1.0 POLICY:

It is the policy of the Division (including agencies) to utilize Housing and Urban Development (HUD) Shelter Plus Care (SPC) program funds to serve homeless persons with disabilities such as mental illness, chronic substance abuse and/or AIDS and related conditions. SPC provides rental assistance (currently tenant-based) that Division agencies match with an equal value of supportive services to the target population.

2.0 PURPOSE:

This policy is to ensure the rights of consumers by providing information regarding SPC assistance and provide procedures to ensure the proper coordination of these services within the Division.

3.0 SCOPE:

Division Wide

4.0 DEFINITIONS:

4.1 SHELTER PLUS CARE (SPC) PROGRAM: The Shelter Plus Care Program is authorized by Title IV, Subtitle F, of the McKinney Homeless Assistance Act. Shelter Plus Care is designed to link rental assistance to supportive service for hard-to-serve homeless persons with disabilities (primarily those who are seriously mentally ill, have chronic problems with alcohol, drugs or both, or have Acquired Immunodeficiency Syndrome (AIDS) or related conditions. The program provides grants to be used for rental assistance for permanent housing for homeless persons with disabilities. Rental assistance grants must be matched in the aggregate by supportive services that are equal in value to the amount of rental assistance and appropriate to the needs of the population to be served.

4.2 ELIGIBLE PARTICIPANTS: To be eligible for the Shelter Plus Care Program a person must be both homeless and disabled (disabled persons are defined as those having serious mental illness, chronic substance abuse problems, a
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physical/developmental disability or those with AIDS and related conditions). In the case of a homeless household, at least one adult member must meet the program definition of being disabled.

4.3 VERY LOW INCOME: Very low income means an annual income not in excess of 80 percent of the median income for the area, as determined by HUD, which may establish income limits higher or lower than 80 percent of the median income for that area, on the basis of its finding that such variations are necessary because of the prevailing levels of construction costs or unusually high or low family incomes.

4.4 RENTAL ASSISTANCE: Provides affordable housing for program participants by using Shelter Plus Care grant funds to pay the difference between the actual rent for a unit and 30 percent of the participant’s monthly adjusted income. Rental assistance may include, 1) monthly rent payments, 2) when necessary, a security deposit in an amount up to one month’s rent, and 3) one month’s rent for housing units vacated by a program participant (the term “vacated” excludes brief periods of inpatient care, limited to 90 days for each occurrence.”

4.5 TENANT-BASED RENTAL ASSISTANCE: Allows for rental assistance which permits participants to choose housing of an appropriate size in which to reside.

4.6 SPONSOR-BASED RENTAL ASSISTANCE: Provides grants for rental assistance through contracts between the grant recipient and sponsor organizations (a sponsor may be a private, non-profit organization or a community mental health agency established as a public non-profit organization).

4.7 SUPPORTIVE SERVICES: Supportive Services means assistance that 1) addresses the special needs of eligible persons and 2) provides appropriate services or assists such persons in obtaining appropriate services, including health care, mental health treatment, alcohol and other substance abuse services, child care services, case management services, counseling, supervision, education, job training and other services essential for achieving and maintaining independent living. Inpatient care does not qualify as a supportive service.
4.8 SUPPORTIVE SERVICE MATCH: To qualify for rental assistance grants an applicant (DPBH mental health agency) must certify that it will provide or ensure the provision of supportive services including funding the services itself if the planned resources do not become available for any reason appropriate to the needs of the population being served and at least equal in value to the aggregate amount of rental assistance funded by HUD. The supportive services may be newly created for the program or already in operation and may be provided or funded by other federal, state, local, or private programs.

4.9 SINGLE ROOM OCCUPANCE (SRO): SRO housing means a unit for occupancy by one person which may not contain food preparation or sanitary facilities or both.

4.10 ADMINISTRATIVE COSTS: Grantees may use up to, but no more than eight percent of the Shelter Plus Care grant for certain allowable administrative costs associated with the program which includes receiving new participants into the program, providing housing information and search assistance, determining participant income and rent contributions; inspecting units for compliance with Housing Quality Standards, and processing rental payments to landlords. Administrative costs do not include costs related to administering the grant, preparing reports to HUD and conducting audits of the grant.

4.11 CALCULATING TENANT RENT PAYMENTS: To determine the appropriate rent payment for a Shelter Plus Care participant, program operators need to follow the HUD published directive entitled Tenant Rent Calculations for Certain HUD McKinney Act Programs.

4.12 SHELTER CARE PLUS QUALITY HOUSING INSPECTIONS: Housing Quality Standards (HQS) set acceptable conditions for interior living space, building exterior, heating and plumbing systems, and general health and safety. Physical inspections of all units must be conducted on an annual basis. Inspections must be completed by certified housing inspectors. The HUD Inspection Form HUD-52580 must be used and completed when conducting inspections.
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#### 5.0 PROCEDURE:
5.1 All DPBH agencies must designate staff that is responsible for administering their Shelter Plus Care Programs. This includes grant writing, fiscal management, landlord dealings, coordination of housing quality standard inspections, and oversight of service coordination and oversight of providers. All DPBH agencies are required to develop, maintain and update a manual containing policies, procedures and protocols on their Shelter Plus Care Programs. This includes ensuring that applicable DPBH agency staff is aware of current HUD rules and regulations, as well as ensuring that they are notified of any changes to HUD Shelter Plus Care rules and regulations.

5.2 As a minimum, DPBH agency’s Shelter Plus Care policy, procedures and protocol manuals must address:

5.2.1 Consumer eligible activities and services;
5.2.2 Leasing requirements;
5.2.3 Supportive Services;
5.2.4 Financial Management;
5.2.5 Recordkeeping and reporting;
5.2.6 Renewals, extensions and terminations; and
5.2.7 General Grant Administration

5.3 DPBH agencies will ensure that consumers are informed of their rights and responsibilities within the Shelter Plus Care Program, using either information developed by HUD, the agencies own information or a combination thereof. All information utilized must address and assure compliance with Title IV, Subtitle F, of the McKinney Homeless Assistance Act of 1987, and specific requirements set forth in 24 CFR, state law and Division/Agency policy.

5.4 DPBH agencies will write, manage and administer all HUD Shelter Plus Care grants, operationally and fiscally, in an ethical, cost effective and person-centered manner, following guidelines and stipulations outlined by HUD in the previously referenced federal regulations.
5.5 While DPBH agencies manage and administer HUD Shelter Plus Care Grants at their agency levels, they will strive for consistency and compatibility with all Shelter Plus Care operations, particularly with the utilization of forms. All agencies participating in local Continuum of Care activities will coordinate and communicate local Continuum of Care activities with other agencies and DPBH Division/Central Office.

5.6 As a minimum, each DPBH agency staff utilize forms/documents/applications to address the following key components of the operation of its Shelter Plus Care Program:

5.6.1 Initiating Shelter Plus Care Services;
5.6.2 Shelter Plus Care Services Review;
5.6.3 Homelessness Interview;
5.6.4 Mental Health Interview;
5.6.5 Authorization for Release of Information/Privacy Act Notice;
5.6.6 Shelter Plus Care participant Contact;
5.6.7 Income and Rent Calculation Methodology;
5.6.8 Rent Reasonableness;
5.6.9 Assisted Lease;
5.6.10 Billing/Payment;
5.6.11 Treatment/Service Plan; and
5.6.12 Service Contract (e.g., SLA, ISLA services)

5.7 Agencies will send to the DPBH Central Office (Division) Residential Supports Program Manager a copy of 1) any grant application or grant related activity it submits to HUD; 2) annual progress reports it submits to HUD, and 3) any other information requested by DPBH Central office/Division.

5.8 Agencies will participate in Division-required residential meetings as designated by the DPBH Central Office/Division Residential Support Coordinator. Additionally, agency staff need to participate in local/regional Continuum of Care meetings and related activities as a requirement for obtaining HUD funding.
5.9 To assist DPBH Central Office/Division with the writing of its annual Centers for Mental health Services (CMHS) Block Grant, agency Shelter Plus Care staff must provide, when asked, data/information on Uniform Reporting Standards (URS) pertaining to homelessness. DPBH will provide the reporting/data structure to assist and facilitate the agencies with the collection of federally required URS data.

5.10 Consumers (persons who apply for and receive HUD Shelter Plus Care assistance) of tenant-based rental assistance must receive supportive services at a Division mental health agency (or agency designated to be a sponsor). Information about their HUD assistance and participation in supportive services must be documented in the approved information system.

5.11 Each DPBH agency Shelter Plus Care Program shall be “review/audit” ready at all times, in anticipation of federal HUD compliance reviews and audits. As a minimum, this performance improvement “readiness” must include an address the areas of:

- 5.11.1 Resident Rent;
- 5.11.2 Rent Reasonableness;
- 5.11.3 Housing Quality Standards (HQS);
- 5.11.4 Consumer Eligibility for Services;
- 5.11.5 Financial Management;
- 5.11.6 Match;
- 5.11.7 Consumer Medical Records/Documents; and
- 5.11.8 Written Agreements with Service Providers

5.12 Each DPBH Division agency that receives HUD Shelter Plus Care fund shall develop specific procedures to implement the provisions of this policy.

6.0 ATTACHMENTS:

- N/A

7.0 REFERENCES:

- N/A
8.0 IMPLEMENTATION OF POLICY:

Each Division agency within the scope of this policy shall implement this policy and may develop specific written procedures as necessary to do so effectively.

Effective: 2/8/02

Revision Date: 10/1/08; 7/2/07; 2/20/03; 9/12/08

Approved by Commission: 2/8/02
1.0 POLICY:

If under applicable law a person has authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care, the Division will treat such person as a personal representative with respect to protected health information relevant to such personal representation.

With respect to unemancipated minors, deceased individuals, and others, the Division will follow these procedures in determining whether to treat a person as a personal representative of an individual.

2.0 PURPOSE:

The Division must treat a personal representative of an individual as the individual if the law so requires and if the person has authority under the law to act on behalf of the individual. This policy provides guidance when dealing with a personal representative.

3.0 SCOPE:

Division Wide

4.0 DEFINITIONS:

5.0 PROCEDURE:

5.1 The Division will treat a person as a personal representative of an individual with respect to disclosure of protected health information if under applicable law:

5.1.1 A parent, guardian, or other person acting in loco parentis (in place of a parent) has authority to act on behalf of an individual who is an unemancipated minor in making decisions related to health care, or
5.1.2 An executor, administrator, or other person has authority to act on behalf of a deceased individual or the individual's estate.

5.2 In the following circumstances, the Division will not treat a person as a personal representative of an unemancipated minor; when the minor has authority to act with respect to their protected health information pertaining to a health care service if:

5.2.1 The minor consent to such health care service, applicable law requires no other consent, and the minor has not requested that another person be treated as the personal representative.

5.2.2 Applicable law permits the minor to obtain such health care service without the consent of a parent, guardian, or other person acting in loco parentis, and the minor, a court, or another person authorized by law consent to such health care services, or

5.2.3 A parent, guardian, or other person acting in loco parentis assents to an agreement of confidentiality between a covered health care provider and the minor with respect to such health care service.

5.3 The Division shall treat a person as the personal representative of an individual if:

5.3.1 There is a reasonable belief that the individual has been or may be subjected to domestic violence, abuse, or neglect by such person; or treating such person as the personal representative could endanger the individual, and

5.3.2 In the exercise of professional judgment, the Division decides it is not in the best interest of the individual to treat the person as the individual's personal representative.

5.4 The Division will follow the requirements and/or permissions of applicable state and other law in determining whether to provide or deny access to a minor’s
6.005 05/2007 Treating Personal Representative as the Individual

protected health information to a parent, guardian, or other person acting in loco parentis.

6.0 ATTACHMENTS:

N/A

7.0 REFERENCES:

N/A

8.0 IMPLEMENTATION OF POLICY:

Each Division agency within the scope of this policy shall implement this policy and may develop specific written procedures as necessary to do so effectively.

Effective Date: 04/15/03

Revised/Review Date: 04/15/03, 05/31/07

Approved by DPBH Administrator:

Approved by Commission:
1.0 POLICY:

It is the policy of the Clinical Services Branch to ensure that all policies are relevant, effective, and current.

2.0 PURPOSE:

To establish a system for the development, review, approval and communication of Division policies

3.0 SCOPE: Clinical Services Branch

4.0 REFERENCES:

NRS 433.314(1) (2)

5.0 DEFINITIONS:

5.1 Policy: DPBH Clinical Service Branch guideline or principles upon which a program or course of action is based.

5.2 Agency Protocol: Individual agency guidance that supports and adds clarity at the agency level the implementation of Division policy.

5.3 Procedure: Outline of established steps or specific method of completing desired outcomes or action. Discipline procedures will outline discipline specific processes. Discipline procedure will not duplicate Clinical Services Branch Policy or agency level protocol. Discipline specific procedures will cross walk across DPBH Clinical Service Branch agencies.

5.4 Policy Tech: Online policy and procedure management system used by the Division of Public and Behavioral Health to store track and manage agency policy and procedure.

5.5 Document Owner: The department lead assigned to create, monitor, maintain, and update agency policy. The document owner has the authority to delegate and assign writers, proxy authors, reviewers and readers.
5.6 Writer: Assigned by the document owner to write or collaborate in writing a document.

5.7 Reviewer: An individual assigned by the document owner to review a document for content accuracy and to provide input during the document development process.

5.8 Approver: The approver has final authority and responsibility for approving a policy for adoption by the division or agency.

5.9 Reader: A user assigned to read the policy. Readers have a responsibility to read policies as assigned and mark the policy as read to acknowledge that they have read and understand the contents of the policy. Policies may have short quizzes that must be completed prior to submitting “mark as read”.

5.10 Reports: Policy Tech has the capacity to produce reports sorted by reader (employee) or document. Reports by reader allow a supervisor or other authority to view a list of all the documents “marked as read” by an employee. Reports by document allow management to view a list of all the readers (employees) who have responsibility to read and acknowledge by “mark as read” that they read and understand a policy or procedure.

5.11 Document Control Administrator (DCA): Individuals assigned with the responsibility to manager user accounts (set user names, passwords and assign roles), upload and manage policies and procedures and create “reader groups.”

5.12 Review Cycle: All DPBH policies, protocols and procedures will be reviewed on a reoccurring two (2) year cycle; except for Emergency Management and Specific Communicable Disease policies, which will be reviewed everyone (1) year.

6.0 PROCEDURES:

6.1 A new policy can be initiated by a Division Agency or by the Clinical Services Statewide Policy and Procedure Manager.

6.2 To avoid duplication of efforts, notify the Clinical Services Statewide Policy and Procedure Manager of the intention to develop the policy, and the proposed title or subject of the policy.
6.3 The Clinical Services Statewide Policy and Procedure Manager will forward the draft for next agenda to the DPBH Clinical Services Policy Committee, ensure that the policy meets all regulatory and NRS requirements, and prepare it for submission to the Deputy Attorney General and the Commission on Behavioral Health for final review and approval.

6.4 When the policy is related to direct client or clinical care, the policy will be submitted for review by the Statewide Medical Director for Adult Mental Health Services.

6.5 The Clinical Services Branch Statewide Policy and Procedure Manager will provide the initiating agency with:

6.5.1 Electronic copies of the format to be used (Attachment A);

6.5.2 Policy Review Form (Attachment B); and

6.5.3 Considerations for Policy Development and Review (Attachment C).

6.6 Development of policy content will be enhanced by an inclusive process that provides an opportunity for review and comment from the range of staff within the agencies that are affected by the policy.

6.7 Cited referenced must be current and five (5) years or less.

6.8 The draft of the policy is submitted to the Clinical Services Statewide Policy and Procedure Manager for further review, approval, and distribution process.

6.9 The document is to be marked “DRAFT,” provided electronically in the specified format (Attachment A.). The policy originator’s contact information is to be included. Do not include any dates after the policy; the appropriate date(s) will be added by the Clinical Services Statewide Policy and Procedure Manager.

6.10 The Clinical Services Statewide Policy and Procedure Manager will assign a policy number and submit the policy electronically to the DPBH Policy Committee for their opportunity for review and comment.

6.11 Members of the DPBH Policy Committee will share the draft policy for review with members of their constituency and will be the single voice to bring that input back to the committee.
6.12 Revision recommendation for the new policy must be received by the Clinical Services Statewide Policy and Procedure Manager using "track changes" by close of business the first Wednesday of each month for prior to review at next scheduled DPBH Policy Committee meeting.

6.13 Upon edit, review and approval of the policy, the Clinical Services Statewide Policy and Procedure Manager will submit the draft policy to the assigned Deputy Attorney General for review and input.

6.14 When the policy is related to clinical care it will also be submitted to the Chief Medical Officer and Statewide Psychiatric Medical Director. In the absence of a response from the Chief Medical Officer and the Statewide Psychiatric Medical Director in seven (7) calendar days, the policy will be deemed appropriate to move forward to the Deputy Attorney General for final review.

6.15 Upon final review by the Deputy Attorney General, the Clinical Services Branch Deputy Director will have final review.

6.16 In the absence of revisions that affect intent or process, the policy will then be prepared for submission at the next DPBH Commission on Behavioral Health for final approval.

6.17 When there are changes that affect intent or process, the policy will be routed for re-review by the DPBH Policy Committee.

6.18 Upon completion of all reviews, the policy will be submitted to the DPBH Commission on Behavioral Health.

6.19 If a policy needs to be implemented between Commission on Behavioral Health meetings, the DPBH Administrator has the authority to approve the policy on an "expedited" basis provided the policy is then reviewed by the Commission for approval at the next meeting.

6.20 To meet open meeting law requirements, policies must be submitted to DPBH Administration no later than three (3) weeks prior to the Commission meeting. If received after that, they will be held for the next Commission meeting.
6.21 Upon approval by the Commission, the Clinical Services Statewide Policy and Procedure Manager will process the policy including ensuring that the policy is in the appropriate format, adding the approval date, and facilitating placement of the policy in Policy Tech.

6.21.1 To ensure communication about the new policy, the Clinical Services Statewide Policy and Procedure Manager will assign the policy to all appropriate reader’s groups in Policy Tech.

6.21.2 It is the responsibility of each Agency Director and the DPBH Policy Committee Members to ensure that agency Policy Tech reader’s groups are kept current.

6.22 The policy identification convention is described below;

6.22.1 Policies are divided into six (6) categories:

6.22.1.1 Consumer Rights and Responsibilities (CRR)

6.22.1.2 Services and Programs (SP)

6.22.1.3 Communicable Disease Management (CD)

6.22.1.4 Information Management, Records, and Technology (IMRT)

6.22.1.5 Human Resources (HR)

6.22.1.6 Administrative (A)

6.22.1.7 Fiscal (F)

6.23 The policies will be identified with the letter or letters of the appropriate category, a number to indicate the topic, and a number following a period to indicate the specific policy; the title of the policy will follow. Example: This policy, A – 1.1 Policy Development and Review Process is labeled: Administrative (A), the topic (1) is policies, and after the period is the number (1) of the specific policy, which is followed by the title of the policy.

7.0 ATTACHMENTS:
A. DPBI Clinical Services Policy Template

8.0 Implementation of Policy: Each Division agency within the scope of this policy shall implement this policy and may develop specific written procedures as necessary to do so effectively.

EFFECTIVE DATE: 11/20/06
REVIEWED / REVISED DATE: 11/13/07, 08/06/10, 10/2016
SUPERSEDES: #4.066 Policy Development and Review Process
APPROVED BY MHDS ADMINISTRATOR: 08/06/10
APPROVED BY MHDS COMMISSION: 11/17/06, 09/17/10
APPROVED BY THE DPBH COMMISSION ON BEHAVIORAL HEALTH: 11/2016
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
CLINICAL SERVICES

Control #  Rev. Date:  Title:  Effective Date:
A 7.2  New  Healthcare Professional Licensing Requirement  Next Review Date:

1.0 POLICY:

To provide guidelines for insuring current licensure credentials of Clinical Health Services staff.

2.0 PURPOSE:

Health professionals, who are employed on a full-time basis, or under contractual arrangement, will comply with appropriate state and federal licensure, certification, or registration requirements. Verification of current licensure credentials will be maintained on file in the appropriate Human Resource Office for the agency.

Any person employed in a position that requires certification or licensure must be certified or licensed by the appropriate state licensing board for their respective profession.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

4.1 Licensure: a process by which an agency of government regulates a profession by granting an individual authority to engage in an occupation if the applicant has attained and maintains the qualifications.

4.2 Professional licensure: protects the public by enforcing standards that restrict practice to qualified individuals who have met specific qualifications in education, work experience, and exams.

4.3 Credential: a qualification, achievement, personal quality, or aspect of a person's background, typically used to indicate that they are suitable for something, a document or certificate proving a person's identity or qualifications.

4.4 Credentialing: the process of obtaining and reviewing documentation to determine qualifications to practice in a position that requires professional licensure or certification.
4.5 The documentation may include, but not be limited to, the applicant's education, training, clinical privileges, experience, licensure, accreditation, certifications, professional liability insurance, malpractice history and professional competence.

4.5.1 Generally, the terms credentialing and re-credentialing include the review of the information and documentation collected, as well as verification that the information is accurate and complete.

5.0 REFERENCES:

5.1 NRS 433.265
5.2 NAC 284.546
5.3 NAC 284.646
5.4 NAC 284.650
5.5 NAC 632.890

6.0 PROCEDURE:

6.1 Requirement to Maintain Licensure
All individuals applying for positions that require professional licensure will be credentialed on hire.

6.1.1 Individuals who do not hold appropriate professional licensure will not be hired for positions requiring professional licensure.

6.1.2 Individuals holding positions which require periodic renewal of a professional license are responsible for continuing to meet renewal qualifications and providing evidence of current licensure to their respective agency on or before the date of expiration of their existing license.

6.1.2.1 Individuals may not practice in any professional capacity at DPBH Clinical Service Branch facilities without current licensure beyond the date of expiration of a current license.

6.1.2.2 Individuals who do not maintain professional licensure may be required to:

6.1.2.2.1 Use annual leave until their license is restored and they provide documentation to the respective personnel office.

6.1.2.2.2 In the absence of accrued annual leave the employee will remain on leave without pay status until their licensure is restored or there is a personnel action terminating employment.

6.2 Social work Interns working toward licensure as an underfill must work under professional supervision and must complete their required hours toward licensure within three (3) years.

6.3 Psychological Assistants working toward licensure as an underfill under the supervision of a Psychologist and must complete their required hours and pass licensing exams within three (3) years.
6.4 Dismissals

6.4.1 Per NAC 284.646 an appointing authority may immediately dismiss an employee for the following causes:

6.4.1.1 The suspension, revocation or cancellation (expiration) of a professional or occupational license, certificate, permit or driver’s license if the possession of such professional or occupational license, certificate, permit or driver’s license is a requirement of the position at the time of appointment as stated in the standards of work performance, essential functions or class specifications for the position and/or in other documentation provided to the employee at the time of appointment or is required thereafter pursuant to federal or state laws.

6.4.1.2 If an employee fails to report suspension, revocation or cancellation (expiration) of a professional or occupational license, certificate, permit or driver’s license, the appointing authority may immediately dismiss the employee pursuant to NAC 284.646 or appropriate disciplinary or corrective action may be taken against the employee pursuant to NAC 284.650.

6.4.1.3 Unprofessional conduct.

7.0 ATTACHMENTS: N/A

8.0 IMPLEMENTATION OF POLICY:

Each Division agency within the scope of this policy shall implement this policy and may develop specific written protocols as necessary to do so effectively.

Effective Date:
Approved by Administrator:
Approved by Commission:
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

CLINICAL SERVICES

Control #  Rev. Date:  Title:  Effective Date:  Next Review Date:
SP 3.1  05/2018  Involuntary Administration of Medication in Civil Clients  10/16  05/2020

1.0 POLICY:

DPBH provides psychotropic medication only with the consumer’s consent, in an emergency, or in accordance with the procedure outlined here to protect the rights and safety of our consumers.

2.0 PURPOSE:

The purpose of this policy is to protect the rights and safety of clients’ of mental health services by ensuring that all due process procedures are followed if medication is provided on an involuntary basis.

3.0 SCOPE:

This policy applies to civil inpatient settings within DPBH.

4.0 DEFINITIONS:

4.1 Consent to Treatment — Informed consent requires that the consumer has been adequately informed as to the nature of his/her condition and the nature and purposes of the proposed treatment including its reasonable risks and benefits, alternative treatment options available and the potential consequences if treatment is refused. Informed consent is evidenced by the treating medical staff documentation in the electronic medical records and the consumer’s signature on an approved medication consent form. If the consumer refuses to sign documents but states that consent to treatment, a witness must indicate they have witnessed this statement.

4.2 Emergency Treatment — Emergency treatment allows for the administration of psychotropic medication for consumers who are refusing psychotropic medication and are acting in a manner that poses an imminent danger to themselves or others, or who are suffering from an acute illness, disease or condition, if within a
reasonable degree of medical certainty, delay in the initiation of emergency
care or treatment would endanger the health of the consumer and for who
a Denial of Right to Refuse Medication has been reported pursuant to NRS
433.535.4 4. The Administration of psychotropic drugs under these
circumstances shall not extend beyond the duration if the emergency situation
without the consumers consent or the meeting of the committee and
administrative review as detailed in this policy.

4.3 **Medication Hearing Coordinator** - The Medication Hearing Coordinator is a
staff member designated by the agency director to coordinate the scheduling of
the review by the Medication Review Committee and any review by the medical
director or designee.

5.0 **PROCEDURE:**

5.1 Recommendation of medication and consent consultation:
5.1.1 The treating psychiatrist must determine that the consumer suffers from a
mental illness and is gravely disabled or poses a likelihood of serious harm
to himself or others, requiring the administration psychotropic or other
medication.
5.1.2 The treating medical staff must explain to the consumer the purpose, risks
and benefits of the medication to be prescribed, including possible side
effects of the medication and alternative treatments, and the potential
consequences if treatment is refused. The consumer then can provide
written informed consent to treatment.
5.1.3 This process shall be reflected in the consumer’s medical record.

5.2 Determination of the need for involuntary medication:
5.2.1 If the consumer refuses to accept psychotropic medication, and the
treating medical staff, in their professional judgment, determines that
involuntary administration of medication is both appropriate and the least
restrictive method of treatment, or if the physician determines to a
reasonable degree of medical certainty that the consumer lacks capacity to understand and appreciate the nature of his/her condition and the nature of proposed treatment, medical staff shall complete Form 1, "Recommendation for Administration of Medication."

5.2.2 A copy of the completed Form 1 shall be given to the consumer’s social worker who will meet with the consumer to explain Form 1 and this policy.

5.2.3 The social worker will notify the consumer of the right to receive assistance from an advisor for the hearing.

5.2.4 In the event the consumer still indicates an unwillingness to take the medication and declines to sign consent, the social worker shall then assist him/her in filling out Form 2 "Notice to Consumer of Intention to Medicate and Request for Review."

5.2.5 If the consumer refuses to meet with the advisor, the social worker will assist in completing the form.

5.2.6 The social worker shall give the completed Form 2 to the Medication Hearing Coordinator who shall schedule the hearing, notify the advisor, and at least twenty-four (24) hours prior to the hearing, and provide the consumer with written notice of their rights related to the process.

5.3 Consumer Rights Related to the Hearing:

5.3.1 The consumer will be notified no less than twenty-four (24) hours in advance of the hearing.

5.3.2 The consumer may not be medicated during this twenty-four (24) hour period absent of an emergency.

5.3.3 The consumer has a right to be informed of the diagnosis, the factual basis for the diagnosis, and why the treatment team believes medication is necessary.

5.3.4 The consumer has the right to attend the hearing if they so desire.

5.3.5 The consumer may cross examine any staff witnesses the committee interviews.
5.3.6 The consumer has the right to assistance from an advisor. The advisor must be not involved with the consumer’s case and who understands the psychiatric issues.

5.3.7 The consumer has a right to a copy of the minutes of the hearing.

5.3.8 The consumer may appeal the Committee’s decision to the Medical Director.

5.4 Advisor for the hearing:

5.4.1 The advisor will be an individual who meets the following criteria:

5.4.1.1 The advisor is not involved with the consumer’s current episode of care;

5.4.1.2 The advisor understands the psychiatric issues; and

5.4.1.3 The advisor has received training (as arranged by DPBH or its agencies) on the purpose and process of the hearing and the role of the advisor.

5.4.2 The advisor shall meet with the consumer in sufficient time prior to the hearing to prepare for the hearing.

5.4.3 The role the advisor is to assist the consumer to communicate his/her position to the committee. The advisor shall not express his/her own opinion as to the appropriateness of the proposed treatment.

5.4.4 The advisor shall complete the appropriate portion of Form 3.

5.4.5 Each DPBH agency within the scope of this policy will establish a procedure for having advisors available.

5.5 The Hearing Process:

5.5.1 The Medication Hearing Committee is a group composed of at least three mental health professionals, one of whom must be a psychiatrist and none of whom may be currently involved in the consumer’s diagnosis or treatment or serve as the Medical Director or designee who reviews the decision of the committee.

5.5.2 Factors the committee must consider:
5.5.2.1 Consumer’s stated objections, if any, to the medications;
5.5.2.2 All documents or evidence offered by the consumer’s behalf;
5.5.2.3 Whether the consumer will harm himself or others without the medication;
5.5.2.4 Whether the consumer cannot improve without the medication, or whether the consumer would improve but at a significantly slower rate;
5.5.2.5 Whether there are less restrictive means that would accomplish the same or similar results;
5.5.2.6 The consumer’s prior experience with the proposed medications; and
5.5.2.7 Other factors deemed relevant by the committee and noted in its decision.
5.5.2.8 The committee may interview any persons it feels may be of assistance in conducting its review and/or receive any additional documents offered on behalf of staff or the consumer.

5.5.3 The decision of the committee involves the following:
5.5.3.1 To approve use of the medication, the majority, which must include the psychiatrist, must find that the consumer suffers from a mental illness as defined in NRS 433A.155 and that the consumer is a danger to self or others or is gravely disabled.
5.5.3.2 The vote of the committee will be noted in the consumer’s chart.
5.5.3.3 The committee will complete Form 3, “Committee Review and Findings.” A copy of Form 3 will be given to the social worker who will review the form with the consumer and assist him/her in filling out Form 4, “Notice of medication Review Committee and Request for Review.” In the event the consumer refuses to consent to medication and refuses to fill out Form 4, the social worker will complete the form and indicate that the consumer has refused to sign the request. The social worker will explain that the consumer
has a right to appeal the decision of the committee to the Medical Director.

5.5.4 Record of Hearing will be maintained either in writing or by recording.

5.5.5 Consumer’s presence at hearing:
   5.5.5.1 Unless the consumer indicates verbally or through conduct that they do not intend to participate in the hearing, the proceedings will not commence until the consumer has arrived. The consumer has the right to be present for the entirety of the proceedings.

5.6 Review by Medical Director/Designee:

5.6.1 If within twenty-four (24) hours of being served the committee decision of the necessity for administration of the medication, the consumer indicates on Form 3 that he/she wants a review of the committee findings, or the consumer still refuses to consent to treatment or sign Form 4, a copy of Forms 1 through 4 shall immediately be transmitted to the medical director or designee.

5.6.2 The medical director or designee, who must be a psychiatrist, has twenty-four (24) hours from the consumer’s request for review to decide in accordance with this process.

5.6.3 The medical director or designee shall conduct a review of the process of denial of the consumer’s right to decline the medication as soon as possible.

5.6.4 The same factors considered by the committee shall be reviewed by the medical director or designee, in addition to:
   5.6.4.1 Whether the proper procedures were followed by the committee;
   5.6.4.2 Whether the proposed medication is medically appropriate based on the consumer’s diagnosis, and medical history;
   5.6.4.3 Whether medication is the least restrictive mean of treatment; and
   5.6.4.4 Any other factors deemed relevant by the medical director or designee.
5.6.4.5 The medical director or designee shall review the chart and any other documents that were present to the committee during the review.

5.6.4.6 If it is deemed necessary, the medical director or designee may interview any persons he/she feels may assist in conducting the review and may conduct an independent examination of the consumer.

5.6.4.7 The medical director or designee may approve the medication as prescribed, limit the dosage of the prescribed medication or disapprove the medication altogether.

5.6.4.8 The medical director or designee shall enter his decision on Form 5, a copy shall be given to the social worker as well as the treating medical staff. The social worker shall transmit a copy of Form 5 to the consumer within one working day of receiving Form 5 from the medical director or designee.

5.6.4.9 The social worker is responsible for notifying the consumer of the medical director’s decision and explaining the right to request judicial review. This process is to be documented on Form 6. If the consumer requests judicial review, the social worker will fax the Denial of Rights (DOR) to the Attorney General’s office immediately.

5.7 Administration of Medication

5.7.1 If the medical director or designee confirms that the medication is appropriate, and the consumer knowingly does not request judicial review and continues to refuse to consent to treatment, the consumer may be medicated without his/her permission. No medication will be given until the entire procedure is carried out, including the administrative review by the medical director or designee and judicial review where applicable.

5.7.2 Before administering the medication, the treating medical staff shall initiate a Denial of Right to Refuse Medication form to which all forms

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referred to in this policy shall be attached, and which will be reviewed by the Commission on Behavioral Health pursuant to NRS 433.534.

5.7.3 The administration of the medication does not have to await Commission on Behavioral review.

5.8 Continuation of Medication

5.8.1 Medication can continue for 14 days because of the first hearing. If the consumer continues to refuse to consent to treatment, a second hearing is necessary to continue treatment beyond 14 days. The Medication Hearing Committee can re-authorize treatment based on review of the written record. The medication can only continue with either consent from the consumer, or periodic review.

5.8.2 If the consumer is medicated following this process, his/her treating medical staff must submit bi-weekly reports to the medical director or designee for the duration of the treatment documenting the need to continue the involuntary administration of medication, if the need to involuntarily administer the medication persists.

5.8.3 If the need to continue involuntary administration of medication persists after 30 days of the original involuntary administration of medication, this review process shall take place anew. This process will be repeated every 30 days while the consumer continues to refuse the voluntary administration of medication.

5.9 Documentation

5.9.1 All the APM 92-4R Involuntary Administration of Medication Forms (A-F) will be added to consumer’s medical record.

6.0 ATTACHMENTS:

6.1 Form 1: Recommendation for Administration of Medication

SP 3.1 Involuntary Administration of Medication in Civil Clients Attachment A

6.2 Form 2: Notice to Client of Intent to Medicate and Request for Review

SP 3.1 Involuntary Administration of Medication in Civil Clients Attachment B
6.3 Form 3: Committee Review and Findings  
   SP 3.1 Involuntary Administration of Medication in Civil Clients Attachment C

6.4 Form 4 Notice of Recommendation for Medication Review Committee and Request for Review  
   SP 3.1 Involuntary Administration of Medication in Civil Clients Attachment D

6.5 Form 5 Decision of Medical Director page 1  
   SP 3.1 Involuntary Administration of Medication in Civil Clients Attachment E

6.6 Form 6 Decision of Medical Director page 2  
   SP 3.1 Involuntary Administration of Medication in Civil Clients Attachment F

7.0 Implementation of Policy:

Each Division agency within the scope of this policy shall implement this policy and may develop specific written protocol as necessary to do so effectively.
1.0 POLICY:

It is the policy of the Clinical Services Branch to provide psychotropic medication only with the client's consent, in an emergency, or in accordance with a court order to protect the rights and safety of our clients.

2.0 PURPOSE:

The purpose of this policy is to protect the rights and safety of clients of mental health services by ensuring that all due process procedures are followed if medication is provided on an involuntary basis.

3.0 SCOPE:

This policy applies to forensic inpatient settings within DPBH.

4.0 DEFINITIONS:

4.1 Forensic Client – A client who is committed by the court for evaluation and/or restoration to competency, treatment after a finding of Not Guilty by Reason of Insanity (NGRI) or commitment after a finding of Incompetent Without Probability of achieving competence and dangerous per Nevada Revised Statute (NRS) 178.461.

4.2 Forensic Facility – Means a secure facility of the Division of Public and Behavioral Health of the Department of Health and Human Services that provides services to individuals involved with the Criminal Justice System that are diagnosed with or may have a mental disorder.

4.3 Consent to treatment – Informed consent requires that the client has been adequately informed as to the nature of his/her condition and of the nature and purpose of the proposed treatment including its reasonable risks and benefits, alternative treatment options available and the potential consequences if treatment is refused. Informed consent is evidenced by the treating medical staff documentation in the electronic medical records and the client’s signature on an
approved medication consent form. If the client refuses to sign documents but states they consent to treatment, one witness must indicate they have witnessed this statement.

4.4 Emergency treatment – Emergency treatment allows for the administration of psychotropic medication for forensic clients who are refusing psychotropic medication and are behaving in a manner that poses an imminent danger to themselves or others, or who are suffering from an acute illness, disease or condition, if within a reasonable degree of medical certainty, delay in the initiation of emergency medical care or treatment would endanger the health of the client. The administration of psychotropic drugs under these circumstances shall not extend beyond the duration of the emergency without the client’s consent or administrative review as detailed in this policy.

Emergency medication is initiated by a Denial of Rights form immediately by the treating psychiatrist and Washington V. Harper case law precedent. Advisor - An advisor to patients during the DOR process may be the client’s counsel of record, a social worker not on the client’s treatment team trained to provide appropriate information and services to the patient/defendant.

5.0 Procedure Involuntary Medication for Dangerousness:

5.1 Procedure for Emergent Medication
  5.1.1 Recommendations of medication and consent consultation: The treating medical staff must determine that the patient suffers from a mental illness and is gravely disabled and poses a likelihood of serious harm to himself or others requiring the administration of medication.
  5.1.2 The treating psychiatrist must explain to the client the purpose, risks and benefits of the medication to be prescribed, including possible side effects of the medication and alternative treatments, and the potential consequences if treatment is refused. The client then can provide written informed consent to treatment.
  5.1.3 This process shall be reflected in the client’s medical record.

5.2 Determination of the need for involuntary medication
  5.2.1 If the client refuses to accept psychotropic medication, and the treating medical staff, in his/her professional judgment determines that involuntary
administration of medication is appropriate, the medical staff shall complete Form 1, "Recommendation for Administration of Medication."

5.2.2 A copy of the completed Form 1 shall be given to the social worker who will meet with the client to explain Form 1 and this policy.

5.2.3 The social worker will notify the client of the right to receive assistance from an advisor for the hearing.

5.2.4 In the event the client still indicates an unwillingness to take the medication and declines to sign consent, the social worker shall then assist him/her in filling out Form 2, "Notice to Client of Intention to Medicate and Request for Review."

5.2.5 If the client refuses to meet with the advisor, the social worker will assist in completing the form.

6.0 The Hearing Process for Denial of Rights for Dangerousness:

6.1 The Medication Hearing Committee (committee) is a group composed of at least three mental health professionals, one of whom must be a psychiatrist and none of whom may be currently involved in the client’s diagnosis or treatment or serve as the Medical Director or designee who reviews the decision of the committee.

6.2 Factors the committee must consider:

6.2.1 Client’s stated objections, if any, to the medications;
6.2.2 All documents or evidence offered by the client;
6.2.3 Any witness testimony offered by the client or on the client’s behalf;
6.2.4 Whether the client will harm himself or others without the medication;
6.2.5 Whether the client cannot improve without the medication, or whether the client would improve but at a significantly slower rate.
6.2.6 Whether there are less restrictive means that would accomplish the same or similar results;
6.2.7 The client’s prior experience with the proposed medications; and,
6.2.8 Other factors deemed relevant by the committee and noted in its decision.
6.2.9 The Medical Hearing Committee may interview any person it feels may be of assistance in conducting its review and/or receive any additional documents offered on behalf of staff or the client.
6.3 The decision of the committee involves the following:

6.3.1 To approve use of the medication, the majority, which must include the psychiatrist, must find that the client suffers from a mental illness as defined in NRS 433A.155 and that the client is a danger to self or others, is gravely disabled.

6.3.2 The vote of the Medical Hearing Committee will be noted in the client’s chart.
In the event the client refuses to consent to medication and refuses to fill out Form 4, the social worker will complete the form and indicate that the client has refused to sign the request. The social worker will explain that the client has a right to appeal the decision of the committee to the Medical Director.

6.4 Record of Hearing:

6.4.1 A record of the hearing will be maintained.

6.5 Client’s presence at hearing:

6.5.1 Unless the client indicates verbally or through conduct that they do not intend to participate in the hearing, the proceedings will not commence until the client has arrived. The client has the right to be present for the entirety of the proceedings.

6.6 Review by Medical Director/Designee:

6.6.1 In the event that within twenty-four (24) hours of being served the Medical Hearing Committee decision of the necessity for administration of the medication, the client indicates on Form 4 that he/she wants a review of the committee findings, or the client still refuses to consent to treatment or sign Form 4, a copy of Forms 1 through 4 shall immediately be transmitted to the medical director or designee.

6.6.1.1 The medical director or designee, who must be a psychiatrist, has twenty-four (24) hours from the client’s request for review to make
a determination in accordance with this process. If the Medical Director review does not occur within twenty-four (24) hours the reason for the inability to review shall be documented.

6.6.1.2 The medical director or designee shall conduct a review of the process of denial of the client’s right to decline the medication as soon as possible but no later than twenty-four (24) hours after the request.

6.7 Administration of Medication:

6.7.1 If the Medical director or designee confirms that the medication is appropriate, and the client continues to refuse to consent to treatment, the client may be medicated without his/her permission. (The administrative review per Washington v. Harper is sufficient for administration of medication subsequent to a determination of dangerousness.

6.8 Continuation of Medication:

6.8.1 Medication can continue for 14 days because of the initial administrative review and approval by the Medical Director. If the client continues to refuse to consent to treatment, a second review by the Review Committee is necessary to continue treatment beyond 14 days. A second Review Committee should review after 180 days if the client is still hospitalized.

6.8.2 If the client is medicated following this process, his/her treating physician must submit bi-weekly reports to the medical director or designee for the duration of the treatment documenting the need to continue the involuntary administration of medication if the need to involuntarily administer medication for dangerousness persists.

7.0 Involuntary Medication for Restoration of Competency to Stand Trial:

7.1 Medication to competency is initiated by a petition from the district attorney in the client’s county of origin wherein the petition is filed in the court of criminal venue or if one is available, the specialty Competency Court in the County of origin by the district attorney for an Evidentiary Hearing for Involuntary Medication.
7.2 The treating psychiatrist shall assist the court, at the prosecutor’s request, with the appropriate medical assessment regarding whether the client is likely to be restored with medication, the appropriate medications to accomplish the restoration, whether there will be any significant side effects that would impact the client’s ability to participate in court, whether side effects would adversely impact the client in any other way and any other relevant information as delineated in the protocols outlined in the pertinent case law.

7.3 If the treating team perceives that the client is unlikely to be restored to competency without the benefit of medication, the treatment team leaders may notify the appropriate District Attorney and provide a report to the court stating the evaluator’s conclusion in that regard.

7.4

7.5 Should the prosecutor determine that the client’s charges are sufficient to warrant filing a petition for an Evidentiary Hearing for Involuntary Medication, the prosecutor will request the appropriate report as outlined above from the physician and ask the court to docket a hearing.

7.6 The treating psychiatrist shall be available via subpoena to testify at the hearing regarding the appropriateness of the medication and treatment plan for restoring the client to competency to proceed to adjudication.

7.7 If the court determines that a court order for medication to restore the client to competency is appropriate, the treating physician will initiate involuntary medication per that order as soon as it is practicable after the order is received.

7.8 Orders for Involuntary Medication to Restore to Competency remain in effect until the adjudicative process for the relevant charges has been completed and the case disposition resolved. No further court hearings are necessary and the order continues to be in place when the client returns to the county of origin.

8.0 Attachments:

8.1 Form 1: Recommendation for Administration of Medication

SP 3.1 Involuntary Administration of Medication in Civil Clients Attachment A
8.2 Form 2: Notice to Client of Intent to Medicate and Request for Review
SP 3.1 Involuntary Administration of Medication in Civil Clients Attachment B

8.3 Form 3: Committee Review and Findings
SP 3.1 Involuntary Administration of Medication in Civil Clients Attachment C

8.4 Form 4 Notice of Recommendation for Medication Review Committee and Request for Review.
SP 3.1 Involuntary Administration of Medication in Civil Clients Attachment D

8.5 Form 5 Decision of Medical Director page 1
SP 3.1 Involuntary Administration of Medication in Civil Clients Attachment E

8.6 Form 6 Decision of Medical Director page 2
SP 3.1 Involuntary Administration of Medication in Civil Clients Attachment F

9.0 Implementation of Policy:

Each Division agency within the scope of this policy shall implement this policy and may develop specific written procedures as necessary to do so effectively.
1.0 POLICY:
Recognizing the therapeutic importance of mutual collaboration between the treatment
team and the patient, as well as the potential for side effects caused by psychotropic
medication, medical staff will obtain informed consent prior to treatment.

2.0 PURPOSE:
DPBH formulary approved medications may be prescribed by all medical staff who
have been privileged and licensed to do so. Non-formulary medications require prior
approval. Unless otherwise justified and documented in the clinical chart,
psychotropic medications shall be prescribed according to FDA regulations and/or
professionally accepted standards of medical practice and shall be consistent with the
patient’s clinical condition. Other treatment interventions will be utilized in
accordance with professional standards of practices and within the capabilities of
DPBH.

3.0 SCOPE: Clinical Services Branch

4.0 DEFINITIONS:

4.1 Forensic Client: a client admitted by court order to a forensic facility, typically for
purposes of restoration to competency to stand trial or continues to represent a
danger to himself or others due to a mental disorder despite dismissal of felony
charges.

4.2 Voluntary Consent: the consent is freely given by the client or legal guardian,
without being subject to fraud, misrepresentation, coercion, or other undue
influence by DPBH staff.

4.3 Competent Consent: the consent in which a client demonstrates evidence of
understanding of their condition, proposed interventions (including those not
available in DPBH facilities), risks and benefits of proposed treatment and likely
outcomes if treatment is refused.

4.4 Medical Staff: Medical Staff members include, physicians, advance practice
registered nurses and physician assistants who are licensed, credentialed and
privileged to perform patient care duties within their scope of practice.
5.0 REFERENCES:

5.1 NRS 433A.115 – 433A.490

6.0 PROCEDURE:

6.1 Competency to Grant Consent: An individual is considered legally competent to grant informed consent, unless a minor by age or otherwise adjudicated incompetent and lacking legal capacity to knowingly grant consent (NRS 433.033 and 433A.460)

6.1.1 Provision of adequate information on which to base Consent:
   6.1.1.1 A fair and uncomplicated explanation of patient’s condition for which the treatment is proposed;
   6.1.1.2 A fair and uncomplicated explanation of treatment(s) involved and proposed procedure of administration;
   6.1.1.3 A description of discomforts and risks reasonably expected;
   6.1.1.4 A description of the benefits reasonably expected;
   6.1.1.5 Explanation of medically reasonable alternative treatment;
   6.1.1.6 Explanation of likely results of refusing treatment;
   6.1.1.7 Offering an opportunity to the individual to ask questions concerning any aspect of the explanations;
   6.1.1.8 Explanation of the individual’s freedom to withdraw consent, even after it was provided in writing, without it prejudicing other modalities of authorized treatment.

6.2 The consent must be given voluntarily.

6.3 Appropriate significant persons to grant consent are:
   6.3.1 A competent adult patient age eighteen or over, or a legally emancipated minor.
   6.3.2 The legal guardian of a patient who lacks the mental or legal capacity if said guardian has the proper legal authority.

6.4 Documentation
   6.4.1 Medical Staff shall document in electronic medical records the fact of obtaining informed consent from patient.
   6.4.1.1 Medical Staff shall document in electronic medical records any exceptions to obtaining informed consent in part or completely along with justification for not obtaining informed consent.
6.4.2 The patient or guardian with the proper legal authority is encouraged to confirm in writing giving their informed consent by signing the “Treatment/Medication Consent Form” which will be witnessed by staff.

6.4.3 If the patient or guardian with the proper legal authority is unwilling or unable to sign “Treatment/Medication Consent Form”, but has verbally and/or behaviorally indicated his/her understanding of the information provided and agreed to receive medication(s) as recommended by medical staff, this should be documented in the electronic medical records by staff to whom the patient or a guardian with the proper legal authority communicated consent to treatment.

6.4.4 Medical Staff shall regularly review with the patient or a guardian standing consent, with the proper legal authority annually and document this renewal in the progress notes.

6.4.5 Administration of psychotropic medications without patient’s Informed Consent:

6.4.5.1 Non-consented medication can only be prescribed for patients who are admitted to inpatient units under an Involuntary Court Commitment and who are additionally Court Ordered to receive Involuntary Administration of Medications.

6.4.5.2 The Involuntary Administration of Medication packet shall be completed when the medical staff determine that the patient meets clinical criteria for pursuing a Court Order for the Involuntary Administration of Psychotropic Medication, as defined by NRS. Instructions are included at the front of the attached packet.

6.4.5.3 Forensic clients admitted at the discretion of the treating medical staff, may undergo the denial of rights process for involuntary administration as described above in instances where the client represents a continual danger to self or others secondary to a mental illness, and/or for the purposes of restoration to competency to stand trial.

6.4.5.4 Informed Consent for Medication does not imply or constitute global Informed Consent for Treatment or Services.

6.5 Considerations

6.5.1 If the patient requests treatment of symptoms for which they have never taken medications, the nurse shall consult with medical staff. The medical staff recommendations shall be discussed with the patient.
6.5.1.1 If available, Drug Information sheets shall be provided for the patient.

6.5.1.2 If the patient consents to medical staff or prescribing clinician’s recommendations, the nurse will encourage the patient to sign the medication consent form.

6.5.1.3 Medication administration will be documented in the Medication Administration Record. All actions are to be documented in Avatar (electronic medical record).

6.6 If the patient requests a one (1) time dose of medication that he/she has previously taken and indicates to the staff that he/she is fully aware of the nature of the requested medication and alternative options, the nurse shall consult with medical staff or prescribing clinician.

6.6.1 If the order is received, the nurse shall encourage the patient to sign the medication consent form, administer the medication as ordered, document in the medication administration record, and then document all actions in Avatar (electronic medical record).

7.0 ATTACHMENTS:
7.1 PF-RRE-05 Medication Consent Form Attachment A (English)
7.2 PF-RRE-05 Medication Consent Form Attachment B (Spanish)

8.0 IMPLEMENTATION OF POLICY:
Each Division agency shall implement this policy and may develop specific written protocols and procedures as necessary to do so effectively.

EFFECTIVE DATE:
DATE APPROVED BY DPBH ADMINISTRATOR:
DATE APPROVED BY THE COMMISSION ON BEHAVIORAL HEALTH: