DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
ADMINISTRATIVE BULLETIN A.B. 5:04B

EFFECTIVE DATE: **June 4, 2012**

SUBJECT: The Non-Emergent Administration of Psychotropic Medication to Non-Consenting Involuntary Patients (Non-Emergent Involuntary Medication Procedure)

I. Policy

A. This policy describes the procedures to be followed in situations in which:
(1) an involuntarily committed consumer has been has been diagnosed with a mental illness, and, as a result of mental illness, poses a likelihood of serious harm to self, others, or property if psychotropic medication is not administered; and
(2) the consumer will not or cannot provide informed consent to the administration of psychotropic medication recommended by the prescriber.

B. Through the implementation of this policy, State psychiatric hospital staff shall assure that the administration of psychotropic medication in such circumstances conforms to the standards in N.J.S.A. 30:4-24 et seq., which provides that every individual who is treated for a mental illness is entitled to medical care and other professional services in accordance with accepted standards, and that patients in the care of the State have the right to participate in planning for their own treatment to the extent that their conditions permit.

II. Responsibilities

A. The Medical/Clinical Director is responsible for oversight of clinical decision-making under this bulletin at each psychiatric hospital, for reviewing the decisions of the prescribers, for supporting the actions of the Client Service Advocates at the hospital level, and for correcting any deviations from the policy by prescribers through counseling, using the PAR/PES system for evaluation of professional performance, and where necessary invoking discipline through A.O.4:08 and the appropriate licensing board.

B. The CEO is responsible for the implementation of this and all policies at the hospital level. As such, the CEO or the Deputy CEO as his or her designee shall direct the deployment of CSAs to participate in hearings and provide consultation to treatment teams within the limits of their licenses, and shall create a pool of administrators and clinicians other than independent psychiatrists to serve on the panels for medication review hearings as described in this policy.

C. The Division shall arrange for psychiatrists, who are not currently involved in the patient's treatment ("non-treating psychiatrists"), to chair Medication Review Hearings and provide other staff development and consultative services as needed.

D. The hospital's Medical Director shall assign two panelists, other than the non-treating psychiatrist, out of the pool created by the CEO to participate in medication review hearings. The Medical Director shall review weekly with the CSA and the CSR as needed all incidents in which a patient is medicated without his or her consent.

E. The CSA at each hospital is responsible for reviewing the chart of each patient who is prescribed psychotropic medication and for reporting, both on a monthly basis and as needed and appropriate, any departures from the bulletin to the hospital's Medical/Clinical Director and the DMHAS Medical Director. S/he, or, if unavailable, his/her designee shall meet with the hospital's Medical Director and other medical staff weekly to review difficult cases and any current medication issues. S/he also has the responsibility to ensure that those patients who consent to medication have done so voluntarily, and that those who are medicated without consent are medicated in accordance with the policy. The Client Services Advocate shall have access to all charts and prescribers, and shall ensure that the hospital provides an orientation for new patients that includes information about their medication rights.

The CSAs and their staff are responsible for maintaining confidentiality of all information obtained when reviewing clinical records and for advising the executive staff of the hospital about questions patients ask about medications and the implementation of the involuntary medication policy.

Each CSA shall submit monthly statistical reports to the Coordinator which shall include statistical data compiled by the CSR, and shall report any non-compliance with the involuntary medication policy to the Coordinator and to the CEO.

F. Each prescriber is required to become familiar with the procedures in this bulletin and to conform his or her prescribing activity to its standards.

G. All direct care and nursing staff are to report observed side effects of medications to the prescriber, to inquire about an involuntarily medicated patient's willingness to accept medication on a regular basis, to observe and report any change in a patient's ability or willingness to consent to medication, and to monitor the proper administration of medication.

H. All staff are responsible for participating in treatment activities as appropriate to their title, and doing so in a way that encourages shared decision-making and patients' wellness and recovery.

III. **Definitions**

Client Services Advocate (CSA) – is a licensed prescriber or Master's-prepared psychiatric nurse who directly reports to the CEO or Deputy CEO of each hospital and has a reporting relationship to the DMHAS Medical Director through the Coordinating Chief of CSAs (hereinafter Coordinator) and whose primary responsibility is to evaluate individuals receiving treatment with psychotropic medication. The CSA accomplishes this by individual patient assessment, consultation with the treatment team, and participation in the Medication Review Hearings process, as ongoing assessment and oversight to ensure that medication is only continued if that medication is the least restrictive alternative and appropriately approved. The CSA is responsible for developing and providing orientation and training programs on these procedures for staff and patients. The CSA may delegate non-clinical monitoring and patient communication and education activities to appropriate staff including Client Services Representatives.

Client Services Representative (CSR) – is a hospital employee who reports to the hospital's CSA and who is responsible to ensure compliance with due process procedures when a patient will not or cannot provide informed consent for psychotropic medication in non-emergent situations. The CSR will meet with patients to understand their concerns, inform patients of their rights to least restrictive effective treatments, and explain their right to give informed consent and the circumstances under which that right can be overridden by their need for treatment. The CSR shall document side effects as reported by the patient or as noted in the record, and report side effects or other events to the CSA. The CSR shall conduct record reviews, follow-up with the teams when procedural discrepancies occur, compile monthly reports, collect other data as required by the CSA, and shall meet with the CSAs and Coordinator as needed to assure conformity across the system with the standards in this policy.

Coordinating Chief of Client Services Advocates / Coordinator ("Coordinator")- is an employee of the Division qualified by education and experience to clinically guide the CSAs who reports to the Division Medical Director. He/she shall provide guidance to the CSAs, review their reports and assist with quality improvement. The Coordinator shall work with the CEOs in establishing work duties of the CSAs, selecting qualified candidates, providing input into their performance evaluations, and ensuring coverage for all of the hospitals. The Coordinating Chief shall also assist the Division Medical Director in arranging for independent, non-treating

psychiatrists for Medication Review Hearings and for providing for their orientation and training. S/he shall meet regularly with the CSAs and the CSRs.

Decision-making capacity is the ability to understand and appreciate the nature and consequences of mental health care decisions, including the benefits and risks of each, and alternatives to any proposed mental health care, and to reach an informed decision. A patient's decision-making capacity is evaluated by a licensed professional relative to the demands of a particular mental health care decision.

Division means the Division of Mental Health and Addiction Services (DMHAS) in the New Jersey Department of Human Services.

Division Medical Director refers to the Medical Director for the Division of Mental Health and Addiction Services.

Involuntary patients are those consumers placed by DHS at a State psychiatric hospital or the Ann Klein Forensic Center who are civilly or criminally committed by a court pursuant to New Jersey Court Rule 4:74-7, N.J.S.A. 30:4-27.1 et seq., or N.J.S.A. 2C:4-6(b), or N.J.S.A. 2C:4-8 (Not Guilty by Reason of Insanity/Krol patients), or involuntary patients on CEPP status pursuant to R. 4:74-7(h)(2).

Less restrictive intervention means a treatment that has, compared to another, fewer probable negative lasting effects on the consumer, is less likely to interfere with the consumer's therapeutic progress, and interferes less with the consumer's rights to autonomy and liberty. A proposed intervention can be requested by the consumer at the time it is needed or can be implemented pursuant to an advance directive or negotiated as part of the consumer's patient safety plan. Less restrictive alternatives available in an emergency in the state psychiatric hospitals typically include verbal de-escalation, re-direction, and the offer of consensual oral medication. The most restrictive interventions available in an emergency in the state psychiatric hospitals are seclusion, restraint, and injected medication used consistent with those policies.

Likelihood of Serious Harm or Dangerousness means that within the reasonably foreseeable future either: (a) a substantial risk that physical harm will be inflicted by an individual upon his own person, as evidenced by threats or attempts to commit suicide, or to inflict physical harm on one's self, or by such severe self-neglect as evidenced by a dangerous deterioration in essential functioning and repeated and escalating loss of cognitive and volitional control as is essential for the individual's health or safety; or (b) a substantial risk that physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; or (c) a substantial risk that physical harm will be inflicted by an individual upon property as evidenced by behavior which has caused substantial loss or damage to property.

Medical Director – means the Hospital Medical Director, as referenced throughout this policy. Each of the five State psychiatric hospitals has its own Medical Director. Whenever the Medical Director is referenced in this policy it allows for the Medical Director or hospital CEO to appoint a clinical designee at the Director or Supervisory level to perform functions where appropriate.

Medication or psychotropic medication, in this bulletin, means agents used for the treatment of psychiatric disorders, including but not limited to antipsychotics, antidepressants, mood stabilizers, anti-anxiety agents, anti-Parkinson agents, hypnotic agents, stimulants, and drugs for dementia , as well as any tests required for the safe and effective administration of such agents.

Mental Health Care Representative means the individual designated by a declarant pursuant to the proxy directive part of an advance directive for mental health care for the purpose of making mental health care decisions on the declarant's behalf, and includes an individual designated as an alternate mental health care representative who is acting as the declarant's mental health care representative in accordance with the terms and order of priority stated in an advance directive for mental health care.

Mental illness means any current substantial disturbance of thought, mood, perception or orientation which significantly impairs judgment, functioning, capacity to control behavior or capacity to recognize reality caused by any organic, mental or emotional impairment.

Prescriber means a professional licensed in New Jersey to prescribe or renew a prescription for psychotropic medication.

State means the State of New Jersey.

IV. **Procedure**

In a non-emergency situation, when an involuntary patient (or, where applicable, guardian or mental health care representative) does not provide or cannot provide consent to the proposed administration of psychotropic medication after being given the opportunity to consent pursuant to the informed consent policy, and the patient's prescriber documents that the patient has been diagnosed with a mental illness, and, as a result of mental illness, poses a likelihood of serious harm to self, others, or property without the medication, the treating prescriber shall initiate the Involuntary Medication Procedure as follows, if he or she has determined, after considering less restrictive interventions, that medication is appropriate:

A. The prescriber shall complete the first section of the Involuntary Medication Administration Report ("IMAR") and document the following: the patient's name and hospital number, diagnosis, the specific medication(s) and co-medications to address side effects as well as any testing required because of the administration of the specific psychotropic medication being recommended for the patient, the rationale for the recommendation (including an explanation of the patient's likelihood of serious

harm to self or others or property due to non-compliance), the formulations and dosage ranges of the proposed medication(s), less restrictive alternatives attempted or ruled out, the efforts made to explain the need for the medication to the patient, and the objections, if any, expressed by the patient to the medication(s).

B. The prescriber shall submit the IMAR to the hospital's Medical Director who shall review it for completeness.

C. When the IMAR is complete, the Medical Director shall take appropriate steps to appoint a three person Panel to conduct a Medication Review Hearing. The composition of the panel shall include a non-treating psychiatrist who shall act as chairperson of the committee. This psychiatrist shall be trained to implement the procedures of this policy. The non-treating psychiatrist may have other duties at the hospital or Division, but shall not be currently involved in the treatment of the patient who is challenging the administration of medication.

D. The Panel shall consist of three individuals: a non-treating psychiatrist, an administrator (Unit Director or above), and another clinician --none of whom is currently involved in the patient's treatment or diagnosis. Any Unit Director assigned shall not be from the patient's unit. Utilizing the list created in accordance with Section IIA. of this policy, the Medical Director shall select the names of an administrator and a clinician and list the names of all panel members in a separate section of the IMAR. The administrators and clinicians who are assigned to sit as panel members shall be selected on a rotating basis.

E. The purpose of the hearing is for the Panel to hear relevant evidence, including but not limited to the treating prescriber's recommendation and the patient's objections, and to determine whether the patient may be medicated without consent in accordance with this policy.

F. Once the Medical Director has reviewed the IMAR and found it to be complete, he or she shall notify the hospital's CSA to participate in the hearing and to support the patient in presenting his or her objections to taking the proposed medication. The CSA shall consult with the patient within one business day of being assigned to the patient if such consultation has not already occurred.

G. The Medical Director or his/her administrative staff shall give the patient (or any guardian or mental health care representative) and the CSA a Notice of Hearing with a copy of the IMAR attached. A copy of the Notice of Hearing and IMAR shall also be provided to the treating prescriber and the three Panel members. The Notice of Hearing shall provide the date, time and location of the hearing and advise the patient of the right to consult with the CSA, to have the CSA assist the patient at the hearing, to testify, to present witnesses and documentary evidence and to question witnesses. The patient shall also have the right at his/her own expense to have another mental health professional or counsel present at the hearing. If a patient cannot consent the

CSA shall be at the hearing to assist the patient in all circumstances.

H. The Medical Director shall schedule the Medication Review Hearing to take place no later than five (5) business days after receiving the completed IMAR and shall provide the patient and the CSA with the Notice of Hearing and the IMAR at least two (2) business days prior to the hearing date.

I. The Medication Review Hearing shall take place on the patient's unit. The treating prescriber shall be present, as shall the patient, his or her guardian or mental health care representative if applicable, and any other mental health professional or representative retained by the patient, and any other witness, if available, called by the patient. The patient shall have the right to attend and present testimony and documentary evidence, and to question witnesses and question documents during the hearing. Testimony shall be taken concerning the diagnosis, the specific medication(s) and co-medications to address side effects as well as any testing required because of the administration of the specific psychotropic medication being recommended for the patient, the rationale for the recommendation (including an explanation of the patient's likelihood of serious harm to self or others or property due to non-compliance), the formulations and dosage ranges of the proposed medication(s), less restrictive alternatives attempted or ruled out and the objections, if any, expressed by the patient to the medication(s).The CSA shall be present at the hearing in order to support the patient and may assist the patient in presenting evidence if requested.

J. In addition to receiving the IMAR and Notice of Hearing, the panel members shall be provided with copies of any documentation the patient submits prior to the Medication Review Hearing. The patient's clinical records shall be made available to the panel members and to the CSA prior to the hearing. The chairperson will review the patient's clinical record prior to the hearing.

K. After all witnesses have been heard, the members of the panel shall convene out of the presence of the patient and other hearing participants to discuss the matter. If the panelists determine by a majority vote, with the non-treating psychiatrist in the majority, that the patient has a mental illness and that, as a result of that mental illness, without psychotropic medication the patient poses a likelihood of serious harm to self, others, or property, the patient may be medicated without his or her consent. If the chairperson/non-treating psychiatrist is not in the majority or votes against the involuntary medication, the proposed medication shall not be authorized. The panel shall record its decision and complete the required information on the Hearing Outcome Form, which shall be provided to the CSA and the patient and the prescriber by the end of the business day in which the hearing is held. If medication has been authorized, the CSA shall provide to the patient verbal and written notice of his or her appeal rights. A copy of the Hearing Outcome Form shall be sent to the Medical Director and a copy shall be placed in the patient's chart.

L. The Hearing Outcome Form shall contain the following information:

1. The disposition.
2. The names of the witnesses presented.
3. A list of the evidence presented.
4. A summary of the patient's position and objections to the proposed medication.
5. If the medication of the patient was not authorized, what alternative treatments the panel believes should be attempted, if any.
6. If the medication was authorized over the objection of the patient, why the medication is necessary to treat the patient and to avoid the likelihood of dangerousness or harm to self, others or property and as such is essential to the current treatment plan.
7. Whether or not the patient has requested any modifications or will consent to other types of medication.
8. Authorization for the treating prescriber to administer medication for up to 14 days.
9. The formulation and dosage of the medication(s) authorized by the panel.

M. If the involuntary administration of psychotropic medication is not authorized by the panel, the patient's treatment team shall convene to adjust the treatment plan to reflect the absence of the proposed psychotropic medication. If a different medication is part of the new treatment plan, and the patient subsequently refuses the medication, the Involuntary Medication Administration process must be repeated before the revised medication can be administered on a nonemergency basis.

N. The involuntary medication can be authorized by the panel for up to 14 days after the first administration of medication. The treating prescriber shall submit a report to the CSA by the 12th calendar day after the hearing describing the patient's positive and negative responses to the medication, what less restrictive interventions have been attempted or ruled out, and whether the patient is continuing to withhold consent. The CSA shall send copies to the panel that will be holding hearings that week, which shall convene before the expiration of the 14 day period to decide whether to authorize further involuntary medication up to 90 days. For the duration of the involuntary treatment, the treating prescriber must submit biweekly reports to the Medical Director, with a copy to the CSA, setting forth the patient's progress and the justification for continued involuntary treatment. Continued treatment must be supported by the clinical record and the report from the treating prescriber. If the patient consents to the medication at any time, the biweekly report shall so note, the CSA shall confirm and document in the patient's chart that the consent is informed and voluntary, and the authorization and review process shall end. If the medication is continued and the patient has not consented at the end of 90 days, a new IMAR form and Medication Review Hearing is required to consider the need for continued involuntary medication.

O. The patient will have 24 hours following notice of the panel's initial decision permitting involuntary medication to submit an appeal to the Hospital Medical Director or the next business day if that falls on a holiday or weekend. The CSA shall offer to assist the patient in filing an administrative appeal. The patient may continue to refuse medication and medication shall not be administered in accordance with the panel decision until the time in which to appeal the Panel's decision to the Hospital Medical Director has passed. While an administrative appeal is pending, only emergency medication may be administered to the patient without his or her consent.

P. If the patient appeals the panel's decision, the Hospital Medical Director, or his/her designee if the Medical Director is absent, shall review the patient's appeal, the Involuntary Medication Administration Report, and the Hearing Outcome Form. If s/he concludes that the Panel followed the Involuntary Medication Procedures in this Policy and that its conclusions of fact were supported by the evidence presented and that the medications authorized are within the current standard of care, s/he shall affirm the decision in writing. The panel's decision to medicate will be vacated by the Medical Director if the policy was not adhered to procedurally. The Medical Director shall issue his/her decision within 24 hours of his/her receipt of the appeal, or the next business day if that falls on a holiday or weekend. The Medical Director will arrange for the delivery of the decision to the patient, the CSA's office, and the prescriber.

Q. Any further appeal beyond the Medical Director shall be to the Appellate Division of the Superior Court pursuant to New Jersey R. Ct. 2:2-3(a)(2).

V. Implementation and Follow-up

A. An oral form of medication must be offered if medically appropriate before an injection is forced.

B. If the patient is medicated without his or her consent through the Non-Emergent Involuntary Medication Procedure, the CSA shall meet with the patient as soon as possible and shall also review the patient's chart at that time and once every month thereafter. The CSA shall document the review on a Medication Review Form, sign the original and notify the prescriber by email or in writing of the results of the review. The prescriber shall acknowledge receipt of the notification, by email or in writing, and report the results of any discrepancies noted during the review to the Client Service Advocate.

C. Unless a shorter time is approved by the panel or the biweekly review or consent ends the authorization, an Involuntary Medication Administration Report expires 90 days from the date the medication is first administered under the process for patients who

do not or cannot consent to medication. If the patient continues not to provide consent for medication at the time of expiration, a new Involuntary Medication Administration Report shall be completed, and the Medication Review Hearing procedures shall be followed. At the time any second or subsequent Involuntary Medication Administration is initiated, the prescriber shall consider alternative medications and interventions, shall indicate his or her opinion as to why the medication has not improved the patient's clinical condition and encouraged his/her voluntary adherence, and shall document the reason for the patient's continued rejection of alternatives.

D. The CSA shall maintain files on every patient receiving an Involuntary Medication Administration review. In addition to containing copies of the Involuntary Medication Administration Report and the Hearing Outcome Report, the file shall contain copies of the Medication Review forms, although originals shall be maintained in the patient's medical record. The Medical Director shall maintain a log of all patients receiving involuntary medication.

Lynn A. Kovich, Assistant Commissioner