

104 CMR: DEPARTMENT OF MENTAL HEALTH

104 CMR 27.00: LICENSING AND OPERATIONAL STANDARDS FOR MENTAL HEALTH FACILITIES

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27.01: Legal Authority to Issue

104 CMR 27.00 is promulgated under the authority of M.G.L. c. 19, §§ 1, 7, 8, 18 and 19 and M.G.L. c. 123.

27.02: Scope

Unless the contrary is specified in a particular section, the provisions of 104 CMR 27.00 apply to all facilities that are licensed, contracted for, or operated by the Department.

SUBPART A: LICENSING

27.03: Licensing; Generally

(1) All private, county or municipal mental health facilities are subject to licensing by the Department pursuant to M.G.L. c. 19, § 19.

(2) Types of Licenses. Licensed mental health facilities shall be issued a single license which may incorporate one or more of the following classes:

(a) Class II. License to provide diagnosis and treatment of adults on voluntary admission status under M.G.L. c. 123, § 10.

(b) Class III. License to provide diagnosis and treatment of adults on conditional voluntary admission status under M.G.L. c. 123, §§ 10 and 11, and on involuntary committed status under M.G.L. c. 123, §§ 7 and 8, and to use restraint and seclusion.

(c) Class IV. License to provide diagnosis and treatment of adults on involuntary committed status under M.G.L. c. 123, § 12, and to use restraint and seclusion.

(d) Class V. License to provide evaluation, diagnosis and treatment of patients committed by order of a criminal court to determine competency to stand trial or criminal responsibility or for treatment under M.G.L. c. 123, §§ 15, 16, 17 and 18, and to use restraint and seclusion.

(e) Class VI. License to provide diagnosis and treatment of minors on voluntary or conditional voluntary admission status under M.G.L. c. 123, §§ 10 and 11, and on involuntarily committed status under M.G.L. c. 123, §§ 7, 8 and 12, and to use restraint and seclusion.

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- (f) Limited Class VI. License to provide diagnosis and treatment of minors age 16 and 17 on adult units on voluntary or conditional voluntary admission status under M.G.L. c. 123, §§ 10 and 11, and on involuntarily committed status under M.G.L. c. 123, §§ 7, 8 and 12, and to use restraint and seclusion.
- (g) Class VII. License to provide diagnosis and treatment of adolescents in an Intensive Residential Treatment Program (IRTP) on conditional voluntary or conditional voluntary admission status under M.G.L. c. 123, §§ 10 and 11, and on involuntarily committed status under M.G.L. c. 123, §§ 7 and 8, and to use restraint and seclusion.
- (h) Class VIII. License to administer electroconvulsive treatment.
- (3) Every licensed facility shall maintain complete records for each patient in accordance with the provisions of M.G.L. c. 23, § 36 and 104 CMR 27.17.
- (4) Duration of License. Licenses issued under 104 CMR 27.03 shall be valid for a term of two years and may be renewed for like terms, subject to limitation, suspension or revocation for cause. Licenses are not transferable from one licensee to another individual or agency or from one location to another.
- (5) Requirements for License or Renewal.
- (a) Every applicant for a license or for a subsequent renewal of such license shall use the forms prescribed by the Department and shall submit the fee established by the Department. A schedule of licensing fees may be obtained from the Department.
- (b) A hospital, clinic or nursing home licensed by the Department of Public Health under M.G.L. c. 111 which admits mentally ill persons only on voluntary admission status pursuant to 104 CMR 27.06, need not be licensed by the Department of Mental Health as Class II. All other hospitals licensed by the Department of Public Health which admit mentally ill persons on any admission status other than, or in addition to, voluntary status shall also be licensed by the Department of Mental Health.
- (c) Every facility seeking a license or a renewal of such license shall meet all applicable fire, health, building and safety codes, and shall make available upon request copies of all required licenses, permits, certificates of inspection and/or occupancy necessary for the operation of the facility in the location where it is situated.
- (d) Every facility seeking a license or a renewal of such license shall demonstrate compliance with the standards of the American Institute of Architecture, or other nationally recognized standards, for facilities of the type licensed.
- (e) Every facility seeking a license shall submit a statement of ownership, a plan showing the extent of the property, location and plans of existing buildings, and any plans and specifications of buildings to be erected. Notice shall be given to the Department by the applicant or licensee of any changes in these matters.
- (f) Every facility seeking a license shall submit written plans describing:
1. its plan for delivery and supervision of clinical services. All clinical services, as well as the supervision of such services, shall be performed by personnel qualified by license or experience in the field in which they are performing.
 2. its plan for assuring adequate and appropriate staffing to meet the needs of the patient population at all times.
 3. its program of orientation and continuing in-service education for all personnel, both professional and non-professional, who provide care and treatment to patients.
- (6) Staffing.
- (a) The director of a facility licensed as Class II, III, IV, V, VI, Limited VI, VIII or any combination thereof, shall hold an advanced degree from an accredited college or university in a discipline appropriate to the care and treatment of the mentally ill. If the director of a facility licensed as Class II, III, IV, V, VI, Limited VI, VIII or any combination thereof is not a fully licensed physician, there shall be a director of psychiatric or medical services for such facility who is a physician fully licensed to practice medicine under Massachusetts law, and who is certified or eligible to be certified by the American Board of Psychiatry and Neurology in psychiatry; provided that in the discretion of the Department, experience and expertise may be considered in *lieu* of Board certification or eligibility.

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(b) Facilities licensed as Class II, III, IV, V, VI, Limited VI, VIII or any combination thereof, shall have a physician, under full or limited licensure as defined by Massachusetts law, on the premises at all times.

(c) The director or chief of nursing of a facility licensed as Class II, III, IV, V, VI, Limited VI, VIII or any combination thereof, shall hold an advanced degree in psychiatric nursing and shall be licensed to practice professional nursing. If such director or chief of nursing does not hold such a degree, the facility shall provide for a person with such a degree and license to oversee in-service training for its nursing personnel.

(d) The director or chief of nursing of a facility licensed as Class II, III, IV, V, VI, Limited VI, VIII or any combination thereof, shall hold an advanced degree in psychiatric nursing and shall be licensed to practice professional nursing. If such director or chief of nursing does not hold such a degree, the facility shall provide for a person with such a degree and license to oversee in-service training for its nursing personnel.

(e) The nursing personnel of every facility subject to licensure shall be adequately prepared by education, training and experience to provide care and treatment for patients with mental illness. The facility shall maintain such nursing force at levels deemed adequate by the Department

(7) Additional Requirements for Class VI, Limited VI, and VII Facilities. In addition to complying with all applicable standards in this title, a facility licensed as Class VI, Limited VI, or VII shall comply with the following requirements

(a) In its application for a license, or for renewal of a license, the facility shall include a detailed description of its physical facilities as well as its plan for providing age appropriate programming and services. This plan and description shall be subject to approval by the Commissioner or designee. The plan shall include but not be limited to psychiatric, medical, nursing, social work and psychological services, family-focused treatment, occupational therapy, physical therapy if any, educational programs, recreational activities and equipment, and outdoor facilities.

(b) A child and adolescent psychiatrist certified or eligible to be certified in child and adolescent psychiatry by the American Board of Psychiatry and Neurology or the American Board of Adolescent Psychiatry shall provide on-site supervision of the care and treatment of patients in Class VI and VII facilities and shall be available for consultation and case supervision as needed for patients in Limited Class VI facilities.

(c) The facility shall have on its staff, or as consultants, a pediatrician and a pediatric neurologist, both of whom shall be fully licensed to practice medicine under Massachusetts law.

(d) If the facility employs behavioral management, it must meet the requirements of 104 CMR 27.10(7)

(8) Additional requirements for Class VIII Facilities. In addition to complying with all applicable standards in this title, a facility licensed as Class VIII shall comply with the following requirements:

(a) The facility shall establish a written plan for the administration of electroconvulsive treatment in compliance with the standards set forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and with current practice guidelines established by the American Psychiatric Association.

(b) Monthly Reports. All facilities administering electroconvulsive treatment (ECT) to inpatients or outpatients shall maintain aggregate data, which shall be available to the Department for inspection upon request.

(9) Additional Requirements for Class III through VII Facilities. In addition to complying with all applicable standards in this title, a facility to be licensed as Class III through VII shall include the following in its application for a license or renewal of a license:

(a) the facility's plan to reduce and, wherever possible, eliminate restraint and seclusion as required by 104 CMR 27.12(1);

(b) a comprehensive statement of the facility's policies and procedures for the utilization and monitoring of restraint and seclusion, including a listing of all types of mechanical restraints used by the facility, a statistical analysis of the facility's actual use of such restraint and

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seclusion, and a certification by the facility of its ability and intent to comply with all applicable statutes and regulations, including 104 CMR 27.12, regarding physical space, staff training, staff authorization, record keeping, monitoring and other requirements for the use of restraint and seclusion.

(10) Accreditation.

(a) A facility seeking a license as Class II, III, IV, V, VI, Limited VI, VIII, or any combination thereof, or a renewal of such license, shall be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other nationally recognized accreditation agency approved by the Commissioner utilizing the applicable standards as promulgated by said Joint Commission or agency. Facilities that have not yet attained accreditation shall be in substantial compliance with those standards, and must submit a plan for obtaining accreditation within a reasonable period of time.

(b) A facility seeking a license as Class VII, or a renewal of such license shall be accredited as a residential treatment program by JCAHO or other nationally recognized accreditation agency approved by the Commissioner. Facilities that have not yet attained accreditation must be in substantial compliance with the standards for residential treatment programs set forth by said Joint Commission or agency, and must submit a plan for obtaining accreditation within a reasonable period of time.

(11) Deemed Status. In addition to the Departmental action on license applications as set forth below, and any additional requirements for Class VII facilities set forth in 104 CMR 27.04, the Department may approve licensure of accredited facilities in accordance with the following requirements for deemed status.

(a) A facility requesting deemed status shall provide to the Department a copy of the facility's current accreditation letter and the accrediting agency's explanation of its survey findings.

(b) A facility requesting deemed status shall submit for Department review and approval written plans for compliance with Department regulations governing restraint and seclusion, human rights, and investigation of complaints.

(c) A facility which has been granted deemed status shall notify the Department of the time and place of the summation conferences scheduled at the completion of an accreditation, and shall permit Department observers to attend such conferences.

(d) The Department may at any time require a facility which has been granted deemed status to demonstrate its compliance with applicable law, accreditation standards, Department regulations, or implementation of any recommendations for corrections or deficiencies, by submitting such documentation or reports or permitting such inspection as may be requested by the Department. The Department may require a validation survey of an accredited facility to verify such compliance.

(e) A facility which has been granted deemed status shall immediately notify the Department of any change in its accreditation status.

(f) The Commissioner or designee may revoke the deemed status of an accredited facility if:

1. The facility loses its accreditation;
2. The facility fails to cooperate with the Department's validation survey or requests for documentation or reports;
3. The facility fails to cooperate with a Department investigation in accordance with 104 CMR 32.00;
4. The facility is out of compliance with applicable accreditation standards and a significant deficiency is determined to exist;
5. The facility is out of conformity with its plans for compliance with Department regulations on restraint and seclusion, human rights, and investigation of complaints.
6. The facility is out of compliance with other applicable Department regulations.

(g) A facility whose deemed status has been revoked may be subject to a licensing review or full survey pursuant to 104 CMR 27.00.

(h) A facility may request an informal administrative review of a decision to deny or revoke deemed status. The facility must request an informal administrative review in writing within 15 days of the date it receives notice of the denial or revocation of its deemed status by the Commissioner or designee. The request shall state the reasons why the facility considers the

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denial or revocation of deemed status incorrect. The written request shall be accompanied by any supporting evidence or arguments.

(i) The Commissioner or designee shall notify the facility, in writing, of the results of the informal administrative review within 20 days of receipt of the request for review. Failure of the Commissioner or designee to respond within that time shall be considered confirmation of the denial or revocation of deemed status.

(12) If a facility is not yet accredited by JCAHO or if an accredited facility chooses not to apply for deemed status, it shall be subject to a full survey for licensure by the Department.

(13) Provisional License. A provisional license shall be used for facilities not currently in operation or for which compliance cannot fully be determined without an evaluation of the facility in operation. After the granting of a provisional license or the initial provision of services by the facility, the Department shall conduct a timely evaluation of the facility to determine what action regarding licensure should be taken.

(14) Departmental Action on License Application. Upon receipt and review of all required documentation, and after any site visit, the Department may take one of the following actions:

- (a) Approve the facility for licensure, if no deficiencies are outstanding;
- (b) Approve the facility for licensure, subject to demonstrated progress by the program applicant in implementing a plan of correction approved by Department;
- (c) Disapprove the facility for licensure until such time as deficiencies are corrected.
- (d) Approve the facility for a provisional license subject to such conditions as the Department deems necessary.

(15) Departmental Inspection.

(a) Notwithstanding a facility's deemed status, the Department may conduct random, periodic surveys or inspections of any facility licensed hereunder to determine compliance with accreditation standards or the provisions of 104 CMR. Such random survey need not pertain to any actual or suspected deficiency in compliance with accreditation standards or 104 CMR 27.00. Refusal to permit inspection shall be sufficient cause for revocation of a facility's license.

(b) Without limiting the generality of the foregoing, the Department shall conduct annual inspections of facilities granted deemed status to determine their compliance with Department regulations governing restraint and seclusion, human rights, investigation of complaints, and interpreter services.

(c) Licensed facilities shall immediately notify the Department of any substantial change in its physical plant, staffing or services, and shall submit documentation of such changes as may be requested by the Department.

(d) The scope of the Department's inspections shall include any aspect of the operation of the facility, and may include, but is not limited to, confidential interviews with patients and staff, and examination and review of all records, including those of current and discharged patients.

(e) The Department shall provide a copy of the inspection report to the facility director.

(16) Revocation or Limitation of License. Failure to comply with the requirements for licensure as set forth in 104 CMR 27.00 may constitute sufficient cause for the Department to refuse to grant, suspend, revoke, limit or restrict the applicability of, or refuse to renew one or more classes of licenses pursuant to the procedural requirements and provisions of M.G.L. c. 30A. The Department, under the authority of M.G.L. c. 19, § 19, may take reasonable action, including, but not limited to, temporarily suspending a license prior to a hearing in cases of emergency if it deems that such action would be in the public interest; provided, however, that upon request of an aggrieved party, a hearing pursuant to M.G.L. c. 30A, § 13 shall be held after such action is taken.

(17) In restricting or limiting the applicability of one or more classes of licenses, the Department may issue deficiency orders, reprimands or other appropriate orders to obtain compliance with 104 CMR 27.00; provided that such actions may be subject to the procedural requirements and provisions of M.G.L. c. 30A.

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(18) Waiver.

- (a) The requirements of 104 CMR 27.03 through 27.17 shall be strictly enforced, and shall not be subject to waiver, except as specifically authorized by the Commissioner or designee in accordance with the provisions of 104 CMR 27.03(18).
- (b) No waiver may be granted by the Commissioner or designee without a determination by the Commissioner or designee that:
 - 1. The health, safety, or welfare of neither patients nor staff may be adversely affected by granting the waiver; and that
 - 2. In justification of the waiver, a substitute provision or alternative standard has been stated and is found by the Department to result in comparable services to the patients, and to which the facility will be held accountable to the same degree and manner as any provision of 104 CMR 27.00.
- (c) Waivers may be granted for the duration of a facility's license, or for such other period of time as the Department may determine, and may be renewable.
- (d) The granting of a waiver for any single facility or period of time shall not require or signify the granting of a waiver for any other facility or period of time.

27.04: Licensing: Intensive Residential Treatment Programs

(1) Adolescent Intensive Residential Treatment Program. An adolescent intensive residential treatment program (IRTP) is a residential mental health program which provides comprehensive treatment and education in a secure setting to mentally ill adolescents and which has the capacity to admit such adolescents on an involuntary basis pursuant to the provisions of M.G.L. c. 123 §§ 3, 7, 8, 10 and 11. IRTPs are not authorized to administer electroconvulsive treatment.

(2) Eligibility. Only individuals who meet the following criteria may be eligible for admission to an IRTP:

- (a) The individual shall be from 13 through 18 years of age. An individual already admitted to an IRTP who becomes 19 years of age may remain there to complete his or her course of treatment; and
- (b) The individual has been determined to require long-term (*i e.*, typically, at least three months or longer) treatment in a secure residential setting; and
- (c) Treatment in a less restrictive setting has been determined to be inappropriate for the individual; and
- (d) Failure to place the individual in a secure treatment setting would create a likelihood of serious harm by reason of mental illness.

(3) Admission. Individuals who meet the IRTP eligibility criteria may be admitted to and retained in an IRTP only in accordance with the provisions of M.G.L. c. 123, §§ 3, 10 & 11 or 7 and 8, and the regulations promulgated thereunder. For IRTPs operated by or under contract with the Department, individuals may only be admitted upon approval of the Department. Referrals for admission shall be made through an admissions process, as designated by the Department, and shall contain such clinical information and documentation as the Department may require.

(4) Location. If an IRTP is located on the grounds of a state hospital or in the same building as an adult inpatient mental health unit or an adolescent continuing care inpatient unit, it shall have program, kitchen and eating facilities separate from those of the state hospital or inpatient unit.

(5) Staffing. Each IRTP shall be staffed at a level sufficient to meet the clinical needs of the patients, as well as the administrative and ancillary services necessary to the operation of the program, consistent with the requirements of JCAHO or other accreditation agency approved by the Commissioner. Among the clinical staff shall be persons qualified to provide services in appropriate disciplines, including, but not limited to: psychiatric and psychological intervention; individual, group and family therapy; milieu management; medication administration; discharge planning; education; vocational training; and recreation.

- (a) Each IRTP shall have sufficient full-time senior management to provide adequate oversight of program, clinical and psychiatric operations. Senior managers with responsibility for clinical matters shall be mental health professionals, licensed as independent clinicians in their field of training and expertise. At least one member of senior

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management shall be a licensed mental health professional who is, by training or experience, a specialist in the treatment of adolescents.

(b) Each IRTP shall have a psychiatrist, board certified (or eligible) in child and adolescent psychiatry, available for consultation and shall have a psychiatrist on site or on call, 24 hours a day, for psychiatric emergencies, including but not limited to seclusion and restraint.

(c) Each IRTP shall have sufficient qualified nursing staff for the administration of regularly prescribed medications, as well as for administration of PRN and emergency medication and conducting examinations pursuant to 104 CMR 27.12.

(d) Each IRTP shall have a sufficient number of independently licensed mental health professionals such that the primary individual and family therapist for each patient shall be so licensed.

(e) Provision shall be made to ensure that sufficient back-up personnel are available to respond within a reasonable time in emergency situations.

(6) General Physical Requirements.

(a) Each program shall provide space that is safe, comfortable, well-lighted, well-ventilated, adequate in size and of sufficient quality to be utilized in a manner consistent with the overall philosophy and treatment goals of the program.

(b) Each program shall provide sufficient security features to enable the staff to prevent physical harm to patients and to staff and to prevent escape from the program, including the capacity to lock the program to prevent unauthorized access to the community.

SUBPART B: OPERATIONAL STANDARDS FOR MENTAL HEALTH FACILITIES

27.05: General Admission Procedures

(1) For the purpose of involuntary commitment, mental illness is defined as a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, but shall not include alcoholism or substance abuse which is defined in M.G.L. c. 123, § 35.

(2) For the purposes of voluntary or conditional voluntary admission to mental health facilities in the Commonwealth, any degree of severity of a mental disorder including alcoholism may qualify a person for admission to a mental health facility at the discretion of the facility director or designee when it is determined that such admission is necessary and appropriate.

(3) Admission Examination. Upon admission, each person shall receive a mental status examination and, within 24 hours of admission, a complete psychiatric and physical examination. In the case of admissions to an IRTP, such physical examination shall occur within seven calendar days of admission. As part of the admission examination, staff shall seek to determine from the patient, the patient's record, the patient's legally authorized representative or, if appropriate and authorized, from other sources, whether the patient has a history of trauma, including but not limited to physical or sexual abuse or witnessing violence. At the completion of each admission examination, the physician shall make an admission diagnosis, and shall enter the findings of such admission examination in the patient's medical record.

(4) Admission Examination for Persons under the Age of 22.

(a) In addition to the requirements above, the admission examination for persons under the age of 22 shall include a determination as to whether the individual has special educational needs.

(b) If the individual has special educational needs, the facility director shall seek written authorization to provide necessary clinical information to the patient's Local Education Authority (LEA) in order that an educational program can be jointly developed for such patient by the LEA and the facility.

(5) Notice to Family or Others.

(a) Admission of Individuals Age 16 or Over. Within 48 hours after admission of any patient, including a patient age 16 or 17 who has applied for admission himself or herself, the director of the facility, or designee, shall notify the patient's legally authorized representative

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and, unless requested not to do so, the nearest relative regarding the admission of such patient to the facility. In the alternative, a competent patient over the age of 18 may designate any two persons to receive such notification. Notice may be given by telephone, telegram, letter or other appropriate means.

(b) Admission of all other minors. Except in an emergency, or pursuant to court order, no minor, except a 16 or 17 year old who has applied for admission himself or herself, shall be admitted to a facility without notice to and consent of the minor's legally authorized representative. In an emergency or pursuant to a court order (including application for admission pursuant to M.G.L. c. 123, § 12 with or without the consent of the legally authorized representative), the legally authorized representative shall be notified forthwith upon receipt of the minor at the facility.

(6) Denial of Admission. Applicants for voluntary or conditional voluntary admission to mental health facilities shall not be denied admission without an explanation of the basis for such refusal, and alternatives shall be offered or recommended by the admitting physician where feasible.

(7) Prohibition of Admission of Individuals under the Age of 19 to Adult Inpatient Units; Exceptions. Except as provided in 104 CMR 27.05(7), no individual under the age of 19 years shall be admitted to an adult unit of a Department facility.

(a) The Department may place an individual age 17 or 18 on such an adult inpatient unit where a judge of a court of competent jurisdiction has issued an order for the commitment of the individual to a mental health facility pursuant to the provisions of M.G.L. c. 123, §§ 15, 16, 17, or 18, or where the individual has been committed to the Department of Youth Services, and the Commissioner or designee has determined that one or both of the following factors exist:

1. placement of the individual on an adolescent inpatient unit would create a likelihood of serious harm to the individual or others; or
2. the individual is in need of stricter security than is available on an adolescent inpatient unit.

(b) The factors to be considered in the above determinations include, but are not limited to the following:

1. the nature, circumstances and seriousness of the offense with which the individual has been charged;
2. the individual's court and delinquency record;
3. the individual's maturity;
4. the individual's history of mental illness;
5. the individual's social history;
6. the risk of harm presented by the individual's placement on an adolescent inpatient unit;
7. the individual's history of victimizing others;
8. the mental health treatment most suitable for the individual

(c) The statewide specialty Deaf Unit at Westborough State Hospital and the Commonwealth Research and Evaluation Unit at Erich Lindemann Mental Health Center may admit individuals under the age of 19 provided that the Units ensure appropriate separate physical space and programmatic services for them, as approved by the Commissioner.

(8) Computation of Time. Unless otherwise specified, all computation of days within 104 CMR 27.00 SUBPART B shall be in accordance with the following:

- (a) when the time period is less than 7 calendar days, Saturdays, Sundays, and legal holidays are not counted;
- (b) when the time period is 7 calendar days or longer, the time is counted in calendar days, except when the last day is a Saturday, Sunday, or legal holiday, in which case the final day counted is the next business day;
- (c) the day on which action or event is initiated is not counted.

27.06: Voluntary and Conditional Voluntary Admission

(1) Eligibility for Voluntary or Conditional Voluntary Admission.

(a) A person may be admitted on a voluntary or conditional voluntary admission status to a facility upon written application, provided that in the opinion of the facility director, or designee, such person is in need of care and treatment and that the admitting facility is suitable for such care and treatment.

(b) In order to be admitted on voluntary or conditional voluntary admission status, a person must be competent to apply for such admission, and desirous of receiving treatment.

(c) A person's application for voluntary or conditional voluntary status shall only be accepted upon a determination by the admitting or treating physician that the person has attained the age of 16 and is competent to apply for such status, or, if application is made on behalf of the person by a guardian, that the guardian has specific authority to do so. An application made on behalf of a minor by the minor's parent or guardian may be accepted upon a determination by the admitting or treating physician that the person making such application is in fact the minor's legally authorized representative.

(d) For purposes of 104 CMR 27.06, competent means:

1. that a patient admitted on a voluntary status understands that he or she is in a facility for treatment and that he or she may leave the facility at any time.
2. that a patient admitted on a conditional voluntary status understands that he or she is in a facility for treatment, understands the three-day notice provisions, and understands the facility director's right to file a petition for commitment and thereby retain him or her at the facility.

(2) Prior to admission such person shall be afforded the opportunity for consultation with an attorney, or with a person who is working under the supervision of an attorney, concerning the legal effect of the admission.

(3) Upon admission the patient and his or her legally authorized representative shall receive information concerning the legal and human rights which he or she retains after admission to the facility.

(4) Voluntary admission status shall be totally voluntary, and may be terminated by the patient or facility director at any time without notice.

(5) A patient on conditional voluntary admission status, or any parent or guardian who applied for the admission of such person, may be required to give three days prior written notice to the facility director of his or her intention to leave such facility or to withdraw such person from the facility. Such three day notice may only be retracted by written notice to the facility director. Such three day notice and any retraction thereof shall become part of the patient's record. The form and content of such three day notice or retraction thereof shall be deemed sufficient so long as it conveys the patient's intention, without requirement that it be on any particular form of the facility.

(6) Prior to admitting a person on conditional voluntary admission status, the admitting personnel shall inform such person of the three day notice requirements established in M.G.L. c. 123, § 11, and of the facility director's right to file a petition for commitment upon notice that the patient wishes to leave, pursuant to M.G.L. c. 123, § 11.

(7) A person who is 16 or 17, or during the course of hospitalization attains the age of 16, and who has been admitted to a facility as a voluntary or conditional voluntary patient by application of a legally authorized representative shall have the same rights as those persons 16 or over who have applied and been admitted on their own behalf, including the right to leave the facility upon submission of a three day notice of intent to do so, and the right to remain at the facility, upon written application, despite notice by a legally authorized representative of intention to withdraw such patient.

(8) Application for conditional voluntary admission shall be made only upon such form as the Commissioner may prescribe.

27.07: Three Day Involuntary Commitment

(1) No person shall be admitted to a facility upon application for involuntary hospitalization pursuant to M.G.L. c. 123, § 12 unless the person, his or her legal guardian with authority to admit to a facility or, if a minor, his or her legally authorized representative, has been given the opportunity by the facility to apply for admission under M.G.L. c. 123, §§10 and 11. For a patient aged 16 or 17 this opportunity must be given to both the patient and his or her legally authorized representative. The right to convert to voluntary or conditional voluntary admission status may be exercised by a patient, his or her legal guardian with specific authority to admit to a facility, or, if a minor, by his or her legally authorized representative at any time within the three day period. A mental health professional responsible for the patient shall again inform the patient or legally authorized representative, within three days of admission, of the right to change status, and shall record so informing the patient or the legally authorized representative in the patient's record.

(2) Examination Prior to Admission. Persons for whom application has been made for three day involuntary hospitalization by the appropriate party pursuant to M.G.L. c. 123, § 12, and who have not been examined by a designated physician prior to reception at the admitting facility, shall receive such examination immediately after reception at such facility. For the purposes of this paragraph, "immediately" shall mean within two hours and before the person has been classified as a patient or has been assigned to a bed or ward by the admitting staff. In the event that the designated physician on call at the facility is engaged in an emergency situation elsewhere, he or she shall conduct such an examination as soon as such emergency no longer requires his or her attention.

(3) Upon admission of a person to a facility pursuant to M.G.L. c. 123, § 12(b), the facility shall inform the person and his or her legally authorized representative that it shall, upon request, notify the Committee for Public Counsel Services of the person's name and location, upon which notice the Committee will appoint an attorney to meet with the person.

(4) Emergency Hearing. The facility shall inform a person admitted pursuant to M.G.L. c. 123, § 12(b) and his or her legally authorized representative of the right to request an emergency court hearing if he or she or his or her legally authorized representative has reason to believe that the admission is the result of an abuse or misuse of the provisions of M.G.L. c. 123, §12(b). The facility shall, upon request, provide the person and his or her legally authorized representative with the form that may be used to request such a hearing and shall take steps to transmit any such completed forms to the court in accordance with the requirements of the court with jurisdiction over the facility.

27.08 Transfer and Transport of Patients

(1) 104 CMR 27.08 governs the transfer of patients pursuant to M.G.L. c. 123, § 3 and the transport of persons pursuant to M.G.L. c. 123, § 21.

(2) For the purposes of 104 CMR 27.08(3) to (8), "emergency" shall mean those medical, surgical and psychiatric crises which in the opinion of the facility director threaten the safety, health or life of the patient or others, and which could not be appropriately treated in the transferring facility.

(3) Permitted Transfers; Exceptions. Any person admitted to a facility may be transferred from that facility to any other facility, provided that except in an emergency:

(a) Patients on voluntary admission status under 104 CMR 27.06 shall not be subject to transfer without their written consent; and

(b) Patients on conditional voluntary admission status under 104 CMR 27.06 may refuse transfer. Such refusal may be considered equivalent to submission of the patient's three day written notice of his or her intention to leave or withdraw from the facility. Upon such refusal, the facility director may:

1. File a petition for commitment under the provisions of M.G.L. c. 123, §§ 7 and 8 if the person meets the criteria for commitment; or,

2. Withdraw the notice of transfer provided to the person pursuant to 104 CMR 27.08(8).

(4) Absent an emergency, and except for a patient under the age of 16 or under a guardianship with authority to admit to a psychiatric facility, a patient on conditional voluntary admission status at a facility may not be transferred from that facility against his or her will unless a court of competent jurisdiction enters a commitment order pursuant to M.G.L. c. 123, §§ 7 and 8.

(5) Absent an emergency, a patient under the age of 16 or under a guardianship with authority to admit to a psychiatric facility, who has been admitted to a facility pursuant to his or her legally authorized representative's authority, may not be transferred from that facility over the objection of the legally authorized representative unless a court of competent jurisdiction enters a commitment order pursuant to M.G.L. c. 123, §§ 7 and 8.

(6) In no event shall an order of commitment for observation pursuant to M.G.L. c. 123, § 12 be issued in order to transfer a patient in lieu of compliance with the requirements of M.G.L. c. 123, § 3 or 104 CMR 27.08.

(7) Transfer of a patient committed pursuant to M.G.L. c. 123, § 12 shall not extend the period of such hospitalization.

(8) Transfer Procedures.

(a) The approval of the director of the receiving facility shall be obtained by the transferring facility.

(b) The director of the transferring facility shall give six days written notice to the patient to be transferred and to his or her nearest relative, unless the patient knowingly objects, or his or her legally authorized representative; provided, however, that if such transfer must be made immediately because of an emergency, notice shall be given within 24 hours after the transfer pursuant to M.G.L. c. 123, § 3. The notice shall be provided in a form prescribed by the Commissioner.

(c) A patient, legally authorized representative of a patient under the age of 18, or duly appointed guardian with authority to admit the ward to a psychiatric facility may, but shall not be required to, waive the six days notice requirement.

(d) A copy of the Notice of Transfer, along with a copy of the patient's underlying admission status documentation, shall accompany the patient to the receiving facility, and the underlying status shall remain valid upon admission to the receiving facility.

(9) Transport of Persons Admitted to a Facility; Limitations of Use of Restraint

(a) The transport with restraint of a person in a facility by or under the supervision of the facility's staff may be authorized by a physician authorized to order restraint pursuant to 104 CMR 27.12(5)(a)1, or in an emergency when an authorized physician is not available, by a staff person authorized to initiate restraint pursuant to 104 CMR 27.12(5)(a)2, on a form approved by the Department, for the following purposes:

1. Transfer to another facility pursuant to M.G.L. c. 123, § 3;
2. Movement among separate campuses of a single facility;
3. Evaluation and/or treatment at a medical facility or office and return to the facility;
4. Attendance at court proceedings and return to the facility;
5. Transfer to or from another state pursuant to the Interstate Compact on Mental Health, M.G.L. c. 123 App. §§ 1-1 through 1-4;
6. Other destinations with the approval of the facility director or designee.

(b) Restraint may not be used in the course of transport unless such restraint is necessary for the safety of the person being transported or of others who are likely to come into contact with him or her, and in any case such restraint must be by the least restrictive method to assure the safety of the person or others in accordance with 104 CMR 27.08(9).

1. If the person is being transported by the facility, or under the supervision of the facility's staff, then the physician's authorization shall describe the circumstances

under which restraint may be used in the course of transport and method of restraint that may be employed.

- a. No locked mechanical restraint devices requiring the use of a key for their release may be used in the course of transport.
- b. Only restraint procedures or devices that have been approved by the facility for such purposes may be used for restraint during transport, and monitoring staff must have received appropriate training on such approved procedures and devices.
- c. No person shall be placed in restraints in the course of transport unless a staff member is assigned to provide one-to-one monitoring as provided in 104 CMR 27.12(5)(h)1-6.
- d. During the transport, the monitoring staff person must carry a copy of the form which authorizes the restraint during transport.
- e. The driver of the vehicle in which the person is being transported may not be assigned to provide such monitoring.
- f. No staff member who has not been trained in accordance with 104 CMR 27.12(2) may be authorized to apply restraints to a person in the course of transport, or to monitor a person who is in restraints in the course of transport.
- g. Except as provided in 104 CMR 27.08(9)(c) and (d), restraint ordered pursuant to 104 CMR 27.08(9) may only last while the person is under the supervision of facility staff, and shall terminate if the person is admitted to a medical facility, including the emergency department of such medical facility for evaluation or treatment.

(c) If the person is being transported by ambulance, then restraint may be used only in accordance with M.G.L. c. 111C, § 18.

(d) Nothing in 104 CMR 27.08(9) shall be deemed to regulate the use of restraint by licensed law enforcement personnel in the transport of persons in the custody of such personnel.

(e) The use of seatbelts or a “child safety door lock” shall not be considered restraint for purposes of 104 CMR 28.08(9).

(f) Where the need for restraint during transport for purposes described in 104 CMR 27.08(9)(a) is anticipated, consideration should be given to delaying such transport until such person no longer requires restraint, if such delay is reasonable.

27.09: Discharge

(1) Discharge Procedures.

(a) A facility shall arrange for necessary post-discharge support and clinical services. Such measures shall be documented in the medical record.

(b) A facility shall make every effort to avoid discharge to a shelter or the street. The facility shall take steps to identify and offer alternative options to a patient and shall document such measures, including the competent refusal of alternative options by a patient, in the medical record. In the case of such discharge, the facility shall nonetheless arrange for or, in the case of a competent refusal, identify post-discharge support and clinical services. The facility shall keep a record of all discharges to a shelter or the street in a form approved by the Department and submit such information to the Department on a quarterly basis.

(c) When a patient in a facility operated by or under contract to the Department is a client of the Department pursuant to 104 CMR 29.00, the service planning process outlined in 104 CMR 29.00 shall be undertaken prior to discharge.

(d) A facility shall keep a record of all patients discharged therefrom, and shall provide such information to the Department upon request.

(2) Voluntary Admission Status. A patient voluntarily admitted to a facility under 104 CMR 27.06 shall be discharged without a requirement of a three day notice upon his or her request.

(3) Discharge Initiated by Facility Director. The facility director may discharge any patient admitted as a voluntary or conditional voluntary patient at any time he or she deems such discharge in the best interest of such patient; provided, however, that if a legally authorized representative made the application for admission, 14 days notice shall be given to such legally

authorized representative prior to such discharge, in accordance with M.G.L. c. 123, § 10(a). With the consent of such legally authorized representative, the superintendent may discharge a patient under the age of 16 years at any time.

27.09: continued

(4) Conditional Voluntary Admission Status. A patient admitted to a facility on conditional voluntary admission status under 104 CMR 27.06 shall be discharged by the facility upon his or her request, but he or she shall give three days written notice to the facility director. The facility director may require an examination of such patient to be conducted to determine his or her clinical progress and suitability for discharge, including such factors as legal competency and family, home or community situation. Such persons may be retained at the facility beyond the expiration of the three day notice period if, prior to the expiration of the said three day notice period, the facility director files with the district court a petition for the commitment of such person at the said facility.

(5) Discharge at Request of Parent or Guardian. Hospitalization of a person under the age of 16 may be terminated at the request of his or her legally authorized representative in the same manner as any other patient.

(6) Patients Aged 16 or 17. A person who is 16 or 17 years old, or who becomes 16 during the course of hospitalization, and who has been admitted to a facility as a voluntary or conditional voluntary patient by application of a legally authorized representative shall have the same rights pertaining to release, withdrawal and discharge as those persons over the age of 16 who have applied and been voluntarily admitted to the facility on their own behalf.

(7) Involuntary Commitment Status.

(a) Three day commitment. A person admitted to a facility under M.G.L. c. 123, § 12, may be discharged by the facility director at any time during such period of hospitalization if the facility director determines that such person is not in need of care and treatment in the facility. The three day hospitalization period authorized under M.G.L. c. 123, § 12 shall not be extended, and, at the end of such period, a person so hospitalized shall be discharged by the facility unless, prior to expiration, such person has applied for voluntary admission to the facility, or the facility director has filed a petition for an order of commitment.

(b) Prolonged Commitment. A person committed to a facility by order of a court of competent jurisdiction shall be discharged by the facility at the expiration of the time period established by the order, unless the commitment order is renewed under the procedures established in M.G.L. c. 123, §§ 7 and 8.

(c) At any time during the period of hospitalization, the facility director may discharge such person if he or she determines that such person is no longer in need of care and treatment.

(8) Forensic Commitment Status.

(a) A person committed to facility under M.G.L. c. 123, § 15 shall not be discharged except to the committing court, or upon other court order.

(b) A person committed to a facility under M.G.L. c. 123, § 16 shall not be discharged unless appropriate notice has been given by the facility director to the court exercising jurisdiction over such person and to the district attorney of the district within which the alleged crime or crimes occurred. If within 30 days of the receipt of such communication the district attorney has not filed a petition for further commitment of such person, the person may be discharged. If such a petition is filed, a hearing shall take place pursuant to M.G.L. c. 123, § 16(c).

(c) In the event the facility director intends to remove or modify any court ordered restrictions on such a person's movements, he or she shall communicate the intention to remove or modify such restriction in writing to the court. If within 14 days the court does not make written objection thereto, such restrictions may be removed or modified.

(d) A person hospitalized at a facility pursuant to M.G.L. c. 123, § 18, shall not be discharged except to prison, a correctional facility, or the court, unless such person's sentence has expired.

27.10: Treatment(1) Consent to Treatment.

(a) Upon admission to a facility for care and treatment, a person shall, upon giving informed consent, receive treatment and rehabilitation in accordance with accepted therapeutic practice, including oral, subcutaneous and intramuscular medication when appropriate and when ordered by a physician. Informed consent means the knowing consent, voluntarily given by the patient, or his or her legally authorized representative, who can understand and weigh the risks and benefits of the particular treatment being proposed.

(b) Treatment with antipsychotic medication, Electroconvulsive Treatment (ECT), psychosurgery, involuntary sterilization or abortion, and other highly intrusive or high risk interventions may not be administered or performed without the patient's specific informed consent. In the case of a patient incapable of giving informed consent, such interventions may not be administered or performed without prior review and approval by a court of competent jurisdiction or the consent of his or her legally authorized representative..

(c) Prior to an adjudication of incompetence, and court approval of a treatment plan, a patient retains the right to accept or refuse treatment as prescribed.

(d) For a patient who is believed to be incompetent to give informed consent to treatment with antipsychotic medication, the right to refuse such medication may be overridden prior to an adjudication of incompetence and court approval of a treatment plan only in rare circumstances to prevent an immediate, substantial and irreversible deterioration of the patient's mental illness. If treatment is to be continued over the patient's objection, and the patient remains incompetent, then an adjudication of incompetence and court approval of a treatment plan must be sought.

(e) Chemical restraints may be used only in an emergency situation pursuant to 104 CMR 27.12.

(2) Electroconvulsive Treatment for Patients under the Age of 16.

(a) Electroconvulsive treatment shall not be administered to any patient under the age of 16 unless the Commissioner or designee concurs.

(b) The approval of the administration of electroconvulsive treatments to patients under 16 shall be based on such written recommendations and independent consultations as the Commissioner or designee deems appropriate under the circumstances of the individual case.

(c) The Commissioner or designee's approval, and the basis therefor, shall become a permanent part of the patient's record.

(3) Routine and Preventive Treatment. A patient shall be informed upon admission and at each periodic review of the routine and preventive treatment that is ordinarily performed at, or arranged by, the facility. Routine and preventive treatment includes standard medical examinations, clinical tests, standard immunizations, and treatment for minor illnesses and injuries. A patient who is capable of giving informed consent regarding routine and preventive treatment has the right to refuse such treatment, except that such refusal may be overridden by the facility director, without special court authorization, when the treatment consists of:

(a) a complete physical examination, and associated routine laboratory tests, required by law to be conducted upon admission and at least annually thereafter.

(b) immunizations or treatment required by law or necessary to prevent the spread of infection or disease.

(5) Written Treatment Plan. As part of the treatment of a patient in a facility, there shall be a written assessment of the needs and strengths of the individual and a written, multi-disciplinary treatment plan, which shall be developed with the maximum possible participation of the patient or the patient's legally authorized representative. The treatment plan, upon acceptance by the patient or his or her legally authorized representative, shall be implemented by the facility staff in good faith within the limits of available resources. There shall be a periodic written assessment of treatment progress, and significant modifications of the treatment plan and the rationale for such modifications shall be recorded by the responsible clinicians.

27.10: continued

(6) Additional Requirements for Patients Eligible for Public School Education.

(a) Treatment plans for patients who are "children with special needs," as defined in M.G.L. c. 71B shall, where appropriate, take into account the plan for providing special education services developed in accordance with regulations of the Department of Education.

(b) Treatment plans for patients who are eligible for public school education but who are not "children with special needs" as defined in M.G.L. c. 71B, § 1, shall, if appropriate, and in addition to all other requirements for treatment plans, reflect such patient's educational needs.

(7) Behavior management as defined in 104 CMR 27.10 may only be used in facilities licensed as Class VI, Limited VI or VII or in units of Department facilities that admit patients under 19. Each facility that employs behavior management techniques shall submit a behavior management plan, which shall be subject to Department approval. The plan shall outline the facility's philosophy, policy and procedures for behavior management whereby behavior management interventions are used as an educational process by which staff assist the patients in developing the experience and self control necessary to assume responsibilities, make daily living choices, and learn to live in reasonable conformity with accepted levels of social behavior. The plan shall include a description of acceptable and unacceptable behavior for the patients, as well as the sanctions that will result from unacceptable behavior. The plan shall be submitted to the Human Rights Officer and, where applicable, to the Human Rights Committee, for review.

(a) No behavior modification techniques which involve corporal punishment, infliction of pain or physical discomfort, or deprivation of food or sleep shall be used for behavior management.

(b) Seclusion and restraint, as defined in these regulations, may not be used for behavior management, but may only be used in accordance with 104 CMR 27.12.

(c) The treatment plan for each patient for whom behavior management will be employed shall contain specific, individualized behavior management interventions, consistent with the program's behavior management plan. The treatment plan including behavior management interventions may not be instituted without the consent of the patient or his or her legally authorized representative.

(d) Each behavior management plan shall describe behavior management interventions that may be used. These may include but are not limited to the following:

1. level/point systems of privileges, including procedures for the patient's progress in the program;
2. the type and range of restrictions a staff member can authorize for misbehavior of a patient;
3. the use of the practice of separating a patient from a group or facility activity.

(e) When feasible and appropriate, patients shall participate in the establishment of rules, policies and procedures for behavior management.

(f) Upon admission, the facility shall provide patients and their legally authorized representatives with a copy of the facility's behavior management plan.

(g) Any behavior management plan which provides that a patient may be separated from the group or facility activities shall include, but not be limited to, the following:

1. guidelines for staff in the utilization of such procedures;
2. persons responsible for implementing such procedures;
3. the duration of such procedures, including provisions for approval by the facility director or his or her designee of a period longer than 30 minutes;
4. a requirement that patients shall be observable at all times and that staff shall be in close proximity at all times;
5. a procedure for staff to directly observe the patient every 15 minutes;
6. a means of documenting the use of such procedures if used for a period longer than 30 minutes including, at a minimum, length of time, reasons for this intervention, who approved the procedure, and who directly observed the patient at least every 15 minutes.

(h) A time out room shall not be locked.

(i) Any room or space used for the practice of separation must be physically safe.

27.11: Periodic Review

(1) Schedule of Periodic Reviews. Every facility shall conduct a periodic review of each inpatient upon admission, and for patients whose hospitalizations are expected to be at least 90 days, during the first three months, during the second three months, and annually thereafter until discharge, except that for facilities licensed as Class VI, Limited Class VI and VII and for units of Department facilities that admit patients under 19, such periodic reviews shall be conducted quarterly.

(2) Notice to Patient and Family. Prior to the periodic review, the facility director or designee shall give reasonable advance written notice to each patient and his or her legally authorized representative and, unless the patient knowingly objects, to the nearest relative, giving the date of such review and requesting their participation in such review.

(3) Thorough Clinical Examination. Each periodic review shall include a thorough clinical examination, which shall consist of: a mental status examination; a review of the patient's clinical history, including a review of the treatment plan, of response to treatment, and of medications administered; and an evaluation of general behavior and social interaction by clinical personnel from the various disciplines providing treatment. At least once in every 12 month period, a thorough clinical examination shall also include a physical examination.

(4) Evaluation of Competency. For each periodic review, the legal competency of a patient shall be evaluated by the senior reviewing clinician in terms of whether he or she is competent to remain on, or to apply for, conditional voluntary admission status, to render informed consent to customary and usual medical care or extraordinary treatment, including administration of antipsychotic medications, or to manage his or her own funds in accordance with the requirements of 104 CMR 30.01(3).

(a) If a patient is on voluntary or conditional voluntary admission status, and the patient is believed no longer to be competent, and the patient remains in need of continued hospitalization, then the facility director shall take reasonable steps to obtain alternate authority for continued hospitalization either by seeking an order of commitment pursuant to M.G.L. c. 123, §§ 7 and 8, or a guardianship with authority to admit the ward to a psychiatric facility.

(b) If the question of a patient's competency is raised by a periodic review or if the facility director has reason to believe that a patient who has been under the care of the facility, who is not under guardianship or conservatorship, is unable to care for his or her property, he or she shall promptly take reasonable steps to initiate the process for the appointment of a guardian or conservator.

(5) Consideration of Alternatives to Hospital. For each periodic review the alternatives to hospitalization should be evaluated, with consideration being given to specific and available resources in the community which the patient could utilize.

(6) Results of the Periodic Review.

(a) Upon completion of every periodic review subsequent to admission, the person in charge of conducting the review shall prepare a full and complete record of all information presented at such review, including medical evidence or information, the reasons for a determination that a patient requires continued care and treatment at the facility, and the consideration given to alternatives to continued hospitalization. This written record of each periodic review shall become part of the patient's permanent medical record.

(b) If upon completion of the periodic review, it is determined that the patient is in need of further care and treatment, facility director or designee shall notify the patient and his or her legally authorized representative, or, if there is no such legally authorized representative and the patient does not knowingly object, his or her nearest relative, of that determination, and of the right to leave the facility if he or she was not committed under a court order. If said patient is not committed under a court order and does not choose further treatment as an inpatient, within 14 days of said notification the patient shall be discharged or shall be made the subject of a petition for a court ordered commitment. Following any review under the provisions of 104 CMR 27.11, or at any other time, any patient who is no longer in need of care as an inpatient shall be discharged.

27.12: Prevention of Restraint and Seclusion and Requirements When Used

(1) Prevention/Minimal Use of Restraint and Seclusion. A facility licensed as Class III through VII shall develop and implement a plan to reduce and, wherever possible, eliminate the use of restraint and seclusion. The facility's plan shall include, at a minimum, the following:

- (a) a posted statement of the facility's commitment to the prevention and minimal use of restraint and seclusion;
- (b) policies and procedures that support the prevention and minimal use of restraint and seclusion;
- (c) staff training that focuses on crisis prevention, de-escalation and alternatives to restraint and seclusion;
- (d) programming and milieu that are consistent with the prevention and minimal use of restraint and seclusion;
- (e) the development and use of sensory interventions and therapies designed to calm and comfort patients that utilize sight, touch, sound, taste, smell, pressure, weight or physical activity;
- (f) the development and use of an individual crisis prevention plan for each patient;
- (g) assessment of the impact of trauma experience and the potential for retraumatization;
- (h) the regular use of debriefing activities;
- (i) the process for addressing patient concerns and complaints about the use of restraint or seclusion;
- (j) the use of data to monitor and improve quality and prevent and minimize the use of restraint and seclusion, such as identifying times or shifts with a high incidence of restraint or seclusion.

(2) Staff Training.

(a) A facility shall ensure that all unit staff and other staff who may be involved in restraint and seclusion receive training in the prevention and minimal use of restraint and seclusion during orientation, which shall be no later than one month after hire, and receive annual training thereafter. Training shall include, at a minimum, the following:

1. the harmful emotional and physical effects of restraint and seclusion on patients and staff;
2. the impact of trauma, including sexual and physical abuse and witnessing of violence, on individuals;
3. the impact of restraint or seclusion on individuals with a history of trauma, including the potential for retraumatization;
4. crisis prevention approaches and de-escalation strategies;
5. the use of the individual crisis prevention plan.

(b) In addition to the training in 104 CMR 27.12(2)(a), staff who may be directly involved in authorizing, ordering, administering or applying, monitoring, or assessing for release from restraint or seclusion shall receive additional training, and annual retraining thereafter. No staff shall be permitted to participate in any restraint or seclusion prior to receiving such additional training. Such training shall include, at a minimum, the following:

1. applicable legal and clinical requirements for restraint and seclusion;
2. the safe and appropriate initiation of physical contact and application and monitoring of restraint and seclusion;
3. approaches to facilitate the earliest possible release from restraint or seclusion.

(c) Following initial training and each annual retraining, a facility shall require each staff member to demonstrate competencies in all areas of training. A facility shall maintain documentation of staff training and competencies.

(3) Individual Crisis Prevention Planning. A facility shall develop an individual crisis prevention plan for each patient.

(a) Definition. An individual crisis prevention plan is an age and developmentally appropriate, patient-specific plan that identifies triggers that may signal or lead to agitation or distress in the patient and strategies to help the patient and staff intervene with de-escalation techniques to reduce such agitation and distress and avoid the use of restraint and seclusion.

(b) Development of the Individual Crisis Prevention Plan. As soon as possible after admission, facility staff shall collaborate with each patient and his or her legally authorized representative, if any, and, where appropriate, with other sources, such as family members, caregivers, and the patient's health care proxy, to complete and implement an individual crisis

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prevention plan. If the patient refuses or is unable to participate in the initial development of the plan, staff shall develop a plan using available information and shall make continuing efforts to include the patient's participation in review and revision of the plan. Relevant clinical data, including medical risk factors, physical, learning, or cognitive disability, and the patient's history of trauma shall inform the development of the plan. The plan shall include, at a minimum, the following elements:

1. identification of triggers that signal or lead to agitation or distress in the patient and, if not addressed, may result in the use of restraint or seclusion;
2. identification of the particular approaches and strategies that are most helpful to the patient in reducing agitation or distress, such as environmental supports, physical activity, and sensory interventions;
3. in order to minimize trauma or retraumatization if restraint or seclusion is used, identification of the patient's preferences, such as type of intervention and positioning, gender of staff who administer and monitor the restraint or seclusion, and supportive interventions that may have a calming effect on the patient.

(c) Update and Revision of Plan. The plan shall be updated as necessary to reflect changes in such triggers and strategies and shall be reviewed at each treatment plan review.

(d) Access to Plan. A facility shall ensure that all staff on all shifts are aware of and have ready access to the individual crisis prevention plans for the patients in their care. A copy of the individual crisis prevention plan and any revisions thereto shall be placed in the patient record.

(4) Debriefing Activities. A facility shall develop procedures to ensure that debriefing activities occur after each episode of restraint or seclusion in order to determine what led to the incident, what might have prevented or curtailed it, and how to prevent future incidents. Debriefing activities shall be documented and used in treatment planning, revision of the individual crisis prevention plan, and ongoing facility-wide restraint and seclusion prevention efforts.

(a) Staff Debriefing. As soon as possible following each episode of restraint or seclusion, supervisory staff and staff involved in the episode shall convene a debriefing. The debriefing

shall, at a minimum, include the following:

1. identification of what led to the incident;
2. determination of whether the individual crisis prevention plan was used;
3. assessment of alternative interventions that may have avoided the use of restraint or seclusion;
4. determination of whether the patient's physical and psychological needs and right to privacy were appropriately addressed;
5. consideration of counseling or medical evaluation and treatment for the involved patient and staff for any emotional or physical trauma that may have resulted from the incident;
6. consideration of whether other patients and staff who may have witnessed or otherwise been affected by the incident should be involved in debriefing activities or offered counseling;
7. consideration of whether the legally authorized representative, if any, family members, or others should be notified of and/or involved in debriefing activities;
8. consideration of whether additional supervision or training should be provided to staff involved in the incident;
9. determination of whether the incident should be referred for senior administrative review because it meets one or more of the criteria outlined in 104 CMR 27.12(4)(c)1. through 6. or otherwise warrants such review.

(b) Patient Debriefing. Within 24 hours after a patient's release from restraint or seclusion, the patient shall be asked to debrief and provide comment on the episode, including the circumstances leading to the episode, staff or patient actions that may have helped to prevent it, the type of restraint or seclusion used, and any physical or psychological effects he or she may be experiencing from the restraint or seclusion. Whenever possible and appropriate, the staff person providing the patient with the opportunity to comment shall

not

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have been involved in the episode of restraint or seclusion. As part of the debriefing, the patient shall be provided with a copy of the restraint and seclusion order form required pursuant to 104 CMR 27.12(5)(i) 1. with an attached patient debriefing and comment form approved by the Commissioner and shall be offered the opportunity to provide comment in writing. The staff person shall provide the patient with any necessary assistance in completing the patient debriefing and comment form. If the patient does not complete the form, but provides verbal or other response to the episode, the staff person shall document such response on the form. If the patient provides verbal or other response to the episode at any other time, the staff person witnessing the response shall document it in writing. The patient debriefing and comment form or other documentation shall be attached to the restraint and seclusion order form and included in the patient record and copies of the form shall promptly be forwarded to the treatment team and the human rights officer. The patient shall also be notified of the availability of the complaint procedure outlined in 104 CMR 32.00. The human rights officer shall meet with a patient who has expressed a response to an episode of restraint or seclusion that suggests a possible rights violation or other harmful consequence.

(c) Senior Administrative Review. The facility director shall ensure that senior administrative and clinical staff who are empowered to make recommendations and decisions about the need for expert consultation, training, performance improvement activities, change in policy, or other appropriate measures conduct regular reviews of all incidents of restraint and seclusion. In addition, such staff shall conduct a specific review of an episode of restraint or seclusion by the next business day if any of the following apply:

1. A patient or staff member experienced significant emotional or physical injury as a result of the episode.
2. The episode of restraint or seclusion exceeded six hours or episodes of restraint and/or seclusion for a patient exceeded 12 hours in the aggregate in any 48-hour period.
3. An exception to the restrictions on mechanical restraint of minors has occurred pursuant to 104 CMR 27.12(5)(g)5.
4. The episode appears to be part of a pattern warranting review.
5. The episode is marked by unusual circumstances.
6. The episode resulted in a complaint or reportable incident pursuant to 104 CMR 32.00.
7. the staff involved in the episode requested such a review pursuant to 104 CMR 27.12(4)(a)9.

(5) Requirements for the Use of Restraint and Seclusion.

(a) Definitions. For purposes of 104 CMR 27.12, the following definitions shall apply:

1. Authorized Physician. An authorized physician is any physician who has been authorized by the facility director to order medication restraint, mechanical restraint, physical restraint or seclusion, to examine patients in such restraint or seclusion, and to assess for readiness for release and order release from restraint or seclusion.
2. Authorized Staff Person. An authorized staff person is any member of the licensed clinical staff at a facility who has been authorized by the facility director to initiate or renew mechanical restraint, physical restraint or seclusion pursuant to 104 CMR 27.12(5)(e)2. or (01., and to assess for readiness for release and order release from restraint or seclusion.
3. Restraint. Restraint, for purposes of 104 CMR 27.00, means behavioral restraint, including medication restraint, mechanical restraint and physical restraint. Restraint means bodily physical restriction, mechanical devices, or medication that unreasonably limit freedom of movement. Restraint does not include the use of restraint in association with acute medical or surgical care, adaptive support in response to the patient's assessed physical needs, or standard practices including limitation of mobility related to medical, dental, diagnostic, or surgical procedures and related post-procedure care.

- a. Medication Restraint. Medication restraint occurs when a patient is given medication involuntarily for the purpose of restraining the patient. Medication restraint shall not include:

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- i. involuntary administrations of medication when administered in an emergency to prevent immediate, substantial and irreversible deterioration of serious mental illness, provided that the requirements of 104 CMR 27.10(1)(d) are complied with; or
 - ii. for other treatment purposes when administered pursuant to a court approved substituted judgment treatment plan.
- b. Mechanical Restraint. Mechanical restraint occurs when a physical device or devices are used to restrain a person by restricting the movement of a patient or the movement or normal function of a portion of his or her body.
- c. Physical Restraint. Physical restraint occurs when a manual method is used to restrain a person by restricting a patient's freedom of movement or normal access to his or her body. Physical restraint may only include bodily holding of a patient with no more force than is necessary to limit the patient's movement. Physical restraint shall not include:
- i. non-forcible guiding or escorting of a patient to another area of the facility;
 - ii. taking reasonable steps to prevent a patient at imminent risk of entering a dangerous situation from doing so with a limited response to avert injury, such as blocking a blow, breaking up a fight, or preventing a fall, a jump, or a run into danger;

4. Seclusion.

- a. Seclusion occurs when a patient is involuntarily confined in a room and is prevented from leaving, or reasonably believes that he or she will be prevented from leaving, by means that include, but are not limited to, the following:
 - i. manually, mechanically, or electrically locked doors, or "one-way doors," that, when closed and unlocked, cannot be opened from the inside;
 - ii. physical intervention of staff;
 - iii. coercive measures, such as the threat of restraint, sanctions, or the loss of privileges that the patient would otherwise have, used for the purpose of keeping the patient from leaving the room.
- b. Seclusion shall not include voluntary, collaborative separation from a group or activity for the purpose of calming a patient.

(b) Emergency Basis for Medication Restraint, Mechanical Restraint, Physical Restraint or Seclusion. Medication restraint, mechanical restraint, physical restraint or seclusion may be used only in an emergency, such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide. Such emergencies shall only include situations where there is a substantial risk of, or the occurrence of, serious self-destructive behavior, or a substantial risk of, or the occurrence of, serious physical assault. As used in the previous sentence, a substantial risk includes only the serious, imminent threat of bodily harm, where there is the present ability to effect such harm.

1. Restriction on Medication Restraint, Mechanical Restraint, Physical Restraint or Seclusion; Use of Individual Crisis Prevention Plan. Medication restraint, mechanical restraint, physical restraint or seclusion may be used only after the failure of less restrictive alternatives, including strategies identified in the individual crisis prevention plan, or after a determination that such alternatives would be inappropriate or ineffective . under the circumstances, and may be used only for the purpose of preventing the continuation or renewal of such emergency condition. The preferences in the patient's individual crisis prevention plan, such as type of restraint or seclusion and gender of staff, shall be considered in ordering or initiating restraint or seclusion.
2. Duration of Medication Restraint, Mechanical Restraint, Physical Restraint, or Seclusion. Medication restraint, mechanical restraint, physical restraint or seclusion may only be used for the period of time necessary to accomplish its purpose but in no event beyond the periods established in 104 CMR 27.12(5)(e), (f) and (g).
3. PRN Orders Prohibited. No "PRN" or "as required" authorization of medication restraint, mechanical restraint, physical restraint or seclusion may be written.
4. Seclusion Used with Mechanical Restraint Prohibited. No patient shall be placed in seclusion while in mechanical restraints.
5. Other Requirements. When an emergency condition exists justifying the use of medication restraint, mechanical restraint, physical restraint or seclusion, such use must

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conform to all applicable requirements of 104 CMR 27.12.

(c) Physical and Mechanical Restraint or Seclusion - Physical Conditions.

1. Position in Physical or Mechanical Restraint. A patient shall be placed in a position that allows airway access and does not compromise respiration. A face-down position shall not be used, unless:

- a. there is a specified patient preference and no psychological or medical contraindication to its use; or
- b. there is an overriding psychological or medical justification for its use, which shall be documented.

2. Personal Needs and Comfort. Provision shall be made for appropriate attention to the personal needs of the patient, including access to food and drink and toileting facilities, by staff escort or otherwise, and for the patient's physical and mental comfort.

3. Personal Dignity. Patients in restraints or seclusion shall be fully clothed, limited only by patient safety considerations related to the type of intervention used, and the restraint devices used shall afford patients maximum personal dignity.

4. Physical Environment. The physical environment shall be as conducive as possible to facilitating early release, with attention to calming the patient with sensory interventions where possible and appropriate.

5. Seclusion - Observation. Any room used to confine a patient in seclusion must provide for complete visual observation of the patient so confined.

6. Mechanical Restraint - Locks Prohibited. No locked mechanical restraint devices requiring the use of a key for their release may be used.

(d) Medication Restraint - Order. A patient may be given medication restraint only on the order of an authorized physician who has determined, either while present at the time of (i.e., at any time during the course of) the emergency justifying the use of the restraint or after telephone consultation with a physician, registered nurse or certified physician assistant who is present at the time and site of the emergency and who has personally examined the patient, and using all relevant information available regarding the patient, that such medication restraint is the least restrictive, most appropriate alternative available.

1. Such order along with the reasons for its issuance shall be recorded in writing at the time of its issuance.
2. Such order shall be signed at the time of its issuance by such authorized physician if present at the time of the emergency.
3. Such order, if authorized by telephone, shall be transcribed and signed at the time of its issuance by the physician, registered nurse or physician assistant who is present at the time of the emergency.
4. An authorized physician shall conduct a face-to-face evaluation of the patient as soon as possible but no later than within one hour of the initiation of the restraint if the restraint was authorized by telephone.

(e) Initiation of Mechanical Restraint, Physical Restraint or Seclusion.

1. The order that a patient be placed in mechanical restraint, physical restraint, or seclusion shall be made by an authorized physician who is present when an emergency as defined in 104 CMR 27.12(5)(b) occurs, except as provided in 104 CMR 27.12(5)(e)2.

- a. Such order along with the reasons for its issuance and criteria for release shall be recorded in writing and signed at the time of its issuance by such physician.
- b. Such order shall authorize use of mechanical restraint, physical restraint or seclusion for no more than two hours, subject to the additional restrictions in 104 CMR 27.12(5)(g).
- c. Such order shall terminate whenever a release decision is made pursuant to 104 CMR 27.12(5)(h)8., and shall be subject to the monitoring, examination and release provisions of 104 CMR 27.12(5)(h).

2. If an authorized physician is not present when an emergency justifying the use of mechanical restraint, physical restraint or seclusion occurs, a patient may be placed in mechanical restraint, physical restraint or seclusion at the initiation of an authorized staff person, subject to the following conditions and limitations;

- a. Such initiation shall be subject to the additional restrictions in 104 CMR 27.12(5)(g).

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- b. Such initiation along with the reasons for its issuance shall be recorded in writing and signed at the time of the incident by such authorized staff person.
 - c. Such initiation shall authorize use of mechanical restraint, physical restraint or seclusion for no more than one hour, shall terminate whenever a release decision is made pursuant to 104 CMR 27.12(5)(h)8., and shall be subject to the monitoring, examination and release provisions of 104 CMR 27.12(5)(h).
 - d. An authorized physician shall examine the patient as soon as possible but no later than one hour of such initiation of mechanical restraint, physical restraint, or seclusion.
3. At the time of initiation of restraint, an authorized staff person or authorized physician shall observe and make written note of the patient's physical status, including respiratory functioning, skin color and condition, and the presence of undue pressure to any part of the body.

(f) Mechanical Restraint, Physical Restraint or Seclusion - Renewals to Continue Use.

1. Continuation for a Second Hour of Mechanical Restraint, Physical Restraint or Seclusion Initiated by an Authorized Staff Person - Exceptional Circumstances. In exceptional circumstances, where an authorized physician has not examined the patient within the first hour of initiation of restraint or seclusion as required by 104 CMR 27.12(5)(e)2.d., an authorized staff person may issue a single renewal for a second one hour period, subject to the following conditions and limitations:

- a. Such renewal shall be subject to the additional restrictions in 104 CMR 27.12(5)(g).
- b. Such renewal may only be issued if such authorized staff person determines that such restraint or seclusion is necessary to prevent the continuation or renewal of an emergency condition or conditions as defined in 104 CMR 27.12(5)(b).
- c. Such renewal shall authorize use of mechanical restraint, physical restraint or seclusion for no more than one hour, shall terminate whenever a release decision is made pursuant to 104 CMR 27.12(5)(h)8., and shall be subject to the monitoring, examination and release provisions of 104 CMR 27.12(5)(h).
- d. An authorized physician shall examine the patient as soon as possible but no later than within one hour of such renewal of mechanical restraint, physical restraint or seclusion, and may order the restraint to continue for no more than two hours from the initiation of the restraint or seclusion by the authorized staff person, subject to the additional restrictions in 104 CMR 27.12(5)(g).

2. Continuation of Mechanical Restraint or Seclusion for Additional Two-Hour Periods. Subsequent orders for renewals of mechanical restraint or seclusion may be made for up to two-hour periods only if an authorized physician has examined the patient and ordered such renewal prior to the expiration of the preceding order, subject to the following conditions and limitations.

- a. Such a renewal order shall be subject to the additional restrictions in 104 CMR 27.12(5)(g).
- b. Such a renewal order may only be issued if such physician determines that such restraint or seclusion is necessary to prevent the continuation or renewal of an emergency condition or conditions as defined in 104 CMR 27.12(5)(b).
- c. Each such order shall be recorded in writing and signed by such physician, but only after examination of the patient in restraint or seclusion by such physician.
- d. Each such order shall authorize continued use of mechanical restraint or seclusion for no more than two hours from the time of expiration of the preceding order, shall terminate whenever a release decision is made pursuant to 104 CMR 27.12(5)(h)8., and shall be subject to the monitoring, examination and release provisions of 104 CMR 27.12(5)(h).

(g) Additional Restrictions and Limitations on the Use of Restraint or Seclusion.

- 1. No episode of physical restraint shall exceed two hours.
- 2. No order for the restraint or seclusion of a minor under age nine may exceed one hour.
- 3. No minor under age nine shall be in seclusion or restraint for more than one hour in any 24-hour period.

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4. No minor age nine through 17 shall be in seclusion for more than two hours in any 24-hour period.
5. No minor under age 13 may be placed in mechanical restraint, except under the following conditions:
 - a. The facility medical director is notified prior to the use of such restraint or immediately after the initiation of the restraint, if an emergency as defined in 104 CMR 27.12(5)(b) occurs. The facility medical director shall inquire about the circumstances warranting the use of such restraint, the efforts made to de-escalate the situation, the alternatives to such restraint considered and tried, any preferences indicated in the individual crisis prevention plan, and whether other measures or resources might be helpful in avoiding the use of mechanical restraint or in facilitating early release.
 - b. The facility director shall also be immediately informed of the use of such restraint and shall report it in writing to the Commissioner or designee by the next business day.
 - c. All other applicable provisions of 104 CMR 27.12 shall be complied with.
6. Mechanical Restraint or Seclusion Exceeding Six Hours or Multiple Episodes. If an episode of mechanical restraint or seclusion has exceeded five hours and it is expected that a new order will be issued to extend the episode beyond six hours or if there are two or more episodes of any restraint or seclusion for a patient in any 12 hour period, the facility director and facility medical director shall be notified. The facility medical director shall inquire about the circumstances of the episode(s) of restraint or seclusion, the efforts made to facilitate release, and the impediments to such release, and help to identify additional measures or resources that might be beneficial in facilitating release or preventing additional episodes.
7. Mechanical Restraint or Seclusion Exceeding 12 Hours or Total Episodes Exceeding 12 Hours in a 48-Hour Period. If an episode of mechanical restraint or seclusion has exceeded 11 hours and it is expected that a new order will be issued to extend the episode beyond 12 hours, or if episodes of restraint and/or seclusion for a patient have exceeded 12 hours in the aggregate in any 48-hour period, the following shall occur:
 - a. The patient shall receive a medical assessment.
 - b. The facility director and facility medical director shall be notified. The facility medical director shall inquire about the outcome of the measures identified pursuant to 104 CMR 27.12(5)(g)6., in the case of a continuous episode, and about the circumstances that resulted in the continued or multiple use of restraint or seclusion. The facility medical director shall take steps, including consultation with appropriate parties, to identify and implement strategies to facilitate release as soon as possible and/or eliminate the use of multiple episodes, such as psychopharmacological reevaluation or other consultation, assistance with communication, including interpreter services, and consideration of involving family members or other trusted individuals.
 - c. The episode(s) shall be reported to the Commissioner or designee by the next business day.
8. Release Prior to Expiration of Order. If a patient is released from restraint or seclusion prior to the expiration of an order and an emergency as defined in 104 CMR 27.12(5)(b) occurs prior to such order's expiration, but no later than one-half hour after release, the patient may be returned by an authorized staff person to restraint or seclusion without a new order for the time remaining in the order. Such return to restraint or seclusion shall be documented in the record. If the time permitted by the order or one-half hour has elapsed at the time of such emergency, the procedures for ordering or initiating restraint or seclusion pursuant to 104 CMR 27.12(5)(e) shall be followed.

(h) Monitoring and Assessment of Patients in Mechanical Restraint, Physical Restraint or Seclusion; Release.

1. One-on-One Staff Monitoring. Whenever a patient is in physical or mechanical restraint or seclusion, a staff person shall be specifically assigned to monitor such person one-on-one.
2. The staff person conducting such monitoring may be immediately outside a space in

which a patient is being secluded without mechanical restraint provided that the following conditions are met:

- a. The staff person must be in full view of the patient (e.g., the patient may approach the seclusion door and see the staff person through a window in the door if he or she wishes to do so); and
 - b. The staff person must be able at all times to observe the patient.
3. The staff person shall monitor a patient in mechanical or physical restraint by being situated so that the staff person is able to hear and be heard by the patient and visually observe the patient at all times. It is not necessary for a staff person monitoring a patient in mechanical or physical restraint to be in full view of the patient, although if such visibility has been expressed as a preference by the patient, consideration shall be given to honoring such preference.
4. Staff who monitor a patient in physical or mechanical restraint or seclusion shall continually assist and support the patient, including monitoring physical and psychological status and comfort, body alignment, and circulation, taking vital signs when indicated, and monitoring for readiness for release pursuant to 104 CMR 27.12(5)(h)6. Such monitoring activities shall be documented every 15 minutes.
5. Staff who monitor a patient in restraint or seclusion shall continue appropriate interventions designed to calm the patient throughout the episode of restraint or seclusion and shall ensure that the patient has access to a means of marking the passage of time, either visually or verbally.
6. Monitoring for Readiness for Release.
- a. Staff conducting monitoring shall continually consider whether a patient in mechanical restraint, physical restraint or seclusion appears ready to be released. If the staff person believes that the patient may be ready to be released from such restraint or seclusion either because the criteria for release have been met or an emergency condition or conditions as defined in 104 CMR 27.12(5)(b) no longer exists, he or she shall immediately notify an authorized physician or authorized staff person, who shall promptly assess the patient for readiness to be released.
 - b. If a patient falls asleep while in mechanical restraint, staff conducting monitoring shall notify an authorized physician or authorized staff person, who shall release the patient from the restraint or seclusion, unless such efforts are reasonably expected to re-agitate the patient.
 - c. If, at any time during mechanical restraint, physical restraint, or seclusion, a patient is briefly released from such restraint or seclusion to attend to personal needs pursuant to 104 CMR 27.12(5)(c)2. or for other purpose, staff conducting monitoring shall consider the patient's readiness to be permanently released, rather than returned to the restraint or seclusion, and notify an authorized staff person if the patient appears ready to be released.
7. Assessment. An authorized staff person or authorized physician shall assess a patient in mechanical or physical restraint or seclusion for physical and psychological comfort, including vital signs, and readiness to be released at least every 30 minutes and at any other time that it appears that the patient is ready to be released. Such assessments shall be documented in the record.
8. Permanent Release. A patient shall be released from mechanical restraint, physical restraint or seclusion as soon as an authorized physician or authorized staff person determines after examination of the patient or consultation with staff that such mechanical restraint, physical restraint, or seclusion is no longer needed to prevent the continuation or renewal of an emergency condition or conditions as defined in 104 CMR 27.12(5)(b) and, in no event, no later than the expiration of an initial or renewed order for such mechanical restraint or seclusion, unless such order is renewed in accordance with the requirements or 104 CMR 27.12(5)(f). The circumstances considered in making such a determination shall be documented and signed by the authorized physician or authorized staff person making the determination.

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(i) Documentation Requirements.

1. The Restraint and Seclusion Order Form. Each facility subject to these regulations shall ensure that a restraint and seclusion order form is maintained and completed on each occasion when a patient is placed and maintained in restraint or seclusion. The restraint and seclusion order form shall conform to the following requirements:

- a. The restraint and seclusion order form must be in a form approved by the Commissioner.
- b. The restraint and seclusion order form shall be completed in triplicate, one copy of which shall be placed in the patient's record, one copy of which shall be used for the patient's comments pursuant to 104 CMR 27.12(4)(b), and one copy of which shall be used for the review by the Commissioner or designee pursuant to 104 CMR 27.12(5)(i)2.
- c. Any attachments required by 104 CMR 27.12 shall be attached to each copy of the restraint and seclusion order form.

2. Submission to the Commissioner; Review. At the end of each month, a facility shall submit to the Commissioner or designee copies of all restraint and seclusion forms with attachments, if any, required by 104 CMR 27.12 and an aggregate report for each facility unit, on a form approved by the Commissioner, containing statistical data on the episodes of restraint and seclusion for the month. The Commissioner or designee shall review such aggregate reports and review a sample of restraint and seclusion forms, and shall maintain statistical records of all uses of restraint or seclusion, organized by facility and unit.

3. Human Rights Committee/Human Rights Officer Review. At the end of each month, copies of all restraint and seclusion order forms and attachments, if any, sent to the Commissioner or designee pursuant to 104 CMR 27.12(5)(i)2. shall be sent to the human rights committee of the facility, if operated by or under contract to the Department, and otherwise to the human rights officer, which shall review the use of all restraints by the facility or program. The committee or human rights officer shall have the authority to:

- a. review all pertinent data concerning the behavior that necessitated restraint or seclusion;
- b. obtain information about the patient's needs from appropriate staff, relatives and other persons with direct contact or special knowledge of the patient;
- c. monitor the use of the individual crisis prevention plan and consider all less restrictive alternatives to restraint and seclusion in meeting the patient's needs;
- d. review and refer to the person in charge for action in accordance with 104 CMR 32.00 all complaints that the rights of a patient are being abridged by the use of restraint or seclusion; and
- e. generally monitor the use of restraint and seclusion in the facility.

27.13: Human Rights

(1) No right protected by the Constitutions or laws of the United States and the Commonwealth of Massachusetts shall be abridged solely on the basis of a patient's admission or commitment to a facility, except insofar as the exercise of such rights have been limited by a court of competent jurisdiction. Furthermore, no person shall be deprived of the right to manage his or her affairs, to contract, to hold professional, occupational or vehicle operator's licenses, to make a will, to marry, to hold or convey property or to vote in local, state, or federal elections solely by reason of his or her admission or commitment to a facility.

(2) In cases where there has been an adjudication that a person is incompetent, or when a conservator or guardian has been appointed for such person, such person's human rights may be limited only to the extent of the guardian or conservator's adjudicated responsibility. If at any time during a patient's treatment, the clinical team believes the patient to be incompetent to make treatment or other personal or financial decisions, the director or designee shall notify the patient that a recommendation has been made that there be an adjudication or other determination of the competency of such patient.

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- (3) Right to Treatment. Each patient admitted to a facility shall, subject to his or her giving informed consent, receive treatment suited to his or her needs which shall be administered skillfully, safely, and humanely with full respect for dignity and personal integrity.
- (4) Right to Education. Patients under the age of 22, under the care and treatment of the Department, shall receive education and training appropriate to their needs in accordance with M.G.L. c. 71B and the regulations promulgated thereunder.
- (5) In addition to the foregoing, a patient of a facility:
- (a) shall have reasonable access to a telephone to make and receive confidential telephone calls and to assistance, when desired and necessary to implement this right, provided that such calls do not constitute a criminal act or represent an unreasonable infringement of other persons' right to make and receive phone calls;
 - (b) shall have the right to send and receive sealed, unopened, uncensored mail, provided, however, that the facility director or designee may direct, for good cause and with documentation of specific facts in the patient's record, that a particular patient's mail be opened and inspected in front of the patient, without it being read by staff, for the sole purpose of preventing the transmission of contraband. Writing materials and postage stamps in reasonable quantities shall be made available for use by patients. Reasonable assistance shall be provided to patients in writing, addressing and posting letters and other documents upon request;
 - (c) shall have the right to receive visitors of such patient's own choosing daily and in private, at reasonable times. Hours during which visitors may be received may be limited only to protect the privacy of other patients and to avoid serious disruptions in the normal functioning of the facility and shall be sufficiently flexible as to accommodate individual needs and desires of such patients and their visitors;
 - (d) shall have the right to a humane psychological and physical environment. Each such patient shall be provided living quarters and accommodations which afford privacy and security in resting, sleeping, dressing, bathing and personal hygiene, reading and writing, and in toileting. 104 CMR 27.13 shall not be interpreted as requiring individual sleeping quarters;
 - (e) shall have the right to receive, or refuse, visits and telephone calls from his or her attorney or legal advocate, physician, psychologist, clergy or social worker at any reasonable time, regardless of whether the patient initiated or requested the visit or telephone call;
 - (f) shall, upon admission and upon request at any time thereafter, be provided with the name, address, and telephone number of the Mental Health Legal Advisors Committee, Committee for Public Counsel Services, and authorized Protection and Advocacy organizations, and shall be provided with reasonable assistance in contacting and receiving visits or telephone calls from attorneys or paralegals from such organizations; provided, further, that the facility shall designate reasonable times for unsolicited visits and for the dissemination of educational materials to patients by such attorneys or paralegals;
 - (f) shall have the right to file complaints and to have complaints responded to in accordance with 104 CMR 32.00.
- (6) Any rights set forth in 104 CMR 27.13(5)(a) and (c) may be temporarily suspended, but only by the facility director or designee upon concluding that based on the experience of the patient's exercise of such right, such further exercise of it in the immediate future would present a substantial risk of serious harm to said patient or others and that less restrictive alternatives have either been tried or failed or would be futile to attempt. The suspension shall last no longer than the time necessary to prevent the harm, and its imposition shall be documented with specific facts in the patient's record.
- (7) Patients have the right to be free from unreasonable searches of their person or property.
- (8) Right of Habeas Corpus. Any patient involuntarily committed to any facility who believes or has reason to believe he or she should no longer be retained may make written application to the superior court for a judicial determination of the necessity of continued commitment pursuant to M.G.L. c. 123, § 9(b).

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(9) Rights at Court Hearing. Whenever a court hearing is held under the provisions of M.G.L. c. 123 for the commitment or further retention of a person in a facility, such person shall have the right to a timely hearing and representation by counsel as provided by law.

(10) Rights of Aliens. Aliens shall have the same rights under the provisions of M.G.L. c. 123 as citizens of the United States.

(11) Human Rights Information to Each Patient on Admission. A member of the admitting staff shall give each patient, and, if applicable, his or her legally authorized representative, at the time of admission a copy of the rights set forth in 104 CMR 27.13, or other materials explaining his or her rights prepared in accordance with Departmental guidelines.

(12) Copies of Rights Posted and Available in Facilities. Each facility shall post a copy of the rights set forth in 104 CMR 27.13 in the admitting room of the facility, in each unit, and in other appropriate and conspicuous places in the facility, and shall make copies available upon request.

27.14: Human Rights Officer; Human Rights Committee

(1) Human Rights Officer. Each facility shall have a person or person employed by or affiliated with the facility appointed to serve as the human rights officer and to undertake the following responsibilities:

- (a) To participate in training programs for human rights officers offered by the Department;
- (b) To inform, train and assist patients in the exercise of their rights;
- (c) To assist patients in obtaining legal information, advice and representation through appropriate means, including referral to attorneys or legal advocates when appropriate;
- (d) In the case of Department facilities, to serve as staff to the facility's human rights committee.

In the case of Department facilities, the Commissioner or designee shall appoint the human rights officer. Otherwise, the facility director shall make such appointment.

(2) Human Rights Committee. For each facility operated by, or under contract to the Department, the Commissioner or designee shall establish, impanel and empower a human rights committee in accordance with the provisions of 104 CMR 27.14. Such a human rights committee may be established jointly with other programs in an Area; provided, however, that the number, geographical separateness or programmatic diversity of the programs is not so great as to limit the effectiveness of the committee in meeting the requirements of 104 CMR 27.14.

(3) Each such human rights committee shall be composed of a minimum of five members, a majority of whom shall be consumers of mental health services, family members of consumers, or advocates; provided, however, that no member shall have any direct or indirect financial or administrative interest in the facility or the Department.

(4) The general responsibility of each such human rights committee shall be to monitor the activities of the facility with regard to the human rights of the patients in the facility. The specific duties of the committee shall include:

- (a) Reviewing and making inquiry into complaints and allegations of patient mistreatment, harm or violation of patient's rights and referral of such complaints for investigation in accordance with the requirements of 104 CMR 32.00;
- (b) Reviewing and monitoring the use of restraint, seclusion and other physical limitations on movement;
- (c) Reviewing and monitoring the methods utilized by the facility to inform patients and staff of the patient's rights, to train patients served by the program in the exercise of their rights, and to provide patients with opportunities to exercise their rights to the fullest extent of their capabilities and interests;
- (d) Making recommendations to the facility to improve the degree to which the human rights of patients served by the facility are understood and enforced;
- (e) Visiting the facility with prior notice or without prior notice provided good cause exists.

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(5) Each such human rights committee shall meet as often as necessary upon call of the chairpersons, or upon request of any two members, but no less often than quarterly. Minutes of all committee meetings shall be kept and shall be available for inspection by the Department upon request. The committee shall develop operating rules and procedures, as necessary.

(1) A visit is a temporary release of any patient, with the exception of those patients committed pursuant to M.G.L. c. 123, §§ 15, 17 and 18, to the community for a period of not more than 30 days.

(2) A patient committed pursuant to M.G.L. c. 123, § 16 may be released on visit only if not restricted by court order, and upon authorization by the facility director after review by senior clinical staff.

(3) Readmission to Facility. A patient on visit may be readmitted to the facility at any time within 30 days from the day of release without new admission procedures. In the case of persons involuntarily committed, the original commitment order shall remain in effect. Readmission to the facility terminates a visit.

(4) Every facility shall maintain a record of the names of all patients on visit status.

27.16: Absence Without Authorization

(1) Classification as AWA. Any patient admitted or committed to a Department facility pursuant to M.G.L. c. 123, §§ 7 & 8, 10 & 11, 12, 15, 16, 17, or 18, who leaves the facility grounds or an off-grounds program or activity without permission and fails to return within a reasonable time, or any patient who, having left the facility with permission, fails to return at the designated time or within a reasonable time thereafter, shall be classified by the facility director as “absent without authorization.” (AWA).

(2) Classification as AWA: Action to Be Taken.

(a) Immediate classification: A patient who is admitted or committed pursuant to M.G.L. c. 123, §§ 7 & 8, 10 & 11, or 12 and who is at a high risk of harm to self or others or a patient who is committed pursuant to M.G.L. c. 123, §§ 15, 16, 17, or 18 shall be immediately classified as AWA.

(b) Classification by midnight census: A patient who does not meet the criteria of 104 CMR 27.16(2)(a) shall be classified as AWA if he or she has not returned within a reasonable time based on clinical judgment or by the midnight census, whichever is earlier.

(c) The facility shall take prompt and vigorous measures to secure the patient’s return.

(d) When a patient is classified as AWA, the facility director or designee shall immediately notify the following parties:

1. local and state police. The police shall be provided with the patient’s description, other information that would assist the police in locating the patient, and information of the patient’s tendencies to be assaultive, homicidal, suicidal or to use weapons;
2. the district attorney of the county in which the facility is located;
3. the patient’s next of kin;
4. the patient’s legally authorized representative;
5. any person known to be placed at risk because the patient has left the facility;
6. designated individuals within the Department.

If such notification is made by telephone, it shall be followed by written notification.

(3) Return from AWA: Action to Be Taken.

(a) A patient may return or be returned to the facility under the original patient status within six months of being classified as AWA.

(b) All parties who were notified at the time of a patient’s classification as AWA, shall be notified of the patient’s return to the facility by the facility director or designee.

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(4) Discharge of Patients on AWA: Action to Be Taken.

(a) Six months after being classified as AWA, a patient on AWA who is not committed pursuant to M.G.L. c. 123, §§ 15, 16, 17, or 18 may be discharged from the facility upon authorization by the facility director after review by senior clinical staff. After such six month period, subsequent hospitalization of patients discharged while on AWA status shall require new admission proceedings. However, under specific circumstances, the facility director, in consultation with senior clinical staff, may discharge a patient on AWA status at an earlier date.

(b) There shall be no such discharge after a six month period for persons committed to a Department facility pursuant to M.G.L. c. 123, §§ 15, 16, 17 or 18.

(c) All parties who were notified at the time of a patient's classification as AWA, shall be notified of the facility's decision to discharge the patient pursuant to 104 CMR 27.16(4)(a).

(5) All incidents of AWA shall receive clinical review and such other review as may be determined by the Commissioner.

27.17: Records

(1) "Individual record" shall refer to the medical and psychiatric record of a patient admitted to a facility providing care and treatment, and shall not include any financial, statistical or bookkeeping records of the facility.

(2) Contents of Individual Record. The facility shall maintain a permanent individual record containing all significant clinical information for each person admitted to the facility. Such record shall include:

- (a) identification data, including patient's admission status;
- (b) admission information, including admission diagnosis;
- (c) health care proxies and advance directives;
- (d) history and results of physical examination and psychiatric examination or mental status;
- (e) consent forms;
- (f) social service and nurses' notes, and psychological reports;
- (g) reports of clinical laboratory examinations and X-rays, if any;
- (h) reports of diagnostic and therapeutic procedures;
- (i) diagnoses recorded in accordance with the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association;
- (j) progress notes;
- (k) reports of periodic reviews;
- (l) conclusions, including primary and secondary final diagnoses and clinical resume;
- (m) all restraint and seclusion orders, including comment forms;
- (n) commitment orders and records of transfer, including notice of transfer;
- (o) records of all placements;
- (p) reports of treatment for accidents, injuries or severe illnesses while the patient is in the care of the facility;
- (q) requests for and consents to disclosure of information from such individual patient record;
- (r) discharge information; and
- (s) any other information deemed necessary and significant to the care and treatment of the patient.

(3) Maintenance of Records for 30 Years. Each facility providing care and treatment shall maintain individual patient records for at least 30 years after closing of the record due to discharge, death, or last contact.

(4) Microfilmed or Electronic Storage of Records. Facilities may put on microfilm or other form of electronic storage an individual case record after ten years have elapsed from the last contact with such patient. However, such microfilmed records shall be maintained for at least 20

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years after being microfilmed. Any form of electronic storage system shall have adequate backup and security provisions to safeguard against data loss, as well as against unauthorized
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access.

(5) Reporting Patient Data to the Department. Each facility shall maintain and make available to the Department such statistical and diagnostic data as may be required by the department.

(6) Confidentiality of and Access to Records. Except as provided in 104 CMR 27.17, all records relating to any persons admitted to or treated by a facility shall be private and not open to public inspection.

(a) Records of patients shall be open to inspection upon proper judicial order, whether or not such order is made in connection with pending judicial proceedings. For the purposes of 104 CMR 27.17(6), the term "proper judicial order" shall mean an order signed by a justice or special justice of a court of competent jurisdiction as defined from time to time by the

General Laws, or a clerk or assistant clerk of such a court acting upon instruction of such a justice. A subpoena shall not be deemed a "proper judicial order." Wherever possible, a patient's legally authorized representative, if any, shall be informed of a court order commanding production of the patient's record.

(b) The Commissioner or designee shall permit the attorney of a patient to inspect the records of said patient upon the request of the patient or attorney. For the purposes of 104 CMR 27.17(6), the Commissioner or designee may require that the request be in writing and may further require appropriate verification of the attorney-client relationship.

(c) A patient and the patient's legally authorized representative shall be permitted to inspect the patient's records, absent a determination by the Commissioner or designee, provided that the individual making the determination must be a licensed health care professional, that: inspection by the patient is reasonably likely to endanger the life or physical safety of the patient or another person; the record makes reference to another person (other than a health care provider) and inspection is reasonably likely to cause substantial harm to such other person; or inspection by the legally authorized representative is reasonably likely to cause substantial harm to the patient or another person. The facility director may require the legally authorized representative's consent before permitting a patient under the age of 18 to inspect his or her own records, provided that a patient who is 16 or 17 years old and admitted himself or herself pursuant to G.L. c. 123, §§ 10 & 11, may inspect records of the admittance without such consent. The records of emergency medical or dental treatment of a patient under 18 who consented to such care in accordance with G.L. c. 112, § 12F shall be confidential between the minor and physician or dentist and shall not be released except upon the written consent of the patient under 18 or a proper judicial order. Clinical staff may offer to read or interpret the record when necessary for the understanding of the patient or his or her legally authorized representative. In no circumstance may an individual be denied access to a record solely because he or she declines the offer of clinical staff to read or interpret the record. If access to a record is denied based on the criteria in 104 CMR 27.17(6)(c), the patient or legally authorized representative shall be informed of the right to appeal. The individual making a determination on appeal must be a licensed health care professional, and such determination shall be final.

(d) Records or parts thereof shall be open to inspection by other third parties, upon the written informed consent of the individual or legally authorized representative, provided that such written informed consent shall meet the requirements for authorization set forth in 45 CFR 164.508.

(e) Records may be disclosed as required by law. In addition to the laws and regulations of the Department, such laws include, but are not limited to:

1. M.G.L. c. 6, §§ 178C through 178O (the Sex Offender Registry Law - Department only);
2. M.G.L. c. 19, § 15 (Department of Elder Affairs - abuse of elderly persons, age 60 or over);
3. M.G.L. c. 19C, § 10 (Disabled Persons Protection Commission – abuse of disabled persons ages 18 to 59);
4. M.G.L. c. 119, § 51A (Department of Social Services – abuse or neglect of children under 18);
5. 42 U.S.C. 10806 (Protection and Advocacy for Mentally Ill Individuals);

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6. M.G.L. c. 221, § 34E (Mental Health Legal Advisors Committee).

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(f) The Commissioner or designee may in his or her discretion permit inspection or disclosure of the records of a patient where the Commissioner or designee has made a determination that such inspection or disclosure would be in the best interest of the patient and that such disclosure is permitted by the privacy regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA) at 45 CFR Parts 160 and 164. Prior to authorizing any release of records under 104 CMR 27.17, other than by court order or to the attorney for a patient, the Commissioner or designee shall have made a determination that it is not possible or practicable to obtain the informed written consent of the patient, if competent, or the patient's legally authorized representative.

(g) Without limiting the discretionary authority of the Commissioner or designee to identify other situations where inspection or disclosure is in the patient's best interest, if it is not possible or practicable to obtain the informed written consent of the patient, if competent, or

the patient's legally authorized representative, such inspection or disclosure may be made in the patient's best interest in the following cases:

1. from a sending facility to a receiving facility for purposes of transfer pursuant to M.G.L. c. 123, § 3;
2. to a physician or other health care provider who requires such records for the treatment of a medical or psychiatric emergency; provided however that the patient is given notice of the access as soon as possible;
3. to a medical or psychiatric facility currently caring for the patient, when the disclosure is necessary for the safe and appropriate treatment and discharge of the patient;
4. where the patient has provided consent for a particular treatment or service, to those persons involved in such treatment or service;
5. between the Department and a contracted vendor regarding individuals being served by the vendor for purposes related to services provided under the contract;
6. to persons authorized by the Department to monitor the quality of services being provided to the individual;
7. to enable the patient, or someone acting on his or her behalf, to obtain benefits, protective services, or third party payment for services rendered to such patient;
8. to persons conducting an investigation involving the patient pursuant to 104 CMR 32.00;
9. to persons engaged in research if such access is approved by the Department pursuant to 104 CMR 31.00;
10. to the Joint Commission on Accreditation of Healthcare Organizations or other accrediting bodies;
11. reports of communicable and other infectious disease to the Department of Public Health and/or local board of health consistent with 105 CMR 300.000 *et seq.*;
12. in the case of death, to coroners, medical examiners, or funeral home directors.

(h) Any disclosure pursuant to the exceptions outlined in 104 CMR 27.17(6)(a) through (g) shall be limited to the minimum information necessary to achieve the purpose of the exception.

(i) Notwithstanding the provisions of 104 CMR 27.17(6)(a) through (h), inspection or disclosure of records or information shall not be permitted in the following circumstances:

1. if the record or information was obtained from someone other than a health care provider on a promise of confidentiality, and the requested disclosure would likely reveal the source;
2. on a temporary basis only, during the course of research involving treatment, where the subject of the research agreed to such temporary suspension of access when consenting to participation in the research study;
3. if the subject of the record is in the custody of a correctional institution and the correctional institution has requested that access not be provided for health and safety reasons;
4. if the records are restricted under the Federal Clinical Laboratory Improvement Amendments;
5. if the records are created in anticipation of litigation.

27.18: Interpreter Services

(1) For the purposes of 104 CMR 27.18, the following words shall have the following meanings:

(a) Competent interpreter services means interpreter services performed by a person who is fluent in English and in the language of a non-English speaker, who is trained and proficient in the skill and ethics of interpreting and who is knowledgeable about the specialized terms and concepts that need to be interpreted for purposes of receiving care or treatment.

(b) Facility shall mean a Department-operated hospital, community mental health center with inpatient unit, or psychiatric unit within a public health hospital; a Department-licensed psychiatric hospital; or a Department-licensed psychiatric unit within a general hospital.

(c) Non-English speaker means a person who cannot speak or understand, or has difficulty with speaking or understanding, the English language because the speaker primarily or only uses a spoken language other than English.

(2) Each facility shall in connection with the delivery of inpatient services, if an appropriate bilingual clinician is not available, provide competent interpreter services to every non-English speaker who is a patient.

(3) Based on the volume and diversity of non-English-speaking patients served by the facility, the facility shall use reasonable judgment as to whether to employ, or to contract for, the on-call use of one or more interpreters for particular languages when needed, or to use competent telephonic or televiewing interpreter services; provided that such facility shall only use competent telephonic or televiewing interpreter services in situations where either:

(a) there is no reasonable way to anticipate the need for employed or contracted interpreters for a particular language; or

(b) there occurs, in a particular instance, an inability to provide competent services by an employed or contracted interpreter.

(4) Interpreter services shall be available 24 hours a day and seven days a week.

(5) The facility shall not require, suggest, or encourage the use of family members or friends of patients as interpreters and shall not, except in exceptional circumstances, use minor children as interpreters.

(6) The facility shall post signs and provide written notification of the right to and availability of interpreter services to patients in their primary language.

(7) The facility shall develop written policies and procedures that are consistent with 104 CMR 27.18 and that assist staff and patients in accessing interpreter services.

REGULATORY AUTHORITY

104 CMR 27.00: M.G.L. c. 19, §§ 1 and 18; c. 123, § 2.

NON-TEXT PAGE