DMH POLICY

Title: Community Risk Mitigation	**Policy #: 13-01** **Date Issued: April 29, 2013** **Effective Date: July 15, 2013**
Approval by Commissioner: **Signature: Marcia Fowler**	**Date:**

I. PURPOSE

This policy establishes procedures governing community risk mitigation activities at the Department of Mental Health (DMH), including processes and tools to help identify and monitor public and personal safety related to Individuals in the community. These procedures are designed to standardize and organize activities that currently occur throughout the DMH service system. DMH will work collaboratively with Individuals, family members as appropriate, Legally Authorized Representatives (LAR), and DMH contracted service providers, to provide systematic evaluation of an Individual's risk. It is DMH's goal that Individuals who are found at risk of engaging in violent/aggressive behavior or placing their personal safety at risk will receive services and interventions to help prevent and mitigate such risk. DMH recognizes that sharing of relevant information regarding identified risks is a critical part of risk mitigation. Accordingly this policy also sets forth processes that facilitate the sharing of information between contracted providers and DMH for Individuals who are identified as being at risk of physical harm to themselves or others.

In establishing this policy DMH acknowledges that most people with serious mental illness are not violent, and that risk and safety issues only arise in particular contexts for some persons served by DMH. Acknowledging risk that is inherent in living is a fundamental dimension of supporting persons in recovery. However, when risk and safety issues are identified, DMH and its contracted service providers are expected to incorporate an evaluation and formulation of those safety concerns into assessment and planning activities as appropriate. The primary goal of the DMH service system is to engage Individuals and their families, where appropriate, to provide services and supports that promote recovery and resiliency, and assist Individuals to live productive lives in the community. This requires culturally competent service planning activities that are person-centered, strength-based, and trauma-informed. DMH recognizes that although identification, prevention, and mitigation of physical harm and safety risks is one important component of this goal and is the focus of this policy, there are many other aspects of the full array of other services

that are inherent to DMH's mission and service delivery model to help support Individuals in their efforts to lead meaningful and productive lives in the community.

II. SCOPE

This policy applies to all DMH Areas and Site Office personnel with responsibilities for Individual service and care planning, service delivery, monitoring, service coordination, clinical treatment, and/or consultation including staff responsible for the supervision of such personnel. Although this policy addresses risk mitigation for Individuals who have been approved for DMH community services pursuant to 104 CMR 29.04, the Area activities including the Clinical Review process described herein may also be used in appropriate situations to guide decision-making for other persons who receive a DMH operated service(s) (e.g. outpatient clinic services, respite, crisis intervention and emergency screening). Although this policy applies to persons approved for child/adolescent services, it does not apply to Flex provider referrals or services authorized through Community Services Agencies (CSA) such as After School Services and other non-residential services. For Individuals who receive services from more than one state agency, DMH will collaborate and consult with such agencies in carrying out this policy.

III. DEFINITIONS

Area Office: DMH Administrative offices providing a number of oversight functions over the provision of DMH community services, including those of the DMH Site Offices.

Business Associate: A person or entity, other than a DMH workforce member, who, on behalf of DMH, performs or assists in the performance of a function or activity involving the use or disclosure of protected health information (PHI)

Clinical Review: The process whereby clinicians provide a clinical consultation to address an Individual's risk.

Community Risk Identification Tool (CRIT): A standardized form[1] approved by the DMH Deputy Commissioner for Clinical and Professional Services that provides a structure for systematic functional and safety screening in order to inform service and safety planning and to help identify whether there are specific risk domains that should be considered for a particular Individual to facilitate risk mitigation and safety planning. The CRIT screening includes a review of the Individual's risk behavior, including, but not limited to, history of Criminal Involvement.

Criminal Involvement: An individual's criminal or juvenile justice history within the adult or juvenile court system that involves charges of serious violence, stalking, firesetting or other crimes that pose a serious risk of harm.

Facility: An adult or adolescent inpatient hospital, unit or bed contracted for or operated by DMH, including DMH-operated units in a Department of Public Health hospital.

[1] Although the forms delineated in this policy are identified herein by one name, the forms may have distinct versions for youth and adults.

Independent Forensic Risk Assessment (IFRA): An evaluation completed pursuant to DMH Policy #10-01R.

Individual: A person whose application for DMH services has been approved and who is enrolled in a DMH service pursuant to DMH regulation 104 CMR 29.04.

Inpatient Enhanced Clinical Review (ECR): A review process, conducted pursuant to DMH Policy #12-02, related to risk mitigation and community access determinations for Patients for whom particular risk considerations have been identified. The Enhanced Clinical Review includes safety planning that is developed as part of routine inpatient treatment planning.

Legally Authorized Representative: A guardian or other fiduciary granted applicable authority by a court of competent jurisdiction, or, in the case of a minor, the parent(s) or other individual or entity with legal custody of the minor.

Mental Illness/Problematic Sexual Behavior (MI/PSB): Inappropriate or illegal sexual behavior by an individual with a co-occurring major mental illness or served by DMH that requires assessment and treatment in accordance with agency practices.

Patient: An adult or child/adolescent who is admitted to a Facility regardless of whether he or she has been authorized for DMH community services.

Peer: A person with lived experience, who may or may not be certified as a peer specialist.

Risk Review Summary: A brief summation of key safety and risk findings from assessments and screenings of an Individual conducted and/or obtained during the DMH service authorization process.

Risk and Safety Management Plans: Any written plan to identify, prevent and mitigate an Individual's risk of physical harm to self or others through early recognition, support and implementation of appropriate action steps. Plans shall identify areas of risk, triggers, and interventions to mitigate those risks.

Sex Offender Registry Board (SORB): An administrative agency of the Commonwealth established by M.G.L. c. 6 sec. 178K, that is responsible for the classification and registration of sex offenders and for disseminating sex offender registry information to the public in accordance with law.

Site Office: Local DMH offices that oversee DMH-operated or contracted community services, including DMH case management services within each DMH Area.

IV. POLICY

A. Overview

Each DMH Area shall, through committees and functions outlined in this policy, perform risk mitigation activities. Such risk activities shall include, but not be limited to, the following:

- Prospective activities
- Retrospective activities
- Systemic risk mitigation activities and initiatives
- Referrals to appropriate services and supports

B. Service Authorization Risk Mitigation Related Activities

1. If DMH determines that an applicant meets its service authorization criteria, the applicable DMH Site Office or Area Child/Adolescent Director/Designee must complete the Community Risk Identification Tool (CRIT) screening with the Individual to the fullest extent possible. When a person is hospitalized at a Facility and applying for DMH community services, the person's Risk Identification Tool (RIT) conducted in the Facility, pursuant to DMH Policy #12-02, along with other accompanying documents, may serve as the Community Risk Identification Tool.

2. The results of the CRIT or RIT screening, together with relevant additional history, shall be compiled into a Risk Review Summary (RRS). If as a result of the CRIT screening, or at any other time during the service authorization process it is determined the Individual has a relevant history of behaviors that pose serious risk of harm to self or others, which may include a history of criminal involvement on charges of serious violence, this determination shall be incorporated into the RRS, which shall be reviewed by the Site Office Director or the applicable Area Child/Adolescent Director who may in his or her discretion seek further review by the Area Medical Director or Area Child Psychiatrist, or designees. The purpose of this review is to provide input regarding services that may be relevant to an Individual's risk issues, to identify barriers to accessing supports that a particular Individual may face because of his or her history, and/or to develop risk mitigation strategies.

3. The CRIT and RRS shall be placed in the Individual's record.

4. It is expected that the CRIT and RRS will be completed as soon as practical but no later than within the maximum timeframe for the initial authorization for services in accordance with DMH regulation 104 CMR 29.04.

C. Transitions in Service Delivery

1. At any point of transition in service delivery from DMH to a provider (e.g. upon first entry into DMH, first referral to provider, transition from DMH Facility to a provider, etc.), the following information shall be shared by DMH with the service provider of record:

- Service Authorization Application
- Any relevant medical documents (e.g., psychiatric assessments, hospital admission/discharge reports, psychosocial summaries)
- Community Risk Identification Tool (or hospital-based Risk Identification Tool)
- Risk Review Summary
- Independent Forensic Risk Assessment Report(s), if applicable and available

- MI/PSB Report(s), if applicable and available
- DMH Inpatient Enhanced Clinical Review documentation, if applicable and available.

2. When there is a change in an Individual's service providers, the current service provider and receiving service provider must work with DMH to determine appropriate information and documents that will be shared with the Individual's new provider.

3. An Individual's protected health care information shall only be disclosed pursuant to this Policy to facilitate transition in service delivery to a Business Associate or upon the written consent of the Individual or Legally Authorized Representative.

D. Area Committees

1. Critical Incident and Complaint Review Committee(s)

a. Each DMH Area shall establish one or more Critical Incident and Complaint Review Committee(s) to review, at a minimum on a weekly basis, all critical incidents reported pursuant to Commissioner's Directive #23 and complaints regarding an incident or condition that is believed to be dangerous, illegal, or inhumane. The review shall include a discussion of the incident, an action plan, if indicated, and in accordance with 104 CMR 32.00, a determination whether a complaint needs to be filed on behalf of the Individual in cases where the Individual has not filed a complaint.

b. The Area Medical Director and the Area Director or their respective designees shall co-chair the committee and shall include the following individuals or their respective designees:

- Director of Community Services;
- Child/Adolescent Director;
- Area Child/Adolescent Psychiatrist;
- Area Forensic Director;
- A representative from the Area who is responsible for quality management and/or performance improvement activities;
- Human Rights Coordinator;
- Peer;
- Others deemed appropriate by the chairs.

c. The Area representative responsible for quality management and/or performance improvement activities shall identify for the committee any Critical Incident Reports that involve Individuals who have been identified as meeting the criteria for Area Risk Committee review (see Subsection D. 2. below).

d. The committee must document the review of each critical incident including any follow-up information obtained and/or any action plans.

e. The Critical Incident and Complaint Review Committee may request a Clinical Review in accordance with Subsection E.

f. Pursuant to 104 CMR 32.00, the Critical Incident and Complaint Review Committee shall review all complaints and determine the need for:

- 10-day Fact-Finding
- 104 CMR 32.05 Investigation
- Referral to Licensing Department for Investigation

2. **Area Risk Review Committee(s)**
   - **a.** Each DMH Area shall establish one or more Risk Review Committee structures to (i) maintain a system to assure that Individuals who are identified as meeting the criteria for Risk Committee review are brought to the Committee's attention as needed and on a periodic basis; and (ii) regularly review those Individuals with providers, case management and others (e.g., other agency representatives involved in supporting the Individual), sharing Individual information related to risk, and identifying issues that may require further clinical review or consultation.
   - **b.** Criteria for Identifying Individuals for Risk Committee Review. Individuals who demonstrate the following behaviors should be included in the Risk Review Committee's reviews:
     - **i.** Individuals with behaviors that raise concern about public safety include Individuals:
       - with a history of Criminal Involvement or behavior related to serious violence, stalking, fire setting, or pose a risk of harm to others;
       - whose histories resulted in the need for an IFRA consultation during a DMH inpatient hospitalization;
       - who are known to have been leveled by the Massachusetts Sex Offender Registry Board (SORB);
       - with problematic sexual behavior that has created public safety concerns**;** or
       - who exhibit other behaviors that, in the discretion of the Area Medical Director or Area Director, or their designees, warrant review by the Risk Review Committee(s).
     - **ii.** Individuals with serious suicide or self injurious histories.
   - **c.** Risk Review Committee(s) shall meet regularly and be chaired by the Area Medical Director or designee and the Area Director or designee, and shall include the following individuals or their respective designees:
     - Director of Community Services;
     - Area Forensic Director;
     - Area Child/Adolescent Director;
     - Area Child/Adolescent Psychiatrist;
     - Area Site Directors;
     - Director of Program Management;
     - Director of Quality or Performance Improvement;
     - Director of MIPSB Program;
     - Human Rights Coordinator;
     - Peer;
     - Clinical consultants and DMH service providers invited to participate in meetings as indicated; and
     - Others deemed appropriate by the chairs.
   - **d.** For each Individual who has been identified as meeting the criteria for Risk Committee Review the Risk Review Committee shall conduct a review at least quarterly. However, the Risk Review Committee may determine based on an Individual's current clinical status that an Individual does not require a quarterly review and that such Individual will be reviewed at an interval as determined by the committee. Reviews shall include updates on the Individual's present clinical status and may include changes in risk status since last review by the committee, updates on the status of

previous recommendations, and new recommendations the committee may make. Individuals may only be determined to meet, not meet, or no longer meet the criteria for Risk Committee review through the Risk Review Committee discussion; provided however, that the final decision lies with the Area Medical Director or designee and Area Director or designee.

E. Clinical Reviews

1. **Purpose.** The purpose of a Clinical Review is to review an Individual's current status and make recommendations for service needs and/or actions as a result of developments such as a critical incident, an adverse event, or a complex treatment or discharge plan. Clinical Reviews may also be requested as part of development of an Individual Service Plan or an Individual Action Plan to provide additional clinical guidance and to help resolve a disagreement regarding an Individual's services and/or supports.

2. **Structure.** Clinical Reviews are conducted by or with the Area Medical Director or Child Adolescent Psychiatrist or designees, along with relevant Area/Site Office staff and providers when indicated. Individuals and Legally Authorized Representatives, if any, shall be invited to participate in discussions regarding their services as appropriate. If an Individual participates in a Clinical Review, peer/family and human rights supports must be offered to the Individual, if desired by the Individual or the Individual's Legally Authorized Representative. The psychiatrist conducting the Clinical Review shall determine who from the Area/Site Office will attend the Clinical Review. Area Offices shall have processes for tracking Clinical Reviews.

3. **Criteria for Clinical Reviews**
   - **a.** Clinical Reviews are mandatory for:
     i. any Patient who has received an IFRA during the course of his or her current hospitalization, and is being discharged to the community from a DMH Continuing Care Facility;
     ii. any Patient who has been classified by the SORB as a level 2 or 3 sex offender (or a level 0 with a recommendation for level 2 or 3 pending final classification hearing) and is being discharged to the community from a DMH Continuing Care Facility;
     iii. any Individual identified with significant concerns regarding public safety prior to discharge from DMH continuing care services or Facilities, excluding patients who are being discharged back to court or a correctional setting from a forensic status pursuant to M.G.L. c. 123, ss. 15(a), 15(b), 15(f), 16(a), or 18(a). Some Individuals may require additional reviews and protocols in accordance with separate policies;
     iv. any suicide attempt for whom the Area Medical Director, Area Child Adolescent Psychiatrist, or designees determines that a clinical review could be helpful in further supporting the Individual;
     v. any critical incidents leading to an Individual being charged with an offense that would trigger an IFRA in the inpatient setting[2] (see DMH Policy #10-01R); and

[2] An Individual with the following charges will require a Clinical Review: murder, manslaughter, kidnapping, rape, mayhem, assault and battery w/intent to murder, assault and battery w/attempt to rape, assault with intent to murder, assault w/intent to rape, indecent assault and battery on a child (under 14), arson and stalking.

vi. any unexpected death of an Individual authorized to receive DMH services or a person hospitalized in a DMH operated or contracted inpatient unit.

b. Clinical Reviews may also be conducted when:

i. requested by an Area Office, Site Director and/or by a CBFS, PACT and/or other service provider through a Site Director or Area Child/Adolescent Director pursuant to Subsection 4.c below.

ii. after review by the Critical Incident and Complaint Review Committee, the Area Medical Director or designee determines a critical incident warrants further review.

4. Process to Request Clinical Reviews

a. Whenever an Individual or Patient meets the Clinical Review criteria set forth in this policy, the Site Office, Facility, or Area must contact the applicable Area Office to schedule the review.

b. The applicable Site Office, Area Child/Adolescent Director or Facility shall complete the Clinical Review Form, submit relevant supporting documents (e.g., Individualized Action Plan and supporting documentation, Risk and Safety Management Plan) and provide any additional information that the Area Medical Director or designee may request at least two days prior to the scheduled Clinical Review.

c. A DMH service provider may make a request to DMH for a Clinical Review of an Individual, enrolled or referred, to the DMH Site Office or Area Child/Adolescent Director that has programmatic oversight of the service for which the Individual is enrolled or referred. If a determination is made that a Clinical Review is warranted, the Site Office or Area Child/Adolescent Director must contact the Area Office to initiate the request. The service provider is responsible for completion of the Clinical Review Form and the submission of all relevant supporting documents.

5. Documentation

a. The discussion and subsequent recommendations resulting from the Clinical Review shall be documented on the Clinical Review Form.

b. Completed forms shall be sent to the Area Medical Director or Area Child Adolescent Psychiatrist, or designees (regardless of their participation in the Review) for review, approval signature, or request for additional follow-up actions or documentation.

c. Signed Clinical Review Forms shall be submitted to the Area representative responsible for quality management and/or performance improvement who is responsible for follow-up on any actions. The Area representative responsible for quality management and/or performance improvement will request any follow-up actions or documentation and obtain final sign-off from the Area Medical Director or Area Child/Adolescent Psychiatrist or designees if applicable.

d. All completed Clinical Review Forms shall be maintained by the Area department responsible for quality management and/or performance improvement and a copy shall be added to the Individual's record where it shall be maintained as a clinical consultation.

e. The Area department responsible for quality management and/or performance improvement shall maintain a log of all requests for Clinical Review, track timelines for completion and send reminders for overdue completed Clinical Review Forms.

f. The Area department responsible for quality management and/or performance improvement must establish protocols to ensure that recommendations and necessary action steps documented on the Clinical Review Form are followed through and documented.

F. Risk and Safety Management Plans

1. Site Offices or Area Child/Adolescent Directors/Designee shall ensure that Risk and Safety Management Plans are in place for Individuals who are identified as meeting the criteria for Risk Committee Review or who are otherwise identified as needing a Risk and Safety Plan. It is DMH's expectation that the specific risk issue will be documented in the provider's assessment (e.g., the ACA), and whenever possible in the Individualized Action Plan (IAP). For Individuals receiving services from a DMH contracted provider, the Site Office will ensure that Risk and Safety Management plans are developed by the Individual's service provider when indicated. Risk and Safety Management Plans shall be tailored to the Individual's needs and developed in partnership with the Individual and Legally Authorized Representative, if any. Depending on the Individual's unique needs, family members, payors and others, including Emergency Services Programs, may be involved in this collaborative planning.

These plans serve to:

- provide a vehicle through which knowledge gained from previous treatment successes/challenges can be documented and used to guide future interventions; and
- increase opportunities for prevention (e.g. crises, hospitalization, etc.) through early recognition and intervention.

2. The initial Risk and Safety Management Plan developed for Individuals who are identified as meeting the criteria for Risk Committee review shall be reviewed and approved by the Site Director or Area Child/Adolescent Director or designees prior to finalization.

3. Annual Reviews. The Site Director or Area Child/Adolescent Director or designees shall review Risk and Safety Management Plans, as needed. However, the Risk and Safety Management Plans for Individuals who have been identified as meeting the criteria for Risk Committee review shall be reviewed at least annually, and revised as needed. When revisions to the Plan are necessary as a result of the review the Site Director or Area Child/Adolescent Director or designees shall ensure that the Individual's service provider responsible for the development of the Plan makes the needed revisions. Revised Risk and Safety Management Plans shall be re-distributed to all parties involved in the plan.

G. Critical Incidents Data & Review

1. In accordance with Directive #23, each Area's department for quality management and/or performance improvement shall maintain a record of all Critical Incident Reports and Death Reports, forward copies to Central Office and enter the information into a designated state-wide database.

2. The Area Director of Quality or Performance Improvement shall review aggregate data to identify trends related to Individual care and risk management. The Area Quality/ Performance Improvement Council or Leadership Committee shall review summary reports.

3. The department responsible for quality management and/or performance improvement shall ensure that all incidents involving suspected abuse or omission of care by a caretaker are also reported by the mandated reporter to the agencies required under law:
    - Suspected physical or emotional abuse of disabled adults (aged 18-59) by a caretaker is reported to the Disabled Persons Protection Commission (DPPC). All deaths of DMH Individuals aged 18-59 are reported to DPPC.
    - Suspected abuse or neglect and deaths of DMH Individuals aged 60 or older is reported to Department of Elder Affairs.
    - Suspected abuse or neglect of DMH Individuals under age 18 is reported to the Department of Children and Families.

V. POLICY IMPLEMENTATION

The Deputy Commissioners for Mental Health Services and Clinical and Professional Services are responsible for ensuring that Area Directors and Area Medical Directors implement the provisions of this policy. The Assistant Commissioner of Forensic Services shall serve as a consultant to the policy implementation.

Attachments as identified within this policy may be revised and re-issued, as needed, without reviewing and/or re-issuing this policy.

VI. REVIEW OF THIS POLICY

This policy and its implementation shall be reviewed at least every three (3) years.