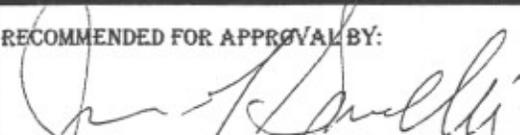
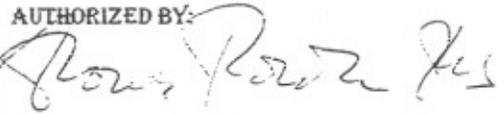




DEPARTMENT OF CORRECTIONS
 AGENCY OF HUMAN SERVICES
 STATE OF VERMONT

NUMBER

____ POLICY
 ____ DIRECTIVE
 ____ PROCEDURE
 361.01.14 PROTOCOL

SUBJECT Psychotropic Medications	EFFECTIVE DATE 8/20/97	REVIEWED AND RE-ISSUED	SUPERSEDES NEW
RECOMMENDED FOR APPROVAL BY:  SIGNATURE	AUTHORIZED BY:  SIGNATURE		

I. AUTHORITY

28 V.S.A. Section 801; 28 V.S.A. Section 903; 28 V.S.A. Section 906; 28 V.S.A. Section 907.

II. PURPOSE

The purpose of this policy is to ensure that all psychotropic medications, will be administered to inmates in a timely manner, appropriately documented, and in accordance with all legal requirements.

III. APPLICABILITY/ACCESSIBILITY

All individuals and groups affected by operations of the Department of Corrections may have a copy of this procedure.

IV. DEFINITIONS

Administration of Medication: the act in which a single dose of an identified drug is given to a patient.

Medication Administration Record (MAR): the legal document upon which administration of medication is documented.

Medication Distribution System: the system of delivery, storage of and accounting for drugs from the source of supply to the point at which they are administered to the patient.

Psychotropic Medication: medication that effects the central nervous system and which is employed to treat symptoms of mental illness. These medications may influence thinking, mood and behavior and include antipsychotics, antidepressants, anti-anxiety agents, sedative hypnotics, psychomotor stimulants, lithium and anticonvulsants prescribed to control mood fluctuations. These medications include any medications approved by the FDA for the treatment of psychiatric illness as well as those medications commonly used in the private sector for treatment of psychiatric illness.

Serious Mental Illness: means a substantial disorder of thought, mood, perception, orientation or memory, any of which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.

Mental Health Professional: means a person with professional training, experience and demonstrated competence in the treatment of mental illness, who is a physician, psychiatrist, psychologist, social worker, nurse, psychiatric nurse practitioner or other qualified person determined by the Commissioner of Developmental and Mental Health Services.

V. PROTOCOL

It is the policy of the Vermont Department of Corrections to provide an inmate with psychotropic medications when a physician or psychiatric nurse practitioner prescribes this treatment as a part of the inmate's overall comprehensive individualized treatment plan. Psychotropic medications shall be utilized for clinical benefit only; never as a form of punishment or method of controlling non-psychiatric behavior. Medications will be prescribed based on clinical presentation, mental health diagnosis and in accordance with the prevailing standard of care in the psychiatric community. Inmates shall be advised of the potential risks, benefits and potential side effects of accepting psychotropic medication. The appropriate process of informed consent shall be documented.

- A. Referral to physician or psychiatric nurse practitioner by a qualified mental health professional
 1. Inmates who are admitted to the facility are referred to the physician or psychiatric nurse practitioner for psychotropic medications based on the results of the mental health evaluation.
 2. Institutional staff may not refer an inmate directly to the physician or psychiatric nurse practitioner for psychotropic medications but rather they must follow procedures in accordance with Mental Health Referral policy.
- B. Inmates admitted to the facility who are currently taking psychotropic medications
 1. When the Initial Need Survey and/or Intake Medical Screening indicate that the inmate has been receiving psychotropic medication, the correctional officer shall deliver all such medicines to the appropriate health services staff. Health services shall contact the physician or psychiatric nurse practitioner, or his or her designee, to obtain a 14 day order of appropriate medication to ensure continuity of care.

2. The Health Care Administrator or designee shall facilitate the scheduling of a mental health appointment by contacting Mental Health staff who will schedule an appointment with the physician or psychiatric nurse practitioner to occur within 14 days to ensure continuity of care.
- C. Psychiatric evaluation for use of psychotropic medication shall include review of the medical and mental health records, direct examination and laboratory tests if indicated in accordance with the guidelines and protocols set forth in Appendix A.
- D. While the physician or psychiatric nurse practitioner will be permitted to prescribe psychotropic medication based on his or her clinical judgment, the following guidelines shall be adhered to:
1. No inmate shall be prescribed psychotropic medication absent a psychiatric diagnosis made in accordance with the Diagnostic and Statistical Manual of Mental Disorders - IV and recorded in the Mental Health and Medical charts;
 2. Psychotropic medications will be ordered for a period of time consistent with the DRC Health Care Services Policy, "Automatic Stop Order for Medications";
 3. Unless contraindicated, psychotropic medication will be prescribed to be administered once or twice per day in accordance with the pharmacodynamics of the specific medication prescribed.
 4. The physician or psychiatric nurse practitioner initially prescribing and/or continuing to prescribe psychotropic medication must review the inmate's condition and response to medication at clinically appropriate intervals to document said response, untoward symptoms and side effects and to adjust the medication as appropriate.
 - a. During the initial stage of outpatient medication administration, progress notes and follow-up visits will be made by the physician or psychiatric nurse practitioner as often as necessary and clinically indicated, but not less frequently than:
 - (1) bi-weekly for the first 30 days of medication administration;
 - (2) monthly for the next 60 days of medication administration;
 - (3) every 60 to 90 days thereafter. Inmates seen at 60-90 day intervals by the psychiatrist can have their prescription written every 60 to 90 days.
 - b. During the initial two weeks of medication administration for inmates housed in the Secure Residential Treatment Program, the physician or psychiatric nurse practitioner shall examine the inmate and make progress notes at least once per week. Thereafter, follow-up visits and progress notes shall be made by the psychiatrist at least every 30 days.
 5. Inmates who report mild symptoms of anxiety, insomnia or nervousness, in the absence of serious mental illness, shall be referred for psychological intervention prior to initiation of psychotropic medication. For those inmates whose symptoms do not respond satisfactorily to counseling or therapy may then be referred for psychiatric consultation.
 6. Prescribing practices of psychiatric medications will be periodically reviewed by the CQI process.

7. Medication management of inmates with substance abuse problems
 - a. When an inmate's primary diagnosis is substance abuse/dependency, attempts should be made to encourage the inmate to resolve his or her problems without the use of psychoactive medications, including the use of stress-reduction training, relaxation training, and other non-pharmacological interventions.
 - b. Attempts to refer these inmates to more appropriate treatment programs shall be made (i.e., substance abuse groups and other services).
 - c. When a question of major mental illness exists, or when an inmate is intransigent about reformulating his or her problems and persists in seeking medication, the psychiatrist should consult with the primary mental health provider in the development of psychiatric intervention.

E. Documentation Requirements

1. Psychiatrist documentation

- a. initial psychiatric evaluation shall be recorded as indicated in the Mental Health Evaluation policy and made a permanent part of the inmate's mental health record, and shall include the clinical rationale for any medication prescribed.
- b. psychiatric progress notes for follow-up visits shall legibly document the inmate's mental status, response to treatment, observation of side effects and referral for laboratory studies.
- c. results of formal Abnormal Involuntary Movement Scale (AIMS) examination by the physician or psychiatric registered nurse conducted, at a minimum, every six months for inmates receiving antipsychotic medications shall be recorded in the psychiatric progress notes and on the AIMS examination form.
- d. medication orders shall also be recorded on the *Physician Order* form and specify the type of medication ordered, amount, route, duration of order and frequency of administration.
- e. laboratory tests requested shall be recorded on the *Physician Order* form and the results of said tests shall be initialed by the ordering psychiatrist and subsequently filed in the inmate's mental health file.

2. Nursing documentation

a. administration

- (1) each dose of medication shall be recorded on the Medication Administration Record (MAR) in accordance with Medication Distribution System policy.
- (2) medication administered STAT and/or PRN will additionally be documented in the progress notes of the psychiatric record with the reasons for need clearly recorded.
- (3) each dose of medication administered STAT and/or PRN will require documentation in the Progress Notes regarding the inmate's response to the medication.

b. information regarding the inmate's compliance to medication shall be documented in the progress notes of the psychiatric file as follows:

- (1) crisis cells: Every day;
- (2) secure residential treatment program: Every week;
- (3) psychiatric General Population: Every month.

3. Mental health staff who have contact with an inmate who is prescribed medication have the responsibility of recording the following information in the psychiatric file:

- a. information relayed to them by the inmate;
- b. observations which may be related to medication.

4. Each inmate who is prescribed medication shall have a treatment plan which addresses at a minimum the following information:
 - a. frequency of medication reviews;
 - b. medication education activities;
 - c. medication compliance counseling.
- F. Informed consent for the use of psychotropic medication shall be secured from inmates at the time of initial prescription unless clinically contraindicated at that time.
1. The treating physician shall instruct the inmate of the risks and benefits of the proposed medication, possible side effects, and alternative treatments at the time such medication is ordered or initiated, utilizing the *Informed Consent* forms as a guide.
 2. When the prescribing physician or psychiatric nurse practitioner is not available to obtain informed consent (verbal telephone orders), a registered nurse may obtain and document verbal consent. The treating physician shall obtain written consent as delineated above within seven (7) calendar days.
 3. The inmate shall sign the appropriate *Informed Consent* form indicating he or she has received information regarding the said medication. The form shall become a permanent part of the inmate's mental health file. Inmates shall receive a copy of any available information sheets (i.e., patient education forms).
 4. Informed consent must be given by the inmate each time a new class of medication is initiated, unless the inmate's consent for that class of medication is currently active. Active informed consents shall be renewed whenever inmates move between levels of mental health care services (i.e., from the CAU or segregation status to the general population) or at least annually for ongoing treatment.
 5. Absent an order for involuntary medication, an inmate is always able to withdraw his or her informed consent.
- G. Inmates on psychotropic medications should not be exposed to sustained elevated temperature or direct sunlight for extended periods of time. Patients on psychotropic medications have increased sensitivity to sunlight and are at higher risk of heat-induced syndromes including heatstroke, hyperthermia and heat prostration. In view of these factors, the following recommendations should be made:
1. When under direct sunlight, inmates should wear protective clothing and/or sunscreen. Provisions should be made for suntan lotions and protective clothing (i.e., shirts) for such inmates.
 2. Excessive exhausting activities in the heat of summer should be avoided;
 3. An adequate intake of fluid (8-12 glasses of liquid per day) should be maintained to avoid dehydration;
 4. The temperature of the S RTP must be monitored regularly and logged on a temperature log in accordance with specific directives issued by the Director of Clinical Services at Central Office. If inmate housing areas exceed 90 degrees Fahrenheit, the following measures must be instituted:
 - a. increased ventilation to the area through utilization of fans to improve air flow and reduce room temperature to less than 90 degrees;
 - b. provision of increased fluids and ice;
 - c. allowance of additional showers to provide cooling;
 - d. recommendation to the Superintendent to permit temporary transfer of the inmate to an area of the institution that is more compatible with the inmate's clinical status.

VII. REFERENCES

NCCHC Adult Standards 1992 P-30

NCCHC Adult Standards 1996 J-26

VII. DRAFT PARTICIPANTS

This directive was drafted by Thomas Powell, Ph.D., Clinical Director, 103 S. Main St., Waterbury, VT 05671. Also actively participating in development of this directive were Erin Turbitt, Sandy Dengler, Shirley Meier, R.N., M.Ed., and Chris Carr, Ph.D.

ABNORMAL INVOLUNTARY MOVEMENT SCALE

Inmate Name: _____
 Facility: _____

DOB: _____
 Date: _____

Involuntary Movement Ratings	Code
<p><i>Rate highest severity observed. Rate movements that occur upon activation one less than those observed spontaneously.</i></p>	<p>0 - Normal, no involuntary movement 1 - Minimal, fleetingly present 2 - Mild, occurs more than four times 3 - Moderate, persistent 4 - Severe, very pronounced and continuous</p>

FACIAL AND ORAL MOVEMENTS	MUSCLES OF FACIAL EXPRESSION: <i>Movements of forehead, eyebrows, periorbital area, cheeks; include frowning, blinking, smiling and grimacing</i>	0 1 2 3 4									
	LIPS AND PERIORAL AREA: <i>Puckering, pouting, smacking</i>	0 1 2 3 4									
	JAW: <i>Biting, clenching, chewing, mouth opening, lateral movement</i>	0 1 2 3 4									
	TONGUE: <i>Rate only increase in movement both in and out of mouth; NOT inability to sustain movement</i>	0 1 2 3 4									
EXTREMITY MOVEMENTS	UPPER (arms, wrists, hands, fingers): <i>include choreic movements (rapid, objectively purposeless, irregular, spontaneous), athetoid movements (slow, irregular, complex, serpentine). DO NOT INCLUDE tremor (repetitive, regular, rhythmic).</i>	0 1 2 3 4									
	LOWER: (legs, knees, ankles, toes): <i>lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot.</i>	0 1 2 3 4									
TRUNK MOVEMENTS	NECK, SHOULDERS, HIPS: <i>rocking, twisting, squirming, pelvic gyrations.</i>	0 1 2 3 4									
GLOBAL JUDGMENTS	SEVERITY OF ABNORMAL MOVEMENTS	0 1 2 3 4									
	INCAPACITATION DUE TO ABNORMAL MOVEMENTS	0 1 2 3 4									
	INMATE'S AWARENESS OF ABNORMAL MOVEMENTS: <i>rate only patient's report.</i>	<table style="width: 100%; border: none;"> <tr><td>No awareness</td><td style="text-align: right;">0</td></tr> <tr><td>Aware, no distress</td><td style="text-align: right;">1</td></tr> <tr><td>Aware, mild distress</td><td style="text-align: right;">2</td></tr> <tr><td>Aware, mod. distress</td><td style="text-align: right;">3</td></tr> <tr><td>Aware, severe distress</td><td style="text-align: right;">4</td></tr> </table>	No awareness	0	Aware, no distress	1	Aware, mild distress	2	Aware, mod. distress	3	Aware, severe distress
No awareness	0										
Aware, no distress	1										
Aware, mild distress	2										
Aware, mod. distress	3										
Aware, severe distress	4										
DENTAL STATUS	CURRENT PROBLEMS WITH TEETH AND/OR DENTURES	<table style="width: 100%; border: none;"> <tr><td>NO</td><td style="text-align: right;">0</td></tr> <tr><td>YES</td><td style="text-align: right;">1</td></tr> </table>	NO	0	YES	1					
	NO	0									
YES	1										
DOES INMATE USUALLY WEAR DENTURES?	<table style="width: 100%; border: none;"> <tr><td>NO</td><td style="text-align: right;">0</td></tr> <tr><td>YES</td><td style="text-align: right;">1</td></tr> </table>	NO	0	YES	1						
NO	0										
YES	1										

MH/Medical Staff Signature and Degree: _____

Date: _____

PSYCHOTROPIC MEDICATION USE PROTOCOLS

Laboratory Testing

I. General Psychiatric Screening - to be performed as clinically indicated

A. Routine Tests - The following comprise a general screening battery for possible organic causes of psychiatric symptoms and shall be ordered by the psychiatrist when initial prescription is ordered if they have not been performed within the last six (6) months. The screening battery shall be repeated annually for inmates who continue to receive medication.

1. CBC
2. SMAC-24
3. U/A
4. Thyroid Function Tests (T3, T4, T7 & TSH)

B. Additional tests may need to be ordered, based upon history, physical, and mental status examination.

II. Required Tests for Antipsychotic Agents - upon review of physical exam, lab tests to be performed as clinically indicated

A. Pre-Treatment

1. Routine Tests
 - a. General Psychiatric Screening (as listed in A1-A4 above)
 - b. EKG (baseline) - as clinically indicated
2. Other pretreatment laboratory tests should be ordered as clinically indicated and based upon the inmate's past medical history, results of the physical examination, previous history of adverse drug reactions, and knowledge of the potential adverse effects of the different antipsychotics.

B. Follow-up

1. Routine Tests - General Psychiatric Screening (annually)
2. Other follow-up tests should be ordered as clinically indicated and based upon the inmate's past medical history, results of physical examination, previous history of physical reactions, and knowledge of the potential adverse effects of the different antipsychotics.

III. Required Tests for Antidepressant Agents

A. Pre-Treatment

1. Routine Tests
 - a. General Psychiatric Screening
 - b. EKG (baseline) - as clinically indicated

2. Other pretreatment laboratory tests should be ordered as clinically indicated and based on the inmate's past medical history, results of the physical examination, previous history of adverse drug reactions, and knowledge of the potential adverse effects of the different antidepressants.

B. Follow-up

1. Routine Tests - General Psychiatric Screening (annually)
2. Other follow-up tests should be ordered as clinically indicated and based on the inmate's past medical history, results of the physical examination, previous history of adverse drug reactions, and knowledge of the potential adverse effects of the different antidepressants.

IV. Required Tests for Lithium - upon review of physical exam, lab tests to be performed as clinically indicated

A. Pre-Treatment

1. CBC
2. Creatine, Electrolytes and BUN
3. Thyroid Function Tests (T3, T4, T7, & TSH)
4. EKG (baseline) - as clinically indicated
5. Pregnancy Tests (females) - if indicated
6. Urinalysis
7. 24-hour Urine for Creatinine Clearance and Protein (in patients with a history of kidney disease or if expecting long-term lithium treatment)

B. Follow-up (at least yearly)

1. BUN, Serum Creatinine
2. Thyroid Function Tests (T3, T4, T7, & TSH)

C. Assessing Lithium Serum Levels

1. Blood for Lithium level should be collected at least 8 to 12 hours after the last dose and prior to the next dose (usually before breakfast).
2. Required frequency of assessment:
 - a. Determine Lithium serum levels once weekly during the acute phase and until the serum level and clinical condition of the inmate have been stabilized.
 - b. After serum level and clinical condition of the inmate have been stabilized, determine serum level as follows:
 - (i) Once a week for two weeks;
 - (ii) Then once per month for three months (if stabilized at 0.6 to 1.2 mEq/L).
 - (iii) Thereafter, determine serum level in uncomplicated cases receiving maintenance therapy during remission every two to three months or as clinically indicated. Monitor the elderly on maintenance therapy more frequently.

V. Required Tests for Carbamazepine (Tegretol) - upon review of physical exam, lab tests to be performed as clinically indicated

A. Pre-Treatment

1. CBC
2. Reticulocyte Count
3. SMAC-24
4. EKG (baseline) - as clinically indicated
5. U/A
6. Thyroid Function Tests (T3, T4, T7 and TSH)
7. Pregnancy Tests (females) - if indicated
8. Liver Function Tests

B. Follow-up

1. Hematological Tests
 - a. Perform CBC every two weeks for two months, then perform CBC monthly for two months; then CBC should be performed quarterly if previous tests are normal.
 - b. Watch for petechia, pallor, unexplained weakness, fever or signs of infection. If present, an immediate CBC is indicated.
2. Tegretol Blood Levels - perform monthly for two months, then quarterly.
3. Other Tests:
 - a. Ever six months, perform liver function tests, serum electrolytes, U/A, and BUN
 - b. Yearly, perform an EKG