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| NH DEPARTMENT OF CORRECTIONS<br>POLICY AND PROCEDURE DIRECTIVE  | CHAPTER <u>Health Services</u><br>STATEMENT NUMBER <u>6.23</u>  |
| SUBJECT: <b>INFORMED CONSENT STANDARDS</b><br><br>PROPONENT: <u>Helen Hanks, Administrative Director</u><br><i>Name/Title</i><br><u>Medical/Forensic Services 271-3707</u><br><i>Office Phone #</i> | EFFECTIVE DATE <u>06/15/14</u><br>REVIEW DATE <u>06/15/15</u><br>SUPERSEDES PPD# <u>6.23</u><br>DATED <u>10/15/12</u> |
| ISSUING OFFICER:<br><br><hr/> <i>William Wrenn, Commissioner</i>  | DIRECTOR'S INITIALS: _____<br>DATE: _____<br>APPENDIX ATTACHED:<br>YES _____ NO _____                                 |
| REFERENCE NO: See reference section on last page of PPD.  |   |

I. PURPOSE:

To provide guidance with regard to ensuring that all inmates of the Department of Corrections provide informed consent when receiving treatment by departmental treatment personnel.

II. APPLICABILITY:

To all staff who provide or prescribe mental health or medical treatment to inmates and inmates.

III. POLICY:

It is the policy of the NH Department of Corrections to ensure that all inmates being treated by departmental employees be provided with informed consent regarding treatment in a language understood by the inmate and that said consent is documented and in conformance with the laws, rules and regulations of the jurisdiction. If health care is rendered against the inmate's will, it is in conformance with the laws, rules and regulations of the jurisdiction.

IV. PROCEDURES:

- A. Informed consent means a choice made by a person who has the ability to make such a choice and makes it voluntarily after being provided with all the relevant information, including:
  - 1. Providing treatment choices and the options available to make the decision
  - 2. Understanding that they are free to choose or refuse any available alternative
  - 3. Clearly indicating or expressing their choice of the available alternatives knowing the consequences.
- B. Treatment means medical, dental or psychiatric intervention in an attempt to cure or stabilize an identified ailment, condition, or illness. It does not mean examination, diagnosis, or sample taking for the purpose of advancing a valid penological interest of determining whether or not such an ailment, condition or illness exists.
- C. All persons receiving treatment shall have the right to be informed of and give consent before administration of any treatment.

- D. All persons shall have the right to refuse all forms of medication or treatment except emergency treatment under the terms and conditions prescribed by law or by Cor 303.02 (Attachment 1)
- E. In the event that an inmate has been judicially decreed as being incompetent or is a minor, the right to provide informed consent is given to the guardian or legally responsible person as determined by said decree. Therefore, all the rights, privileges and duties generally afforded a person with regard to informed consent and treatment is transferred to the legally responsible person.
- F. Documentation of an inmate's consent to treatment will be documented on a consent form (Attachments 2, 3, & 4). The original form shall be filed in the inmate's offender or medical record.
- G. In instances of involuntary treatment, see PPD 6.18.
- H. In the event an inmate refuses to sign an authorization for treatment form, but knowingly, intelligently and voluntarily accepts treatment when offered, an entry is made by treatment personnel in the inmate's medical file and on the offered authorization for treatment form as to the facts and circumstances surrounding said refusal to sign.

#### REFERENCES:

Standards for the Administration of Correctional Agencies  
Second Edition. Standards

Standards for Adult Correctional Institutions  
Fourth Edition Standards  
**4-4397**

Standards for Adult Community Residential Services  
Fourth Edition. Standards  
**4-ACRS-4C-19**

Standards for Adult Probation and Parole Field Services  
Third Edition. Standards

Other  
**COR 303.02**

HANKS/clr

Attachments

Cor 303.02 Involuntary Emergency Medical Treatment.

(a) "Emergency" means the physical or mental status of an inmate or patient that, if not treated promptly, will likely result in substantial harm to the inmate or patient or others.

(b) The department shall maintain the general health and well being of persons under departmental control. Such person whose medical condition requires, in the opinion of the departmental physician, physician's assistant or advanced registered nurse practitioner (ARNP), expeditious emergency medical treatment to prevent death, substantial worsening illness or injury, contagion or infection of others, or harm to self or others shall be treated in the least intrusive manner as prescribed by the physician, physician's assistant or ARNP, even over the objection of the individual inmate or patient, pursuant to RSA 627:6, VII (b).

(c) In the case of an incompetent inmate or patient, pursuant to RSA 627:6, VII(b), emergency treatment shall be administered when the physician, physician's assistant or ARNP reasonably believes that a reasonable person concerned for the welfare of the inmate or patient would consent. Legally responsible persons shall be notified before the proposed treatment, if possible, but in no event later than 24 hours after the administration of such treatment.

(d) Involuntary emergency medical and/or psychiatric treatment shall be administered by a physician, physician's assistant or ARNP only upon personal examination and/or observation prior to the decision to administer such treatment, except in situations where emergency physical or mechanical restraint or seclusion is necessary as described in (j) below.

(e) Involuntary emergency medical treatment, pursuant to RSA 627:6, VII (b) shall be limited to the extent that:

- (1) The authorization by the departmental physician, physician's assistant or ARNP to impose involuntary treatment issued pursuant to Cor 303.02 shall last for not longer than 72 hours unless the physician issues a new 72 hour authorization;
- (2) No treatment shall be administered pursuant to Cor 303.02 which is not reasonably expected to alleviate or ameliorate the condition which has caused the need for said involuntary treatment; and
- (3) The treatment that is administered shall be a form of treatment that is the least restrictive effective treatment.

(f) When any emergency treatment is administered pursuant to Cor 303.02 the physician, physician's assistant or ARNP administering or directing such treatment shall record in the inmate or patient's medical record the specific reasons that such involuntary treatment is necessary.

(g) Documentation pursuant to (f) above shall be distributed as follows:

- (1) The original of the physician's, physician's assistant's or ARNP's note regarding the involuntary treatment shall be retained in the resident's medical record; and
- (2) A copy shall be promptly transmitted to the chief medical officer to keep him/her informed of inmates and patients receiving treatment pursuant to Cor 303.02.

(h) An inmate or patient or legally responsible person may complain against and appeal the administration of involuntary treatment pursuant to Cor 303.02 in accordance with the inmate and patient grievance procedure as outlined in the SPU patient handbook. The commissioner shall expeditiously act on the appeal after securing additional advice and expertise from medical professionals.

(i) Each instance of involuntary emergency treatment shall require an administrative review conducted by the bureau of quality improvement which shall review the treatment and circumstances and make recommendations to the commissioner.

(j) Departmental employees shall use the minimal amount of force and restraint necessary to prevent serious bodily harm to the inmate or patient or others.

(k) All such interventions shall be limited to the extent that:

- (1) Any such intervention shall be imposed for a period not to exceed one hour until a physician, physician's assistant or ARNP can be consulted to authorize emergency treatment;
- (2) The physician, physician's assistant or ARNP shall authorize the use of restraint or seclusion by telephone order for a period not to exceed 4 hours;
- (3) Such authorization shall expire unless it is renewed by telephone order for an additional 4 hours; and
- (4) Any further extensions of restraint or seclusion shall require a personal examination or observation by a physician, physician's assistant or ARNP.

Source. (See Revision Note at chapter heading for Cor 300)  
#7448, eff 2-6-01; ss by #9383, INTERIM, eff 2-3-09, EXPIRES:  
8-3-09; ss by #9508, eff 7-8-09

N.H. Department of Corrections

AUTHORIZATION FOR TREATMENT

I, the undersigned, a resident of the N.H. Department of Corrections hereby give authorization to the N. H. Department of Corrections to administer such treatment as is considered therapeutically necessary on the basis of findings during the course of said admission.

I understand that any person requiring care has the right to withdraw completely from treatment or to withdraw from any specific form of treatment prescribed by him/her at any time.

I hereby certify that I have read and fully understand the above authorization for treatment. I also certify that no guarantee or assurance has been made to the results that may be obtained.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

PERMISSION FOR NOTIFICATION

I, \_\_\_\_\_, give permission for the N.H. Department of Corrections to notify the following persons in the event of an emergency:

\_\_\_\_\_  
Name of Person To Notify

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Relationship

AUTHORIZATION FOR TREATMENT

(SECURE PSYCHIATRIC UNIT)

I, the undersigned, a resident in the care, custody or supervision of the Department of Corrections, hereby give authorization to the Department of Corrections to administer such treatment as is considered therapeutically necessary on the basis of findings during the course of said care, custody or supervision.

I understand that any person under such care, custody or supervision has the right to withdraw completely from treatment or to withdraw from any specific form of treatment prescribed for him/her at any time.

I hereby certify that I have read and fully understand the above authorization for treatment. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

If offender is:

To be signed by:

- Over 18, competent
- Over 18, incompetent
- Under 18, competent
- Under 18, incompetent

- Patient
- Legal guardian
- Patient (if over 14) and parent or guardian
- Parent or legal guardian

Legal guardian should present photocopy of appointment. Natural parent of person under 18 years of age is guardian and does not need to be appointed by Probate Court.

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| DEPARTMENT OF CORRECTIONS | <p style="text-align: center;">IDENTIFICATION</p> Name _____<br>DOB _____ Age _____ DOAdm _____<br>Religion _____ Hospital No. _____<br>Building _____ Ward _____ |
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STATE OF NEW HAMPSHIRE  
DEPARTMENT OF CORRECTIONS  
DIVISION OF MEDICAL and FORENSIC SERVICES

**Informed Consent for Psychiatric Medication Treatment**

I have discussed the following information with my behavioral health medical provider for each medication below:

- The diagnosis and target symptoms for the medication recommended.
- The possible benefit/intended outcome of treatment, and as applicable, all available procedures involved in the proposed treatment;
- The possible risks and side effects;
- The possible alternatives;
- The possible risks of not taking the recommended medication;
- The possibility that my medication dose may need to be adjusted over time, in consultation with my behavioral health medical provider;
- My right to actively participate in my treatment by discussing medication concerns or questions with my behavioral health medical provider, and
- My right to withdraw voluntary consent for medication at any time (unless the use of medication is required by a court order or determined by a court appointed guardian).

***I understand the medication information that has been provided to me. By signing below I agree to the use of each medication.***

| Medication | Target Symptoms to be Addressed* | How Discussed**   | Person/Guardian Initials & Date*** | Behavioral Health Medical Provider Initials & Date |
|------------|----------------------------------|---|------------------------------------|--|
|            |                                  | <input type="checkbox"/> In-Person<br><input type="checkbox"/> Telephone<br><input type="checkbox"/> Previously | Initials: _____<br>Date: _____     | Initials: _____<br>Date: _____                     |
|            |                                  | <input type="checkbox"/> In-Person<br><input type="checkbox"/> Telephone<br><input type="checkbox"/> Previously | Initials: _____<br>Date: _____     | Initials: _____<br>Date: _____                     |
|            |                                  | <input type="checkbox"/> In-Person<br><input type="checkbox"/> Telephone<br><input type="checkbox"/> Previously | Initials: _____<br>Date: _____     | Initials: _____<br>Date: _____                     |
|            |                                  | <input type="checkbox"/> In-Person<br><input type="checkbox"/> Telephone<br><input type="checkbox"/> Previously | Initials: _____<br>Date: _____     | Initials: _____<br>Date: _____                     |

Person/Guardian Printed Name \_\_\_\_\_ Person/Guardian Signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

Behavioral Health Practitioner Printed Name \_\_\_\_\_ Practitioner Signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

\* Target Symptoms refer to specific symptoms associated with a diagnosis, such as tearfulness, lack of energy, fearfulness, anxiety, hallucinations, insomnia. List the target symptoms rather than the underlying diagnosis.

\*\* "Previously" indicates the medication had been discussed in a previous setting (hospital, another clinic, etc) or by another behavioral health medical practitioner and you are verifying that the person continues to consent to treatment with this medication.

\*\*\* Ensure informed consent form with the original patient signature is located in patient's file. If consent obtained by telephone, inmate may initial and date at the next face-to-face visit.

Inmate's Name \_\_\_\_\_ Inmate ID# \_\_\_\_\_