I. AUTHORITY

Ohio Revised Code 5120.01 authorizes the Director of the Department of Rehabilitation and Correction, as the executive head of the department, to direct the total operations and management of the department by establishing procedures as set forth in this policy.

II. PURPOSE

The purpose of this policy is to establish procedures that govern the use of involuntary psychotropic medications to incarcerated individuals with serious mental illness in emergency and non-emergency situations.

III. APPLICABILITY

This policy applies to all persons who provide health care or mental health services to incarcerated individuals in the custody of the Ohio Department of Rehabilitation and Correction (ODRC) or agents thereof.

IV. DEFINITIONS

The definitions for the below listed terms can be found at the top of the policies page on the ODRC Intranet at the following:

**Definitions Link**
- Advanced Level Provider (ALP)
- Electronic Health Record (EHR)
- Gravely Disabled
- Independently Licensed Mental Health Professionals (ILMHP)
- Involuntary Psychotropic Medication
- Likelihood of Serious Harm
- Mandated Medication Committee
- Mandated Medication Coordinator
- Mental Health Administrator/Mental Health Manager (MHA/MHM)
- Mental Health Professionals (MHP)
- Patient Advisor
V. POLICY

It is the policy of the ODRC to consider involuntary treatment of any incarcerated individual with a serious mental illness who refuses voluntary treatment and for whom there is a substantial likelihood of serious physical harm towards self or others, a substantial likelihood of significant property damage or who is gravely disabled as a result of diagnosed serious mental illness.

VI. PROCEDURES

A. Emergency Involuntary Psychotropic Medication

1. In a psychiatric emergency, efforts shall be made to deescalate the situation. Emergency psychotropic medication administration may be considered if there is an imminent likelihood of serious harm and the threat continues after less intrusive alternatives have been ineffective.

2. Involuntary psychotropic medication may also need to be administered when a patient who is ordered mandated medications, as authorized by the Mandated Medication Committee, refuses to take oral medications. Refer to subsection VI.C of this policy.

3. If involuntary treatment is found clinically appropriate, it may be provided in an emergency with appropriate clinical safeguards and monitoring per Mental Health Protocol I-19, Emergency Psychotropic Medication Administration and Operational Protocol B-10, Medication Administration.

4. Emergency administration of involuntary psychotropic medication may be ordered for a maximum of seventy-two (72) hours. The MH-ALP assigned to the case may modify the planned treatment interventions to minimize the occurrence of emergency interventions.

5. Where force is required, only the amount of force reasonably necessary under the circumstances shall be used to accomplish the administration of the drug in accordance with ODRC Policy 63-UOF-01, Behavioral Intervention/Use of Force, and as outlined in subsection VI.B of this policy. The individual shall have the opportunity to voluntarily accept the medication until the actual injection.

6. While focusing on safety, prior to a physical hold or physically immobilizing restraints, staff shall make a reasonable attempt to assist the patient by less restrictive interventions, per ODRC Policy 63-UOF-04, Physically Immobilizing Restraints. These include, but are not limited to:

   a. Attempts to deescalate the situation by an on-duty crisis responder, hostage negotiator, or crisis intervention team (CIT) member,

   b. Placing the patient in a crisis cell without resorting to the use of restraints, if possible,

   c. Offering medications ordered by an ALP, and/or

   d. Administering emergency medication if ordered by an ALP:

       i. Prior to restraint application,
ii. Throughout restraint application.

7. If the crisis/emergency episode persists longer than seventy-two (72) hours, additional doses of emergency medication may be ordered and administered after an evaluation by an onsite MH-ALP, or registered nurse if the MH-ALP is not on site.

8. Initiating the Mandated Psychotropic Medication procedure (VI.C) should be considered by the treatment team whenever:

   a. The need for emergency involuntary medication persists longer than seventy-two (72) hours,
   b. Another crisis/emergency episode requiring emergency involuntary medications arises within thirty (30) calendar days of the original episode,
   c. Any other time when the criteria outlined in subsection VI.C of this policy are met.

B. Use of Force

1. The emergency administration of involuntary psychotropic medication shall be considered a planned use of force and shall be administered in accordance with ODRC Policy 63-UOF-01, Behavioral Intervention/Use of Force, 63-UOF-02 Use of Force Report, 63-UOF-04 Physically Immobilizing Restraints, 310-SEC-29 Cell Extractions and shall include continuous consultation with clinical staff.

2. The administration of involuntary medication shall be monitored as part of the CQI process. The MHA/MHM and security supervisor shall review the digital recording within three (3) business days of any incident that involved the administration of involuntary medication, either emergency or following a refusal of mandated medication. The findings shall be included in the monthly CQI meeting as part of the monitoring of high-risk activities.

C. Mandated Psychotropic Medication

1. Mandated psychotropic medication shall be considered for any incarcerated individual with a serious mental illness who refuses voluntary treatment and for whom there is a substantial likelihood of serious harm towards self or others, a substantial likelihood of significant property damage or who is gravely disabled as a result of diagnosed serious mental illness.

2. The facility mandated medication coordinator is responsible for oversight of the mandated medication process and to protect patient rights per Mental Health Protocol I-20, Mandated Psychotropic Medication Process Guidelines.

3. To avoid conflicts of interest, the Mandated Medication Committee members shall not be involved in the care of the patient considered for, or currently prescribed, mandated medications. Additionally,

   a. Members shall not be involved in the incarcerated individual’s current diagnosis or treatment plan and shall have had no past or future treatment relationship with the individual for a minimum of six (6) months before or after the mandated medication
hearing, except in a psychiatric emergency as defined in subsection IV of this policy or upon admission to a specialized unit.

b. A psychology supervisor and their supervisee, or a psychiatrist and their collaborating advance practice nurse (APN), shall not be included in the same involuntary medication hearing committee or sign the mandated medication request.

c. A psychiatrist shall not serve on a committee if they are the collaborating physician of the APN-MH seeking the mandated medication.

d. The psychiatrist acting as head of the Mandated Medication Committee shall not be involved in the treatment of the individual within six (6) months after the hearing except in a psychiatric emergency as defined in section IV of this policy (see definitions link), or upon admission to a specialized unit.

4. Essential Components of the Mandated Medication Hearing Process

a. Initial hearing requests are for thirty (30) days and follow-up requests are for 180 days. Any medication additions or dose changes to an existing mandation require a thirty (30) day hearing. Refer to Mental Health Protocol I-20, Mandated Psychotropic Medication Process Guidelines for specific requirements for 30-day and 180-day hearings.

b. The Residential Treatment Unit (RTU) and intensive treatment programs that are linked to a supportive housing unit are the preferred settings for the initiation of the mandated medication process. If clinically indicated, the process may be initiated in the outpatient setting with permission from the State Psychiatry Director or designee.

c. The MHA/MHM shall be immediately notified of a mandated involuntary psychotropic medication request by a designated member of the treatment team.

d. All documentation related to the mandated medication hearing shall be completed per Mental Health Protocol I-20, Mandated Psychotropic Medication Process Guidelines.

e. For mandated psychotropic medication to be approved, it must be demonstrated by clear and convincing evidence that the individual suffers from a serious mental illness and as a result of the illness there is a substantial likelihood of serious harm to self or others, significant property damage, or that the individual is gravely disabled.

f. Mandated Medication Request (DRC5234) must be completed by the MH-ALP and documented in the patient’s EHR by their multidisciplinary treatment team. The request shall be reviewed by the mandated medication coordinator for accuracy and fidelity to the policy per OCHC Behavioral Health Protocol I-20, Mandated Psychotropic Medication Guidelines.

g. The mandated medication coordinator shall schedule the hearing with a Mandated Medication Committee and a copy of the Mandated Medication Notice of Hearing & Patient Rights (DRC5237) shall be provided to the patient at least twenty-four (24) hours prior to any Mandated Medication Hearing.
5. The Mandated Medication Hearing

a. The mandated medication hearing may be held with a Mandated Medication Committee at the facility or with a remote committee via teleconferencing per Mental Health Protocol I-20, Mandated Psychotropic Medication Process Guidelines.

b. The institution staff members shall present evidence in person or via teleconferencing per Mental Protocol I-20, Mandated Psychotropic Medication Process Guidelines.

c. If the patient chooses not to be present at the hearing; is precluded from attending by the chair; if testimony presented by the patient or their witnesses objecting to the proposed medication, or cross examination of the institution’s witnesses is substantially limited or disallowed; the chair of the Mandated Medication Hearing Committee shall document reasons for the absence of the individual or restrictions in testimony or cross examination as part of the final decision.

d. The patient shall have an advisor to assist them during the process. If the patient is absent from the hearing, the patient advisor shall exercise the rights of the patient on their behalf.

e. At the conclusion of the hearing, the Mandated Medication Committee shall decide, based on the evidence presented, whether involuntary medication may be administered to the patient. Each committee member is required to document their decision and sign the Mandated Medication Committee Decision (DRC5241). Each committee member shall also document their rationale for the decision in the EHR. If the Mandated Medication Committee decision is not unanimous, mandated medication shall not be authorized unless the psychiatrist is in the majority for authorizing the mandated medication.

6. Post-Authorization Procedure and Appeal Process

a. The Mandated Medication Committee Decision (DRC5241) shall be sent to the managing officer or administrative designee for review and signed within eight (8) hours of the hearing. If approved, the incarcerated individual shall promptly receive a copy of the decision, and documentation shall be made in the EHR that they were notified of the decision.

b. A patient shall be permitted to appeal, in writing, the decision of the Mandated Medication Committee within twenty-four (24) hours of receipt of the written committee decision, signed by the managing officer or administrative designee.

   i. Access to the patient advisor shall be provided to assist them in this process.
   ii. Documentation shall be entered on MH SOAP Note (DRC5287) in the EHR and labeled “Appeal Decision”, identifying that the patient either appealed the decision (including date and time), or did not appeal.
   iii. If the patient is not able to verbalize whether they want to appeal, is severely decompensated, or lacks capacity, an appeal shall be filed on their behalf by the patient advisor.
c. The State Psychiatry Director/designee shall review all appeals to the Mandated Medication Committee decisions to determine if all procedures required by this policy and Mental Health Protocol I-20, Mandated Psychotropic Medication Process Guidelines were followed and if the decision is supported by substantial evidence.

   i. A decision on the appeal shall be rendered within twenty-four (24) hours upon the receipt of the appeal (excluding holidays and weekends).

   ii. The appeal decision and the patient notification shall be documented in the EHR on MH SOAP (DRC5287).

d. If mandated medications are authorized and an appeal has not been upheld by the State Psychiatry Director/designee, the MH-ALP shall order medications and monitor patient response per Mental Health Protocol I-20, Mandated Psychotropic Medication Process Guidelines.

e. Medication shall NOT be administered involuntarily until the appeal has been acted upon and the decision to medicate is affirmed. A psychiatric emergency, as outlined in subsection VI.A of this policy, may override this subsection.

f. Appropriate laboratory testing as clinically necessary is authorized as part of the mandated medication order. Refer to Mental Health Protocol I-20, Mandated Psychotropic Medication Process Guidelines for specific recommendations.

7. Temporary Suspension of Mandated Medication Orders

a. The MH-ALP and treatment team may consider a temporary suspension of the mandated medication order to evaluate the need for continuing mandation. Allowing suspension of the order requires careful review of patient history including the risk of harm to self and others. The following criteria shall be met for at least one (1) year prior to the suspension of the order:

   i. Stable mood,
   ii. 100% compliance with medications without the need for emergency medication intervention,
   iii. Insight into the need for medication, including perceived benefit and understanding of why medications were initially mandated,
   iv. No chequeing or diversion of medications,
   v. No self-harming incidents, or violence towards others - threatened or actual

b. APN-MH shall discuss with collaborative psychiatrist prior to final decision being made.

c. If the treatment team decides the patient meets criteria, the MH-ALP shall request a review by the State Psychiatry Director or designee.

d. If approved, the mandated medication orders may be put on hold, and compliance expectations shall be made clear to the patient. Medications may be written as essential with parameters for notification to mental health per Operational Protocol B10 Medication Administration.
e. Mandated medications shall not be allowed to expire during the trial periods.
f. If patient is not compliant, the suspended order shall be cancelled and immediately reverts to the original mandated order.

D. Completion of Forms and Processing of Mandated Medication Packets

Completion of the required forms and processing the post-hearing packet pertaining to the Mandated Medication Hearing shall follow Mental Health Protocol I-20, Mandated Psychotropic Medication Process Guidelines.

E. Electronic Health Record (EHR)

The procedures contained within this policy shall always be executed in accordance with ODRC Policy 69-OCH-06, Electronic Health Record Utilization and Responsibilities.

Referenced Protocols:

B-10 Medication Administration
I-19 Emergency Psychotropic Medication Administration
I-20 Mandated Psychotropic Medication Process Guidelines

Referenced ODRC Policies:

63-UOF-01 Behavioral Intervention/Use of Force
63-UOF-02 Use of Force Report
63-UOF-04 Physically Immobilizing Restraints
67-MNH-29 Involuntary Psychotropic Medication: Emergency and Mandated
69-OCH-06 Electronic Health Record Utilization and Responsibilities
310-SEC-29 Cell Extractions

Referenced Forms:

Mandated Medication Request DRC5234
Mandated Medication Notice of Hearing and Patient Rights DRC5237
Mandated Medication Committee Decision DRC5241
MH SOAP Notes DRC5287