

# **CHAPTER 12: MEDICAL SERVICES DURING CONFINEMENT**

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# MEDICAL SERVICES DURING CONFINEMENT

This chapter should be read in conjunction with the following chapter, “Mental Health and Substance Abuse Services During Confinement.”

For youth in programs licensed by the state Department of Early Education and Care (DEEC), this chapter should also be read in conjunction with the explanation of DEEC regulatory requirements regarding medical care, discussed above in the chapter entitled “Overview of Rights During Confinement.”

This chapter does not apply to youth held in pre-arraignment detention facilities known as Alternative Lockup Programs (ALPs) perhaps with certain exceptions for youth in DYS-run ALP beds.

## Right to medical services

Youth in state custody have a right under the U.S. Constitution to adequate basic care, medical care, and protection from harm.<sup>1</sup>

Youth who are detained or committed at DYS have the right to receive medical services during such confinement.<sup>2</sup> Medical services include both diagnosis and treatment and include both physical and mental health services.<sup>3</sup> Treatment for routine ailments may be provided at the DYS facility or at a community medical facility.<sup>4</sup>

However, in some respects, DYS has different obligations for detained youth and committed youth, discussed below.

For youth in facilities licensed by DEEC, this chapter should be read in conjunction with the explanation of state DEEC regulatory requirements regarding medical care, discussed above in the chapter entitled “Overview of Rights During Confinement.”

## Intake and medical evaluation of detained youth

### Intake screening

At the time of arrival of a detained youth at DYS, DYS must do a preliminary clinical assessment to detect urgent psychiatric and medical needs and suicidal ideation, as well as conduct a visual inspection for signs of trauma, recent surgery, abscesses, open wounds, needle punctures, jaundice and communicable diseases.<sup>5</sup>

DYS also seeks to determine if the youth has any current health problems (acute or chronic) or is currently being treated with medication which needs to be continued while in custody.<sup>6</sup> In addition, DYS offers all detained youth a screening for sexually transmitted diseases.<sup>7</sup>

This assessment, called an intake assessment or screening, should be performed by a licensed provider.<sup>8</sup> DYS conducts this assessment within 24 hours of a youth's admission.<sup>9</sup>

### Medical evaluation

Within 30 days of the youth's arrival at DYS, DYS conducts a medical evaluation.<sup>10</sup> Typically, this evaluation begins after the youth's 17th day in detention and will be completed by day 30 if the youth is still in detention at that time.<sup>11</sup>

When the intake screening and/or medical evaluation indicate the need for more tests or for treatment and when the youth is transferred within the DYS system, this medical information and travels with the youth.<sup>12</sup>

## **Intake, medical evaluation, and full assessment of of committed youth**

### Intake screening

As DYS does for detained youth, DYS performs an intake screening of all committed youth.<sup>13</sup>

### Medical evaluation

In addition, if the committed youth has not had a complete medical evaluation (because he had not remained in detention for sufficient time for such evaluation to be completed), he will have that evaluation on the assessment unit. DYS regulation requires that this evaluation occur within 30 days of commitment to DYS.<sup>14</sup> However, DYS will complete it within 30 continuous days of confinement to DYS (so a youth who has been detained prior to commitment may have the evaluation completed prior to the regulatory deadline).<sup>15</sup>

## Full assessment

In addition, DYS must thoroughly evaluate each committed youth when he enters DYS custody in order to determine what services the youth needs.<sup>16</sup>


To meet this requirement, as soon as a bed in an assessment unit is available, the youth is moved there and DYS conducts a full assessment of the committed youth.<sup>17</sup> Assessment consists of an examination of the youth's medical, dental, psychiatric, family, behavioral, systemic and educational history.<sup>18</sup>

Information from the assessment is presented at the staffing where the treatment team develops a treatment plan.<sup>19</sup> For further discussion of what happens on the assessment unit, see the section on "Assessment" in the chapter entitled "Commitment and Assessment."

In addition, DYS staff must take certain steps upon the commitment of a youth to ensure continuity of care.<sup>20</sup> Among these requirements, medical staff must obtain past medical records, continue or reevaluate any current medical treatments without interruption, continue specialty treatment in collaboration with or, if possible, by the same community provider who last treated the youth, provide treatment information to the parent or legal guardian.<sup>21</sup>

In order for DYS to ensure such continuity, it is important for parents and legal guardians to provide DYS with as much medical information as possible. Parents or legal guardians must complete the DYS Medical Consent Form to enable DYS to obtain the medical records and speak with the current health providers and medication prescribers to continue any existing treatment.<sup>22</sup> Committed youth may not be able to access their community health care provider while in a secure setting.<sup>23</sup>

Committed youth receive a complete medical history and physical exam by a physician, nurse practitioner or physician assistant unless already completed during detention.<sup>24</sup> Immunization status is reviewed and immunizations are updated as required.<sup>25</sup> Youth also are screened for tuberculosis, sexually transmitted diseases, and for other diseases indicated by their history.<sup>26</sup> A dental examination and treatment also are scheduled within 30 after commitment.<sup>27</sup>

 **Tip for families:** If DYS does not conduct an evaluation of your child after he is committed OR if DYS does not re-evaluate your child within one year of a previous evaluation, your child may petition the court for an order of discharge.<sup>28</sup> If the order is granted, your child will

no longer be in DYS custody. However, the fact that your child was not evaluated according to the law does not guarantee that he will be discharged, but only that he has the right to request discharge.<sup>29</sup>

Unfortunately, this process of seeking an order of discharge is rarely used and is not likely to achieve that goal. However, it may get your child's situation some needed attention. If you believe that your child's circumstances warrant such a petition, contact your child's original lawyer or the Juvenile Defense Network at (617) 445-5640.

## **Annual examinations of committed youth**

In addition, DYS must conduct periodic examinations of all committed youth.<sup>30</sup> These examinations may be made as frequently as DYS considers desirable, but must occur at least annually.<sup>31</sup> DYS reports that a medical history and physical exam by Health Services staff are repeated annually as long as the client is in an out-of-home placement.<sup>32</sup>

## **Further rights of detained or committed youth to screening upon placement in program**

Upon being placed in any program, each detained or committed youth must receive a medical, psychiatric and dental screening.<sup>33</sup> This evaluation must occur within seven days of arrival.<sup>34</sup> Staff must assist youth in contacting parents or guardians after the intake screening is complete.<sup>35</sup>

DYS staff must take certain steps to ensure continuity of care during the intake screening process.<sup>36</sup> Included among these steps is the requirement that clinical staff telephone parents or legal guardians to confirm or clarify the nature of any current medical or psychiatric problem and obtain the name and telephone number of anyone currently treating the youth.<sup>37</sup> Staff must obtain permission to speak with providers and obtain treatment records.<sup>38</sup>

## **Right to consent to and refuse treatment for youth in general**

In Massachusetts, except in very limited emergency situations involving life saving treatment, a competent adult has the right to decide his or her course of treatment and, more specifically, to accept or refuse treatment.<sup>39</sup> This right includes mental health and substance abuse treatment.

Before administering any kind of treatment, including medication, a physician must obtain the adult's informed consent.<sup>40</sup> An adult is presumed competent to make treatment decisions.<sup>41</sup> With certain exceptions, a minor (a person under age 18) is considered incompetent by age.

Except in the case of incompetence by age (a person under 18), incompetence to consent to or refuse treatment only may be established by a court determination.<sup>42</sup>

Except in special circumstances, a parent or legal guardian has the capacity to provide informed consent for a minor.<sup>43</sup> Any individual with the capacity to consent to treatment also enjoys the capacity to withdraw that consent at any time.

## **Right to consent to and refuse treatment for DYS involved youth**

Informed consent is required for all medical care except for care given in an emergency.<sup>44</sup>

In a non-emergency, consent to routine medical care may be given by the youth. If a youth has no living parent and no legal guardian,<sup>45</sup> DYS will arrange for the Department of Children and Families to file a Care & Protection petition or guardianship to secure consent to routine care.<sup>46</sup> Routine medical care includes a long list of procedures, such as medical tests, preventative care, dental care, treatment of physical illnesses (including sexually transmitted diseases), and drug dependency treatment.<sup>47</sup>

In addition, a youth in DYS or a provider-run facility, even if under age 18, who is pregnant or believes herself to be pregnant may give consent to her own medical and dental care (except abortion or sterilization).<sup>48</sup> Similarly, a youth in DYS or a provider-run facility, even if under age 18, who reasonably believes he is suffering from or came in contact with any sexually transmitted disease, may consent to his own medical care related to the diagnosis or treatment of such disease.<sup>49</sup> Last, youth age 12 or older in DYS or provider-run facilities may give consent to treatment for drug dependency.<sup>50</sup> No other consent, such as parental consent, is needed in these three situations.

In a non-emergency, to administer extraordinary medical treatment to a youth under age 18, DYS must obtain parental or guardian consent or seek prior judicial approval.<sup>51</sup> For psychotropic medications to be administered to a DYS client under age 18, parents or legal guardians must complete a separate consent form.<sup>52</sup>

In some cases, however, parental or guardian authority may have been limited by state law or by an agreement between parents and the Department of Children and Families.<sup>53</sup> Determining whether care constitutes “extraordinary medical treatment” requires examining a number of factors outlined in DYS regulation.<sup>54</sup> Such care includes all medications prescribed for psychiatric or behavioral treatment.<sup>55</sup>

In an emergency, medical providers may administer medical treatment without consent from the youth, the youth’s parent or DYS.<sup>56</sup> A medical emergency is a situation where failure to take immediate action would place a child at substantial risk of imminent death, or serious emotional or physical injury.<sup>57</sup> In practice, DYS will likely be with the youth at the time emergency treatment is being sought, the medical provider will ask DYS to consent to the treatment, and DYS will provide that consent.<sup>58</sup>

## **Reporting medical information to parents or legal guardians**

DYS must inform parents or legal guardians of a youth under age 18 if there is a significant change in the youth’s medical treatment or conditions.<sup>59</sup> Such changes include: refusal to accept medical treatment; change or discontinuation of psychotropic medication; and significant deterioration of a youth’s medical condition.<sup>60</sup>

## **How DYS delivers health services in secure programs**

DYS provides health services in secure programs through contracts with hospitals or health care agencies.<sup>61</sup> Each DYS region may have its own contract.<sup>62</sup> For example, in 2005, there were four contracts in place for the provision of health services for each of the (at that time) four regions.<sup>63</sup> In 2005, the last year for which DYS has reported, these contracts provide primary care delivered on-site by health staff during daytime hours, Monday through Friday, and Saturday mornings.<sup>64</sup>


## **Access to medical specialists and promoting continuity of care**

DYS policy is to preserve continuity of medical care whenever possible.<sup>65</sup> The Health Services staff associated with the youth’s program determines the need for and chooses a qualified medical specialist.<sup>66</sup> When possible and safe to do so, DYS shall continue pre-existing relationships with medical specialists.<sup>67</sup> Moreover, when a newly

committed youth has a chronic illness, DYS policy is to preserve pre-existing medical relationships whenever possible.<sup>68</sup> DYS will determine how to transport and maintain security for a client to access specialty care.<sup>69</sup>

## Medication

Medication prescribers prescribing new medication to the youth must explain to him certain information: the purpose of the medication; the benefits and risks of taking (and not taking) the proposed medication; how to take the medicine; cautions and possible side effects; and alternative treatments.<sup>70</sup>

 **Tip for families:** It is in most cases good practice for doctors working for DYS to speak with a youth's family and/or the youth's treating physician/psychiatrist in the community before adding or changing medications. However, once parents or legal guardians provide consent to routine medical care, prescribers may add new medications (excluding medications that constitute extraordinary medical treatment such as psychotropics) or adjust existing medications without first having such conversations. Similarly, once a parent or legal guardian (or, in certain circumstances, the youth) provides consent to extraordinary treatment or a court-ordered treatment plan is obtained, a doctor may act (within the limits of the consent or court order), without further consultation with family or the youth's community clinician.

The topic of medication is discussed in much greater detail in the following chapter, "Mental Health and Substance Abuse Services During Confinement."

## Isolation for medical reason

If a youth becomes ill and is contagious (that is, he can give the sickness to others), DYS may keep him in isolation, apart from the other children.<sup>71</sup> However, the staff must observe the ill youth during this time to make sure that there are no psychological effects of this isolation.<sup>72</sup> Such observation is in accordance with the DYS Suicide Assessment Policies.<sup>73</sup>

If the parent or legal guardian of a youth under age 18 does not consent to treatment for a disease that is considered dangerous to the public health, a court order will be sought to force treatment.<sup>74</sup> Similarly, if a youth age 18 or older does not consent to treatment for such a disease, he may be brought to court in order to force treatment.<sup>75</sup>

## Health care coverage from health insurance programs

Health care coverage is a complicated topic, encompassing both public and private health insurance programs. This section focuses most closely on one type of publicly-funded coverage, Medicaid.

### Medicaid

DYS detained or committed youth in secure settings are enrolled in and covered by the Massachusetts Medicaid program called “MassHealth.” Once returned to a residential or community placement, an eligibility determination for public health coverage is made, considering the family’s insurance coverage. More details of these general principles follow.

Medicaid is a government program that pays for health care for uninsured or underinsured children from low income families and for children with disabilities. In Massachusetts, it is called “MassHealth.” The state agency responsible for administering the Medicaid program is the Executive Office of Health and Human Services (EOHHS). The division within EOHHS that administers Medicaid is called the Office of Medicaid.

Access to Medicaid coverage is complicated for youth involved with DYS because there is a federal restriction on providing *federal* Medicaid dollars to an individual who is eligible for Medicaid but who is an “inmate of a public institution.”<sup>76</sup> This restriction applies to DYS-involved youth who are eligible for Medicaid, but who are confined to public facilities.

However, it is important to emphasize that a youth who is an inmate of a public institution does not lose his Medicaid *eligibility* during that confinement but only his federal Medicaid *coverage*.<sup>77</sup> Thus, once the youth leaves confinement in a public institution, he again can receive federal dollars from his Medicaid coverage.<sup>78</sup> Therefore, federal Medicaid dollars are immediately available to Medicaid-eligible youth when they are no longer confined.<sup>79</sup>

In addition, certain youth who are held by the Juvenile Court and sent to a DYS-run detention facility may not be considered inmates of public institutions at all.<sup>80</sup> For example, youth taken to a hospital after arrest but before entering detention, youth in detention awaiting foster care or group home placement, and youth transferred to a hospital for treatment may not qualify as inmates and may, therefore, have a right to Medicaid coverage.<sup>81</sup>

### *DYS-detained youth*


DYS detained youth in secure settings are enrolled in and covered by MassHealth.<sup>82</sup>

### *DYS-committed youth*

DYS committed youth, in secure settings also are enrolled in and covered by MassHealth, although the details of coverage are different than they are for the detained youth.<sup>83</sup>

The type of MassHealth that these youth are enrolled in is called “MassHealth Standard” – this refers to the level of coverage that is provided. As a result, for these youth, medical and dental care (including psychiatric care) is paid for by MassHealth.<sup>84</sup>

Before explaining further what happens when DYS enrolls a youth in MassHealth, it is useful to describe what happens when a youth in the community first enrolls in MassHealth. In that case, the youth’s parent or legal guardian chooses one health plan from the five offered by the state to Medicaid-eligible individuals. Four of the plans are managed care organizations (MCOs) covering certain geographic areas. These MCOs are Fallon, Neighborhood Health Plan, Boston Medical Center HealthNet and Network Health, The fifth plan, called the Primary Care Clinician (“PCC”) plan, is state-managed and available state-wide.

 **Tip for families:** MCOs often are called health maintenance organizations (HMOs).

Two of the four MCO plans for the MassHealth participants (Fallon and Neighborhood Health) “carve out” their mental health and substance abuse coverage from other types of health care coverage and arrange for such coverage to be managed by a separate company. Similarly, with the PCC plan for MassHealth participants, the state carves out mental health and substance abuse coverage by contracting with a private company, the Massachusetts Behavioral Health Partnership (the “Partnership” or “MBHP”), to administer coverage of these services. (The Department of Mental Health has a role in overseeing the Partnership’s management of MassHealth services.) BMC HealthNet and Network Health manage their own mental health and substance abuse benefits.


Returning to DYS detained and committed youth in secure settings, regardless of the type of insurance coverage the youth had in the community, all these youth are enrolled in the MassHealth program and assigned to the Partnership for the provision of behavioral and mental health services.

If a youth received MassHealth prior to being enrolled by DYS, he may already have been served by the Partnership. Alternatively, the youth may have been served by one of the four MCOs which provides health care services to Medicaid recipients. In the latter case, the youth will be switched from that MCO to the Partnership while in DYS.

The same is true for youth who have an open case with the Department of Children and Families (DCF) – even if they are in the physical custody of their parents. DCF will arrange for them to be enrolled in MassHealth and then in the Partnership.

### Private health insurance

When a youth has private health insurance through his family, this insurance, to the extent that coverage is available, must be used prior to drawing on Medicaid dollars.<sup>85</sup> The Massachusetts mental health parity law, requiring some private insurers to pay for certain mental health services, does not require those private insurers to pay for mental health services for youth in DYS custodial facilities when those services are covered by other health insurance plans (i.e. MassHealth).<sup>86</sup>

 **Tip for families:** Despite the potential limits of coverage that may exist, it is probably a good idea to maintain private health insurance for your child (even if your child is age 18 or older) if it is affordable and provides a rich array of benefits with low co-pays and deductibles.

## **Other state agency health care services**

DYS-involved youth may be able to get health care services from state agencies other than MassHealth.

Substance abuse services are funded by both MassHealth and by the Bureau of Substance Abuse Services (BSAS) within the Department of Public Health (DPH).

DYS-involved youth who are also DMH clients may receive services funded through DMH, in addition to receiving MassHealth services.

## Endnotes

- 1 *Youngberg v. Romeo*, 457 U.S. 307 (1982). Conditions of confinement for youth in custody -- who have not been convicted of a crime -- are governed by the Due Process Clause of the Fourteenth Amendment, and not the less protective Eighth Amendment. *Santana v. Collazo*, 714 F.2d 1172, 1179 (1st Cir. 1983), cert. denied, 466 U.S. 974 (1984).
- 2 Mass. Gen. L. ch. 18A, § 2. DYS regulation 109 CMR 11.23(1)(a) requires DYS to provide detained youth with “minimal medical services,” but the U.S. Constitution likely requires a higher level of services than that standard.
- 3 Mass. Gen. L. ch. 18A, § 2.
- 4 109 CMR 11.23(3).
- 5 109 CMR 11.23(1).
- 6 DYS, 2005 Annual Report (Mar. 2007), [http://www.mass.gov/Eeohhs2/docs/dys/annual\\_report\\_2005.pdf](http://www.mass.gov/Eeohhs2/docs/dys/annual_report_2005.pdf), at 23.
- 7 DYS, 2005 Annual Report (Mar. 2007), [http://www.mass.gov/Eeohhs2/docs/dys/annual\\_report\\_2005.pdf](http://www.mass.gov/Eeohhs2/docs/dys/annual_report_2005.pdf), at 23.
- 8 Correspondence from Jane E. Tewksbury, Department of Youth Services to MHLAC (Dec. 27, 2007).
- 9 DYS, 2005 Annual Report (Mar. 2007), [http://www.mass.gov/Eeohhs2/docs/dys/annual\\_report\\_2005.pdf](http://www.mass.gov/Eeohhs2/docs/dys/annual_report_2005.pdf), at 23.
- 10 109 CMR 11.22(1)(for committed youth).
- 11 Communication of Edward Dolan, Department of Youth Services to MHLAC (Jan. 17, 2008).
- 12 109 CMR 11.23(4).
- 13 Correspondence from Jane E. Tewksbury, Department of Youth Services to MHLAC (Dec. 27, 2007).
- 14 109 CMR 11.22(1).
- 15 Communication of Edward Dolan, Department of Youth Services to MHLAC (Jan. 17, 2008).
- 16 Mass. Gen. L. ch. 120, § 5(a)-(c) (the statutory provision terms this evaluation an “examination”).
- 17 Correspondence from Jane E. Tewksbury, Department of Youth Services to MHLAC (Dec. 27, 2007).
- 18 Correspondence from Jane E. Tewksbury, Department of Youth Services to MHLAC (Dec. 27, 2007).
- 19 See 109 CMR 11.22(1).
- 20 DYS Policy # 2.5.7, Continuity of Care (Mar. 14, 2000), Procedures, C.
- 21 DYS Policy # 2.5.7, Continuity of Care (Mar. 14, 2000), Procedures, C.1, 2, 3, 4.
- 22 Correspondence from Jane E. Tewksbury, Department of Youth Services to MHLAC (Dec. 27, 2007).
- 23 Correspondence from Jane E. Tewksbury, Department of Youth Services to MHLAC (Dec. 27, 2007).
- 24 DYS, 2005 Annual Report (Mar. 2007), [http://www.mass.gov/Eeohhs2/docs/dys/annual\\_report\\_2005.pdf](http://www.mass.gov/Eeohhs2/docs/dys/annual_report_2005.pdf), at 23.
- 25 DYS, 2005 Annual Report (Mar. 2007), [http://www.mass.gov/Eeohhs2/docs/dys/annual\\_report\\_2005.pdf](http://www.mass.gov/Eeohhs2/docs/dys/annual_report_2005.pdf), at 23. The Department provides all immunizations recommended for adolescents by the Massachusetts Department of Public Health. DYS, 2005 Annual Report (Mar. 2007), [http://www.mass.gov/Eeohhs2/docs/dys/annual\\_report\\_2005.pdf](http://www.mass.gov/Eeohhs2/docs/dys/annual_report_2005.pdf), at 23.
- 26 DYS, 2005 Annual Report (Mar. 2007), [http://www.mass.gov/Eeohhs2/docs/dys/annual\\_report\\_2005.pdf](http://www.mass.gov/Eeohhs2/docs/dys/annual_report_2005.pdf), at 23.

- 27 DYS, 2005 Annual Report (Mar. 2007), [http://www.mass.gov/Eeohhs2/docs/dys/annual\\_report\\_2005.pdf](http://www.mass.gov/Eeohhs2/docs/dys/annual_report_2005.pdf), at 23; Correspondence from Jane E. Tewksbury, Department of Youth Services to MHLAC (Dec. 27, 2007).
- 28 Mass. Gen. L. ch. 120, § 5(d).
- 29 Mass. Gen. L. ch. 120, § 5(d).
- 30 Mass. Gen. L. ch. 120, § 5(b).
- 31 Mass. Gen. L. ch. 120, § 5(b).
- 32 DYS, 2005 Annual Report (Mar. 2007), [http://www.mass.gov/Eeohhs2/docs/dys/annual\\_report\\_2005.pdf](http://www.mass.gov/Eeohhs2/docs/dys/annual_report_2005.pdf), at 23; Correspondence from Jane E. Tewksbury, Department of Youth Services to MHLAC (Dec. 27, 2007).
- 33 DYS Policy # 2.1.1(c), Intake Procedures (Jan. 1, 1999).
- 34 DYS Policy # 2.1.1(c), Intake Procedures (Jan. 1, 1999).
- 35 DYS Policy # 2.1.1(c), Intake Procedures (Jan. 1, 1999), Procedures, B.7.
- 36 DYS Policy # 2.5.7, Continuity of Care (Mar. 14, 2000), Procedures, B.
- 37 DYS Policy # 2.5.7, Continuity of Care (Mar. 14, 2000), Procedures, B.3.
- 38 DYS Policy # 2.5.7, Continuity of Care (Mar. 14, 2000), Procedures, B. 4.
- 39 See, e.g., *Shine v. Vega*, 429 Mass. 456, 463 (1999); *Guardianship of Doe*, 411 Mass. 512, 517 (1992); *Harnish v. Children's Hosp. Med. Ctr.*, 387 Mass. 152, 154-155 (1982).
- 40 Mass. Gen. L. ch. 111, § 70E.
- 41 *Rogers v. Comm'r of the Dep't of Mental Health*, 390 Mass. 489, 497 (1983).
- 42 *Rogers v. Comm'r of the Dep't of Mental Health*, 390 Mass. 489, 497 (1983).
- 43 There are two special circumstances. First, an emancipated minor may consent to or refuse medication as if he were an adult. Mass. Gen. L. ch. 112, §12F. Second, a "mature minor" is one who may consent to or refuse his own medical treatment when the best interests of the minor are served by not notifying the parents or guardians of the medical treatment, and the minor is determined capable of giving informed consent to the treatment. *In re Rena*, 46 Mass. App.Ct. 335, 337 (1999); *Baird v. Att'y Gen.*, 371 Mass. 741, 754 (1977).
- 44 DYS Policy # 2.5.4, Authorization for Medical Care (Mar. 14, 2000), Policy section.
- 45 DYS Policy # 2.5.4, Authorization for Medical Care (Mar. 14, 2000), Policy section; see also 109 CMR 11.05(2).
- 46 Correspondence from Jane E. Tewksbury, Department of Youth Services to MHLAC (Dec. 27, 2007); see also Mass. Gen. L. ch. 120, § 23; DYS Policy # 2.5.4, Authorization for Medical Care (Mar. 14, 2000), Policy section.
- 47 109 CMR 11.05(1); see also DYS Policy # 2.5.4, Authorization for Medical Care (Mar. 14, 2000), Procedures, A.4.
- 48 109 CMR 11.06.
- 49 109 CMR 11.10(2).
- 50 109 CMR 11.08.
- 51 109 CMR 11.17(2), (3); see also DYS Policy # 2.5.4, Authorization for Medical Care (Mar. 14, 2000), Policy section (in a non-emergency, only a parent or guardian (and the youth if age 18 or older) may consent to elective or invasive medical care).
- 52 Correspondence from Jane E. Tewksbury, Department of Youth Services to MHLAC (Dec. 27, 2007).
- 53 109 CMR 11.17(3).
- 54 109 CMR 11.17(1).
- 55 DYS Policy # 2.5.4, Authorization for Medical Care (Mar. 14, 2000), Procedures, A.3.
- 56 109 CMR 11.04(3); DYS Policy # 2.5.4, Authorization for Medical Care (Mar. 14, 2000), Policy section.

- 57 109 CMR 11.04(1); *see also* DYS Policy # 2.5.4, Authorization for Medical Care (Mar. 14, 2000), Procedures, A.2 (emergency treatment is medical, dental or psychiatric treatment that is recommended immediately and that, if postponed, may result in permanent injury, loss of function, or death).
- 58 Correspondence from Jane E. Tewksbury, Department of Youth Services to MHLAC (Dec. 27, 2007).
- 59 DYS Policy # 2.5.4, Authorization for Medical Care (Mar. 14, 2000), Procedures, B.9.
- 60 DYS Policy # 2.5.4, Authorization for Medical Care (Mar. 14, 2000), Procedures, B.9.
- 61 DYS, 2005 Annual Report (Mar. 2007), [http://www.mass.gov/Eeohhs2/docs/dys/annual\\_report\\_2005.pdf](http://www.mass.gov/Eeohhs2/docs/dys/annual_report_2005.pdf), at 23.
- 62 DYS, 2005 Annual Report (Mar. 2007), [http://www.mass.gov/Eeohhs2/docs/dys/annual\\_report\\_2005.pdf](http://www.mass.gov/Eeohhs2/docs/dys/annual_report_2005.pdf), at 23.
- 63 DYS, 2005 Annual Report (Mar. 2007), [http://www.mass.gov/Eeohhs2/docs/dys/annual\\_report\\_2005.pdf](http://www.mass.gov/Eeohhs2/docs/dys/annual_report_2005.pdf), at 23.
- 64 DYS, 2005 Annual Report (Mar. 2007), [http://www.mass.gov/Eeohhs2/docs/dys/annual\\_report\\_2005.pdf](http://www.mass.gov/Eeohhs2/docs/dys/annual_report_2005.pdf), at 23.
- 65 DYS Policy # 2.5.6, Access to Diagnostic Services, Consultants, and Continuity of Care (Aug. 25, 2000), Policy section.
- 66 DYS Policy # 2.5.6, Access to Diagnostic Services, Consultants, and Continuity of Care (Aug. 25, 2000), Policy section.
- 67 DYS Policy # 2.5.6, Access to Diagnostic Services, Consultants, and Continuity of Care (Aug. 25, 2000), Policy section.
- 68 DYS Policy # 2.5.7, Continuity of Care (Mar. 14, 2000), Policy section.
- 69 DYS Policy # 2.5.6, Access to Diagnostic Services, Consultants, and Continuity of Care (Aug. 25, 2000), Policy section; Correspondence from Jane E. Tewksbury, Department of Youth Services to MHLAC (Dec. 27, 2007).
- 70 DYS Policy # 2.5.15(b), Medication Administration (Jan. 1, 1999), E.2.
- 71 109 CMR 11.27.
- 72 109 CMR 11.27.
- 73 Correspondence from Jane E. Tewksbury, Department of Youth Services to MHLAC (Dec. 27, 2007).
- 74 *See* 109 CMR 11.09(2).
- 75 *See* 109 CMR 11.09(2).
- 76 42 U.S.C. § 1396d(a)(28)(A); 42 CFR § 435.1009(a)(1).
- 77 The federal restriction will result in loss of federal Medicaid dollars for most youth confined in a public institution by DYS. This restriction will not personally impact youth in DYS custody, who are all enrolled in and covered by MassHealth.
- 78 Youth Law Center, Medicaid for Youth in the Juvenile Justice System (Aug. 2006) at 3 (on file with MHLAC).
- 79 Youth Law Center, Medicaid for Youth in the Juvenile Justice System (Aug. 2006) at 2 (on file with MHLAC).
- 80 Youth Law Center, Medicaid for Youth in the Juvenile Justice System (Aug. 2006) at 3 (on file with MHLAC).
- 81 Youth Law Center, Medicaid for Youth in the Juvenile Justice System (Aug. 2006) at 3 (on file with MHLAC).
- 82 A detained youth held in a public institution (and most detained youth are so held) temporarily loses access to federal dollars from any pre-existing Medicaid coverage that he may have had in the community (or from any newly obtained Medicaid coverage). However, this restriction will not personally affect youth in DYS custody, who are all enrolled in and covered by MassHealth.

- 83 While the federal restriction still applies to committed youth confined to public institutions, DYS enrolls all committed youth (regardless of whether they are confined to public institutions or not) in the state's Medicaid program (MassHealth). (Remember, the restriction discussed above only prohibits access of public inmates to federal Medicaid dollars, not state Medicaid dollars.)
- 84 DYS correspondence to MHLAC (Jan. 14, 2008).
- 85 109 CMR 11.22(9).
- 86 Codified in part at Mass. Gen. L. ch. 175, § 47B(i) (amended most recently by Chapter 256 of the Acts of 2008).