommendations
a. Pharmacological intervention (includes psychoactive polypharmacy)
b. Non-pharmacological intervention

XV. Community Placement
a. Assessment identifies supports and obstacles to placement
b. Interdisciplinary Team members’ recommendation regarding appropriateness of community placement