Vermont Psychiatric Care Hospital Procedure	
Non-Emergency Involuntary Medication	
Revised: X	Date: 04/07/14

DEFINITIONS:

1. **"Competence"** - The ability of an individual to make a decision and appreciate the consequences.

2. **"Involuntary Medication"** - The administration of any medication against a patient's will.

3. **"Household members"** - patients living together or sharing occupancy.

4. **"Medical Director"** - A psychiatrist responsible for supervision of the care and treatment of all patients at the Vermont Psychiatric Care Hospital.

5. **"Physician" or "Treating Physician"**- A licensed physician on the staff of the Vermont Psychiatric Care Hospital.

6. **"Qualified Mental Health Professional"** - A psychiatrist, physician, psychologist, social worker, nursing or area supervisor who by training and experience can identify mental illness and recognize behavior which would constitute an emergency.

7. **"Staff"** - Nurses, physicians, psychologists, psychiatrists, social workers, nursing or area supervisors, and aides who are employed by the Vermont Psychiatric Care Hospital to provide care and treatment for patients.

8. **"Treatment"** - For provisions of this policy, treatment refers specifically to non-emergency involuntary medication.

9. **"Treatment Team"** - An interdisciplinary team including a psychiatrist, psychologist, mental health specialist, social worker, and registered nurse, which designs and implements treatment plans for patients.

CONSIDERATIONS/REQUIRED STEPS:

I. <u>Treatment Considerations</u>

1. Within seven days of filing an application for involuntary treatment or receiving an Order of Hospitalization, patient refusal to accept treatment should be assessed. The treatment team shall make a determination of whether to recommend that the Vermont Psychiatric Care Hospital seek non-emergency involuntary medication. A review of the following issues shall be conducted:
   - **A.** The nature and extent of the mental illness;
   - **B.** The effect of the illness on the patient's behavior with specific attention to the factors listed in 18 V.S.A. §7101(17);
   - **C.** The patient's ability to assimilate material facts and render a reasonable decision to accept or refuse treatment;

D. The present behavioral evidence of deterioration or decompensation of the illness and effect on previous levels of function;

E. The previously expressed views of the patient with respect to the particular type of treatment being sought;

F. Whether the patient has a documented history of clearly demonstrated reduction of symptoms during previous treatments with medication;

G. The various treatment alternatives available that may or may not include drugs;

H. The prognosis with and without the use of medication;

I. The duration of hospitalization and confinement in a restrictive care setting without the use of medication;

J. The efficacy of a partial treatment program developed for the patient, identifying the benefits and risks to the individual of providing involuntary medication or not providing the recommended treatment plan, including:

a. The possibility and degree of improvement; and

b. The possibility and severity of the occurrence of side effects to medication.

2. If the Medical Director determines, after such a review, that the patient has been provided with adequate and necessary information to decide for him or herself whether to accept the proposed treatment and that progress in treatment is not compromised or unduly delayed by the decision of the patient to refuse psychotropic medication, the patient's decision shall be honored.

3. If, after review and at any point in hospitalization, the treating physician in consultation with the Medical Director and following a review of issues in (1) above determines that the patient's decision to refuse psychotropic medication is compromising appropriate clinical care or unduly delaying improved mental health, application for non-emergency involuntary medication shall be initiated. At a minimum, patients refusing psychotropic medication that has been recommended as part of the comprehensive treatment plan should be re-evaluated every 30 days by the Medical Director or designee.

II. <u>Initiating Non-Emergency Involuntary Medication:</u>

1. The Commissioner may commence an action for the involuntary medication of a person who is refusing to accept psychiatric medication and meets any one of the following three conditions:

A. Has been placed in the care and custody of the Commissioner;

B. Has previously received treatment under an Order of Hospitalization and is currently under an Order of Non-hospitalization (ONH); or

C. Has been committed to the custody of the Commissioner of Corrections as a convicted felon and is being held in a correctional facility and for whom the Department of Corrections and the Department of Mental Health have jointly determined that involuntary medication would be appropriate pursuant to subdivision 907(4)(H) of Title 28.

2. A petition for involuntary medication drafted by the Legal Division shall be filed in the family court in the county in which the person is receiving treatment.

3. The petition shall include the physician's certification, executed under penalty of perjury, that includes the following information:

A. The nature of the person's mental illness and presence or absence of trauma history;

B. The necessity for involuntary medication, including the person's competency to decide to accept or refuse medication;

C. Any proposed medication, including the method, dosage range, and length of administration for each specific medication;

D. A statement of the risks and benefits of the proposed medications, including the likelihood and severity of adverse side effects and its effect on:

E. The person's prognosis with and without the proposed medications; and

F. The person's health and safety, including any pregnancy;

G. The current relevant facts and circumstances, including any history of psychiatric treatment and medication, upon which the physician's opinion is based;

H. What alternate treatments have been proposed by the doctor, the patient or others, and the reasons for ruling out those alternatives; and

I. Whether the person has executed a Durable Power of Attorney for Health Care (DPOA-HC) in accordance with the provisions of chapter 121 of Title 14, and the identity of the health care agent designated by the durable power of attorney.

4. A copy of the DPOA-HC, if available, shall be attached to the petition.

III. Continued treatment of patients determined competent to refuse medication and/or benefiting from treatment as determined by the Court:

Patients who have been found by order of the court as competent and/or benefiting from partial treatment or non-treatment shall be evaluated on an ongoing and regular basis to determine maximum benefits achieved through hospitalization and readiness for discharge as a patient who no longer is a person in need of treatment.

If patients who, subsequent to a court hearing denying an order of non-emergency involuntary medication, refuse in part or whole medication, are regularly evaluated in accordance with Treatment Considerations outlined in the first section of this policy, and for whom good clinical care and treatment is compromised, restrictive hospitalization extended, and documentation of clinical instability or de-compensation supports the need for comprehensive care and treatment; a request for non-emergency medication shall again be submitted to the court.

If patients who, subsequent to a court hearing denying an order of non-emergency involuntary medication, refuse in part or whole medication, are regularly evaluated in accordance with Treatment Considerations outlined in the first section of this policy, and for whom treatment response to a partial treatment plan is unremarkable as evidenced by the absence of further clinical de-compensation, absence of imminent risk to self or others, restoration of a functional baseline, absence of clinical documentation to support a request for non-emergency involuntary medication, and an earlier court determination of competence by the patient or DPOA-HC agent for decision-making with regard to treatment; active discharge planning phase shall be initiated.

Approved by	Signature	Date
Frank Reed, Commissioner of DMH		11/29/16