	DEPARTMENT OF CORRECTIONS AND REHABILITATION CORRECTIONS ADMINISTRATION POLICY AND PROCEDURES	EFFECTIVE DATE: January 01, 2024	POLICY NO.: COR.10.G.05
		SUPERSEDES (Policy No. & Date): COR.10.1I.05 (03/09/10)	
	SUBJECT: INFORMED CONSENT AND RIGHT TO REFUSE		Page 1 of 10

1.0 PURPOSE

The purpose of this policy is to ensure that incarcerated individuals or authorized representatives are provided an opportunity to make informed decisions regarding health care, including the opportunity to refuse health care, when applicable.

2.0 SCOPE

This policy and procedure applies to all correctional facilities and their assigned personnel.

3.0 REFERENCES, DEFINITIONS & FORMS

.1 References

a. *Cantebury v. Spence*, 464 F.2d 772 (D.C.Cir. 1972).

b. *Carr v. Strode*, 79 Hawaii 475 (1995).

c. Department of Corrections and Rehabilitation, Policy and Procedures, COR.10.1I.02, Emergency Psychotropic Medication.

d. Hawaii Administrative Rules, Title 16, Chapter 85, Subchapter 4, Informed Consent.

e. Hawaii Revised Statutes §327G, Advance Mental Health Care Directives.

f. Hawaii Revised Statutes §327E, Uniform Health-Care Decisions Act (Modified).

g. Hawaii Revised Statutes §327G, Advance Mental Health Care Directives.

h. Hawaii Revised Statutes §327L, Our Care, Our Choice Act.

i. Hawaii Revised Statutes §329-38.5, Opioid therapy; informed consent process; requirement for written policies.

j. Hawaii Revised Statutes §334E-1, Informed consent.

k. Hawaii Revised Statutes §671-3, Informed consent.

l. *Nishi v. Hartwell*, 473P.2d 116 (Haw.1970).

m. *O'Neal v. Hammer*, 953 P.2d 561 (Hawaii 1998).

n. Standards for Health Services in Prisons. National Commission on Correctional Health Care, (2018).

o. Standards for Health Services in Jails. National Commission on Correctional Health Care, (2018).

p. Standards for Mental Health Services in Correctional Facilities. National Commission on Correctional Health Care, (2015).

.2 Definitions:

a. Capacity: An individual's ability to understand the significant benefits, risks, and alternatives to proposed medical or mental health care or treatment and to make and communicate a health care decision.

b. Informed Consent: The agreement by a patient to a treatment, examination, or procedure after the patient receives the material facts about the nature, consequences, and risks of the proposed treatment, examination, or procedure; the alternatives to it, and the prognosis if the proposed action is not undertaken.

c. Guardian: A judicially appointed guardian having authority to make health care decisions for an individual.

d. Legal Surrogate: An agent designated in a power of attorney for health care or surrogate designated or selected in accordance with HRS §327E.

e. Material Risk: When a reasonable person, in which the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.

f. Provider: A nurse practitioner, physician assistant, or physician.

g. Therapeutic Privilege: If in the judgement of a health care provider the disclosure of information, as required for informed consent, would be detrimental to the patient's mental or physical health, or not in the best interest of the patient, provided that such action is consistent with general standards of medical and surgical practice, the disclosure of such information may be withheld.

.3 Forms:

a. DCR 0417, Refusal to Consent to Medical/Surgical/Dental Treatment/Medication (attached)

b. DCR 0427, Consent to Operation, Post Operative Care, Medical Treatment, Anesthesia, or Other Procedure (attached)

c. Informed Consent for Medication Therapy

d. DCR 0575, Informed Consent for Mental Health Services (attached)

e. Informed Consent for Opioid Prescribed Pills (attached)

f. Informed Consent for Psychoactive Medication Therapy (attached)

g. Informed Consent for Health Services (attached)

h. Informed Consent for Medication Assisted Treatment (attached)

i. Informed Consent for HIV Testing (attached)

4.0 POLICY

.1 All examinations, treatments, and procedures are governed by informed consent practices applicable to the State of Hawaii.

.2 For procedures and medications that in the community setting would require informed consent, written documentation of informed consent is required.

.3 Refusal of health evaluations and treatments by incarcerated individuals are documented and must include the following:

a. Description of the service being refused.

b. Evidence that the incarcerated individual has been informed of any adverse health consequences that may occur because of the refusal.

c. The signature of the patient.

d. The signature of a health staff witness.

.4 If an incarcerated individual does not sign the refusal form, the observation of the refusal of the health care service is noted on the refusal form by a second health or custody staff witness.

5.0 PROCEDURES

.1 Informed Consent when Required by Standards of Medical Practice.

a. When indicated by standards of medical practice in the community setting, providers shall supply the following information to the incarcerated individual or the incarcerated individual's guardian or legal surrogate prior to obtaining consent for a proposed medical or surgical treatment, or for a diagnostic or therapeutic procedure:

1. The condition to be treated or the suspected existence of which is the indication for a diagnostic procedure.

2. A description of the proposed medical or surgical treatment or diagnostic procedure.

3. The intended and anticipated results of the proposed treatment or procedure.

4. The recognized alternative treatments or diagnostic procedures, including the option of not providing treatment or performing the diagnostic procedure.

5. The recognized substantial or material risks of serious complication or mortality associated with the proposed treatment or diagnostic procedure, the recognized alternative treatments or diagnostic procedures, and not undergoing or undertaking any treatment or diagnostic procedure.

6. The recognized benefits of the proposed treatment or diagnostic procedure, of recognized alternative treatments or diagnostic procedures, and of not undertaking treatment or diagnosis.

b. The information to be disclosed may be presented in writing, orally, or by means of audio-visual aids, and in language the incarcerated individual, or the incarcerated individual's guardian or legal surrogate, can reasonably be expected to understand.

c. An incarcerated individual, or the incarcerated individual's guardian or legal surrogate, may elect not to be given any part or all of the information that would otherwise be provided.

d. Providers shall document in the health record the provision or refusal of the information and the results of the discussion with the incarcerated individual, or the incarcerated individual's guardian or legal surrogate.

e. The clinic nurse shall ensure that any required consent forms (e.g., DCR 0427, DCR 0448), have been completed and health information staff shall file completed consent forms in the health record.

f. If a provider initiates complex treatment that relies on multiple practitioners for completion, the referring provider shall inform the incarcerated individual, or the incarcerated individual's guardian or legal surrogate, of all the necessary steps of treatment before commencement of the first irrevocable step.

g. When health care services are delivered through in-reach, telehealth, or community-based and hospital settings, the specialist or provider providing the service to the incarcerated individual shall be responsible for obtaining informed consent, as applicable.

.2 Mental Health Services

a. Before any non-emergency treatment for mental illness is provided to an incarcerated individual, a qualified health care professional or qualified mental health professional shall obtain informed consent (e.g., DCR 0575 Informed Consent for Mental Health Services), from the incarcerated individual, or the incarcerated individual's guardian or legal surrogate, if the incarcerated individual is not competent to give informed consent.

b. Qualified health care professionals or qualified mental health professionals shall document whether informed consent for the non-emergency mental health service was obtained from the incarcerated individual, or the incarcerated individual's guardian or legal surrogate, in the health record.

.3 Dental Services

a. Before any non-emergency invasive diagnostic tests or dental extractions are provided to an incarcerated individual, a dentist shall obtain informed consent (e.g., DCR 0575 Informed Consent for Mental Health Services), from the incarcerated individual, or the incarcerated individual's guardian or legal surrogate, if the incarcerated individual is not competent to give informed consent.

b. Dentists shall document whether informed consent for the non-emergency dental service was obtained from the incarcerated individual, or the incarcerated individual's guardian or legal surrogate, in the dental health record.

.4 Opioids.

a. Providers shall obtain written informed consent using DCR (Informed Consent for Opioid Prescribed Pills) when prescribing opioids to a qualifying opioid therapy patient, defined as follows:

1. A patient requiring opioid treatment for more than three (3) months.

2. A patient who is prescribed benzodiazepines and opioids together.

3. A patient who is prescribed a cumulative dosage of opioids that exceeds ninety (90) morphine milligram equivalents (MME) daily.

b. The term "qualifying opioid therapy patient" shall not apply to any qualifying patient who is issued or receives a prescription pursuant to HRS §327L [Our Care, Our Choice Act].

.5 Human Immunodeficiency Virus.

a. A provider may subject an incarcerated individual's body fluids or tissue to a test for the presence of human immunodeficiency virus infection after:

1. Orally explaining to the incarcerated individual that certain personalized test results are maintained by the department of health, according to strict confidentiality protocols established by law.

2. Orally advising the incarcerated individual that free and anonymous human immunodeficiency virus testing is available through the department of public safety, department of health, and certain community agencies.

3. Providing the incarcerated individual reasonable opportunity to decline the test.

4. Receiving the incarcerated individual's express oral consent to the test.

b. A provider may, for the purpose of obtaining consent to the test and in lieu of the oral-consent procedure specified above, use a written form that, at a minimum, provides equivalent information to that described by paragraphs 1 and 2 above; provided that the provider shall allow the person reasonable opportunity to decline consent by declining to sign the form DCR , Informed Consent for HIV Testing.

c. Informed consent is not required where the incarcerated individual is unable to give consent and it is determined by the incarcerated individual's treating provider that the incarcerated individual's human immunodeficiency virus status is necessary to make a diagnosis or determine an appropriate course of treatment for the incarcerated individual. The incarcerated individual shall be informed in a timely manner that a test for the presence of human immunodeficiency virus has been performed and the provider shall provide all positive and indeterminate human immunodeficiency virus test results and offer appropriate post-test counseling to those individuals with positive and indeterminate human immunodeficiency virus test results.

d. A treating provider may order a human immunodeficiency virus test without the incarcerated individual's informed consent if the provider has determined that the incarcerated individual is incapable of giving consent prior to the rendering of treatment and when there is reason to believe that the safety of a health care worker may be affected due to exposure to the blood or bodily fluids of an incarcerated individual suspected of possible human immunodeficiency virus infection. The availability and quality of health care services shall not be compromised based on the findings and

testing performed. The incarcerated individual and the health care worker shall be informed in a timely manner that a test for the presence of human immunodeficiency virus has been performed. The provider shall provide all positive and indeterminate human immunodeficiency virus test results and offer appropriate post-test counseling to the incarcerated individual being tested and afford the health care worker the opportunity to obtain the test results and appropriate post-test counseling.

.6 Circumstances when Health Care Services may be Provided without Informed Consent.

a. When a life-threatening condition requires immediate medical intervention.

b. When emergency care of patients, who do not have the capacity to understand the information, is required (e.g., COR.10.1I.02 Emergency Psychotropic Medication).

c. When emergency treatment or an emergency procedure is rendered by a health care provider and the obtaining of consent is not reasonably feasible under the circumstances without adversely affecting the condition of the patient's health.

d. When certain public health matters require health care intervention (e.g., see human immunodeficiency virus above; when an incarcerated individual has a suspected or diagnosed contagious disease or otherwise represents a threat to those in the immediate area, the incarcerated individual may be medically isolated or quarantined to control the spread of the disease; when facility security and operations or the safety of individuals is endangered by the incarcerated individual).

e. When health care services are provided as a routine educational, institutional, or organizational activity (e.g., administration of vital signs, intake screening measures, or screening tests; initial and annual health assessments; attendance at sick-call when requested by the incarcerated individual; physically non-invasive assessments conducted during infirmary, sheltered housing, or segregation rounds).

f. When performed in accordance with Advance Health Care Directives or Advance Mental Health Care Directives.

g. When mandated by law, court order, or governmental regulation.

h. When being evaluated for decisional capacity.

i. When a psychiatrist, or court of law, judges an incarcerated individual to be incapable of understanding the necessary medical information according to the standard, legally defined criteria of competence.

.7 Therapeutic Privilege.

a. When a provider considers invoking therapeutic privilege, the provider shall notify the Medical Director and present the circumstances involving the need for therapeutic privilege to a panel of the Quality Assurance Committee.

b. The panel shall include a minimum of three (3) of the following members from the Quality Assurance Committee: Medical Director, Physician Manager, Psychiatrist Manager, Chief Nursing Officer, Mental Health Branch Administrator, or Responsible Physician.

c. The health care provider shall document in the health record the rationale leading to the health care provider's judgement to withhold information prior to obtaining consent for the health care service.

d. The chair of the panel shall document the review and recommendations of the panel.

.8 Refusal of Health Care Evaluations and Treatments.

a. When an incarcerated individual refuses a scheduled health care appointment, health care evaluation, health care treatment, surgical procedure, or medication, the incarcerated individual shall be informed by a qualified health care professional or qualified mental health professional of the adverse health consequences of such a refusal and shall be asked to sign the Refusal to Consent to Medical/Surgical/Dental Treatment/Medication form [DCR 0417]. The qualified health care professional or qualified mental health professional shall document the refusal of the health care service by signing DCR 0417 as witness.

b. If the refusal may have adverse effects on a serious health condition, the qualified health care professional or qualified mental health professional shall document the encounter in health record and refer the incarcerated individual to a provider for review The provider shall review and sign DCR 0417, indicating the refusal was reviewed. If appropriate, the provider shall

further counsel the incarcerated individual regarding the risk of any adverse health consequences for refusing the health care evaluation or treatment.

c. When an incarcerated individual refuses health care evaluations and/or treatments, and declines to sign DCR 0417, the refusal form [DCR 0417] shall be signed by the qualified health care professional or qualified mental health professional and a second health or custody staff witness.

d. Incarcerated individuals who refuse health care evaluation or treatment, in whole or in part, shall continue to be allowed access to subsequent health care in the usual manner, regardless of the past refusal for health care evaluation or treatment.

APPROVAL RECOMMENDED:

JAN 0 1 2024

Deputy Director for Corrections Date

APPROVED:

JAN 0 1 2024

DIRECTOR Date

STATE OF HAWAII

DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

REFUSAL TO CONSENT TO MEDICAL/SURGICAL/DENTAL TREATMENT/MEDICATION

NAME: _____ SID: _____ DOB: _____

FACILITY: _____ DATE: _____ TIME: _____

I, the undersigned patient, refuse the following treatment and/or medication: _____

_____
(Describe Treatment and/or Medication)

The risk of refusing treatment or medication has been explained to me and I accept the risk involved. I release the State, the Department, the facility administration and personnel, the Health Care Division administration and medical personnel from any responsibility or liability for any unfavorable reaction, outcome, or any untoward results due to this refusal on my part to accept treatment or medication.

_____ _____
(Signature of Patient) (Date)

I, the undersigned, have explained to the above named patient the risk involved in refusing treatment or medication recommended for the patient's continued good health and I witness the patient's refusal of the recommended treatment or medication

_____ _____ _____
(Print Name) (Signature & Title) (Date)

A referral has been made to a provider: YES NO

I have reviewed this case and if necessary have further counseled this patient on the risk of refusing treatment or medication.

_____ _____ _____
(Print Name of Provider) (Signature & Title) (Date)

** If the patient refuses treatment and/or medication and refuses to sign this consent, please have refusal witnessed by another correctional employee.*

I have witnessed the above named patient refuse the recommended treatment or medication and I have also witnessed the patient's refusal to sign this consent form.

_____ _____ _____
(Print Name & Title) (Signature & Title) (Date)

CONSENT TO OPERATION, POST OPERATIVE CARE, MEDICAL TREATMENT, ANESTHESIA, OR OTHER PROCEDURE

Patient:
SID: « DOB:
Facility: _____ Date:

You have the right and obligation to make decisions concerning your health care. The physician must provide you with the information and advice concerning the proposed procedure so that you can make an informed decision.

(1) Explain the nature of the condition(s) in professional and ordinary language.
PROFESSIONAL: _____
_____
ORDINARY LANGUAGE: _____
_____
AT _____

(2) Describe procedures(s) to be performed in professional and ordinary language, if appropriate.
PROFESSIONAL: _____
_____
ORDINARY LANGUAGE:_____
_____
_____
AT_____

(3) I recognize that, during the course of the operation, post operative care, medical treatment, anesthesia, or other procedure, unforeseen conditions may necessitate my above-named physician and his or her assistants, to perform such surgical or other procedures as are necessary to preserve my life and bodily functions.

(4) I have been informed that there are many significant risks, such as severe loss of blood, infection, cardiac arrest and other consequences that can lead to death or permanent or partial disability, which can result from any procedure.

(5) No promise or guarantee has been made to me as to result or care.

Any section below which does not apply to the proposed treatment may be crossed out. All sections crossed out must be initialed by both the physician and the patient.

(6) I consent to the administration of (general, spinal, regional, local) anesthesia by my attending physician, by an anesthesiologist, a nurse anesthetist, or other qualified party under the direction of a physician as may be deemed necessary. I understand that all anesthetics involve risks that may result in complications and possible serious damage to such vital organs as the brain, heart, lungs, liver and kidney.

These complications may result in paralysis, cardiac arrest and related consequences or death from both known and unknown causes.

(7) I consent to the use of transfusion of blood and blood products as deemed necessary. I have been informed of the risks which are transmission of disease, allergic reactions, and other unusual reactions.

(8) Any tissue or part surgically removed may be disposed of by the hospital or physician in accordance with accustomed practice.

(9) Any additional comments may be inserted here:
_____
_____

(10) I have had the opportunity to ask questions about this form.

FULL DISCLOSURE

[ ] I AGREE TO AUTHORIZE THE PROCEDURE DESCRIBED ABOVE AND I AGREE THAT MY PHYSICIAN HAS INFORMED ME OF THE:

a) DIAGNOSIS OR PROBABLE DIAGNOSIS.
b) NATURE OF THE TREATMENT OR PROCEDURE RECOMMENDED.
c) RISKS OR COMPLICATIONS INVOLVED IN SUCH TREATMENT OR PROCEDURES.
d) ALTERNATIVE FORMS OF TREATMENT, INCLUDING NON-TREATMENT, AVAILABLE.
e) ANTICIPATED RESULTS OF THE TREATMENT.

_____ _____
Patient/Other Legally Responsible Person Sign, If Applicable Date

_____ _____
Physician Date

INFORMED CONSENT FOR MENTAL HEALTH SERVICES

NATURE AND PURPOSE
I understand that mental health services may include the use of a variety of psychosocial and pharmacological therapies, as well as psychological assessments and/or diagnostic evaluations. The purposes of mental health services are to alleviate symptoms of serious mental disorders, attain improved functioning, and prevent relapse. Additional goals of treatment may include the development of self-understanding, enhanced coping skills, and self-improvement. I am aware that mental health services are available upon request (e.g., by submitting a medical request, telling the nurse at sick call).

BENEFITS/RISKS
I understand that while psychosocial and pharmacological therapies may provide significant benefits, it may also pose risks. Psychosocial therapies may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications may have unwanted side effects.

FEES
All screenings, examinations, and treatments required by the Department of Public Safety or nationally accepted correctional standards are free. Inmate requested non-emergency medical services have a $3.00 co-payment fee.

PRIVACY STATEMENT
In general, I understand that the information shared with mental health professionals is confidential and mental health information will not be released to external agencies without my consent. I further understand that there are specific limitations to this confidentiality in which it may be necessary to discuss information about my treatment with others. Examples of such conditions include, but are not limited to, the following:

1) if there is a risk of imminent danger that I may harm myself or others;
2) if there is suspicion that a child is being sexually or physically abused or is at risk of such abuse;
3) if a court order is issued for the release of medical and/or mental health records;
4) if my mental state and history is an issue in civil, personal injury, or other forms of grievances;
5) if personnel within the Department of Public Safety have a need to know.

CONSENT TO MENTAL HEALTH SERVICES
I authorize and consent to mental health care, including psychiatric and psychological assessment and treatment, which my treating physician and other mental health providers find to be necessary and which is given or performed at their direction. I understand that mental health services are provided by a range of mental health professionals, some of whom are in training. All professionals-in-training are supervised by licensed staff. I understand that I may refuse mental health services at any time.

I acknowledge that this facility has not made any guarantees to me as to the results of psychiatric and psychological assessments and treatments. If I have any additional questions regarding this consent form or about my diagnosis, evaluation, treatment, risks or complications, alternative forms of assessment and/or treatment, and anticipated course and results of treatment, I may discuss them with members of my treatment team.

I certify that I have read this Informed Consent for Mental Health Services form and that I am the patient, or the patient's authorized representative. On my own behalf (and on behalf of the patient) I accept and agree to participate in mental health services offered to me and to be bound by the above, a copy of which will be made available to me upon request.

X _____ X _____
Print Name of Patient or Authorized Representative — Print Name of PSD Representative

X _____ X _____
Signature of Patient or Authorized Representative Date — Signature of PSD Representative Date

☐ **The patient is unable to sign for the following reason(s):**

_____
Reason(s)

X _____ X _____
Print Name of PSD Representative — Signature of PSD Representative Date