10A NCAC 26D .1104 is readopted as with changes as published in 33:06 NCR 567 as follows:

10A NCAC 26D .1104 INVOLUNTARY ADMINISTRATION OF PSYCHOTROPIC MEDICATION

(a) Psychotropic medication may be administered to any non-consenting client who has a mental illness and is receiving inpatient mental health ~~treatment,~~ treatment ~~when~~ if any one or more of the following conditions exist:

(1) failure to treat the client's illness or injury would pose an imminent substantial threat of injury or death to the client or those around him; or ~~if~~

(2) there is evidence that the client's condition is ~~worsening,~~ worsening ~~and~~ and, if not treated, is likely to produce acute exacerbation of a chronic condition that would endanger the safety or life of the client or others; and:

(A) the evidence of substantial and prolonged deterioration is corroborated by medical history; and

(B) the source of the history is documented in the client's record.

(b) ~~A medication refusal exists when a client refuses to take medication within~~ Medication refusal shall mean a client has refused to take medication within 30 minutes of the initial offer. ~~Any~~ A client who accepts medication within 30 minutes of the initial offer shall not be considered to have refused medication.

(c) Medication Refusal:

(1) All incidents of medication refusal shall be:

(A) reported as promptly as possible to the psychiatrist who is treating the client; and

(B) documented on progress notes and the medication chart by staff responsible for administering the medication.

(2) The administering staff shall attempt to determine the reason for refusal by questioning the client and encouraging him to accept the medication. Such shall be documented in the client's record.

(3) ~~Any~~ A member of the treatment team shall discuss the reasons for refusal directly with the client and attempt to resolve those concerns ~~which~~ that are the source of the refusal before a forced medication order is written.

(d) Initial Emergency Situation:

(1) In an initial emergency situation the physician:

(A) may initiate procedures and write an order for administering emergency forced ~~medication,~~ medication for a period not to exceed 72 hours; and

(B) shall document in the client's record the pertinent circumstances and rationale for the psychotropic medication.

(2) Psychotropic medication may be administered if the physician determines that the condition set forth in Paragraph (a)~~(1)~~ of this Rule exists and:

(A) the medication is a generally accepted treatment for the client's condition;

(B) there is a substantial likelihood that the treatment will effectively reduce the signs and symptoms of the client's illness; and

(C) ~~from a therapeutic viewpoint,~~ the proposed medication is the least intrusive of the possible treatments.

In all cases, the medication shall not exceed the dosage expected to accomplish the treatment and the ~~inmate~~ client shall be monitored for adverse reactions and side effects.

(3) Continuation of emergency situation:

(A) If needed, two subsequent emergency periods of 72 hours may be authorized only after the attending psychiatrist has received the written or verbal concurrence from another psychiatrist not currently involved in the client's treatment.

(B) ~~Then if~~ If the client continues to refuse medication after it is determined that psychotropic medication is still warranted, procedures for administering medication in a non-emergency situation shall be implemented.

(e) Non-Emergency Situations:

(1) ~~When~~ If a client refuses psychotropic medication in a non-emergency situation, the attending physician shall:

(A) make every effort to determine the cause of the refusal;

(B) inform the client of indications for psychotropic ~~medication (benefits and risks)~~ medication, including benefits and risk, and the advantages and disadvantages of ~~any~~ alternate courses of treatment; and

(C) request his or her consent.

(2) The treatment team may also assist in efforts to explain the advantages of medication to the client.

(3) The client's record shall contain documentation that efforts have been made to determine the cause of refusal and advantages of medication.

(4) The physician shall initiate a referral to the Involuntary Medication Committee if the client continues to refuse medication. The Committee shall:

(A) determine whether either of the ~~condition~~ conditions as set forth in Paragraph (a) of this Rule exists before authorizing an involuntary medication order; and

(B) apply the criteria set forth in Subparagraphs (d)(1) and (2) of this Rule in making its determination.

(C) If neither of the conditions set forth in Paragraph (a) of this Rule exists, ~~the client's refusal to accept the medication will be honored~~ the client shall not be involuntarily medicated.

(f) Involuntary Medication Committee:

(1) The members of the Involuntary Medication Committee shall be appointed by the Chief of Psychiatry and shall consist of a psychiatrist, a psychologist, and a mental health nurse who is a Registered Nurse.

(A) If the psychiatrist who issued the involuntary medication order is the individual who normally sits on the committee, another psychiatrist shall serve in that capacity.

(B) Other prison ~~staff,~~ staff who have pertinent information that may be useful to the committee in making its ~~determination,~~ determination shall be required by the committee to attend the hearing.

(2) In conducting the hearing, the committee chairman, appointed by the Chief of Psychiatry, shall ensure that the client:

(A) has received written and verbal notice of the time, date, place, and ~~the~~ purpose of the hearing;

(B) is informed of his or her right to hear evidence providing the basis for the involuntary medication, the right to call witnesses ~~in~~ on his or her behalf; and the right to request that the Client Representative attend the hearing as set forth in subsection (g)(2) of this ~~Rule.~~ Rule;

(C) attends the ~~hearing,~~ hearing unless his or her clinical condition is such that his or her attendance is not feasible. In this case, the Committee shall:

(i) state the reasons for determining that the presence of the client is not ~~feasible.~~ feasible;

(ii) allow the client to be interviewed in his or her room by the client representative and one or more members of the ~~Committee, if appropriate;~~ Committee; and

(iii) allow the client representative an opportunity to present facts relevant to whether an involuntary medication order should be ~~issued.~~ issued;

(D) shall be allowed a reasonable number of witnesses, to be determined by the committee chairman, or:

(i) written statements may be considered in lieu of direct testimony; and

(ii) specific client witnesses may be excluded from direct testimony if the unit ~~superintendent,~~ superintendent or ~~designee,~~ designee determines a justifiable security risk would occur if they were brought to the hearing ~~site.~~ site; and

(E) be given the opportunity to question any staff who present evidence that supports the need to involuntarily medicate.

(3) After the committee has received all relevant information, the committee shall:

(A) consider the facts and arrive at a majority decision;

(B) ensure that the authorization to involuntarily medicate shall not exceed 30 days;

(C) prepare and file in the client's record a written summary of the evidence presented and the rationale for the decision; and

(D) consult an attorney from the Attorney General's Office, assigned to represent the Department, ~~at any time questions~~ concerning the legal propriety of forcibly administering medication in a given case.

(4) If, after the initial 30 day period, involuntary medication is still deemed necessary, the psychiatrist may again present the case to the Involuntary Medication ~~Committee~~ Committee, which:

(A) shall conduct a review of the record and the reasons presented in support of continuing involuntary medication; and

(B) may then authorize the administration of involuntary medication for 90 additional days. Subsequent 90-day periods may be authorized only after similar reviews.

(g) Client Representative:

(1) ~~Whenever~~ If a client is recommended for forced medication on a non-emergency basis, the Chief of ~~Psychiatry,~~ Psychiatry or his or her ~~designee,~~ designee shall appoint a member of the treatment staff to serve as a Client Representative, whose role shall include:

(A) assisting the client in verbalizing the reasons for his or her refusal of psychotropic medications in meetings with his or her treatment team;

(B) providing this information to the Involuntary Medication Committee; and

(C) preparing a summary of the reasons for the refusal and documenting it in the client's record.

(2) The Client Representative shall appear before the Involuntary Medication Committee whenever he feels that it is in the best interest of the ~~client,~~ client or at the client's request.

(3) When reviewing ~~any~~ a case involving the involuntary administration of medication, the Involuntary Medication Committee shall consider oral or written comments from the Client Representative.

(h) ~~Whenever~~ If physical force is actually employed, ~~complete~~ documentation of all actions relating to the forceful administration of medication shall be included in the client's record and reported to the Unit Superintendent on a "Use of Force Report" (DC-422).

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, ~~1994.~~ 1994;
Readopted Eff. February 1, 2019.

10A NCAC 26D .1105 is readopted with changes as published in 33:06 NCR 567 as follows:

10A NCAC 26D .1105 PSYCHOTROPIC MEDICATION EDUCATION

(a) To ensure the client's understanding of psychotropic medication, individual or group medication education shall be provided to each client:

(1) who is to begin receiving, or is to be maintained on, psychotropic medication; and

(2) by the prescribing ~~physician,~~ physician or other person approved by the physician;

(b) ~~Documentation in the client health record shall reflect that medication education has been provided~~ Medical education that has been provided to a client shall be documented in the client's record.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, ~~1994.~~ 1994;
Readopted Eff. February 1, 2019.

10A NCAC 26D .1202 is readopted with changes as published in 33:06 NCR 567 as follows:

10A NCAC 26D .1202 USE OF SECLUSION

(a) Seclusion shall be used only under one of the following conditions:

(1) on an emergency basis when it is ~~believed~~ necessary to prevent immediate harm to the client or to others; or

(2) on a non-emergency basis ~~when~~ if ~~it is believed~~ that seclusion will resolve the ~~presenting situation~~ precipitating crisis. ~~or will produce the desired behavioral change.~~

(b) Emergency seclusion shall last no longer than is necessary to control the client.

(c) Seclusion shall not exceed seven days without the review and approval of an internal committee in accordance with Paragraph (e) of this Rule.

(d) ~~Observations,~~ Observations or ~~reviews,~~ reviews of any client in seclusion shall be made as follows:

(1) ~~Any~~ any client placed in seclusion ~~will~~ shall be observed no less ~~than~~ frequently than every 30 minutes;

(2) ~~A~~ a clinician may extend this interval up to 60 minutes if ~~if, in his or her clinical opinion,~~ such an observation would not affect the health, ~~safety~~ safety, or welfare of the client;

(3) ~~Documentation~~ documentation for extending the observation shall be placed in the client's record;

(4) ~~Observations~~ observations by a clinician shall be made at least ~~daily,~~ daily ~~or~~ or, ~~when~~ if the clinician is not present at the facility, observations by a health professional shall be reported by telephone to a clinician; and

(5) ~~Reviews~~ reviews by an internal committee shall be made in accordance with Paragraph (e) of this Rule.

(e) Committee review:

(1) If it appears that seclusion may be indicated for a period to exceed seven days:

(A) an internal committee consisting of a clinician, a nurse or member of the medical staff, and a member of the administrative staff shall review the use of seclusion and interview the client; and

(B) continued use shall not exceed the initial 7 days without the approval of this committee.

(2) Following its initial review, the committee shall review the case at intervals not to exceed 30 days.

(f) ~~When~~ If a client is placed in seclusion, his or her client record shall contain the following documentation:

(1) the rationale and authorization for the use of seclusion, including placement in seclusion pending review by the responsible clinician;

(2) a record of the observation of the client as required in Subparagraph (d)(1) of this Rule;

(3) each review by the responsible clinician as required in Subparagraph ~~(d)(2)~~ (d)(4) of this Rule, including a description of the client's behavior and ~~any~~ all significant changes ~~which~~ that may have occurred; and

(4) each review by the internal committee as required in Paragraph (e) of this Rule.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, ~~1994.~~ 1994;
Readopted Eff. February 1, 2019.

10A NCAC 26D .1203 is readopted with changes as published in 33:06 NCR 567 as follows:

10A NCAC 26D .1203 USE OF RESTRAINT

(a) Restraint shall be used only under the following circumstances:

(1) after less restrictive measures, such as counseling and ~~seclusion~~ seclusion, have been ~~attempted,~~ attempted or ~~when~~ if clinically determined to be inappropriate or inadequate to avoid injury to self or others; and

(2) either:

(A) upon the order of a clinician to control a client who has attempted, threatened, or accomplished harm to himself or others; or

(B) upon the authorization of the officer-in-charge on an emergency basis ~~when~~ if believed necessary to prevent immediate harm to the client or to others.

(3) ~~When~~ In determining if restraint is indicated, a clinician shall consider whether the client:

(A) has inflicted an injury to himself or to others and, if so, the nature and extent of such injury; or

(B) ~~through words or gestures, threatens to inflict further injury, and the manner and substance~~ threatens, through words or gestures, to inflict injury to himself or others and the nature of the threat.

(b) When a client exhibits behavior indicating the use of restraints and under the conditions of Paragraph (a) of this Rule, the following procedures shall be followed:

(1) If, in the judgment of any staff member, immediate restraint is necessary to protect the client or others, the client shall be referred immediately to a clinician for observation and treatment.

(2) If there is insufficient time to make the ~~referral,~~ referral or if a clinician is not immediately available:

(A) the staff in charge may employ emergency use of restraint;

(B) ~~within four hours of the initial restraint,~~ the client shall be reviewed within four hours of the initial restraint, and a restraint may be ordered ~~order~~ by a ~~clinician.~~ clinician pursuant to Paragraph (a) of this Rule. This may be accomplished by:

(i) telephone contact between the senior health professional at the facility and the clinician; and

(ii) if such review cannot be obtained, the client shall be released from restraint.

(C) a restraint order shall not exceed four hours. At the expiration of the restraint order, the client shall be released from restraint unless a new order is issued; and

(D) ~~any~~ a subsequent order for continuing restraint shall be based on:

(i) the client's present condition and behavior; and

(ii) reasons other than the original reasons for restraint, ~~or specifically indicate why~~ unless the order indicates the original reasons are considered applicable at the time of the subsequent order.

(c) ~~Whenever~~ If the client is restrained and subject to injury by another client, a professional staff member shall remain continuously present with the client. Observations and interventions shall be documented in the client record.

(d) All orders for continuation of restraint shall be reviewed and documented in intervals not to exceed four hours thereafter, either by personal examination or telephone communication between health professionals and the responsible clinician.

(e) All orders of restraint issued or approved by a clinician shall include written authorization to correctional staff or health professionals to release the client when ~~he~~ he or she is no longer dangerous to ~~himself~~ him or herself or to others.

(f) The responsible clinician shall be notified upon release of a client from restraint.

(g) Observations or reviews of all clients in restraint shall be made as follows:

(1) observations ~~at least~~ no less frequently than every 30 minutes;

(2) observations every four hours by the responsible clinician either personally or through reports from health professionals; and

(3) reviews by an internal committee in accordance with Paragraph (h) of this Rule.

(h) Committee review: An internal committee consisting of three members of the Department's clinical and administrative staff, including at least one psychologist and one psychiatrist shall review cases in which restraints were used beyond four hours. The incident will be reviewed and include consideration of the following:

(1) the use of appropriate procedures in the decision to restrain;

(2) sufficient indications for the use of restraint; and

(3) release of the client from restraint ~~at the appropriate time.~~ As soon as clinically indicated based upon consideration of the factors listed in Paragraphs (a) and (b) of this Rule.

(i) When a client is placed in restraint, the client record shall contain documentation of the following:

(1) the rationale and authorization for the use of ~~restraint~~ restraint, including placement in restraint pending review by the responsible clinician;

(2) a record of the observations of the client as required ~~in~~ by Paragraph (g) of this Rule.

(3) each review by the responsible clinician as required by this ~~Rule~~ Rule, including a description of the client and ~~any~~ all significant changes ~~which may~~ that have occurred; and

(4) each review by the internal committee as required in Paragraph (h) of this Rule.

History Note: *Authority G. S. 148-19(d);*
Eff. January 4, ~~1994.~~ 1994;
Readopted Eff. February 1, 2019.

10A NCAC 26D .1204 is readopted with changes as published in 33:06 NCR 567 as follows:

10A NCAC 26D .1204 PROTECTIVE DEVICES

Whenever protective devices are ~~utilized~~ used for any client, the Chief of Psychiatry shall:

(1) ensure that the:

(a) necessity for the protective device has been assessed and approved by a mental health professional;

(b) device ~~shall be~~ is applied by a person who has been trained in the ~~utilization~~ use of protective devices;

(c) ~~client,~~ client who is using protective devices which limits his or her freedom of ~~movement,~~ movement is observed every two hours; and

(d) client is given the opportunity for toileting and ~~exercising.~~ exercising as needed.

(2) document the ~~utilization~~ use of protective devices in the client's medical record.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, ~~1994.~~ 1994;
Readopted Eff. February 1, 2019.

10A NCAC 26D .1206 is readopted with changes as published in 33:06 NCR 567 as follows:

10A NCAC 26D .1206 INVOLUNTARY REFERRALS AND TRANSFERS

(a) Involuntary ~~Referrals~~ referrals and transfers to residential or inpatient units ~~on an involuntary basis~~ shall occur only ~~when~~ if the attending clinician determines that:

(1) a client requires treatment services not available at his or her current service delivery site; and

(2) a transfer over ~~his or her~~ the client's objections is required.

(b) Non-emergency involuntary referrals:

(1) ~~If, in the judgment of a qualified professional,~~ If a qualified professional determines that the following conditions exist:

(A) a diagnosable mental disorder; and

(B) determination is made that outpatient services are not effective treatment for the ~~client.~~ client; and

(2) ~~Then,~~ the professional ~~shall give~~ has given the client a written notice of a referral for ~~transfer,~~ transfer and has explained ~~explain~~ to the client his or her rights in accordance with Rule .1207 of this ~~Section.~~ Section; then

(3) ~~If the client does not voluntary consent to the referral and transfer,~~ the following steps shall be ~~taken:~~ taken if the client does not voluntarily consent to the referral and transfer:

(A) the client shall be ~~provided with~~ informed of the time, date and place of a hearing;

(B) the Chief of ~~Psychiatry,~~ Psychiatry or his or her ~~designee,~~ designee shall contact the hearing officer to arrange a hearing; and

(C) a client advisor shall be appointed and a hearing conducted in accordance with the procedures specified in this Rule.

(c) Emergency involuntary referrals:

(1) Such referrals shall be implemented only:

(A) ~~when a client has a diagnosable mental disorder; and~~ if a client has a diagnosable mental disorder; and either:

~~(B) either:~~

(i) presents a substantial risk of harm to himself or others, as manifested by recent overt acts or expressed threats of violence; or

(ii) is so unable to care for his or her own personal health and safety as to create a substantial risk of harm to himself; and

~~(C)~~(B) the Chief of Psychiatry has made a determination ~~is made~~ that outpatient services are not effective treatment for the client's condition.

(2) Such referrals shall be made by the mental health staff, the unit physician, nurse, or officer in charge after consultation with the designated mental health staff of the receiving unit.

(3) The officer in charge shall authorize a transfer only under the following ~~conditions, and when, in his or her opinion:~~ conditions and if the officer determines:

(A) the emergency referral criteria have been met; and

(B) ~~reasonable~~ efforts ~~have been made~~ to contact the referring mental health professional ~~and~~ have failed.

(d) A client who is transferred because he or she meets the criteria of an emergency ~~will~~ involuntary referral shall be afforded a hearing at the receiving unit within 10 days of admission. This hearing will follow the same procedures as those ~~outlined in~~ required by Paragraph (b) of this Rule.

(e) ~~Inmate~~ Client advisors:

(1) Each client referred for a hearing shall have an advisor appointed to assist him or her in preparing for the hearing.

(2) Each area administrator or institution head shall be responsible for appointing advisors for all units within his or her jurisdiction.

(3) ~~Inmate~~ Client advisors shall be free to advise the ~~inmate,~~ client ~~independently,~~ independently and to act solely in his or her ~~behalf;~~ behalf, and shall not be subject to any harassment, discipline, or ~~pressure~~ coercion in connection with such advice for the ~~inmate~~ client.

(4) Ex parte attempts to influence the decision of the hearing officer shall be prohibited.

(f) Hearing officers: The Chief of Psychiatry shall ~~recommend,~~ recommend and the Director of the Division of Prisons shall appoint ~~sufficient numbers of~~ persons to serve as hearing officers who shall:

(1) be qualified ~~professionals,~~ professionals who are neutral and independent;

(2) have the authority to refuse to transfer an ~~inmate~~ client ~~when, in their judgment,~~ if they determine that such a transfer is not justified.

(3) ensure and document that an ~~inmate~~ client advisor has been assigned;

(4) conduct a hearing that follows the procedures ~~as~~ specified in this Rule in a fair and impartial manner; and

(5) determine from evidence presented whether the criteria for emergency or non-emergency referrals have been met.

(g) Hearing procedures:

(1) The hearing shall be conducted no sooner than 48 hours ~~from~~ after the time the ~~inmate~~ client is given written notice that he or she is being considered for a referral to a residential or inpatient unit; however, the ~~inmate~~ client has the right to waive the 48-hour notice.

(2) The hearing officer shall determine the time, ~~place~~ place, and site of the hearing. ~~hearing, after considering the relevant factors.~~

(3) The hearing officer shall consider all relevant and non-repetitive ~~evidence,~~ evidence justifying or disputing the involuntary transfer and that:

(A) the ~~inmate~~ client has a diagnosable mental disorder;

(B) the ~~inmate~~ client requires services that are not currently available on an outpatient basis; and

(C) the unit to which the ~~inmate~~ client is to be transferred is better able to provide the needed treatment or habilitation services than is the currently assigned housing unit.

(4) A copy of the referral form, as well as other relevant written documents, shall be entered as evidence.

(5) All written documents or verbal information are to be considered confidential, in accordance with applicable law and Department policy.

(6) The ~~inmate~~ client shall not have direct access to his or her client record; however, the ~~inmate~~ client advisor may:

(A) review the client's record presented at the hearing; and

(B) consult with the ~~inmate~~ client about its use at the hearing and any other matters which could be relevant at the hearing, including the questioning of all witnesses.

(7) The ~~inmate~~ client who is being considered for ~~transfer,~~ transfer or his or her ~~advisor,~~ advisor may question any witnesses for the State, including mental health or mental retardation professionals.

(8) The ~~inmate~~ client may also present witnesses in his or her own behalf with limitations ~~which~~ that ~~include that:~~ include:

(A) a reasonable number of witnesses will be allowed at the discretion of the Hearing Officer;

(B) testimony may be received by conference telephone call if the hearing is conducted away from the ~~inmate's~~ client's assigned unit;

(C) written statements may be entered in lieu of direct testimony; and

(D) specific ~~inmate~~ client witnesses may be excluded from direct testimony if a justifiable security risk, including threats of harm or inmate escape, as determined by a unit superintendent, or designee, would occur were they brought to the hearing site.

(9) The hearing officer shall:

(A) document the results of the hearing, summarizing the evidence presented and the rationale for his or her decision;

(B) communicate the results of the hearing to the ~~inmate~~ client and staff; and

(C) ensure that a copy of relevant documents is placed in the client record.

(10) The decision to transfer involuntarily ~~is~~ shall be valid throughout the duration of the stay at any residential or inpatient ~~unit,~~ unit. ~~with required 30-day reviews of the need for continued treatment or habilitation~~. There shall be a review of the need for continued treatment or habilitation every 30 days.

(11) A ~~An~~ ~~inmate~~ client may be transferred to another like unit without a rehearing; however, if he or she is discharged from residential or inpatient services, a rehearing ~~is~~ shall be required prior to readmission to that level of service.

(12) At the request of the ~~inmate~~ client, his or her case shall be reviewed by a Hearing Officer within 90 days after the initial hearing to determine whether the assignment to the residential or inpatient unit ~~shall~~ will be extended or terminated. Subsequent reviews by a Hearing Officer ~~thereafter~~ shall take place each 180 days if requested by the ~~inmate~~ client.

(h) The receiving unit shall be responsible for notifying the ~~inmate~~ client of his or her right to inform his or her family of the ~~transfer;~~ transfer, and such notice shall be provided within 24 hours of the admission to the receiving unit.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, ~~1994.~~ 1994;
Readopted Eff. February 1, 2019.