ADMINISTRATIVE ORDER 2:17

DEPARTMENT OF HUMAN SERVICES

EFFECTIVE DATE: May 13, 1985 DATE ISSUED: May 13, 1985

SUBJECT: Administration of Psychotropic Medication to Minors in Institutions and Similar Settings

## I. PURPOSE

The purpose of this administrative order is to promulgate policy and procedures with regard to the administration of psychotropic medication to minors in the settings specified in Section II, Scope, below. Where necessary or appropriate, administering Divisions may promulgate additional policies and procedures which exceed or elaborate on, but in no case may conflict with, the Departmental standards set forth in this document.

It should be noted that Administrative Order 2:13, Guidelines for Psychotropic Medication, issued November 1, 1978, which applies to both adults and children, remains in effect together with this order until further notice.

## II. SCOPE

This order applies to the following settings:

- institutions operated by the Division of Mental Health and Hospitals (DMH&H) or the Division of Mental Retardation (DMR) -- i.e., State psychiatric hospitals and developmental centers;
- crisis homes, with a licensed capacity of 20 or more residents, under the jurisdiction of DMH&H;
- Purchase of Care facilities in New Jersey under the jurisdiction of DMR; and
- residential treatment facilities, with a capacity of 13 or more residents, operated by, under contract with, or regulated by the Division of Youth and Family Services.

## III. DEFINITIONS

The following terms, when used in this order, have the meanings indicated:

Administer (also Administration of, etc.), when used with regard to medication, means the process by which a single dose of medication is given to an individual client for consumption.

Chief Administrator means the Chief Executive Officer, Superintendent, Director, or alternately titled individual who possesses the highest level of administrative and supervisory authority at a given facility.

Client means a minor patient or resident in any of the types of facilities which fall within the scope of this document (refer to Section II, Scope, above).

Dispense, when used with regard to medication, means the process by which medication is prepared for an individual client pursuant to a physician's written prescription.

Drug Holiday means a period of time during which a particular medication is withheld from an individual client, by order of a physician, for the primary purpose of minimizing the possibility of adverse side effects from the medication.

Emergency means a situation in which a physician deems that there is substantial likelihood that a client will harm him/herself or others, or that the client's health will be significantly impaired, in the reasonably foreseeable future if psychotropic medication is not administered immediately.

Facility means an institution or other residential setting included in those enumerated in Section II, Scope, above.

Medical Personnel means physicians, registered nurses, and licensed practical nurses.
Minor means a person under the age of 18 years.

Neuroleptic Drug (also Neuroleptic) means any drug that favorably modifies psychotic symptoms. The main categories of neuroleptics include but are not limited to the phenothiazines, butyrophenones, and thioxanthenes. Neuroleptic drugs are also called "anti-psychotics" and "major tranquilizers."

Parent means the natural or adoptive parent or the legal guardian of a client.

Prescribe, when used with regard to medication, means the process by which a physician licensed and registered in the state in which the facility is located orders medication for a named individual client.

Psychotropic Medication (also Medication, Drug) means those substances which exert a direct effect upon the central nervous system and which are utilized as part of a treatment plan to influence and modify behavior in a positive manner. Specifically, the classes of drugs covered by this administrative order include:

- neuroleptics, such as chlorpromazine;
- anti-depressants, such as imipramine;
- agents for control of mania and depression, such as lithium;

- anti-anxiety agents, such as diazepam;
- sedatives, hypnotics to promote sleep, such as flurazepam hydrochloride; and
- psychomotor stimulants, such as methylphenidate hydrochloride.

Tardive Dyskinesia means a permanent, irreversible syndrome which may be produced by neuroleptic drugs and which is characterized by abnormal, involuntary bodily movements, particularly of the face, tongue, mouth, and jaw.

Treatment Plan means that plan of activities and, where indicated, medication which is determined by an individual client's treatment team to have the best chance of success in habilitating or rehabilitating the client. The terminology used to describe this plan varies depending upon the particular Division (e.g., Individual Habilitation Plan, "IHP", in DMR).

Treatment Team means that group of professional persons responsible for formulating, coordinating, and carrying out and/or directing and ensuring the carrying out of a treatment plan for an individual client. The specific composition of this group of professionals varies depending upon the particular Division and facility, and the terminology used to describe the group also varies (e.g., "IHP Team" in DMR).

## IV. POLICY

A. Psychotropic medication shall be considered a necessary part of a minor client's treatment plan only when either of the following is true:

1. The client is incapable, without medication, of participating in any treatment plan available at the facility that will give him/her a realistic opportunity of improving his/her condition; or

2. Although it is possible to devise a treatment plan that will give the client a realistic opportunity of improving his/her condition and is available at the facility, either:

   a. A treatment plan which includes psychotropic medication would, in the judgment of the client's physician, improve the client's condition within a significantly shorter time period; or

   b. If psychotropic medication is not administered, there is a significant possibility that the client will harm self or others before improvement of his/her condition is realized.

B. Psychotropic medication shall not be used as punishment, nor for the convenience of staff, nor as a substitute for other appropriate treatment.

C. Except in emergencies, as defined herein, and except as set forth in section V A 4 below, clients shall not be given psychotropic medication against their will. (Refer to section V A 3 below for information concerning emergency procedures and to section V A 4 below for information concerning administering medication subsequent to a review procedure.)

D. Except in emergencies, psychotropic medication shall always be prescribed in writing prior to its administration. Telephone orders shall be permitted only to extend emergency medication beyond the initial 72-hour period (refer to section V A 3 below) and only with the provision that the physician countersigns the order within 24 hours. Orders written by unlicensed resident physicians in training and those physicians practicing under an exemption shall be countersigned by a licensed and registered physician within 24 hours.

E. Facilities shall seek informed parental consent to administer a generic class of psychotropic medication (e.g., "antidepressants") to a particular client. The procedures to be followed in seeking informed consent, as well as procedures governing situations in which consent is either denied or fails to be given, are enumerated in sections V A 1 and 4 below.

F. Clients shall be informed, in a manner appropriate to their age and level of functioning, of the generic class of psychotropic medication which is proposed to be given, the purpose of the medication (i.e., the behavior or symptoms it is intended to modify), the dosage, and the possible side effects of the medication. Further details regarding this information-giving process, as well as procedures to be followed if a client refuses medication, are contained in sections V A 2 and 4 below.

G. Psychotropic medication shall be dispensed only by licensed pharmacists or by other individuals who by law possess the authority to do so (e.g., a night nursing supervisor in the absence of a pharmacist), and prescriptions shall always be labeled to reflect the following information:

1. the name and address of the dispensing pharmacy;
2. the full name of the pharmacist;
3. the full name of the client;
4. instructions for use;
5. the prescription file number;
6. the dispensing date;
7. the prescribing physician's full name;
8. the name and strength of the medication;
9. the quantity dispensed; and
10. any cautionary information appropriate to the particular medication.

H. Administration of psychotropic medication shall be accomplished in accordance with standard, accepted nursing procedures and, where medical personnel are not available, oral medication shall be administered by trained non-medical personnel who demonstrate knowledge and competence in all appropriate areas. Training shall be provided by qualified instructors to appropriate non-medical personnel either as a part of regular employee orientation sessions or on an ad hoc basis. Such training shall include but not be limited to the following subjects: obtaining informed consent, indications for drug use, therapeutic and side effects of drugs, alternative treatment methods, proper administration procedures, monitoring drug effects, storage procedures, and record-keeping.

I. Short-acting injectable psychotropic medication used in emergencies, as defined herein, shall be administered only by medical personnel.

J. The self-administration of medication by properly trained and supervised clients shall be encouraged wherever a client's intellectual, emotional, and physical capabilities make such practice appropriate and feasible.

K. All medication administered shall be recorded in the client's clinical record.

L. Clients shall be maintained on the lowest possible effective dosage of psychotropic medication.

M. Drug holidays, as defined herein, shall be instituted wherever possible, as determined by the treating physician.

N. Clients receiving neuroleptic drugs shall be monitored for symptoms of tardive dyskinesia prior to commencement of treatment and no less frequently than at 90-day intervals thereafter by means of the AIMS (Abnormal Involuntary Movement Scale) or other equivalent examination procedure conducted by a physician or a registered nurse. (Refer to Attachment.)

O. Because of potential serious toxicity, lithium shall be used only after a complete history, physical examination, and laboratory assessment of the client. Lithium shall be administered only following psychiatric consultation and under the surveillance of a psychiatrist. At the time of this writing, lithium is not approved for use in children under the age of 12 years.

P. In addition to the 30- and 90-day physician's reviews stipulated in sections V C 2 a and b below, a scheduled formal review of each client's progress and continuing need for psychotropic medication shall be conducted on at least an annual basis or more frequently dependent on the client's individual needs. At minimum, the treating physician, direct care personnel, program staff, and pharmacist shall have input into the reviews, and their findings and recommendations for future treatment shall be recorded in the client's record.

Q. In addition to the scheduled formal review of each client's progress (refer to section IV P above) and the utilization of the AIMS or equivalent examination procedure for clients being maintained on neuroleptic drugs (refer to section IV N above), all clients receiving psychotropic medication shall be monitored on an ongoing basis to determine the effects of the medication and the appropriate future course of action. (Refer to Section V C, Guidelines for Monitoring Drug Effects, below.)

## V. PROCEDURES

### A. Consent Issues

With two exceptions, discussed in sections V A 3 and 4 below, psychotropic medication may be administered to minor clients only if the parent has given informed consent and the client has been informed, in a manner appropriate to his/her age and level of functioning, about the proposed course of treatment and does not refuse the medication. Issues relating to the matter of parental and/or client consent are discussed below.

#### 1. Seeking Parental Consent

NOTE: In cases where both a parent and a legal guardian exist, the consent must be sought from the legal guardian.

a. As stated in section IV E above, facilities must seek informed parental consent to administer a generic class of psychotropic medication to a minor client. This consent is in addition to any general consent to treatment which the parent may also have signed.

b. Information regarding medication may be given in person, by telephone, or through the mail.

c. Wherever possible, this function should be performed by health care professionals (i.e., physicians and registered nurses). If this is not possible, the information should be given by a member of the client's treatment team who has been trained in the obtaining of informed consent. Such training should cover at least the following topics: indications for drug use, therapeutic and side effects of drugs, and alternative treatment methods.

d. Where a request for consent is made by someone other than a physician, the parent must be told that a physician is available for consultation regarding the proposed medication.

e. Consent requests made by mail must be certified, return receipt requested, and sent to the parent's last known address at least ten days before the proposed date for the commencement of treatment. The proposed date for the beginning of treatment must be stated and the parent informed that a failure to respond by that date will empower the facility's chief administrator to grant consent for the medication.

f. Regardless of the method by which consent is sought - in person, by phone, or through the mail - written parental consent must be requested and such request documented in the case record.

2. Informing the Client

a. As stated in section IV F above, clients must be informed, in a manner appropriate to their age and level of functioning, of the generic class of psychotropic medication which is proposed to be given, the purpose of the medication, the dosage, and the possible side effects.

b. Information must be given to clients in person, preferably by a health care professional or, where this is not possible, by an appropriately trained member of the client's treatment team. (Refer to section V A 1 c above for topics which must be covered in this training.)

c. Where the client is informed by someone other than a physician, the client must be told that a physician is available to answer questions or give further information.

d. It is not required that a minor client give written consent for the administration of medication.

3. Emergency Exception

a. Psychotropic medication, with the exception of long-acting drugs, may be administered to a minor client despite the refusal of the client and/or parent if the treating physician certifies in the client's clinical record that an emergency, as defined herein, exists.

b. The initial decision to administer emergency medication must be based on a personal examination of the client by a physician.

c. The initial administration of emergency medication may extend for a maximum period of 72 hours.

d. The Medical Director (if applicable), treating physician, or other consulting physician may authorize the administration of medication for an additional 72 hours upon his/her determination that the continuation of medication on an emergency basis is clinically necessary and appropriate. This authorization may be given by telephone, provided it is coutersigned by the physician and certified as to necessity in the client's clinical record within 24 hours. Authorization to extend emergency medication for the additional 72-hour period must be endorsed by the facility's chief administrator.

e. The administration of psychotropic medication in an emergency situation must be documented on a separate reporting form designed by the facility for this purpose.

4. Exception Based on Review Procedures

The following procedures may be used when the treating physician determines that psychotropic medication is a necessary part of the client's treatment plan and:

- the client refuses or revokes consent to medication, including situations in which a client refuses medication sporadically over a period of three days or more; or

- the parent actively refuses to consent or revokes consent to medication; or

- the parent fails to respond to a request for consent to medication.

a. When Client and/or Parent Actively Refuse or Revoke Consent to Medication

(1) Meeting with Physician

The treating physician must speak to the client and/or the parent to discuss and attempt to respond to the concerns about the medication. The physician must attempt to explain his/her assessment of the client's condition, the reasons for prescribing the medication, the benefits and risks of taking the medication, and the advantages and disadvantages of alternative courses of action.

(2) Treatment Team Meeting

If the client and/or parent continue to refuse or revoke consent to medication and the physician still believes that medication is a necessary part of the client's treatment plan:

(a) The physician must tell the client and the parent that the matter will be discussed at a meeting of the client's treatment team and must invite the client and parent to attend the meeting.

(b) The physician may suggest that the client and/or parent discuss the matter with a person of their own choosing, such as a relative, attorney, physician, or mental health clinician.

(c) The treatment team must meet to discuss the treating physician's recommendation and the response of the client and/or parent. The team must attempt to formulate a viable treatment plan that is acceptable to the client and parent.

(3) Third Step Review

If after the treatment team meeting the client and/or parent continue to refuse or revoke consent to medication and the treating physician still believes that medication is a necessary part of the client's treatment plan, an independent psychiatric review must be conducted. Such review may be by a psychiatrist on staff at the facility, provided the psychiatrist is not the client's treating physician, or by an outside psychiatrist. The consulting psychiatrist must review the client's clinical record, conduct a personal examination of the client, provide a written report for the client's treatment team, and - if the parent is refusing or has revoked consent to medication - must speak with the parent.

(a) Voluntary Clients

If the client's legal status is as a voluntary admission to the facility (as is the case with virtually all DMR clients), and if the client and/or parent continue to refuse or revoke consent to medication, the medication may not be administered except in an emergency (refer to section V A 3 above).

(b) Involuntary Clients

If the client's legal status is as an involuntary admission to the facility, and if the consulting psychiatrist concurs with the treating physician that medication is a necessary part of the client's treatment plan, the medication may be administered for a period of up to 90 days.

b. When Parent Fails to Respond to Consent Request

With the exception noted below, the chief administrator (as defined herein) of a facility may consent to the administration of prescribed psychotropic medication to an individual client under either of the following circumstances:

(1) when the parent fails to respond either positively or negatively to a properly issued consent request (refer to section V A 1 above) by the proposed date for the commencement of treatment; or

(2) when the client has no known parent.

EXCEPTION: The administering Division may choose to promulgate policy requiring that consent be granted in these circumstances by an individual at a level higher than the facility's chief administrator.

B. Pre-Treatment Clinical Procedures

1. Except in emergencies, a comprehensive drug history must be obtained before initiating treatment with psychotropic medication. This history must include consideration of the use of all drugs by the client, as well as a history of cardiac, liver, renal, central nervous system, and other disease and a history of any drug allergies. In order to avoid serious drug interactions, communication is essential between the physician treating the psychiatric illness and other physicians who may be treating other disease entities in the same client. The drug history should be correlated with the client's physical examination and laboratory findings and a copy of the drug history sent to the dispensing pharmacy for inclusion in the client's profile record.

2. Except in emergencies, laboratory work must be done prior to initiating psychotropic medication in order to determine baseline functioning. This work may include but is not limited to the following:

a. complete blood count;
b. urinalysis;
c. wide screening to include the assessment of liver and renal functions; and
d. electrocardiograms and electroencephalograms on clients with previous histories of cardiac abnormalities or central nervous system disorders.

3. Manifestations of the psychiatric illness to be treated must be noted in the client's clinical record as a baseline against which the client's clinical condition and the outcome of treatment interventions will be evaluated.

C. Guidelines for Monitoring Drug Effects

1. Monitoring by Direct Care Staff

On a routine and ongoing basis, direct care personnel must monitor clients receiving psychotropic medication in order to ascertain the effectiveness of the medication and the presence of any undesirable side effects. Any such side effects noted must be communicated immediately to the treating physician and documented in the client's clinical record.

2. Physician Review

The minimum frequency at which clients must be examined by the treating physician is dependent on the type of medication the client is receiving. In all cases, the physician must enter progress notes in the client's clinical record at the time of the review.

a. Clients on Neuroleptic Drugs

Clients being maintained on neuroleptic drugs must be examined no less frequently than at 30-day intervals.

b. Clients on all other Psychotropic Medication

Clients receiving psychotropic medication other than a neuroleptic drug must be examined no less frequently than at 90-day intervals.

George J. Albanese
Commissioner

# ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

## EXAMINATION PROCEDURE

ADMINISTRATIVE ORDER 2:17
ATTACHMENT

EITHER BEFORE OR AFTER COMPLETING THE EXAMINATION PROCEDURE OBSERVE THE PATIENT UNOBTRUSIVELY, AT REST (E.G., IN WAITING ROOM).

THE CHAIR TO BE USED IN THIS EXAMINATION SHOULD BE A HARD, FIRM ONE WITHOUT ARMS.

1. ASK PATIENT WHETHER THERE IS ANYTHING IN HIS/HER MOUTH (I.E., GUM, CANDY, ETC.) AND IF THERE IS, TO REMOVE IT.
2. ASK PATIENT ABOUT THE CURRENT CONDITION OF HIS/HER TEETH. ASK PATIENT IF HE/SHE WEARS DENTURES. DO TEETH OR DENTURES BOTHER PATIENT NOW?
3. ASK PATIENT WHETHER HE/SHE NOTICES ANY MOVEMENTS IN MOUTH, FACE, HANDS, OR FEET. IF YES, ASK TO DESCRIBE AND TO WHAT EXTENT THEY CURRENTLY BOTHER PATIENT OR INTERFERE WITH HIS/HER ACTIVITIES.
4. HAVE PATIENT SIT IN CHAIR WITH HANDS ON KNEES, LEGS SLIGHTLY APART, AND FEET FLAT ON FLOOR. (LOOK AT ENTIRE BODY FOR MOVEMENTS WHILE IN THIS POSITION.)
5. ASK PATIENT TO SIT WITH HANDS HANGING UNSUPPORTED. IF MALE, BETWEEN LEGS, IF FEMALE AND WEARING A DRESS, HANGING OVER KNEES. (OBSERVE HANDS AND OTHER BODY AREAS.)
6. ASK PATIENT TO OPEN MOUTH. (OBSERVE TONGUE AT REST WITHIN MOUTH.) DO THIS TWICE.
7. ASK PATIENT TO PROTRUDE TONGUE. (OBSERVE ABNORMALITIES OF TONGUE MOVEMENT.)
8. *ASK PATIENT TO TAP THUMB, WITH EACH FINGER, AS RAPIDLY AS POSSIBLE FOR 10–15 SECONDS; SEPARATELY WITH RIGHT HAND, THEN WITH LEFT HAND. (OBSERVE FACIAL AND LEG MOVEMENTS.)
9. FLEX AND EXTEND PATIENT'S LEFT AND RIGHT ARMS (ONE AT A TIME).
10. ASK PATIENT TO STAND UP. (OBSERVE IN PROFILE. OBSERVE ALL BODY AREAS AGAIN, HIPS INCLUDED.)
11. *ASK PATIENT TO EXTEND BOTH ARMS OUTSTRETCHED IN FRONT WITH PALMS DOWN. (OBSERVE TRUNK, LEGS AND MOUTH).
12. *HAVE PATIENT WALK A FEW PACES, TURN, AND WALK BACK TO CHAIR. (OBSERVE HANDS AND GAIT.) DO THIS TWICE.

*ACTIVATED MOVEMENTS

LIST:

| EXAMINER'S FULL NAME | INITIALS | TITLE | DATE |
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PATIENT IDENTIFICATION _____ PATIENT NUMBER _____

*Instructions:* Complete examination procedure before making ratings. MOVEMENT RATINGS: Rate highest severity observed. Rate movements that occur upon activation one less than observed spontaneously.

*Rating Key:* 0 — None
1 — Minimal
2 — Mild
3 — Moderate
4 — Severe

RECORD DATES AND RATING KEY

| | DATE | | | | | | |
|---|---|---|---|---|---|---|---|
| **FACIAL AND ORAL MOVEMENTS:** | | | | | | | |
| 1. Muscles of facial expression, e.g., movements of forehead, eyebrows, periorbital area, cheeks; including frowning, blinking, smiling, grimacing. | | | | | | | |
| 2. Lips and perioral area, e.g., puckering, pouting, smacking. | | | | | | | |
| 3. Jaw, e.g., biting, clenching, chewing, mouth opening, lateral movement. | | | | | | | |
| 4. Tongue, rate only increase in movement both in and out of mouth, NOT inability to sustain movement. | | | | | | | |
| **EXTREMITY MOVEMENTS:** | | | | | | | |
| 5. Upper (arms, wrists, hands, fingers), include choreic movements (i.e., rapid objectively purposeless, irregular, spontaneous), athetoid movements (i.e., slow, irregular, complex, serpentine). DO NOT INCLUDE TREMOR (i.e., repetitive, regular, rhythmic) | | | | | | | |
| 6. Lower (legs, knees, ankles, toes) e.g. lateral knee movement, foot tapping, heel dropping, foot squirming, inversion & eversion of foot. | | | | | | | |
| **TRUNK MOVEMENTS:** | | | | | | | |
| 7. Neck - (shoulders, hips) e.g., rocking, twisting, squirming, pelvic gyrations. | | | | | | | |
| **GLOBAL JUDGEMENTS:** | | | | | | | |
| 8. Severity of abnormal movements<br>0- None, Normal 3- Moderate<br>1- Minimal 4- Severe<br>2- Mild | | | | | | | |
| 9. Incapacitation due to abnormal movements<br>0- None, Normal 3- Moderate<br>1- Minimal 4- Severe<br>2- Mild | | | | | | | |
| 10. Patient's awareness of abnormal movements<br>0- No awareness 4- Aware, severe<br>1- Aware, no distress distress<br>2- Aware, mild distress<br>3- Aware, moderate distress | | | | | | | |
| **DENTAL STATUS:** | | | | | | | |
| 11. Current problems with teeth and/or dentures?<br>0 - No 1 - Yes | | | | | | | |
| 12. Does patient usually wear dentures?<br>0 - No 1 - Yes | | | | | | | |
| | Examiner's Initials | | | | | | |

PROCEDURE DESCRIBED ON BACK