I. PURPOSE:

To provide minimum guidelines and requirements for the use of psychotropic medications in the treatment of mental disorders and obtaining informed consent from inmates who are receiving psychotropic medications.

II. DEFINITION:

A. Psychotropic Medications: Medication(s) prescribed by a psychiatrist or other qualified prescribing clinician that exercise effects upon the central nervous system and are employed to treat symptoms of mental illness. These medications may influence thinking, mood, and behavior. Psychotropics may include antipsychotics, antidepressants, anti-anxiety agents, sedatives, anticonvulsants, and mood stabilizers. If a medication is used for physical health reasons (versus to treat psychiatric symptoms), that use will not be considered as psychotropic medication use and the provisions of this health services bulletin will not apply.

B. Emergency Treatment Order: The use of psychotropic medications without an inmate’s informed consent that is restricted to emergency situations in which the inmate presents an immediate danger of causing serious bodily harm to self or others, and no less intrusive or restrictive intervention is available or would be effective. Such treatment may be provided upon the written order of a psychiatrist or other qualified prescribing clinician for a period not to exceed forty-eight (48) hours, excluding weekends and legal holidays. (See also HSB 15.05.10 Psychiatric Restraint.)

III. POLICY:

Psychotropic medication therapy is currently recognized as an effective treatment method for psychiatric disorders. These medications often enhance an inmate’s ability to participate in other forms of treatment.

A. Prescription Use Standards: Current standards require that medications be prescribed in a manner consistent with current pharmacologic knowledge. The most recent editions of Drug Facts and Comparisons and/or the Physicians' Desk Reference are nationally accepted, standard reference works, and will be used to guide the department’s psychotropic medications practice.

B. Individualized Service Plan: The ongoing use of psychotropic medications will be part of a multidisciplinary approach to treatment that is detailed in an Individualized Service Plan.
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C. "S" Grade Classification: Each inmate who is prescribed psychotropic medication for a mental disorder(s) shall be assigned an "S" grade of two (2) or higher.

D. Case Management Services: Each inmate who is prescribed psychotropic medication shall receive case management services by mental health staff.

E. Continuity of Psychotropic Medications: Each major institution authorized to receive inmates S-2 or higher must adhere to the following requirements:

1. A nurse may administer a single dose of medication each time it is indicated in accord with the current medication order in the health record. In most cases, this will ensure continuity of treatment until the inmate can be seen by a psychiatrist or other qualified prescribing clinician. For inmates requiring psychiatric consultation, medication orders that expire before the inmate is afforded the psychiatric consultation shall be reordered by a qualified prescribing clinician, for up to thirty (30) days, until the necessary psychiatric consult is completed.

2. The pharmacy services director will update a list of the medications that may be maintained at the institutions.

3. Any prescribed psychotropic medication shall be provided to the inmate pending transfer by the on-site qualified prescribing clinician.

F. Documentation Requirements:

Information concerning inmate treatment shall be noted in the medical record by all health services staff. The following are to be permanently included in the health record of each inmate receiving psychotropic medication:

1. A psychiatric evaluation that includes identifying data, chief complaint, relevant history (present, past, family and medical), complete mental status examination, diagnosis (or differential diagnosis) and recommendations. This evaluation is completed prior to prescribing psychotropics for an inmate (except in an emergency when it will be completed within three (3) business days). The psychiatric evaluation shall be documented on the "Psychiatric Evaluation," DC4-655.

2. During the psychiatric evaluation, attention should be paid to updating the medical history to help identify organic causes of psychiatric symptoms. A medical referral may be indicated and additional laboratory tests (in addition to the ones suggested in the attached appendix, Testing Standards for Psychotropic Medication Usage) may need to be ordered, based on the history and/or physical examination. If the medical history update indicates the need for a medical evaluation, one will be completed within two (2) weeks of the inmate being started on psychotropic medication. Relevant psychiatric and medical histories shall be updated by the psychiatrist or other qualified prescribing clinician during their follow-up visits with referrals made for a medical evaluation as needs are identified.
3. A medication history, centering on psychotropics shall be documented by the psychiatrist or other qualified prescribing clinician and will include the name of the medication, the dosage, length of time on the medication, and response to the medication(s). The psychiatrist or other qualified prescribing clinician shall also note known allergic reactions to medications and whether the inmate is at present taking other non-psychiatric medications.

4. The prescribing clinician’s orders specifying the date and time of the order, the name and dosage of medication, route, and the frequency of administration shall be recorded in the health record before administration of the initial dose.

5. Laboratory studies shall be ordered by the prescribing practitioner in accordance with guidelines provided in Testing Standards for Psychotropic Medication Usage (see-attached appendix). The results shall be filed in the health record. The psychiatrist or other qualified prescribing clinician will review the lab results and note the need for any modifications to treatment. If the prescribing clinician notes any lab results that indicate previously unidentified medical concerns, s/he will refer the inmate for a medical review.

6. All dosages must be in accordance with Drug Facts and Comparisons or the Physicians’ Desk Reference to obtain optimal management of target symptoms. The inmate should be kept on medication for a sufficient length of time to allow it to act and reach therapeutic blood levels before dosages are significantly increased or the medication is replaced by another medication. Careful comprehensive monitoring during early stages is mandatory. Follow-up visits shall be scheduled and appropriate progress notes written by the psychiatrist or other qualified prescribing clinician as needed at least once every two (2) weeks upon initiation of any new psychotropic medication for a period of four (4) weeks. Thereafter, psychotropic medication therapy and progress of the inmate shall be reviewed and documented at least every ninety (90) days.

7. The prescribing clinician shall include the following in his/her progress notes:
   a. Effects of prescribed medication(s) on targeted symptoms and behavior.
   b. Rationale for change of medication.
   c. Rationale for increasing or decreasing medication.
   d. Side effects of the medication.

8. Inmates receiving antipsychotic medication will be administered the “Abnormal Involuntary Movement Scale,” DC4-653 [AIMS] upon initiation of antipsychotic medication to establish a baseline measure for involuntary movement. As long as the inmate continues to receive antipsychotic medication, an AIMS shall be completed at least once every six (6) months to screen for the presence of tardive dyskinesia and other abnormal involuntary movements.
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9. In the event that the inmate is exhibiting tardive dyskinesia or other abnormal involuntary movements, s/he shall be formally evaluated with the AIMS at least every three (3) months to monitor worsening, stabilization or remission of the condition.

10. The mental health and nursing staff shall document observations of unusual thinking, mood, behavior, and psychomotor activity as well as side effects and any adverse reactions experienced by the inmate.

G. Licensing Requirements: Psychotropic medication must be used under the direction of a Florida licensed physician (to include an active DEA license) for controlled substance prescribing, or psychiatric ARNP.

H. “Drug Exception Request,” DC4-648: This form must be utilized and approved for medications dosage that is at variance with dosage levels specified in Drug Facts and Comparisons or the Physicians' Desk Reference, a non-formulary medication, the use of four (4) or more psychotropics (other than antiparkinsonian agents), two or more psychotropic drugs in the same therapeutic class, or the use of an approved medication for an unapproved use.

1. A DC4-648 shall be properly filled out and submitted for approval/disapproval by the appropriate authority in the regional office of health services.

2. Copies of the DC4-648 will be filed in the inmate’s medical record in the back of prescriptions/orders.

3. All completed DC4-648 whether approved or disapproved are to be faxed to the assigned dispensing pharmacy.

I. Informed Consent for Psychotropic Medication: A consent form must be completed for each prescribed psychotropic medication. The prescribing clinician shall discuss the content of the appropriate consent form(s) with the inmate at the time the medication is ordered.

1. As part of the discussion, the inmate must be informed about the purpose of the medication, the common side effects, if any, and the risks and benefits of the medication.

2. The inmate must also be informed about alternative treatments available, the expected duration of the treatment and the fact that s/he may withdraw his/her consent orally or in writing at any time without compromising access to other health care.

3. Informed consent is to be obtained only after at least a brief history and mental status examination has been completed and it has been determined that the inmate is competent to give consent to treatment. The inmate will be deemed competent
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for this purpose if s/he has an understanding at a basic level that s/he has a psychiatric problem and that medication is being offered to produce relief from that problem.

4. The following drug specific consent forms will be utilized to obtain informed consent for psychotropic medication. For medications that do not have a current corresponding consent form, the appropriate generic consent form will be completed, either “Antipsychotic Medication,” DC4-545A or “Psychotropic Medication,” DC4-545B.

a. DC4-545A - Antipsychotic Medication – Generic Form A
b. DC4-545B - Psychotropic Medication – Generic Form B
c. DC4-545C - Benadryl (Diphenhydramine HCL)
d. DC4-545D - Cogentin (Benztropine Mesylate)
e. DC4-545E - Effexor (Venlafaxine HCL), Effexor XR (Venlafaxine HCL Extended Release Capsules)
f. DC4-545F - Geodon (Ziprasidone)
g. DC4-545G - Haldol (Haloperidol), Haldol Decanoate (Haloperidol Decanoate)
h. DC4-545H - Lithium
i. DC4-545I - Paxil (Paroxetine HCL)
j. DC4-545J - Prolixin (Fluphenazine HCL), Prolixin Decanoate (Fluphenazine Decanoate)
k. DC4-545K - Prozac (Fluoxetine HCL)
l. DC4-545L - Remeron (Mirtazapine)
m. DC4-545M - Risperdal (Risperidone)
n. DC4-545N - Seroquel (Quetiapine Fumarate)
o. DC4-545O - Tegretol (Carbamazepine)
p. DC4-545P - Thorazine (Chlorpromazine HCL)
q. DC4-545Q - Trilafon (Perphenazine)
r. DC4-545R - Valproic Acid
s. DC4-545S - Vistaril (Hydroxyzine Pamoate)
t. DC4-545T - Wellbutrin (Bupropion HCL), Wellbutrin SR (Bupropion HCL Extended Release Tablets)
u. DC4-545U - Zoloft (Sertraline HCL)

5. A signed copy of the informed consent shall be given to the inmate. The original shall be placed in the mental health section of the health record under the sub-divider entitled Mental Health Authorizations/Consents.

6. Informed consent must be given by the inmate each time a new psychotropic medication is prescribed. Informed consent must be obtained even if an inmate is currently on the same drug for non-psychiatric reasons.
7. Informed consent for a medication becomes inactive when the inmate withdraws his/her consent either orally or in writing. Oral withdrawal of consent shall be documented in the inmate's health record. Withdrawal of consent is to be treated as a refusal of the medication.

8. Refusal of individual doses does not constitute withdrawal of consent. After three (3) consecutive medication refusals or five (5) medication refusals in a month, the inmate will be required to sign a “Refusal of Health Care Services,” DC4-711A and the medication will not be offered by nursing personnel based on the completion of the refusal. The completed DC4-711A, along with the chart, will be forwarded to the psychiatrist or other qualified prescribing clinician for review and further clinical disposition. This review will be documented on the DC4-701 in chronological order.

9. For inmates who have refused a prescribed psychotropic medication(s) within the previous two (2) consecutive days, nursing staff will meet with the inmate on the next working day to assess the situation, counsel the inmate, and refer the inmate to the psychiatrist or other qualified prescribing clinician, if warranted.

10. The inmate shall be educated, whenever possible, to improve his/her participation in medication therapy.

11. The use of psychotropic medications by a psychiatrist or other qualified prescribing clinician, without an inmate's informed consent shall be restricted to emergency situations in which the inmate presents an immediate danger of serious bodily harm to self or others and no less intrusive or restrictive intervention is available or would be effective (see Emergency Treatment Order below). Such involuntary treatment shall be limited to a particular episode of immediate danger.

IV. GENERAL GUIDELINES:

A. The psychiatrist or other qualified prescribing clinician must provide treatment in accordance with the Department’s Drug Formulary: ATYPICAL USAGE ALGORITHM and ANTIDEPRESSANT PROTOCOL unless clinical rational for deviating from these guidelines is well documented in the medical record and a DER submitted if clinically indicated.

B. Psychotropic medications shall be used for appropriate treatment of disturbances of mood, thinking, and behavior as part of the Individualized Service Plan. They shall not be used as simply a means of suppressing undesirable behavior. For example,
psychotropic medications shall not be used as punishment, as a substitute for behavioral programs, for staff convenience, or in dosages, which interfere with the rehabilitation/service plan of the inmate.

C. Requests for non-emergent psychiatric consultations for inmates who are graded S-1 or S-2 shall be evaluated by the senior psychologist to determine further disposition. The senior psychologist will document the clinical rationale for his/her disposition in the mental health record. If the senior psychologist determines a psychiatric consultation may be clinically indicated, s/he will discuss his/her findings with a psychiatrist or other qualified prescribing clinician prior to scheduling a psychiatric consultation. The senior psychologist will document the discussion via an incidental note in the health record.

D. When prescribing psychotropic medication(s), each medication should correspond to a target symptom(s) in the "Plan" portion of the SOAP note. This information will document the basis for prescribing decisions.

E. Psychotropic medications shall be used for as short a time as possible in order to control or prevent the reappearance of target symptoms. As soon as the inmate's condition is deemed stabilized, efforts shall be made to gradually discontinue medication or reduce medication dosages to a minimum. If discontinuation or lowering of the medication is not indicated clinically, the psychiatrist or other qualified prescribing clinician shall document the rationale for the decision in the health record.

F. Psychotropic medication prescriptions shall not exceed one-hundred eighty (180) calendar days.

G. Standing orders for psychotropic medication are prohibited.

H. There must be a clear and convincing clinical rationale documented in the medical record for the use of multiple psychotropic medications.

I. Antiparkinsonian medications shall be used only when clinically indicated.

J. Inmates who are taking psychotropic medication at the time of arrival at any institution shall be continued on their medication until evaluated by a psychiatrist or other qualified prescribing clinician.

K. An Emergency Treatment Order is an involuntary medication order, which is administered without the inmate's informed consent.
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1. Choice of medication to be used will be based on the assessed clinical presentation of the inmate.

2. A psychiatrist or other qualified prescribing clinician’s (when co-signatured with DEA licensed physician if benzodiazepine used) order must accompany each use of an emergency treatment order, with concomitant order for admission to a certified isolation management room and placement on self-harm observation status.

3. Such involuntary treatment shall be limited to a particular episode of immediate danger to self or others.

4. Standing orders, “as needed” (PRN) orders, and the use of neuroleptics as a decanoate or extended release preparation are prohibited for use as an emergency treatment order.

The need for periodic involuntary medication (three [3] or more involuntary doses of psychotropic medication in a twenty-four [24] hour period) may indicate a need for referral to a Crisis Stabilization Unit or from a Crisis Stabilization Unit to a Corrections Mental Health Treatment Facility. If involuntary treatment is to be continued beyond forty-eight (48) hours (excluding weekends and holidays), the inmate must be referred for emergency transfer to a mental health treatment facility, and the Chief Health Officer of the institution where the emergency involuntary care is being provided must consult with the psychiatric consultant or the Regional Medical Executive Director, in that order of availability. Mental health treatment facility staff will assist the warden with filing a petition with the circuit court for an order authorizing the placement of the inmate in the a Corrections Mental Health Treatment Facility and an order authorizing involuntary treatment. In the interim, involuntary treatment may be continued with written (not telephone) order of a physician or other qualified prescribing clinician, pending the inmate’s transfer to mental health treatment facility and/or an involuntary medication hearing if the physician determines that the emergency situation continues to present a danger to the safety of the inmate or others.

V. Psychotropic Medication for S-2 Inmates

A. When an inmate has been stabilized on select psychotropic, monthly psychiatric evaluations are not always necessary. A psychiatrist or psychiatric ARNP will determine if an inmate is sufficiently stable for continued medication management by a non-psychiatric qualified prescribing clinician. If so, the psychiatrist or psychiatric ARNP will change the inmate’s S grade to S-2 and refer the inmate for follow-up at an S-I/II institution that has a full-time psychologist assigned. Psychotropic medications for medication management by a non-psychiatric prescribing clinician in consultation with a psychologist include those used to treat affective disorders such as anxiety disorders, depressive disorders, adjustment disorders (e.g. SSRIs or buspirone). Exclusionary criteria include inmates that are prescribed antipsychotic medication for symptoms associated with a bipolar disorder, psychotic disorder or other serious mental disorder.
B. In addition to requisite screening and orientation by medical and mental health staff, medical staff shall ensure continuity of psychotropic medications for newly arriving S-2 inmates that are prescribed psychotropic medications.

C. Within ten (10) calendar days of arrival, each newly arriving S-2 inmate that is prescribed psychotropic medications shall be interviewed by the psychologist, in order to assess mental status, and by the non-psychiatric prescribing clinician, who will be responsible for the medication management. S/he will document any significant physical health changes, all new medications and any diagnostic tests conducted. The DC4-643A Individualized Service Plan will be updated within fourteen (14) days of arrival.

D. At least every 180 days, S-2 inmates that are prescribed psychotropic medications will receive a clinical interview by the psychologist to assess mental status and adaptive functioning, and by the non-psychiatric prescribing clinician to assess medication efficacy and side effects. The evaluations will be done in consultation with the psychologist by the non-psychiatric prescribing clinician, who will have access to a psychiatrist or psychiatric ARNP for consultation as needed.

E. New psychotropic medication(s) can be initiated by the non-psychiatric prescribing clinician in accordance with assessed patient needs and may seek consultation with a psychiatrist or psychiatric ARNP as needed.

F. Consultation with a psychiatrist or psychiatric ARNP can be accomplished either in-person or via telephone. If by telephone, there must be documentation of the consultation in the health record as an incidental note.

VI. RELEVANT FORMS AND DOCUMENTS:

A. HSB 15.05.18 Outpatient Mental Health Services
B. HSB 15.03.04 Periodic Assessments/Examinations/Screenings
C. DC4-545 series
D. DC4-648 Drug Exception Request
E. DC4-653 Abnormal Involuntary Movement Scale (AIMS)
F. DC4-655 Psychiatric Evaluation
G. DC4-701 Chronological Record of Health Care
H. DC4-711A Refusal of Health Care Services
I. Drug Facts and Comparisons
J. 3 kfTHD2’sVD111 V: 5HHI2ce
K. Appendix: Testing Standards for Psychotropic Medication Usage
L. Drug Formulary: A-TYPICAL USAGE ALGORITHM and ANTIDEPRESSANT PROTOCOL
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This Health Services Bulletin Supersedes: HSB dated 4/15/91, 05/03/96 and 07/15/08  
TI 15.05.06 dated 05/06/04