

CONNECTICUT VALLEY HOSPITAL OPERATIONAL PROCEDURE MANUAL

SECTION I:	PATIENT FOCUSED FUNCTIONS
CHAPTER 3:	Medication Management
PROCEDURE 3.1:	Emergency and Involuntary Medication
REVISED:	07/31/07; 08/23/08; 11/2011; 04/13; 12/19/16; 02/18
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PURPOSE: The Department of Mental Health and Addiction Services (DMHAS) has established that patients in all DMHAS inpatient facilities may be administered medication intended for the treatment of psychiatric disabilities only with his/her informed consent, except as provided in the Connecticut General Statutes, Sections 54-56d, 17a-566, 17a-543 and 17a-543a. This procedure specifically addresses (a) administration of medication under emergency circumstances, and (b) the administration of involuntary medications for patients who are (1) capable of providing informed consent and are assessed as posing a direct threat of harm to self or others *or* (2) incapable of providing informed consent and deemed to be in need of medication for the treatment of their psychiatric disabilities. It is the preference/goal of Connecticut Valley Hospital (CVH) that medication decisions be made by the patient (or conservator of person if already so appointed and given authority to consent to psychiatric medication) in consultation with the prescribing physician. At each point in the process described below, the prescriber shall attempt to bring about joint agreement, whenever possible.

SCOPE: All RNs, LPNs, APRNs, Physicians, MHAs and Unit Directors

Definitions:

Informed Consent - means permission given competently and voluntarily after a patient has been informed of the reason for treatment, the nature of the proposed treatment, the potential advantages or disadvantages of the treatment, medically acceptable alternative treatment, the potential risks associated with receiving the proposed treatment and the potential risk of no treatment.

Direct Threat of Harm - means that the patient's clinical history demonstrates a pattern of serious physical injury or life-threatening injury to self or to others which is caused by the psychiatric disability with which the patient has been diagnosed and is documented by objective medical and other factual evidence. Such evidence of past pattern of dangerous behavior shall be manifested in the patient's medical history and there shall exist a high probability that the patient will inflict substantial harm on him/herself or others.

An *emergency* exists when, in the clinical judgement of a physician as determined by personal observation by the physician or a senior clinician, the patient's condition is (a) extremely critical and presents an immediate risk to the patient's well being and/or to the physical safety of others, (b) obtaining consent (in the procedures that follow) would cause a medically harmful delay to the patient or an immediate risk to the physical safety of others. Medically, harmful delay means a delay that could result in serious mental or physical injury to the patient or producing in the patient a disturbed mental state or impaired judgement which may be grossly detrimental to the

patient's physical or mental well being. An emergency exists only as long as the above conditions exist.

PROCEDURE:

I. Emergency Medication

A. Assessment Criteria

1. Medication excluding “depot” or long-acting medications, may be administered on an emergency basis without the consent of the patient, and without obtaining authorization through the procedures set forth in Sections II, III and V of this procedure, only when a physician or a senior clinician has *personally observed* the patient, and determined that an emergency exists and the emergency cannot be addressed through less intrusive means.
2. The decision to administer emergency medications shall be based on an assessment of the patient's condition, and the clinical judgement of the professional making the decision, who may consider the effect that violent behavior would have on the patient's physical and mental well-being.
3. The physician authorizing emergency medication shall document the conditions required to initiate emergency medication in the progress notes of the medical record, including the reason that less intrusive means could not contain the emergency.
4. Involuntary medication may be administered under this section only as long as an emergency continues, and it is documented in the progress notes of the medical record that the conditions needed to initiate emergency medication persist.

II. Involuntary Medication

A. Medication Consultation

1. When medication is thought to be medically indicated in the treatment of any patient, the physician:
 - a. continues to further the therapeutic alliance with the patient to the extent possible;
 - b. informs the patient regarding the reasons for medication;
 - c. discusses the nature of the proposed treatment with the patient;
 - d. describes the potential advantage and disadvantages of treatment;
 - e. discusses medically acceptable alternative treatment;
 - f. discusses the potential risk associated with the proposed treatment;
 - g. discusses the potential risk of no treatment;
 - h. responds as fully and constructively as possible to the patient's questions, concerns, and reasonable preferences; and
 - i. documents these efforts in the patient's medical record in a progress note.
2. The attending physician seeks a second opinion regarding the necessity and appropriateness of medication when:
 - a. efforts at education and advice are not successful;

- b. there is no less intrusive beneficial treatment;
 - c. the patient appears to be incapable of providing informed consent; or
 - d. the patient appears to be capable of informed consent but without medication, the psychiatric disabilities with which the patient has been diagnosed will continue unabated, and place the patient or others in direct threat of harm.
- 3. The attending physician/designee informs the patient orally or in writing of available advocacy services whenever the physician requests a second opinion regarding the necessity and appropriateness of medication (under provisions of Sections II, IV, V and VI below) in order to determine if the patient would like an advocate to represent him/her. This notice and determination shall be documented in the medical record. *See* Notice of Advocacy Services ([CVH-606](#)). The advocate may be:
 - a. the patient's private counsel;
 - b. a member from the Connecticut Legal Rights Projects (CLRP);
 - c. a member of the Office of the Public Defender;
 - d. a member of the Office of Protection and Advocacy; or
 - e. any person of the patient's choice.
- 4. The attending physician/designee shall notify the advocate, if one has been identified by the patient, and if the patient has authorized the release of information to the advocate in writing, within 24 hours, and in writing, of the request for a second opinion including the name of the patient and location at the time this process is initiated.
- 5. The physician rendering the second opinion (the Consultant) shall not be directly involved in the patient's current treatment or evaluation and shall:
 - a. review the patient's medical record;
 - b. perform a direct evaluation of the patient;
 - c. interview others involved in the patient's treatment as appropriate; and
 - d. submit written recommendations to the attending physician and the Division or Service Medical Director/designee within three days of the date the consultation is requested.
- 6. The Consultant shall include in his/her report an opinion as to:
 - a. whether medication is necessary and appropriate for the patient's treatment, and,
 - b. whether the patient is incapable of providing informed consent, or
 - c. whether the patient is capable of providing informed consent but without medication, the psychiatric disabilities with which the patient has been diagnosed will continue unabated, and place the patient or others in direct threat of harm.
- 7. If the Consultant recommends that the medication in question be provided only with the consent of the patient and the attending physician concurs, no further action will occur.
- 8. In the event of disagreement between the attending physician and the Consultant, the Division or Service Medical Director/designee in consultation with the Chief of Professional Services (COPS) shall make an independent recommendation to

the CEO as defined in CGS 17a-540(7), and applying to all further uses of this term below as to whether or not further action should be taken to administer involuntary medication, and the CEO/designee shall make an independent determination regarding the need to proceed.

9. If two physicians agree to go forward with the involuntary medication procedure, the CEO/designee shall review the information available and make an independent determination regarding the need to proceed.
10. If a decision is made to go forward with involuntary medication, the Attending Physician shall determine if:
 - a. an internal involuntary medication hearing should be held following the procedures outlined in Section IIB below; or
 - b. a petition should be filed with the Probate Court either:
 - (1) to appoint a Conservator for purposes of making medication decisions for a patient assessed as being incapable of providing informed consent following the procedures outlined in Section III below; or
 - (2) to order involuntary medication for a patient found to be capable of providing informed consent, but without medication the psychiatric disabilities with which the patient has been diagnosed will continue unabated, and place the patient or others in direct threat of harm, following the procedures outlined in Section IV below; or
 - c. both an internal involuntary medication hearing and a petition to the Probate Court should proceed simultaneously, following the procedures outlined in Section IIB and III below. This should occur if there is an expectation that the patient will require medication for more than 30 days to stabilize his/her psychiatric condition.

B. Internal Involuntary Medication Hearings

1. The attending physician/designee shall notify, in writing (a) the Division or Service Medical Director/designee and (b) the patient, and (c) the patient's selected advocate, if one has been identified by the patient, and if the patient has authorized the release of information to the advocate, within 24 hours in writing of the decision to schedule an internal involuntary medication hearing, including the patient's name and location at the time this process is initiated.
2. The Division or Service Medical Director/designee, the patient, and advocate shall discuss and seek agreement on the appointment of a Hearing Officer who is *not* an employee of the inpatient facility.
3. If no consensus on the choice of a Hearing Officer is reached, the Division or Service Medical Director shall contact the COPS who will make the choice of a Hearing Officer following consultation with the parties.
5. The attending physician shall provide the patient with a copy of the CLRP informational booklet explaining his/her rights and responsibilities regarding consent to medication.
6. The Division or Service Medical Director/designee shall give written notice to the patient and advocate, if one has been identified by the patient, three working days

in advance of the hearing, providing the reason(s) the physician believes the medication is appropriate and necessary.

7. The attending physician may not medicate the patient, absent an emergency, until a decision is rendered from the hearing.
8. Prior to the hearing, the patient is informed of the following rights:
 - a. to attend;
 - b. to present evidence, including witnesses;
 - c. to question witnesses;
 - d. to be assisted by legal counsel or a patient advocate, if selected by the patient.
9. The following participants are present at the hearing, as indicated:
 - a. the patient, if he/she wishes to attend;
 - b. the patient advocate or representative as per the patient's wishes;
 - c. the Hearing Officer;
 - d. the attending physician;
 - e. other representatives of the patient's treatment team from the facility and community programs (where relevant);
 - f. the Consultant who has rendered the second opinion in the case;
 - g. an Assistant Attorney General if requested and, if deemed appropriate by the Attorney General's Office; and
 - h. other relevant witnesses who may be called by either party.
10. The meeting is to be tape recorded and is available to both sides in the event of appeal. The Hearing Officer presides and swears in witnesses, who will testify and be subject to questions. The tape is maintained in the Health Information Management (HIM) as part of the medical record.
11. The Hearing Officer may only authorize involuntary medication if she/he finds that either:
 - a.
 - 1) the patient is incapable of informed consent; and
 - 2) the medication is medically necessary and appropriate; and
 - 3) there is substantial probability that without such medication, the condition of the patient will rapidly deteriorate; and
 - 4) the provision of such medication would not violate an advance health care directive; or
 - b.
 - 1) the patient while capable of giving informed consent is refusing to accept medically appropriate and necessary medication; *and*
 - 2) there is no less intrusive beneficial treatment; *and*
 - 3) without medication the patient's psychiatric disabilities will continue unabated and place the patient or others in direct threat of harm; *and*
 - 4) there is substantial probability that without such medication, the condition of the patient will rapidly deteriorate.
12. The Hearing Officer shall render a written decision within three (3) working days after the hearing and shall forward a copy to the patient, his/her advocate, if one has been identified by the patient, the Division Medical Director/designee, and the attending physician. See Form [CVH-464a](#) Decision of Hearing Officer on Involuntary Medication.

13. The Hearing Officer shall notify the patient and advocate, if any, that he or she may request an expedited hearing before the Probate Court if he/she disagrees with the hearing decision.
14. Should the patient request an expedited hearing before the Probate Court, the attending physician may provide medication to the patient for 15 days or until a decision is rendered by the Probate Court, whichever is sooner.
15. Should the patient not file a request for an expedited hearing, the attending physician may provide medication to the patient for no more than 30 days. If medication is required beyond 30 days, an application may be filed with the Probate Court for appointment of conservator of person as described below, if the patient continues to decline, or be unable to give, consent to the medication.

III. Conservatorship Petitions for Patients Incapable of Informed Consent

A. Consultation and Application

1. If the attending physician concludes that medication is appropriate and necessary and the patient is incapable of providing informed consent for the treatment of psychiatric disabilities, regardless of his/her willingness to accept medication, he/she requests consultation with another physician.
2. If the second physician (consultant) concurs with the attending physician's opinion, the CEO shall review the information available and make an independent decision regarding the need to proceed. If a decision is made to go forward with involuntary medication and if the attending physician determines that a petition should be filed with the Probate Court, the attending physician files a petition with the Probate Court for the appointment of a Conservator of person with specific authority to consent to medication administration. If the patient has a Conservator, the hospital or the Conservator must still petition the Probate Court to grant the Conservator specific authority to consent to medication administration, unless such specific authority has already been granted and is currently invalid.
3. If the patient has not already chosen an advocate, at this time, the physician/designee shall also remind the patient of the availability of advocacy services, following the procedures outlined in Section IIA3 above. If the patient has selected an advocate, and if the patient has authorized the release of information to the advocate in writing, the attending physician/designee shall ensure that the advocate is notified within 24 hours in writing of the patient's name and location at the time this process is initiated. (Notice to Patient's Advocate of Involuntary Medication procedures).
4. The attending physician and consultant physician shall follow procedures outlined in Section IIA3 through 11A 10 in seeking involuntary medication under this Section.

B. Appointment and Responsibility of the Conservator

1. If the court appoints a Conservator, the Conservator shall:
 - a. meet with the patient and the physician;

- b. review the patient's medical records; and
 - c. consider the following in deciding whether to consent to medicate:
 1. risks and benefits from the medication;
 2. the likelihood and seriousness of adverse side effects;
 3. the preferences of the patient;
 4. the patient's religious views; and
 5. the prognosis with and without medication.
2. The Conservator shall sign a form which confirms he/she has complied with the provisions in Section IIIB1 above, and whether or not he/she consents to medication. The original, signed copy of Form [CVH-464b](#) Decision of Conservator on the Administration of Involuntary Medication, will be retained in the patient's medical record.
3. The authority of the Conservator to consent to the patient receiving medication shall be effective for no longer than 120 days.
4. The Conservator has the right to revoke consent to medication at any time.
5. If the patient is continuously hospitalized beyond 120 days, the authority of the Conservator to consent to medication administration may be extended up to 120 days by order of the Probate Court without a hearing upon application by the CEO if the CEO and two qualified physicians determine that:
 - a. the patient continues to be incapable of giving informed consent to medication; and
 - b. such medication is deemed necessary for such patient's treatment.
6. The patient's advocate, if one has been identified by the patient, and if the patient has authorized the release of information to the advocate in writing, shall be notified at the time of the application for the 120 day extension to the Probate Court by the attending physician/designee. (Notice to Patient's Advocate of Involuntary Medication Procedures is attached).

IV. Petitions for Persons Capable of Informed Consent

A. Consultation and Application

1. The attending physician shall request consultation from another physician if:
 - a. he/she concludes that a patient has a psychiatric disability; and
 - b. the patient is capable of providing informed consent for the medication deemed by the attending physician to be appropriate and necessary for the treatment of his/her psychiatric disability; and,
 - c. is refusing to accept such medication; and
 - d. there is no less intrusive beneficial treatment; and
 - e. without medication, the psychiatric disabilities will continue unabated and place the patient or others in direct threat of harm.
2. If the second physician (consultant) concurs with the attending physician's opinion, the CEO shall review the information available and make an independent decision regarding the need to proceed. If a decision is made to go forward with involuntary medication and if the attending physician determines that a petition should be filed with the Probate Court, the attending physician

shall file a petition with the Probate Court requesting authority to provide involuntary medication for up to 120 days.

3. If the patient has not already chosen an advocate, at this time the physician/designee shall also remind the patient of the availability of advocacy services, following the procedures outlined in Section IIA3 above. If the patient has selected an advocate, and if the patient has authorized the release of information to the advocate in writing, the attending physician/ designee ensures that the advocate is notified within 24 hours of the patient's name and location at the time this process is initiated. (Notice to Patient's Advocate of Involuntary Medication Procedures is attached).
4. If the patient is continuously hospitalized beyond 120 days, the authority for medication administration may be extended up to 120 days by order of the Probate Court without a hearing upon application by the CEO and two qualified physicians determine that:
 - a. the patient continues to be capable of giving informed consent to medication but refuses to consent to medication for treatment of his/her psychiatric disabilities; and
 - b. without medication, the psychiatric disabilities will continue unabated and place the patient or others in direct threat of harm.
5. The patient's advocate, if one has been identified by the patient, and if the patient has authorized the release of information to the advocate in writing, shall be notified at the time of the application for 120 day extension to the Probate Court by the attending physician/designee. (Notice to Patient's Advocate of Involuntary Medication Procedures).
6. The attending physician and consultant physician shall follow procedures outlined in Section IIA3 through IIA 10 in seeking involuntary medication under this Section.

B. Decision of the Probate Court

1. If the Probate Court authorizes medication, the attending physician may provide medication in accordance with the Probate Court authorization.
2. If the Probate Court denies authorization, medications may not be administered except in emergencies.