Massachusetts Department of Correction **POLICY**	Effective Date 10/28/2025 Annual Review Date 10/28/2025	Responsible Division Deputy Commissioner, Clinical Services and Reentry
Policy Name 103 DOC 650 MENTAL HEALTH SERVICES	M.G.L. Reference: M.G.L. c. 124, §1(c), (q); G.L. c. 30, §36(a); M. G.L. c. 127 § 39A,39; M.G.L. c. 127 §1 Prison Rape Elimination Act of 2003 Public Law 108-79 NCCHC Standards: P-08, P-10, P-27, P-31, P-37, P-51, P-53, P-66, P-67	
	DOC Policy Reference: 103 CMR 410; 103 DOC 422; 103 CMR 423; 103 CMR 430; 103 CMR 463; 103 CMR 483; 103 DOC 504; 103 CMR 505; 103 DOC 506; 103 DOC 519; 103 DOC 607; 103 DOC 620; 103 DOC 622; 103 DOC 652; 103 DOC 653; 103 DOC 661	
	ACA/PREA Standards: 2-CO-4B-04; 4-ACRS-4C-15; 4-ACRS-4C-16 5-ACI-3A-18; 5-ACI-4B-10; 5-ACI-4B-11 5-ACI-6A-08; 5-ACI-6A-28; 5-ACI-6A-32; 5-ACI-6A-34; 5-ACI-6A-35; 5-ACI-6E-01; 5-ACI-6C-08; 5-ACI-6C-13 PREA: 115.41; 115.64; 115.78; 115.81; 118.83	
Attachments Yes ☒ No ☐ / Library Yes ☒ No ☐	Applicability: Staff	
Public Access Yes ☒ No ☐	Location: Department's Central Policy File Institution's Policy File	

PURPOSE:

The purpose of this policy is to establish guidelines for the identification and treatment of incarcerated individuals in need of mental health services.

RESPONSIBLE STAFF FOR IMPLEMENTATION AND MONITORING OF POLICY:

Deputy Commissioner, Clinical Services and Reentry
Assistant Deputy Commissioner of Clinical Services
Director of Behavior Health
Superintendents
Program Directors of the contractual medical and mental health providers

CANCELLATION:

This policy cancels all previous Department policy statements, bulletins, directives, orders, notices, rules and regulations regarding mental health services for incarcerated individuals.

SEVERABILITY CLAUSE:

If any part of this policy is, for any reason, in excess of the authority of the Commissioner, or otherwise inoperative, such decision shall not affect any other part of this policy.

PRIVATE RIGHT OF ACTION EXCLUSION:

Nothing contained herein is intended to confer, or shall be interpreted as conferring, a private right of action for enforcement or damages.

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ATTACHMENTS

650.01 POLICY STATEMENT

The Massachusetts Department of Correction (Department) is dedicated to providing quality mental health assessment, care and treatment to all incarcerated individuals. Mental health services include a continuum of evidence-based therapies including psychosocial and pharmacological interventions to alleviate symptoms, attain appropriate functioning and prevent relapse. Services are available based on individualized clinical assessment and treatment planning, culminating in effective reintegration and reentry planning.

650.02 DEFINITIONS

Activity Therapist: A bachelor's level mental health staff member who provides activity-based interventions under the direction of Qualified Mental Health Professionals.

Assistant Deputy Commissioner, Clinical Services: The executive staff person who reports to the Deputy Commissioner of Clinical Services and Reentry. The duties of the Assistant Deputy Commissioner, Clinical Services, include, but are not limited to, the management of the Health Services Division (HSD) and the oversight of the Department's health services contracts.

Behavior Assessment Unit (BAU): A housing unit that is not Restrictive Housing that is used for the assessment of incarcerated individuals who pose an unacceptable risk to the safety, security, and orderly operations of the correctional institution, have a possible personal safety need that needs to be investigated, or who pose a threat to others and require separation from general population. The goal of this unit is to expeditiously assess an individual's need(s) and determine if a structured program is recommended to address their need(s).

Civilly Committed Individual: For purposes of this policy, the term Civilly Committed Individual shall mean any person admitted for evaluation or civilly committed individual to the Bridgewater State Hospital, any Massachusetts Treatment Center resident who is not serving a criminal sentence, and any person civilly committed to the Massachusetts Alcohol and Substance Abuse Center or MCI-Framingham.

Director of Behavioral Health: The Health Services Division clinician who reports to the Assistant Deputy Commissioner, Clinical Services, and is responsible for the management and oversight of the Department's mental health care services.

Exigent Circumstances: Circumstances that create an unacceptable risk to the safety of any person.

Incarcerated Individual: A committed offender or other such person as is placed in a Department of Correction Institution or Department of Correction program in

accordance with law, including, but not limited to, persons participating in the Transitional Treatment Program. The term incarcerated individual shall not include persons who have been admitted or committed to Bridgewater State Hospital or Massachusetts Alcohol and Substance Abuse Center at Plymouth pursuant to G.L. c. 123

Inmate Management System (IMS): The Department's automated information system that provides processing, storage and retrieval of incarcerated individual related information needed by Department personnel and other authorized users within the criminal justice system.

Intensive Stabilization Unit (ISU): A temporary clinical placement in a therapeutic milieu that provides treatment services and a structured environment of care for incarcerated individuals unable to effectively progress with placement on therapeutic supervision or assigned housing due to acute mental health or behavioral dysregulation but do not meet criteria for transfer to an inpatient psychiatric setting. The goal of ISU placement is to identify and implement treatment plans effective in addressing the acute and ongoing clinical needs of incarcerated individuals in a manner that supports their placement in a non-ISU environment. As such, ISU placement also may be utilized as a clinical intervention for incarcerated individuals returning from an inpatient psychiatric setting as determined clinically indicated to support their placement in a non-ISU setting.

Inter-System Transfer: The transfer of an incarcerated individual between a Department institution and a non-Department institution, including a facility of another state law enforcement or correctional agency, a county correctional facility, or a facility of the Department of Mental Health (DMH), the Department of Children and Families (DCF) or the Department of Developmental Services (DDS).

Intra-System Transfer: The transfer of an incarcerated individual between Department institutions.

Mental Health Classification: The system that identifies and codes the level of mental health services that an incarcerated individual requires based upon the incarcerated individual's mental health need.

Medical Contractor: The Department's contract medical vendor.

Mental Health Contractor: The Department's contract mental health vendor.

Open Mental Health Case (OMH): An incarcerated individual who is diagnosed with a mental illness or determined to be in need of mental health intervention on an ongoing basis. At any time during the incarcerated individual's incarceration, an incarcerated individual may become an open mental health case (OMH) based on a mental health crisis, including suicidal threats or self-directed violence and/or the display of signs and/or symptoms of mental illness or emotional distress. Based

upon clinical indications and within the discretion of the Primary Care Clinician (PCC), in consultation with the site Psychiatrist (if on medication) and/or Site Mental Health Director, an incarcerated individual may also be removed from the active mental health caseload. However, any incarcerated individual carrying the Gender Dysphoria (GD) diagnosis will remain an OMH case.

Primary Care Clinician (PCC): Qualified Mental Health Professional who is responsible for case management, direct treatment services and the overall mental health care of incarcerated individuals assigned to their caseload while at a Department institution.

Program Mental Health Director: The contractual mental health provider who is responsible for the administration, management, supervision, and development of mental health programs and delivery of behavioral health services at all Department institutions. The Program Mental Health Director provides and supervises mental health care services throughout the Department; evaluates patient care and assesses what is required by way of treatment; determines the condition and adequacy of treatment facilities and programs; identifies the need for appropriate equipment; acts as a consultant for physicians and behavioral health care staff; delivers emergency and ongoing direct clinical service; develops and reviews Treatment Plans; and evaluates incarcerated individuals when clinically indicated.

Program Psychiatric Medical Director: The physician in charge of the statewide mental health services vendor. The Program Psychiatric Medical Director is Board Certified in Psychiatry. The Program Psychiatric Medical Director provides and supervises psychiatric and mental health care services in the correctional setting throughout the Department; evaluates patient care and assesses what is required by way of treatment; determines the condition and adequacy of treatment facilities and programs; identifies the need for appropriate equipment; acts as a consultant for physicians and behavioral health care staff; delivers emergency and ongoing direct clinical service; reviews medical orders for mental health patients; evaluates pharmacy utilization, and develops and reviews Treatment Plans; and evaluates incarcerated individuals when clinically indicated.

Psychotropic Medication: Medication prescribed for the treatment of mental illness.

Qualified Addiction Specialist: A treatment provider who is: (i) a physician licensed by the board of registration of medicine, a licensed advanced practice registered nurse or a licensed physician assistant; and (ii) a qualifying practitioner or qualifying other practitioner, as defined in the federal Controlled Substances Act, as codified at 21 U.S.C. 823(G), who has been issued an identification number by the United States Drug Enforcement Administration pursuant to the federal Controlled Substances Act, as codified at 21 U.S.C. 823(g)(2)(D)(ii) or 21 U.S.C. 823(g)(2)(D)(iii).

Qualified Mental Health Professional: Treatment providers who are psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and others who by virtue of their education, credentials and experience are permitted by law to evaluate and care for the mental health needs of patients.

Qualified Healthcare Professional: Professionals include physicians, advanced practitioners, nurses, dentists, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for Incarcerated individuals.

Residential Treatment Unit (RTU): A general population housing unit that provides an intermediate level of care for incarcerated individuals whose mental illness, combined with significantly impaired social skills and limited ability to participate independently in activities of daily living, makes it difficult for them to function in the general population of a correctional institution, but who are not so impaired as to require psychiatric hospitalization. Additionally, the RTU serves as a transitional level of care for incarcerated individuals discharged from higher levels of care.

Restrictive Housing: A placement, whether for disciplinary or non-disciplinary purposes, that requires an incarcerated individual to be confined to a cell for more than twenty-two (22) hours per day for the safe and secure operation of the institution. For purposes of this policy, Restrictive Housing shall not include the following: any placement ordered by a medical or mental health provider, including but not limited to, the placement of an incarcerated individual in a Health Services Unit (HSU); the placement of an incarcerated individual in a hospital; the placement of an incarcerated individual in a medical setting where treatment is being provided; or the placement of an incarcerated individual on therapeutic supervision. The Department of Correction does not utilize restrictive housing. However, the definition is maintained in policy to underscore that the specialized units (BAUs, ISU, RTUs, SAUs, and STUs) are not restrictive housing.

Secure Adjustment Unit (SAU): For purposes of this policy, an SAU is defined as a highly structured unit that is not Restrictive Housing which provides access to cognitive behavioral treatment, education, programs, structured recreation, leisure time activities, and mental health services for those incarcerated individuals assessed as needing a specific structured program intervention to support positive adjustment. All SAUs follow a graduated phase system designed to encourage maximum participation. For incarcerated individuals already in a BAU for assessment or who are in a SAU and being considered for placement into a different SAU track, placement into an appropriate SAU shall be pursuant to the reclassification process. Incarcerated individuals who are Seriously Mentally Ill (SMI) and are not currently in a BAU, may be diverted to a SAU pursuant to 103 DOC 650, Mental Health Services; 650.12 (B) (5) and 650.13 (H) (1).

Secure Treatment Unit (STU): A secure treatment unit that is designed to provide enhanced treatment for incarcerated individuals based on their assessed clinical

need. These units utilize individualized treatment plans within an incentive-based treatment program focused on the reintegration to a lower intensity clinical environment or general population. The Department currently operates three STUs: the Secured Treatment Program (STP), the Behavioral Management Unit (BMU) and the Intensive Treatment Unit (ITU).

Secure Treatment Unit Review Committee: The committee convened to review STU referrals regarding incarcerated individuals whose clinical needs require a higher level of care than an RTU. The Secure Treatment Unit Review Committee shall be chaired by the Director of Behavioral Health. Membership shall include the Program Mental Health Director, the Department administrators of the STUs, and the Mental Health Vendor's clinical leaders of the STUs.

Serious Mental Illness (SMI): A current or recent diagnosis by a Qualified Mental Health Professional of one or more of the following disorders described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:

i. schizophrenia and other psychotic disorders;
ii. major depressive disorders;
iii. all types of bipolar disorders;
iv. a neurodevelopmental disorder, dementia or other cognitive disorder;
v. any disorder commonly characterized by breaks with reality or perceptions of reality;
vi. all types of anxiety disorders;
vii. trauma and stressor related disorders; or
viii. severe personality disorders.

Site Mental Health Director: The Qualified Mental Health Professional appointed by the mental health vendor, with the approval of the Assistant Deputy Commissioner, Clinical Services, to oversee the contract mental health program at an institution or group of facilities.

Support Person: A Support Person is an individual provided by the health care vendor and is part of the multi-disciplinary team. All institutions that operate therapeutic supervisions shall employ Support Persons. A Support Person engages in non-clinical interactions with incarcerated individuals on therapeutic supervision, provides additional activities outside of the three clinical sessions per day, and documents these interactions and the prisoner's behavior.

650.03 INFORMED CONSENT

A. In non-emergency situations, incarcerated individuals shall be provided information necessary to give informed consent prior to the initiation of mental health treatment services, including treatment with psychotropic medication. The incarcerated individual shall be provided sufficient information upon which the incarcerated individual may make an informed

decision as to the risks and benefits of the treatment offered. This information shall be provided in a language understood by the incarcerated individual.

B. The incarcerated individual's written informed consent shall be obtained where required by a pre-printed informed consent or authorization form approved by the Director of Behavioral Health.

C. Informed consent is not required in appropriate circumstances including:

1. A mental health emergency requiring an intervention for the safety of the incarcerated individual, other incarcerated individuals or staff;

2. An intervention required to address a life-threatening situation;

3. Emergency treatment, including treatment with antipsychotic medication, for an incarcerated individual who is not competent to make treatment decisions;

4. Screening or treatment necessary to address a significant risk to the public health.

D. If an incarcerated individual refuses an evaluation or treatment, the mental health clinician shall document the refusal in the medical record, including:

1. A description of the service being refused;

2. Evidence that the incarcerated individual has been made aware of any consequences to their mental health that may occur as a result of the refusal;

3. The signature of the incarcerated individual and the date on any applicable form, along with the signature of any required witness.

650.04 ADMISSIONS

A. Mental Health Screen

Each incarcerated individual admitted to an institution by a new commitment or by an Inter-System or an Intra-System Transfer shall receive a mental health screen by a Qualified Health Care Professional upon admission.

The Qualified Health Care Professional shall refer the incarcerated individual for further evaluation by a Qualified Mental Health Professional if:

1. The mental health screen is positive for SMI, active Department of Mental Health (DMH) services, developmental disability or acute mental health symptomatology; or

2. The incarcerated individual has a history of sexual use victimization or may be at risk for sexual use victimization while incarcerated; or

3. Screening for risk of victimization and abusiveness:

    a. All incarcerated individuals shall be assessed during an intake screening and upon transfer to another institution for their risk of being sexually abused by other incarcerated individuals or sexually abusive toward other incarcerated individuals.

    b. Intake screening shall ordinarily take place within seventy-two (72) hours of arrival at the institution.

    c. Such assessments shall be conducted using an objective screening instrument.

    d. The intake screening shall consider, at a minimum, the following criteria to assess incarcerated individuals for risk of sexual victimization:

        i. Whether the incarcerated individual has a mental, physical, or developmental disability;
        ii. The age of the incarcerated individual;
        iii. The physical build of the incarcerated individual;
        iv. Whether the incarcerated individual has previously been incarcerated;
        v. Whether the incarcerated individual's criminal history is exclusively nonviolent;
        vi. Whether the incarcerated individual has prior convictions for sex offenses against an adult or child;
        vii. Whether the incarcerated individual is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;
        viii. Whether the incarcerated individual has previously experienced sexual victimization;
        ix. The incarcerated individual's own perception of vulnerability; and

x. Whether the incarcerated individual is detained solely for civil immigration purposes.

e. Within a set time period, not to exceed thirty (30) days from the incarcerated individual's arrival at the institution, the institution will reassess the incarcerated individual's risk of victimization or abusiveness based upon any additional, relevant information received by the institution since the intake screening.

f. An incarcerated individual's risk level shall be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the incarcerated individual's risk of sexual victimization or abusiveness.

g. Incarcerated individuals may not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to 103 DOC 650.04(A)(3), (d)(i),(d)(vii),(d)(viii), or (d)(ix).

h. The agency shall implement appropriate controls on the dissemination within the institution of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the incarcerated individual's detriment by staff or other incarcerated individuals.

4. Medical and mental health screenings; history of sexual abuse.

a. If the screening indicates that an incarcerated individual has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall ensure that the incarcerated individual is offered a follow-up meeting with a medical or mental health practitioner within fourteen (14) days of the intake screening.

b. If the screening indicates that an incarcerated individual has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the incarcerated individual is offered a follow-up meeting with a mental health practitioner within fourteen (14) days of the intake screening.

c. Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be

strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law.

d. Medical and mental health practitioners shall obtain informed consent from incarcerated individuals before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the incarcerated individual is under the age of eighteen (18).

B. Psychotropic Medication Prescription

Each incarcerated individual newly entering the Department of Correction with a prescription for psychotropic medication shall be referred to a psychiatrist. If the prescription is current and verified, the psychiatrist may continue the prescription and schedule an appointment for the incarcerated individual to be evaluated by a psychiatrist within fourteen (14) days. If the prescription is not verified, the psychiatrist shall schedule an appointment for the incarcerated individual to be evaluated by a psychiatrist within fourteen (14) days. If the incarcerated individual is an active Department of Mental Health client, the psychiatrist shall schedule an appointment for the incarcerated individual to be evaluated by a psychiatrist within seven (7) days.

650.05 NON-EMERGENCY MENTAL HEALTH ASSESSMENTS

A. Mental Health Appraisal – New Commitment and Inter-System Transfer

1. Each incarcerated individual admitted to an institution by a new commitment or by an Inter-System transfer shall receive a mental health initial appraisal by a Qualified Mental Health Professional within fourteen (14) days of admission. If the comprehensive mental health evaluation indication is evident, and completed, within the first fourteen (14) calendar days of admission, the initial appraisal may be omitted. A corresponding or included progress note shall be completed and entered into the medical record. A Qualified Mental Health Professional shall document findings in the IMS Mental Health/Substance Use History, Medical Orders, and Restrictions/Special Needs screens as needed. Evaluation of a substance use disorder shall be made by a Qualified Addiction Specialist for any incarcerated individual committed for a term of thirty (30) days or more.

2. The Qualified Mental Health Professional shall refer the incarcerated individual for a comprehensive mental health evaluation as indicated by the appraisal, including referral for the development and implementation of a mental health Treatment Plan.

3. If the mental health assessment indicates that the incarcerated individual has a developmental disability, the Qualified Mental Health Professional shall refer the incarcerated individual for evaluation by a licensed psychologist within fourteen (14) days. Such evaluation may include intelligence testing, if clinically indicated. If the evaluation indicates that the incarcerated individual has a developmental disability, the Site Mental Health Director shall develop an appropriate Treatment Plan and consult with the Superintendent as appropriate. The Primary Care Clinician shall notify the Department of Developmental Services (DDS) for a determination of service eligibility at the time of such incarcerated individual's discharge from the Department.

4. If the Qualified Mental Health Professional determines that the incarcerated individual has a history of sexual abuse victimization or may be at risk for sexual abuse victimization while incarcerated, the incarcerated individual shall be referred for monitoring and counseling as clinically indicated as provided by 103 DOC 650.10, Mental Health Response to Reports of Sexually Abusive Behavior. The Qualified Mental Health Professional shall provide a confidential incident report to the Superintendent and update the IMS Housing Checklist Screen as indicated, upon becoming aware of any report of sexual abuse victimization not previously reported. If the incarcerated individual makes a disclosure that requires the issuance of a confidential incident report, the incarcerated individual shall be advised that such disclosure cannot be held in confidence.

5. The Superintendent and the Director of Behavioral Health shall be notified if the mental health assessment indicates that the incarcerated individual requires acute mental health care beyond that available at the institution (e.g., civil commitment pursuant to G.L. c. 123, § 18(a)).

6. If the mental health assessment indicates that the incarcerated individual has received prior inpatient or outpatient mental health treatment, all reasonable efforts shall be made by the Qualified Mental Health Professional to secure written authorization or releases from the incarcerated individual to obtain such records. Information obtained from such records shall be entered in the incarcerated individual's medical record and in IMS, as appropriate.

B. Mental Health Appraisal – Intra-System Transfer

Upon an Intra-System Transfer, a Qualified Mental Health Professional shall complete a transfer in checklist in accordance with 103 DOC 650.05, Non-Emergency Mental Health Assessments.

C. Mental Health Referral

Mental health referrals may occur by incarcerated individual self-referral (i.e., sick call request) or by staff referral. Each mental health referral shall be classified as (1) Emergent, (2) Urgent, or (3) Routine, and entered in the Sick Call Request/Mental Health Referral log. The mental health referral and the response shall also be documented in the incarcerated individual's medical record. The mental health response to each category of mental health referral shall be as follows:

1. Emergent referrals require an immediate face-to-face response by a Qualified Mental Health Professional. All mental health referrals that indicate that an incarcerated individual or civilly committed individual is at acute risk for suicide or is experiencing acute symptoms shall be classified as Emergent.

2. Urgent referrals require a face-to-face response by a Qualified Mental Health Professional on the same day. All mental health referrals that indicate an incarcerated individual or civilly committed individual is experiencing active symptoms shall be classified as Urgent.

3. Routine referrals require a face-to-face or written response within five (5) business days. Mental health referral requests that do not indicate that an incarcerated individual or civilly committed individual is at acute risk for suicide, experiencing acute symptoms, or experiencing active symptoms, shall be classified as Routine.

4. All mental health referrals that indicate that an incarcerated individual or civilly committed individual is experiencing some form of distress shall require a face-to-face interview.

5. All mental health referrals that indicate an inquiry about mental health services (e.g., when a next appointment will be held or when a particular group is meeting) shall be responded to in writing.

D. Incarcerated Individual Self-Referral

Any incarcerated individual may request mental health services by completing a Sick Call Request Form (Sick Call Request Form - Attachment #1) or by making a verbal request to a Department or Contractor staff. A Qualified Health Care Professional shall review Sick Call Request Forms daily. If the request appears to indicate an emergent mental health issue, the mental health clinician on-call shall be contacted immediately. All non-emergent requests shall be referred to site mental health staff for review and triage in accordance with 103 DOC 650.05 (F), Triage of Mental Health Referrals and 650.05 (G), Triage of Mental Health Referrals when Mental Health Staff are not on Site. Section 650.05 (F) and (G) within twenty-four (24) hours, or within seventy-two (72) hours on weekends. Mental health staff shall document the triage process in mental health staff meeting minutes.

E. Staff Referral

1. Staff shall refer an incarcerated individual to mental health staff upon a belief that the incarcerated individual may be in need of mental health assistance or when an intake, or other housing status assessment indicates a need.

2. In the event that an incarcerated individual is approved for an emergency escorted trip (EET) pursuant to 103 CMR 463, *Furloughs*, for the purpose of a hospital visit of a terminally-ill relative or viewing a deceased relative at a funeral home, staff shall refer an incarcerated individual to mental health staff to be offered a face-to-face assessment upon the incarcerated individual's return from the EET.

3. If any staff member believes that the incarcerated individual is at imminent risk for harm to self or others, the incarcerated individual shall be placed under Constant Observation in accordance with 103 DOC 650.08 (B), Therapeutic Supervision, and DOC staff shall inform mental health staff immediately. When mental health staff are on site, DOC staff shall contact the crisis clinician verbally. When mental health staff are not on site, DOC staff shall contact a nurse who will assess the incarcerated individual. The nurse will then contact the on-call QMHP for disposition and treatment recommendations. The incarcerated individual shall be evaluated by an on-site mental health clinician, or in the absence of an on-site mental health clinician, by an on-call mental health clinician. The mental health clinician shall inform the Shift Commander of the outcome of this evaluation. If the mental health clinician determines that the incarcerated individual is not at imminent risk of harm to self or others, the staff person shall refer to site mental health staff

for review and triage in accordance with 103 DOC 650.08 (B), Therapeutic Supervision. If the incarcerated individual was evaluated by the on-call Qualified Mental Health Professional, the incarcerated individual will be assessed in person by a Qualified Mental Health Professional on the next business day or sooner as determined by the on-call Qualified Mental Health Professional. Mental health staff shall document the triage process in mental health staff meeting minutes.

F. Triage of Mental Health Referrals

Each working day, a Qualified Mental Health Professional shall triage mental health referrals to determine the necessity and priority of follow-up based upon the nature of the clinical situation. Based upon this triage, each mental health referral shall be classified as either (1) Emergent, (2) Urgent, or (3) Routine, as set forth in 103 DOC 650.05(C), Mental Health Referral, followed-up accordingly, and entered in the Sick Call Request/Mental Health Referral log. In addition to a referral pursuant to a mental health screen or a mental health evaluation, an incarcerated individual/civilly committed individual may be referred for a mental health evaluation at any time during their incarceration on the basis of a mental health crisis, including suicidal threats or behavior and the display of the signs and symptoms of mental illness. Referral sources shall include self-referral by the incarcerated individual and referral at the request of any Department or Contractor staff.

1. Emergent referrals require an immediate face-to-face response by a Qualified Mental Health Professional. All mental health referrals that indicate that an incarcerated individual or civilly committed individual is at acute risk for suicide or is experiencing acute symptoms shall be classified as Emergent.

2. Urgent referrals require a face-to-face response by a Qualified Mental Health Professional on the same day. All mental health referrals that indicate an incarcerated individual or civilly committed individual is experiencing active symptoms shall be classified as Urgent.

3. Routine referrals require a face-to-face or written response within five (5) business days. Mental health referral requests that do not indicate that an incarcerated individual or civilly committed individual is at acute risk for suicide, experiencing acute symptoms, or experiencing active symptoms, shall be classified as Routine.

4. All mental health referrals that indicate that an incarcerated individual or civilly committed individual is experiencing some form of distress shall require a face-to-face interview.

5. All mental health referrals that solely include an inquiry about mental health services which is exclusively administrative in nature (e.g., when a next appointment will be held or when a particular group is meeting) shall be responded to in writing.

G. Triage of Mental Health Referrals When Mental Health Staff Are Not on Site

Absent an emergency, upon the determination that an incarcerated individual requires a mental health assessment and/or intervention, the Superintendent or designee shall call and notify the on-call mental health clinician, who shall determine whether an immediate mental health assessment and/or intervention is necessary. The on-call mental health clinician shall follow-up with the referring staff person and arrange for an assessment by a Qualified Mental Health Professional. The referral and outcome shall be documented in the medical record.

In an emergency, the incarcerated individual shall be transported to an institution with on-site mental health staff.

H. Non-Cooperation and Refusal of a Mental Health Assessment

1. If an incarcerated individual refuses or does not cooperate with a mental health assessment and/or intervention, the medical or mental health staff person seeking to perform the assessment shall consult with the Site Mental Health Director or designee to determine what steps should be followed. At a minimum, a mental health clinician shall conduct a face-to-face interview with the incarcerated individual to determine (1) whether the incarcerated individual is continuing to refuse or not cooperate, (2) why the incarcerated individual is refusing or not cooperating, and (3) whether immediate intervention is required. The incarcerated individual's refusal or non-cooperation, along with all subsequent steps taken, shall be documented in the medical record.

2. If an incarcerated individual undergoing detoxification refuses or does not cooperate with a mental health appraisal, the incarcerated individual shall be offered the mental health appraisal upon completion of the detoxification process so as to ensure that the non-cooperation or refusal did not relate to the detoxification process. If the incarcerated individual again refuses or does not cooperate, the Qualified Mental Health Professional shall follow the procedures set

forth in 103 DOC 650.03 (D), Informed Consent and 103 DOC 650.05 (H), Non-Cooperation and Refusal of a Mental Health Assessment.

I. Mental Health Evaluations

1. If a mental health appraisal reveals that an incarcerated individual may require ongoing mental health treatment or services, a Qualified Mental Health Professional shall complete a mental health evaluation within fourteen (14) days of the completion of the mental health appraisal.

2. Following the completion of the mental health evaluation, if the Qualified Mental Health Care Professional believes that further assessment is necessary, they may refer the case to the Site Mental Health Director, who shall determine whether further assessment is required. The Site Mental Health Director may refer the incarcerated individual for ongoing assessment for a period up to thirty (30) days from the completion of the mental health evaluation.

3. An incarcerated individual may be referred for a mental health evaluation at any time during the incarcerated individual's incarceration on the basis of a mental health crisis, including but not limited to, suicidal threats, self-injurious behavior, or the display of signs and symptoms of mental illness. All referrals for a mental health evaluation shall be triaged within twenty-four (24) hours or on the next business day. The incarcerated individual shall be seen in a time frame commensurate with the nature of the referral, but not to exceed fourteen (14) days.

4. If necessary to complete a mental health evaluation or to render a diagnosis, the mental health vendor shall timely obtain further psychological, neurological, medical and laboratory assessments.

5. A mental health evaluation shall be completed prior to and in preparation of a mental health treatment plan.

J. Open Mental Health Cases and Treatment Plans

1. Following the completion of a mental health evaluation or following the completion of the thirty (30) day assessment described in Section 650.05 (I)(2), Mental Health Evaluations, if it is determined that an incarcerated individual requires ongoing mental health treatment or services, the incarcerated individual shall be designated as an OMH and assigned a Primary Care Clinician (PCC).

Within fourteen (14) days of a mental health appraisal conducted pursuant to 103 DOC 650.05 (A), Mental Health Appraisal – New Commitment and Inter-system Transfer and 103 DOC 650.05 (B), Mental Health Appraisal – Intra-system Transfer, the PCC shall determine and document the incarcerated individual's mental health classification code and subcodes as provided by 103 DOC 650.06 (B), Assignment and Review of Mental Health Codes and Subcodes.

2. Within thirty (30) days of the incarcerated individual's designation as an Open Mental Health Case, the PCC shall develop an Initial Treatment Plan.

3. The treatment plan shall be reviewed and updated as follows:

   a. For SMI incarcerated individuals, review and update by the PCC every ninety (90) days for the first twelve (12) months, and every six (6) months thereafter, or more frequently if clinically indicated;

   b. For non-SMI incarcerated individuals, review and update by the PCC every six (6) months, or more frequently if clinically indicated;

   c. For STU and RTU incarcerated individuals, review and update by the PCC and treatment team every ninety (90) days or more frequently if clinically indicated.

   d. Following any diagnostic change, review and update by PCC and psychiatric provider within fourteen (14) days.

   e. Following any incident of self-directed violence, review by the PCC within 24 hours and updated as clinically indicated.

   f. Following discharge from therapeutic supervision, reviewed by the PCC, in consultation with an upper-level provider, if such consultation is indicated, within seven (7) days and updated as clinically indicated following review.

4. While the frequency and type of mental health services shall be dictated by the individual mental health classification (103 DOC 650.06 (B), Assignment and Review of Mental Health Codes and Subcodes), each Open Mental Health Case shall be offered treatment by the assigned Primary Care Clinician every thirty (30) days at a minimum. For classifications of MH1 and MH2, Group treatment can supplement and augment individual treatment when scheduled twice per month, with an individual session at least within

every ninety (90) days. In addition, an incarcerated individual prescribed psychotropic medication shall be seen by a psychiatrist every ninety (90) days at a minimum.

K. Behavior Management Plans

1. When clinically appropriate, the Qualified Mental Health Professional will create an individualized incentive-based behavioral management plan based on the following principles:

    1. Measurable and time-defined goals are agreed upon by the incarcerated individual and mental health staff, with the first goal being "active participation in treatment;"
    2. Incentives or rewards must be individualized and must be provided to the incarcerated individual on a prescribed schedule for achieving these goals;
    3. Incarcerated individuals should be encouraged to talk honestly about any self-injurious thoughts while at the same time avoiding the use of threats to manipulate staff;
    4. All reports of feeling "unsafe" should be taken seriously;
    5. Discouraging the use of disingenuous or false statements to obtain goals other than safety-oriented goals;
    6. Time intervals should be considered carefully and modified based on the incarcerated individuals' clinical presentation and level of functioning such that incarcerated individual's with very poor impulse control may benefit from shorter reward periods and staff can attach greater and cumulative rewards to gradually increased time periods to encourage increased self-control and commitment to the program over time;
    7. Choosing the right treatment interventions must be done with the incarcerated individual, maintaining regular contact with staff, and the incarcerated individual should be given "homework" based on their individual level of function; and
    8. These plans should be time limited to three (3) to six (6) months to look for measurable improvement and then modified to a maintenance model.

L. Procedures for Closing Mental Health Cases of Incarcerated Individuals

1. An SMI incarcerated individual with a current diagnosis of any of the following disorders shall remain on the Mental Health caseload (i.e., the mental health case cannot be closed):

- Schizophrenia
- Schizophreniform Disorder
- Schizoaffective Disorder
- Delusional Disorder
- Brief Psychotic Disorder
- Substance-Induced Psychotic Disorder (excluding intoxication and withdrawal)
- Other specified schizophrenia spectrum and other psychotic disorder
- Unspecified schizophrenia spectrum and other psychotic disorder

2. If an SMI incarcerated individual is diagnosed with Major Depressive Disorder, Bipolar Disorder I, or Bipolar Disorder II in Full Remission (the DSM-5 TR defines "Full Remission" "During the past two (2) months, no significant signs or symptoms of the disturbance were present") the case may be closed when the following criteria have been met:

   a. The incarcerated individual has not been prescribed psychotropic medication for one (1) year; and

   b. The incarcerated individual has consistently presented with no symptoms of depression, mania, or hypomania for one (1) year.

   c. If the PCC, Site Mental Health Director, and psychiatrist agree that case closure is clinically appropriate, the case shall be reviewed by case conference with the following participants: the PCC, psychiatrist, Site Mental Health Director, and the Program Mental Health Director (or designee). This review shall be documented in an administrative progress note indicating the findings of the clinical case conference.

   d. Upon approval by the Program Mental Health Director, the treatment team shall complete the case closure form.

   e. Upon completion of the above steps, and upon the entry of all necessary documentation (i.e., case conference summaries) in the medical record, the Site Mental Health Director shall enter the Mental Health Classification change in IMS to MH-0 with a subcode of "A".

3. For all other case closures, the procedure shall be as follows:

Prior to closing the case:

a. The incarcerated individual has not been prescribed antipsychotic medication for one (1) year, or other psychotropic medications for six (6) months.

b. The Primary Care Clinician (PCC) shall present the rationale for case closure to the Site Mental Health Director. The Site Mental Health Director shall conduct a record review to ensure that the incarcerated individual's behavior and clinical presentation meets the criterion outlined above. This review shall be documented in an administrative progress note indicating the findings of the record review. The Site Mental Health Director may conduct a face-to-face evaluation when clinically indicated.

c. If the Site Mental Health Director determines that case closure is clinically appropriate, a staff psychiatrist shall conduct a face-to-face evaluation for any incarcerated individual prescribed medication in the prior year. This evaluation shall be documented in a progress note.

d. Upon completion of the above steps, a case closure form will be completed, signed and placed in the medical record. The Mental Health Classification code shall be updated by the PCC in IMS.

650.06 MENTAL HEALTH CLASSIFICATION

A. Mental Health Classification System

The mental health classification system identifies the level of mental health services that an incarcerated individual requires due to the incarcerated individual's mental health needs and serves as a guide to mental health staff outlining recommended treatment interventions. The mental health codes and subcodes are set forth in Attachment #2.

B. Assignment and Review of Mental Health Codes and Subcodes

1. The incarcerated individual's PCC shall determine an incarcerated individual's initial mental health code and subcodes within fourteen (14) days of a mental health appraisal conducted pursuant to 103 DOC 650.04 (A), Mental Health Screen or 650.04 (B), Psychotropic Medication Prescription.

a. Mental Health Codes shall be defined as:

MH 5: Severe functional impairment due to a mental disorder; hospitalized at Bridgewater State Hospital or the Department of Mental Health under MGL 123 Section 18a or Section 18(a 1/2)
MH 4: Serious functional Impairment due to a mental disorder; approved for a Residential Treatment Unit level of care.
MH 3: Moderate functional impairment; requires routine and on-going mental health service contacts.
MH 2: Mild functional impairment; demonstrates stability with minimal mental health service contacts.
MH 1: Case Management; demonstrates stability without routine mental health contacts but may warrant monitoring due to continuation of psychotropic medication or designation of a SMI diagnosis.
MH 0: No On Going Mental Health Services; Closed Mental Health case.
MH 9: Pending Evaluation; disposition under review.

b. Sub Codes shall be defined as:
"A": Incarcerated individual meets definition for Serious Mental Illness (SMI).
"B": Incarcerated individual is actively prescribed psychotropic medication by a provider.
"C": Incarcerated individual is actively prescribed a psychotropic medication that requires nursing administration and 7-day per week nursing coverage.
"D": Incarcerated individual has a history of self directed violence and/or positive Q5.

2. As frequently as the incarcerated individual's mental health needs dictate, the PCC or a Qualified Mental Health Professional shall review and update the mental health classification codes and subcodes of each incarcerated individual with an Open Mental Health Case. At a minimum, the mental health codes and subcodes shall be reviewed at the time of the incarcerated individual's treatment plan update, as set forth in 103 DOC 650.05 (J), Open Mental Health Cases and Treatment Plans.

a. Individual Treatment Plans should reflect the following treatment interventions at minimum based on the designated classification code:

MH4: Weekly group programming in the approved program unit and at least one (1) individual session every thirty (30)

days. Treatment Plan Review to be completed at least every ninety (90) days.

MH3: At least one (1) individual session every thirty (30) days. When available, assignment of group outpatient programming as clinically indicated based on the Treatment Review.

MH2: Mental health contact at least one (1) time every thirty (30) days in individual or group sessions. If group intervention is primary modality, contact must occur two (2) times per month; at minimum an individual session shall be held within every ninety (90) days.

MH1: Case Management; at minimum a group or individual session will be held one (1) time every thirty (30) days.

MH0: No Mental Health Services; PRN and crisis services only.

MH9: Pending Evaluation; assessment within thirty (30) days and/or four (4) mental health contacts resulting in a determination for on-going Mental Health Services and Mental Health Classification Code.

3. Upon receipt of a court-approved petition filed pursuant to either G.L. c. 123, § 18(a) or G.L. c. 123, § 18(a 1/2), the sending mental health team shall change the Mental Health Classification to MH-5 prior to patient transport.

4. Upon discharge to a prison from Bridgewater State Hospital State Sentenced Units or from a Department of Mental Health facility, the PCC shall review the incarcerated individual's mental health codes and subcodes.

5. Upon referral to, or discharge from, residential treatment unit level of care, the Program Mental Health Director shall review and approve (1) the decrease of a mental health classification from MH-4 to a lower classification, and (2) the increase of a mental health classification to MH-4 from a lower classification.

C. Documentation of Mental Health Classification

All changes to an incarcerated individual's mental health classification and/or subcodes shall be entered immediately in the incarcerated

individual's medical record and in IMS by the PCC or a member of the mental health team.

650.07 PSYCHOTROPIC MEDICATION

A. General

Psychotropic medications may be utilized as one facet of a multi-faceted treatment program. Each incarcerated individual who is prescribed psychotropic medications shall be considered an open mental health case and shall be followed by a Primary Care Clinician.

B. Prescription and Discontinuation

1. The following clinicians may prescribe psychotropic medication:

   a. A Psychiatrist;

   b. An advanced practitioner (i.e., a Clinical Nurse Specialist or Psychiatric Nurse Practitioner) with the authorization of the Program Psychiatric Director and under the supervision of the Site Medical Director or site Psychiatrist; and

   c. In an emergency, a Physician who is trained or experienced in the use of psychotropic medication.

2. Except in an emergency, psychotropic medication may be prescribed only following a physical examination consisting of the measurement of blood pressure, temperature and pulse readings, and a review of the admission examination and/or most recent periodic health examination which shall occur annually for all incarcerated individuals prescribed psychotropic medications. In an emergency, the physical examination and review of the health examination shall be performed as soon as practical.

3. The prescribing clinician shall inform the incarcerated individual (and document that they has done so) of the reasons for the prescribed medication(s), the anticipated benefits, probable consequences if medication is not accepted, and the possible major side effects of the medication(s). This information shall be reviewed with the incarcerated individual by face-to-face encounters at least every ninety (90) days or each time the medication regimen is changed. The prescribing clinician shall note, in the medical record, a statement of progress that reflects response to and changes in medications. Any incarcerated individual with a history of court authorized treatment shall be assessed at least once every ninety (90)

days, regardless of whether they are currently prescribed psychotropic medications, for as long as the individual remains an open mental health case.

4. A Psychiatrist or an advanced practitioner under the supervision of a Psychiatrist may discontinue the use of psychotropic medication.

5. The decision to initiate or discontinue psychotropic medication and the rationale for such decisions shall be documented in the medical record. Documentation of psychiatric medication shall be entered as a mental health classification sub-code on the IMS Mental Health and substance abuse history screen.

C. Dispensing

1. Medications administered to incarcerated individuals on therapeutic supervision or in shall be crushed whenever possible. In those instances where the prescribed medication cannot be crushed or it would be clinically contraindicated to do so, the use of liquid medication shall be considered.

2. Incarcerated individuals who are on therapeutic supervision shall be removed from their cell prior to medication administration. A complete visual inspection of the incarcerated individual's mouth shall be made by correctional staff to ensure that medications are swallowed and not hoarded.

D. Monitoring and Compliance

The mental health contractor shall establish written policies and procedures for the purpose of monitoring incarcerated individuals' degree of compliance with their medication orders, including written guidelines for the degree of compliance required for specific drugs and dosages. All procedures shall adhere to the following guidelines:

1. The prescribing clinician shall complete a semi-annual AIMS scale or similar instrument on all incarcerated individuals who are prescribed anti-psychotic medication.

2. The incarcerated individual's compliance with prescribed psychotropic medication shall be documented in the medication administration record (MAR).

3. For the purpose of determining an incarcerated individual's compliance with psychotropic medication, non-compliance shall constitute the following: Three (3) consecutive doses missed, or fifty

percent (50%) of doses missed in one week, or a pattern of significant non-compliance.

4. An incarcerated individual's failure to appear to receive prescribed medication shall be noted on the medication administration record (MAR) or medication non-compliance log.

5. An incarcerated individual's report or exhibition of medication side effects shall be documented and conveyed to the mental health team for a psychiatric referral.

6. All medication administration record (MAR) and medication non-compliance logs shall be reviewed on a daily basis to identify non-compliant incarcerated individuals. The list of non-compliant incarcerated individuals shall be provided to the prescriber on a bi-weekly basis, unless the situation requires immediate attention.

E. Treatment Non-Compliance and Refusal

1. An incarcerated individual who repeatedly refuses their psychotropic medication, or has developed an intermittent pattern of non-compliance, shall be referred to the Site Mental Health Director for counseling, and to the Psychiatrist for follow up as needed. The incarcerated individual shall be counseled regarding the possible consequences of medication refusal or non-compliance. This counseling shall be documented in the medical record.

2. If the incarcerated individual continues to engage in non-compliance with the taking of the medication, the incarcerated individual shall be requested to sign a refusal of treatment form. If the incarcerated individual declines to sign the refusal of treatment form, a clinician, with another staff person as a witness, shall enter a notation on the form documenting the incarcerated individual's refusal to sign. Both staff members shall sign the refusal form as witnesses. Documentation of all such encounters shall be entered in the medical record. An incarcerated individual's symptoms or complaints of medication side effects shall be reported to the Psychiatrist.

3. The Psychiatric provider shall see any Secure Treatment Unit incarcerated individual within thirty (30) days of non-compliance with prescribed psychotropic medication.

4. The Site Mental Health Director may request a clinical case conference to consider the incarcerated individual's competence to refuse treatment and the need for a court-authorized treatment plan.

F. Emergency Administration of Psychotropic Medication

The emergency involuntary administration of psychotropic medication is governed by 103 DOC 650.09 (D), Treatment.

G. Non-Emergency Antipsychotic Medications for Incompetent Incarcerated individuals

1. General

a. Court authorization is required for the non-emergency provision of antipsychotic medications to an incarcerated individual who is not competent to provide informed consent. The non-emergency use of other psychotropic medications and non-psychotropic medications requires the approval of either the incarcerated individual's legal guardian or health care agent (see 103 DOC 620, *Special Health Care Practices*, 620.13 - Health Care Proxy Guidelines).

b. The authorization described in paragraph 1.a above is sought from the Probate Court. Such authorization requires a judicial determination of incompetence and a substituted judgment determination. The Probate Court will also appoint a medical guardian for the purpose of monitoring the court authorized treatment plan ("Rogers" treatment plan). An approved Rogers treatment plan shall be filed in the medical record and entered on the IMS Medical Orders Screen.

c. The Program Mental Health Director shall provide the Director of Behavioral Health with an updated list on a monthly basis of all Probate Court Rogers orders and proposed candidates for such orders. A member of the mental health team shall enter information regarding approved Rogers orders on the IMS Medical Issues Screen.

2. Procedure to Obtain a Court-Authorized Treatment Plan

a. All requests to seek a court-authorized treatment plan for incarcerated individuals shall be reported to the Director of Behavioral Health. The Director of Behavioral Health will consult with the Department of Correction Legal Division. The Mental Health Contractor shall cooperate with the Department of Correction by providing court testimony, affidavits, treatment plans and records as may be required to secure court authorization.

b. All treatment plans submitted for court authorization should, when clinically appropriate, incorporate an intramuscular (IM) route of administration order as an alternative to oral administration.

c. A case conference between Bridgewater State Hospital State Sentenced Units and prison mental health clinicians shall be scheduled prior to the discharge to the prison of a patient with a court-authorized treatment plan.

3. Documentation

a. A court-authorized treatment plan shall be entered in the medical record and noted on the incarcerated individual's medication administration record (MAR).

b. When an incarcerated individual is subject to a court-authorized treatment plan, the incarcerated individual's medication administration record will carry a notation on all pages that the psychotropic medications are ordered under the auspices of a Rogers order. A copy of the court-authorized treatment plan shall be filed in the medical record and referenced prior to any psychotropic medication changes to ensure that such changes are consistent with the treatment plan. Requests for court-authorized changes shall be submitted to the Director of Behavioral Health for referral to the Legal Division.

c. Medical and mental health staff shall cooperate with, and provide relevant information to, the guardian/treatment monitor designated by the Court to monitor the treatment plan. The guardian/treatment monitor shall have access to the incarcerated individual's medical records. The treating Psychiatrist shall contact the guardian/treatment monitor, and, if necessary, the assigned Department of Correction counsel regarding all issues concerning the court-authorized treatment plan, including the approval of non-antipsychotic medications.

4. Involuntary Administration of Court-Authorized Treatment

a. Incarcerated individuals receiving antipsychotic medication pursuant to a court- authorized treatment plan may not refuse to attend a medication line. Each Superintendent shall develop a written procedure, pursuant to 103 DOC 661,

Pharmacy and Medications, to ensure that incarcerated individuals attend the medication line and sign formal refusals when medication is not accepted.

b. If an incarcerated individual with a court-authorized treatment plan refuses medication, a clinician shall inform the incarcerated individual that if they refuse to take the medication by mouth, the incarcerated individual will be escorted to the Health Services Unit (HSU) pending mental health consultation and counseling. The on-site or on-call Psychiatrist shall be contacted immediately for assessment and appropriate intervention.

c. If the incarcerated individual continues to refuse the medication following counseling by mental health staff, the Psychiatrist may order that the incarcerated individual be placed in mental health restraints in the HSU for the administration of intramuscular (IM) medication, where IM medication is incorporated in the court-authorized treatment plan. The Psychiatrist may also recommend alternatives to involuntary administration of IM medication.

d. Continuation of restraints beyond the period of time required for the administration of medication must be authorized by a Psychiatrist in accordance with 103 DOC 650.08, Emergency Mental Health Services.

H. Department of Mental Health Initiated Court Authorized Treatment Plans.

1. Upon the civil commitment of an incarcerated individual from a prison to a facility of the Department of Mental Health pursuant to G.L. c. 123, § 18, the Psychiatrist assigned to the prison shall consult with Department of Mental Health staff concerning medication issues, including the need to obtain a court-authorized treatment plan.

2. Upon the discharge of an incarcerated individual to a prison from a facility of the Department of Mental Health with a court-authorized treatment plan obtained by the Department of Mental Health, the court-authorized treatment plan shall be administered as provided herein.

650.08 EMERGENCY MENTAL HEALTH SERVICES

A. Referral for Emergency Mental Health Services

1. General Provisions

Any staff member believing an incarcerated individual is at risk for self- directed violence, harm to others or at risk due to mental health concerns, shall refer for a mental health crisis assessment. When an incarcerated individual is referred, whether by staff or self-referral, for a crisis evaluation, that individual will be held under constant observation watch by security staff until initially assessed/evaluated by mental health staff. During contracted mental health coverage hours, a Qualified Mental Health Professional will respond to assess the incarcerated individual within one (1) hour.

During non-coverage hours, nursing staff will contact the on-call Qualified Mental Health Professional and consult regarding the incarcerated individual's presentation. The on-call Qualified Mental Health Professional will determine what, if any, interventions are clinically indicated and offer recommendations to the appropriate security and nursing/medical staff. The individuals will be evaluated by a Qualified Mental Health Professional on the next business day or sooner if clinically indicated. The nurse who called the on-call QMHP shall document their assessment and any interventions/recommendations deemed clinically indicated in a progress note.

If an incarcerated individual requests to speak to mental health staff because the incarcerated individual believes they are in mental health crisis, that incarcerated individual will not be disciplined for that request.

2. Mental Health Crisis Assessment/Evaluation (Initial)

The initial crisis evaluation will be documented by the QMHP in the incarcerated individual's mental health progress note using the Description/Assessment/Plan (DAP) format. The DAP note will include, at a minimum, the following considerations:

a. Incarcerated individual's mental status;
b. Incarcerated individual's self-report and reports of others regarding self-directed violence;
c. Current suicidal risk, ideation, plans, lethality of plan, recent stressors, family history, factors that contributed to any recent suicidal behavior and mitigating changes, if any, in those factors, goals of behavior;
d. History, according to electronic medical records and Inmate Management System, of suicidal behavior/ideation - how

often, when, method used or contemplated, why, consequences of prior attempts/gestures;

e. Incarcerated individual's report of their potential/intent for self-directed violence; and

f. Incarcerated individual's capacity to seek mental health help if needed and expressed willingness to do so.

g. During the assessment, the QMHP, as clinically indicated, will consult with a QMHP with prescriptive authority for psychiatric medication issues and a mental health director or designee for clinical issues.

3. Therapeutic supervision will not be used as a punishment or for the convenience of staff but will be used only when less restrictive means are not effective or clinically appropriate. Therapeutic supervisions will be the least restrictive based upon clinical risk.

B. Therapeutic Supervision

1. Therapeutic Supervision Cells

Each Superintendent shall designate specific therapeutic supervision cells in the Health Services Units (HSU) that have been designated as suicide resistant. Where door construction allows and if not prohibited by any fire/safety codes, rules or regulations, all therapeutic supervision cells will use door sweeps in an attempt to prevent any contraband and/or foreign bodies that incarcerated individuals may try to use to engage in self-directed violence. The Superintendent, in conjunction with the Site Mental Health Director, may request that the Director of Behavioral Health approve the utilization of therapeutic supervision in cell locations other than in the Health Services Units. The use of a non-suicide resistant cell for therapeutic supervision shall require constant observation. A current listing of the institution's designated therapeutic supervision cells shall be provided to the Director of Behavioral Health on an annual basis, or more frequently should the location or suicide resistant designation of those cells be changed. A site-specific procedure shall also be forwarded to the Director of Behavioral Health which outlines which cells will be used as overflow therapeutic supervision cells in the event that all other cells are occupied.

2. Initiation of Therapeutic Supervision

When a Qualified Mental Health Professional determines that an incarcerated individual is at risk for suicide or immediate self-directed violence, is otherwise at risk due to mental health concerns, or whose presentation is deemed concerning, as evidenced by signs

of clinical decompensation, the incarcerated individual will be initiated on a clinically appropriate level of therapeutic supervision.

3. Level of Supervision

A Qualified Mental Health Professional shall determine the level of supervision indicated for therapeutic supervision based on their assessment of the incarcerated individual's risk of self-directed violence, and shall re-evaluate the level of supervision indicated every twenty-four (24) hours if the incarcerated individual is on constant observation. If the incarcerated individual is on close observation, the incarcerated individual will be evaluated every twenty-four (24) hours (with the exception of Sundays and holidays). The determination of the level of supervision shall not be dictated by the availability of bed space or staff; rather it shall be based upon the specific clinical needs of the incarcerated individual requiring therapeutic supervision/therapeutic intervention.

The incarcerated individual will be placed in a designated suicide resistant cell with sight lines that permit the appropriate supervision level as indicated by the Qualified Mental Health Professional. If the cell used is not suicide resistant, then the therapeutic supervision must be a Constant Observation.

There are two (2) levels of therapeutic intervention:

a. Constant observation utilizes one-to-one supervision;

b. Close observation utilizes checks within fifteen (15) minute intervals.

c. Constant observation is indicated for an incarcerated individual who is actively suicidal, by threatening or engaging in self-injury and whom mental health staff consider to be at high risk for self-directed violence or suicide. An incarcerated individual on constant observation shall be observed by a staff member on a continuous, uninterrupted basis. The staff member conducting the observation will remain in direct line of sight with the incarcerated individual at all times. Although the observation itself is constant, the documentation shall occur at staggered fifteen (15) minute intervals or more frequently when notable behaviors or events occur. Documentation of observation shall reflect the time the observation occurred.

D. Close observation is indicated for the incarcerated individual who is not actively or acutely suicidal, but who is expressing suicidal ideation and/or who has a recent prior history of self-destructive behavior and whom mental health staff considers to be at moderate risk for suicide. In addition, an incarcerated individual who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-directed violence, violence to others due to mental illness, or inability to care for oneself due to mental illness, should be placed under close observation. A security staff member will check for signs of life in the incarcerated individual at staggered intervals every fifteen (15) minutes (e.g., body movement, skin tone, breath sounds, chest expansion). Documentation of observation shall reflect the time the observation occurred.

Closed Circuit Television may be utilized as a supplement, but not as a substitute, for monitoring by staff observation.

E. Unless clinically contraindicated as delineated on an IMS therapeutic supervision form, and in accordance with instructions from mental health staff, the correctional staff member observing an incarcerated individual on therapeutic supervision shall converse with the incarcerated individual. The correctional staff member or the HSU or other correctional supervisor as feasible shall participate in the daily triage to discuss the interactions and progress of the therapeutic supervision. Notable issues shall be documented on the fifteen (15) minute Observation Check Sheet documentation.

4. Out-of-Cell Assessment, Treatment and Intervention

As a matter of routine, incarcerated individuals on therapeutic supervision shall be escorted from their cell to a confidential setting to participate in their individual mental health assessments, therapeutic sessions with their Primary Care Clinician, as well as to participate in therapeutic interventions and activities with mental health staff. Congregate activities with others on therapeutic supervision may occur as clinically indicated. Additionally, the Support Person will offer non-clinical interactions to provide additional engagement and enrichment to individuals on therapeutic supervision as deemed clinically appropriate by a QMHP. These Support Persons' interactions are in addition to the three (3) daily

clinical contacts. The Support Person will document their contact and the incarcerated individual's behavior in the medical record. The Qualified Mental Health Professional will utilize meaningful, evidenced-based treatment interventions with the incarcerated individual to ameliorate the mental health issues which precipitated the therapeutic supervision. These interventions may include the completion an individualized crisis plan and a collaborative safety plan if needed. A cell front assessment shall only be performed if the incarcerated individual refuses an out-of-cell assessment. A Qualified Mental Health Professional shall complete a progress note documenting an incarcerated individual's refusal of an out-of-cell assessment including the stated reason for the refusal and noting the completion of a cell front assessment. Additionally, the daily mental health triage notes will indicate the incarcerated individuals who declined an out of cell assessment, including the incarcerated individual's stated reason for refusing an out of cell assessment. If an incarcerated individual is refusing out of cell contact, the Qualified Mental Health Professional will attempt various strategies to engage the patient in out of cell clinical contact. The QMHP will document their attempts and strategies applied to see the patient out of cell. An incarcerated individual will be seen for an out-of-cell assessment prior to discharge from therapeutic supervision and actuarial assessment tools shall be utilized to support any discharge determination. If an incarcerated individual is not seen for an out-of-cell assessment prior to discharge, the rationale for this decision will be documented in the incarcerated individual's medical record.

All out-of-cell time on therapeutic supervision will be documented, indicating the type and duration of activity.

5. Documentation

a. Cell Checklist: Prior to placing an incarcerated individual in a cell in which a therapeutic supervision will take place, a security staff person will complete a search of the cell to ensure that the cell is free from potential hazards. A Suicide Resistant Cell Check Sheet will be completed. If an incarcerated individual later engages in self- directed violence, a supervisor will review the checklist as an auditing tool. A copy of the completed Suicide Resistant Cell Check Sheet shall be provided to the Deputy Superintendent of Reentry and kept filed in the Deputy's Office.

b. Observation Check Sheet: The staff person conducting constant or close observation shall utilize the Observation Check Sheet (Attachment #8). The Observation Check Sheet

shall be provided to mental health staff upon their request for review and in aid of assessing the incarcerated individual, and shall be discussed at daily triage. A copy of the completed Observation Check Sheet shall be reviewed by the Deputy Superintendent of Reentry and kept filed in the Deputy's Office.

c. Inmate Management System: A Qualified Mental Health Professional shall enter the requisite therapeutic supervision information in IMS. During non-mental health coverage hours, a qualified health professional, under the direction of the on call Qualified Mental Health Professional, should input the information into IMS. The reason for therapeutic supervision shall specify any special considerations for those monitoring such as self-embedding and/or insertion behaviors, self-directed violence or any special monitoring requests such as hours of sleep, self-dialogue or isolative behaviors. After the conditions of the therapeutic supervision are entered, including level of monitoring, any contraindication to officer/incarcerated individual engagement and interaction, clothing and property allowances, recreation and other routine activities, the therapeutic supervision form shall be printed from IMS, and affixed to the cell door where the therapeutic supervision is being conducted. The completed IMS form shall be signed by a member of security, medical and mental health staff. A copy of the completed IMS form shall be filed in the incarcerated individual's medical record.

d. Medical Record: A Qualified Mental Health Professional shall place a completed crisis treatment plan in the incarcerated individual's medical record documenting a suicide risk assessment and the justification for the level of observation. Thereafter, all therapeutic sessions, interventions and success of the intervention, activities, daily assessments and plan shall be documented in a DAP format progress note. Each day a completed IMS form, noting any changes in status or level of observation inclusive of increased treatment needs or alterations to the conditions must be completed. The daily assessment must indicate that there was clinical consultation/discussion with the Mental Health team or with the Mental Health Director. Should there be a medication related issue due to decompensation or non-compliance, the prescriber must be consulted, and that consultation must be documented.

e. The Crisis Treatment Plan will include at a minimum the following elements:
   i. A precipitating events that resulted in the reason for the therapeutic supervision;
   ii. Historical, clinical, and situational risk factors;
   iii. Protective factors;
   iv. The level of watch indicated;
   v. Discussion of current risk;
   vi. Measurable objectives of crisis treatment plan;
   vii. Strategies to manage risk;
   viii. Strategies to reduce risk;
   ix. The frequency of contact;
   x. Staff interventions; and
   xi. Review of current medications (including compliance and any issues described by the prisoner) and referral to a psychiatrist or psychiatric nurse practitioner for further medication discussions if clinically indicated.

6. Conditions

a. Treatment: Incarcerated individuals on therapeutic supervision shall receive multiple mental health contacts per day to address the individualized crisis treatment plan goals, address symptoms, and increase socialization through individual and congregate activities as clinically indicated. If not clinically contraindicated, a minimum of three (3) out of cell contacts per day shall be offered and be documented in the medical record clearly identifying the goal of the contact, the progress or lack thereof toward completion of the goals and a clear plan for ongoing treatment. Any diversion from the minimum contacts must be documented in the record, clearly identifying the clinical contraindication and alternative treatment interventions offered.

b. Property:- Throughout the incarcerated individual's time on therapeutic supervision, a Qualified Mental Health Professional will make and document individualized determinations regarding the incarcerated individual's property, and restrictions should be the least restrictive possible, consistent with incarcerated individual safety. Of note, in the following sections when specific time frame for access to identified property are specified, nothing precludes the approval and issuing of said item before the time frame so long as it does not endanger the physical/mental safety of the incarcerated individual. The incarcerated individual's

property and privileges will be reviewed daily Monday through Saturday and on Sundays for incarcerated individuals on constant observation therapeutic supervision.

In the event of a disagreement over any of these determinations, the matter will be referred to the Mental Health Director and to the Superintendent of the institution as deemed necessary. The Superintendent or Designee will consult with the Deputy Commissioner of Clinical Services and Reentry or Designee and Deputy Commissioner of Prisons or Designee as deemed necessary, who will be responsible for rendering the final decision.

c. Clothing: For the duration of an incarcerated individual's placement on therapeutic supervision, a Qualified Mental Health Professional will make and document individualized determinations regarding the prisoner's clothing, using the following standards:

i. Incarcerated individuals on therapeutic supervision will be permitted their clothing unless there are clinical contraindications, which must be documented and reviewed three times during each day (Monday-Saturday), spaced out throughout waking hours, and one time on Sundays (for incarcerated individuals on Constant Observation Watch), to see if those contraindications remain;

ii. Removal of an incarcerated individual's clothing (excluding belts and shoelaces) and placement in a safety smock (or similar gown) should be avoided whenever possible and only utilized when the individual has demonstrated that they will use the clothing in a self-destructive manner;

iii. If an incarcerated individual's clothing is removed, a Qualified Mental Health Professional will document individual reasons why clothing is contraindicated to their mental health, and it is the goal that no incarcerated individual should be placed in a safety smock for twenty-four (24) hours or more; and

iv. After forty-eight (48) hours, all incarcerated individuals will have their clothes returned with continued monitoring unless MDOC's Director of Behavioral Health is notified and the contracted

medical care provider's Director of Clinical Programs is consulted and approves. Individual reasons why clothing is contraindicated to their mental health will be documented by the assessing clinician in the medical record.

d. Routine Activities: Incarcerated individuals on therapeutic supervision shall be allowed all routine activities including, but not limited to, family visits, telephone calls, chaplain rounds, health care contacts, attorney visits, and activity therapist visits unless a Qualified Mental Health Professional conducting the therapeutic supervision evaluation determines that any such activity is clinically contraindicated. There must be documentation regarding clinical recommendations for the conditions of the therapeutic supervision.

e. Shower: Incarcerated individuals on therapeutic supervision will be approved access to a shower as soon as safely possible unless clinically contraindicated. If an incarcerated individual has been on therapeutic supervision for seventy-two (72) hours and has not been approved for a shower, a Qualified Mental Health Professional will document individual reasons why a shower is contraindicated to their mental health. Correctional staff will document when an incarcerated individual is offered an approved shower. Similarly, if an incarcerated individual has been on therapeutic supervision for longer than seventy-two (72) hours and has not been approved for a shower approximately every two (2) days, a Qualified Mental Health Professional will document individual reasons why a shower is contraindicated to their mental health. Correctional staff will document when an incarcerated individual is offered an approved shower.

f. Lighting: Lighting will be reduced during incarcerated individual sleeping times so long as the individual's hands, restraints, and movements, can be clearly observed by security staff.

g. Privileges: Throughout the incarcerated individual's time on therapeutic supervision, a Qualified Mental Health Professional will make and document individualized determinations regarding the individual's privileges. (For example, access to reading and writing materials, and access to a tablet). The Qualified Mental Health Professional will

use the following the standards: After twenty-four (24) hours, if not approved sooner, incarcerated individuals will have access to library books, inclusive of leisure reading materials, and other reading and writing materials, unless a Qualified Mental Health Professional documents individualized reasons such materials are contraindicated to the incarcerated individual's mental health each day, and repeats this same process each day until such materials are approved.

Likewise, after fourteen (14) days, if not approved sooner, incarcerated individuals will have access to a tablet with headphones, unless a Qualified Mental Health Professional documents individualized reasons the tablet is contraindicated to the incarcerated individual's mental health.

h. Exercise: After seventy-two (72) hours on therapeutic supervision, unless sooner approved, incarcerated individuals will have access to outdoor recreation/exercise. If the incarcerated individual is not approved such access, the assessing Qualified Mental Health Professional, in consultation with the prison's Mental Health Director, will document individualized reasons why outdoor recreation is contraindicated to the incarcerated individual's mental health. Correctional staff will document when an incarcerated individual is offered approved recreation.

Likewise, if, after seventy-two (72) hours on therapeutic supervision, an incarcerated individual is not clinically approved access to outdoor recreation, at least five (5) days per week for one hour, the assessing Qualified Mental Health Professional must document individualized reasons such exercise is contraindicated to the incarcerated individual's mental health each and every day.

During outdoor exercise, escorting officers will provide supervision during the exercise period, consistent with the level of therapeutic supervision. As with considerations regarding use of restraints, alternatives to strip searches will be explored on an individual basis. In determining if strip searches are necessary, factors to consider include but are not limited to; a documented history of inserting or hiding implements to self-injure or harm others, a documented history of behavior that may constitute a security risk, a history of engaging in self- injurious behavior, and the

property items that have been approved for retention by the incarcerated individual while on therapeutic supervision.

i. Restraints: Incarcerated individuals in mental health crisis will not be restrained when removed from their cells unless there is an imminent or immediate threat to safety of the incarcerated individual, other incarcerated individuals, or staff, as determined by security staff. Security staff will consult the Qualified Mental Health Professional to determine whether restraints are contraindicated, and where there is such a finding, the Qualified Mental Health Professional will document the individual reasons why restraints are clinically contraindicated.

j. Meals out of cell: Absent medical, clinical, or safety/security concerns, after seventy-two (72) hours on Mental Health Watch, all incarcerated individuals will have access to meals out of their cells unless the area where the incarcerated individuals are on therapeutic supervision has insufficient space or the Department of Public Health does not permit the space to be used for such purposes. If the reason for not approving meals out of cell is a clinical decision by the Qualified Mental Health Professionals, they will document individualized reasons out of cell dining is contraindicated to the incarcerated individual's mental health.

7. Attorney Visits

a. Incarcerated individuals on therapeutic supervision shall have unimpeded access to their attorneys at all times.

b. Prior to any attorney or other legal visit with an incarcerated individual on therapeutic supervision, a Qualified Mental Health Professional shall conduct a clinical assessment and identify the appropriate conditions of the visit, consistent with the incarcerated individual's mental health status, including but not limited to whether the visit should be a contact or non-contact visit; the appropriate clothing; and the appropriate permissible property, if any (e.g. pen/pencil). These conditions shall be entered on the IMS Therapeutic Supervision screen.

c. The Superintendent shall determine the location and conditions of any legal visit for an incarcerated individual on therapeutic supervision based upon the recommendations of the Site Mental Health Director and also upon the

institution's ability to meet the restrictions imposed on the visit by the Site Mental Health Director, taking into account the physical plant and the safety and security concerns that exist within the institution. The Superintendent or designee shall be responsible for notifying the attorney of the conditions and restrictions of any such visit.

d. All visits shall be entered on the IMS Incarcerated individual Schedule screen. All visits shall be supervised by a DOC employee for safety/security purposes. At the conclusion of all such visits, a clinician shall follow-up with the incarcerated individual to ensure that their mental status has not changed and note the incarcerated individual's mental status in the incarcerated individual's medical record. Any changes to therapeutic supervision status and property allowances shall be updated on the IMS therapeutic supervision report.

8. Duration

a. Therapeutic supervision will be no longer in duration than necessary to deal with the mental health crisis that caused the incarcerated individual to be placed on therapeutic supervision. Regardless of the length of stay. when determined to be clinically appropriate by a Qualified Mental Health Professional, in consultation with the Site Mental Health Director, corresponding Unit Director, and Program Mental Health Director, an incarcerated individual will be transferred to a higher level of care, for example, the Secure Treatment Program, Behavior Management Unit, or Intensive Stabilization Unit, once such unit is operational. When statutory requirements are met pursuant to G.L. c. 123, §18, the individual will be placed at Bridgewater State Hospital or a Department of Mental Health facility in accordance with the orders of the court.

b. In the event that an incarcerated individual is maintained on therapeutic supervision for more than seventy-two (72) hours, the site Mental Health Director shall consult with the Program Mental Health Director, and notification will be made to the Director of Behavioral Health or designee during the daily therapeutic supervision Consultation call. The Qualified Mental Health Professional will document consideration of a higher level of care in the medical record.

c. In the event that an incarcerated individual remains on therapeutic supervision for more than seven (7) days, the Program Mental Health Director and the Site Mental Health Director will consult with and discuss next steps with the Director of Behavioral Health and the Assistant Deputy Commissioner of Clinical Services. The Qualified Mental Health Professional, with input from others as necessary, will document (1) the consideration of a higher level of care and (2) specific individualized reasons if a higher level of care is not clinically indicated in the corresponding progress note.

d. In the event that an incarcerated individual remains on therapeutic supervision for more than fourteen (14) days, for that day and each day following, the Program Mental Health Director and Site Mental Health Director will consult with and discuss next steps with the Director of Behavioral Health, the Assistant Deputy Commissioner of Clinical Services and Deputy Commissioner of Re-entry and Clinical Services. Further, each day an incarcerated individual remains on therapeutic supervision without being transferred to a higher level of care, the assessing Qualified Mental Health Professional, with input from others as necessary, will document (1) consideration of a higher level of care and (2) specific individualized reasons if a higher level of care is not clinically indicated in the corresponding progress note in addition to (3) re-evaluating all mental health interventions and (4) updating the Crisis Treatment Plan.

9. Discharge

The following procedures will govern step down, discontinuation, and follow up from therapeutic supervision.

a. A Qualified Mental Health Professional approves discharge from therapeutic supervision as early as possible after an out-of-cell mental health assessment using a suicide risk assessment format and a consultation with the mental health team during the daily mental health triage meeting, which will include the Site Mental Health Director and, when clinically indicated, an upper-level provider (i.e., psychiatrist, psychiatric nurse practitioner, advanced practice registered nurse, or psychologist), or a consultation with the Site Mental Health Director prior to the daily triage meeting. On Saturday and Sunday, consultation is with the regional on-call mental health clinician. The Qualified

Mental Health Professional will document that they have determined that the incarcerated individual presents lower risk of imminent self-injury prior to discharge. When clinically indicated, for example, decompensation or medication non-compliance, a psychiatrist or psychiatric nurse practitioner will be consulted. If an incarcerated individual is not seen out-of-cell at the time of discontinuation, the rationale for this decision will be documented by the QMHP in the individual's medical record.

b. When an incarcerated individual is discharged from therapeutic supervision, the Qualified Mental Health Professional will document a discharge plan, which will be communicated to appropriate mental health and security staff and will include any recommended referral to clinically appropriate housing, and a safety plan that addresses the risk factors specific to that incarcerated individual, follow-up and continued plan of care, as well as a brief mental status update. This will be documented on a Discontinuation of Crisis Plan form. Additionally, the discontinuation will be entered on the IMS Therapeutic Supervision screen.

c. Prior to discharge, if clinically indicated, individuals on therapeutic supervision will be interviewed by an upper-level provider (i.e., psychiatrist, psychiatric nurse practitioner, advanced practice registered nurse, or psychologist) to determine mental health stability and potential mental health diagnosis (if undiagnosed) or misdiagnosis.

d. An incarcerated individual placed on constant observation shall be downgraded to close observation for a reasonable period of time prior to being discharged from therapeutic supervision, unless the incarcerated individual has been placed on constant observation solely for the reason that the therapeutic supervision cell was not deemed to be suicide resistant. In such cases, the mental health clinician shall document the reason for the constant observation status and note that incarcerated individual's clinically assessed risk level indicates only a close observation.

e. After being discharged from therapeutic supervision, an incarcerated individual shall be assessed by a Qualified Mental Health Professional within twenty-four (24) hours of discharge following the return to their assigned housing unit or other placement to ensure the transition is successful, then

again within seventy-two (72) hours of discharge and then again within ten (10) days of discharge, and a clinical risk assessment shall be completed. If an incarcerated individual who has been discharged from therapeutic supervision is not on the active open mental health caseload, they should be assessed to determine the appropriate level of clinical follow-up required up to and including open for evaluation status.

C. Mental Health Restraints

1. Purpose of Mental Health Restraints

a. Imminent Danger to Self or Others: When an incarcerated individual presents an imminent danger to self or others by reason of mental illness, the use of mental health restraints shall be considered. In this situation, mental health restraints constitute a treatment modality. However, mental health restraints may be ordered as a treatment modality only after determining that other available clinical interventions are ineffective, inappropriate, or have failed previously (e.g., mental health contact, therapeutic supervision, medication).

b. Involuntary Treatment: Mental Health restraints may be utilized where necessary to facilitate the administration of involuntary medical or mental health treatment in an emergency or pursuant to a court order.

2. Authorization for Mental Health Restraints

a. Mental Health restraints may be ordered only by a psychiatrist or approved by the on-call psychiatrist as a temporary measure for the control of behavior. Under no circumstances shall mental health restraints be used as a disciplinary measure. Mental health restraints shall not be used as a convenience for institution medical staff, except as authorized by a court order.

b. Mental health restraints may be ordered by a psychiatrist or approved by the on-call psychiatrist to restrict the movement of an incarcerated individual to allow for the safe involuntary administration of

psychiatric medication. Such restraints should be utilized only if other less restrictive measures are deemed ineffective or inappropriate or have failed previously.

c. Pro re nata (PRN)orders, that is orders for mental health restraints which authorize staff to employ mental health restraints as needed without individualized evaluation and determination, are not permitted.

3. Forms of Mental Health Restraints

a. Padded leather restraints may be used to secure an incarcerated individual in a supine or face-up position to a secure bed for the purpose of restricting movement or behavior which may be harmful to self or others. Metal restraints may be used only if the incarcerated individual has a documented history of escape from soft restraints or ability to be uncontrolled in soft restraints.

b. Padded wedges utilized to facilitate the involuntary injection of medication are not deemed mental health restraints.

4. Location

Mental health restraints shall be used only in specifically designated cells within HSUs and those cells shall be designated in the institution's site specific procedures. Alternative location plans, including the circumstances for such utilization, shall be submitted to the Director of Behavioral Health on an annual basis, or more frequently should the location plan or circumstances for utilization be revised.

5. Procedure for Using Mental Health Restraints

a. Whenever possible, prior to obtaining an order for mental health restraints, the Site Mental Health Director or designee, shall be contacted. The Site Mental Health Director or designee shall consult with the on-site or on-call psychiatrist. The psychiatrist shall make a decision regarding the use of mental health restraints. The psychiatrist shall convey the restraint order to the appropriate on-site mental health or medical professional and appropriate medical staff.

b. The Shift Commander shall be notified if the decision is made to place an incarcerated individual in mental health restraints. The Shift Commander shall direct the correctional staff in placing the incarcerated individual in restraints.

c. Notwithstanding the psychiatric decision regarding the use of mental health restraints, the Superintendent may take any additional steps that the Superintendent deems necessary to ensure the safety and security of staff, the incarcerated individual and other incarcerated individuals.

d. To prevent the potential for positional asphyxiation, the following guidelines have been established to reduce the risk of harm to an incarcerated individual due to restraining an incarcerated individual:

i. Staff shall always maintain observation of a restrained incarcerated individual to recognize breathing difficulties or loss of consciousness. Staff shall be alert to issues such as obesity, alcohol and drug use, or psychotic behavior.

ii. Staff members shall never sit or put their weight on an incarcerated individual's back, chest or abdomen while the incarcerated individual is in restraints.

iii. In situations involving an unrestrained incarcerated individual who is resisting efforts of staff to regain control of them, staff may use their weight for only such period of time as is necessary to gain control of and/or restrain the incarcerated individual.

iv. If, as a result of a use of force, it becomes necessary to restrain an incarcerated individual to the ground, bed, floor, etc., the incarcerated individual, once handcuffed, shall, as soon as possible, be placed on the incarcerated individual's side. The incarcerated individual shall never be kept face down on their stomach. Staff shall take all possible efforts to avoid prolonged compression of an incarcerated individual's abdomen.

v. Staff at no time shall connect handcuffs to leg restraints.

vi. Incarcerated individuals shall never be transported face down on their stomach (i.e., while using a stretcher, gurney, backboard or vehicle).

6. Medical Review of Incarcerated Individuals in Mental Health Restraints

a. Immediately following the placement of an incarcerated individual in mental health restraints, medical staff shall conduct an examination of the incarcerated individual to ensure that no injuries exist, that restraint equipment is not applied in a manner likely to result in an injury, and that there is no medical contraindication to maintaining the incarcerated individual in mental health restraints.

b. Incarcerated individuals in mental health restraints shall be examined by medical staff immediately following placement in mental health restraints and every fifteen (15) minutes subsequent to the initial examination. The purpose of such examinations is to check for injuries and respiration and circulation.

c. Medical staff shall check the incarcerated individual's vital signs at a minimum of every thirty (30) minutes while the incarcerated individual is awake or at least once per shift while the incarcerated individual is asleep. Medical staff shall perform vital sign monitoring more frequently as clinically indicated.

7. Documentation and Review

a. The use of mental health restraints shall be documented in the medical record, on the Physician Order Sheet, in the Progress Notes, and on the IMS Mental Health Watch Screen. The content of this documentation shall include specific reasons for the use of these restraints.

b. All medical examinations conducted shall be documented in the incarcerated individual's medical record and on the Four-Point Restraint Medical Examination Checklist (Attachment #9).

c. The Medical Examination Checklist shall be submitted to the Shift Commander for incorporation in the Use of Force Report governed as required by 103 CMR 505, *Use of Force.*

8. Duration of Mental Health Restraints

a. Mental health restraints may be prescribed for a period not to exceed two (2) hours. Renewal orders may be prescribed for periods not to exceed two (2) hours each. Renewal orders shall be documented. The incarcerated individual shall be evaluated prior to each renewal.

b. During regular business hours, the psychiatrist shall prescribe renewal orders. During non-business hours, the on-call psychiatrist shall be contacted for such renewal orders.

c. After two (2) hours and every two (2) hours thereafter, an incarcerated individual may be allowed to exercise their limbs. Exercise shall be accomplished by freeing one limb at a time from restraints and for a period of approximately two (2) minutes. Exercise shall only be granted if the freeing of the limb will not pose a threat of harm to the incarcerated individual being restrained or to others. Denial of exercise shall be reported to the Superintendent and the psychiatrist. The reporting officer shall document the reasons for the denial. Exercise shall be documented in the comment section of the Correction Officer Observation Sheet (Attachment #8).

d. PRN orders for mental health restraints shall not be written. Within forty-eight (48) hours of the initial use of mental health restraints, the psychiatrist must document the clinical rationale for not pursuing psychiatric hospitalization.

e. If an incarcerated individual is restrained beyond eight (8) hours, the Director of Behavioral Health shall be notified, who in turn shall notify the Deputy Commissioner of Clinical Services and Reentry.

f. No incarcerated individual may be kept in mental health restraints for longer than seventy-two (72) consecutive hours. If continued use of restraints is indicated after seventy-two (72) consecutive hours in which restraints have been continuously ordered, the incarcerated individual shall be considered for possible transfer to the appropriate psychiatric facility at the earliest possible time. Such transfer shall only occur after a court order for involuntary psychiatric hospitalization has been obtained.

g. In all cases, mental health restraints shall be discontinued at the earliest possible time, based upon observation of the incarcerated individual's behavior and clinical condition.

h. All incarcerated individuals in mental health restraints must be under constant observation with notations of condition made at a minimum of every fifteen (15) minutes on the Observation Check Sheet (Attachment #8). Notations shall include incarcerated individual behavior during the designated time period.

9. Feeding

a. Meals shall not be withheld from incarcerated individuals in mental health restraints. The on-site/on-call medical director or Site Mental Health Director shall determine whether the incarcerated individual will receive the same meals as those served to the general population or an alternative meal that meets nutritional guidelines.

b. All feeding and refusals shall be documented on the Observation Check Sheet (Attachment #8). Medical staff shall document nutritional intake on the Intake and Output Chart in the incarcerated individual's medical record.

10. Use of Toilet Facilities

Access to a toilet shall be made available upon request or at reasonable intervals. Use of restraint equipment to ensure the safety of the incarcerated individual and staff shall be reviewed and approved by the Shift Commander.

11. Programs

Incarcerated individuals in mental health restraints shall not be allowed participation in any programs, including visitation. The incarcerated individual shall be provided appropriate psychiatric, psychological or medical examinations and interventions. The Shift Commander shall ensure that proper security is maintained during examinations and interventions.

12. Use of Audio/Visual Equipment

Whenever possible, audio/video equipment shall be used to assist in documentation of placement in mental health restraints, including initial and subsequent medical and psychiatric examinations,

feeding, breaks, removal of restraints, and any other significant incident.

13. Use of Mental Health Restraints at Outside Hospitals

The use of mental health restraints in outside hospitals, including the Lemuel Shattuck Hospital, shall follow the protocol of the hospital.

D. Emergency Involuntary Administration of Psychotropic Medication

The involuntary administration of antipsychotic medication may be used only on an emergency basis and only as set forth herein.

1. Criteria for Involuntary Administration of Psychotropic Medication

The involuntary administration of psychotropic medication may be used if:

a. An incarcerated individual poses a clear and immediate threat to harm their self or others; or to prevent the immediate, substantial and irreversible deterioration of a serious mental illness of an incarcerated individual who is currently incapable of making informed medical decisions on their own behalf; and

b. All less restrictive or intrusive measures have been employed or have been judged by the treating psychiatrist, on-call psychiatrist, or physician to be inadequate.

2. Medical Authorization

Once involuntary administration of psychotropic medication is deemed appropriate by the psychiatrist or an on-call psychiatrist, the following should be documented in the incarcerated individual’s medical record:

a. The incarcerated individual's condition, threat posed, and reason for the involuntary administration of psychotropic medication, including other treatments attempted within the immediately preceding twenty-four (24) hours; and

b. Authorization for involuntary administration of psychotropic medication that is specifically limited to a single dose of such medication; and

c. A description of how the medication is to be administered (e.g. intramuscularly, orally).

d. This can be documented as a written order by the on-site psychiatrist, or communicated via verbal order by an on-call psychiatrist outside of business hours; and

e. When indicated and available, consultation with another psychiatrist or Site Medical Director prior to the involuntary administration of psychotropic medication is encouraged.

3. Monitoring

Following the emergency administration of psychotropic medication, the incarcerated individual shall be monitored for any adverse reactions or side effects, and any such side effects shall be documented in the medical record.

4. Treatment Plan

As soon as possible following the emergency administration of psychotropic medication, the incarcerated individual's treatment plan shall be reviewed to incorporate goals to identify less restrictive treatment alternatives.

E. Psychiatric Hospitalization

1. Bridgewater State Hospital

a. Civil Commitment

G.L. c. 123, §18(a) provides that a court may order the admission of male incarcerated individuals to Bridgewater State Hospital (BSH) for inpatient evaluation and, if necessary, civil commitment and court authorization for treatment with antipsychotic medication. The recommendation for civil commitment to BSH shall be made by a licensed and qualified psychiatrist or psychologist. To facilitate continuity of care, the Site Mental Health Director at the sending prison shall provide the BSH State Sentenced Units Director with a verbal report regarding all pertinent clinical issues. In addition, the Deputy Superintendent of Reentry at the sending prison shall provide the BSH Deputy Superintendent of Patient Services with a verbal report of information that is pertinent for the patient's management, safety and treatment.

G.L. c. 123, §18(a 1/2) provides that an incarcerated individual, a staff person at the request of the incarcerated individual, or the incarcerated individual's legal representative may petition a court to order the transfer of the incarcerated individual to a suitable inpatient psychiatric facility if the incarcerated individual (a) has been on therapeutic supervision for more than seventy-two (72) hours or (b) is at serious risk of imminent and serious self-harm. Once an incarcerated individual has been on therapeutic supervision for forty-eight (48) hours and every twenty-four (24) hours thereafter that the incarcerated individual remains on therapeutic supervision, a QMHP shall inform the incarcerated individual of their right to petition pursuant to G.L. c. 123, §18(a 1/2). A QMHP shall further inform the incarcerated individual that staff will petition on the incarcerated individual's behalf if requested to do so by the incarcerated individual. If the incarcerated individual requests, either orally or in writing, that staff petition pursuant to G.L. c. 123, §18(a 1/2), a QMHP shall file a petition in the appropriate court within twelve (12) hours of the incarcerated individual's request.

b. Discharges

At least forty-eight (48) hours prior to an incarcerated individual's discharge from BSH State Sentenced Units to the petitioning prison, the Medical Director of Bridgewater State Hospital or designee shall provide the Site Mental Health Director at the prison with a verbal report of any information that has implications for the incarcerated individual's management, safety, and treatment at the prison. In addition, the BSH Deputy Superintendent of Patient Services shall provide the Deputy Superintendent with a verbal report of any information that has implications for the incarcerated individual's management, safety, and treatment at the prison.

At discharge, State Sentenced Units will forward a copy of the most recent Section 18(a) evaluation or a Discharge Summary Form to the receiving institution.

Prior to the discharge of a civilly committed BSH State Sentenced incarcerated individual to a prison, an inter-institution case conference shall be requested by the BSH treatment team and scheduled by the Health Services

Division in order to directly discuss clinical recommendations for treatment and to ensure uninterrupted care.

Whenever an incarcerated individual returns to an institution from Bridgewater State Hospital, the incarcerated individual will be reassessed by a Qualified Mental Health Professional to determine if a new placement on therapeutic supervision is appropriate at that time.

2. Department of Mental Health

a. Civil Commitment

G.L. c. 123, §18(a) provides that a court may order the admission of female incarcerated individuals to a facility of the Department of Mental Health (DMH) for inpatient evaluation and, if necessary, civil commitment and court authorization for treatment with antipsychotic medication. The recommendation for civil commitment to a DMH facility shall be made by a licensed and qualified psychiatrist or psychologist. MCI-Framingham mental health clinicians shall communicate with the designated Department of Mental Health clinician to convey pertinent information.

G.L. c. 123, §18(a 1/2) provides that an incarcerated individual, a staff person at the request of the incarcerated individual, or the incarcerated individual's legal representative may petition a court to order the transfer of the incarcerated individual to a suitable inpatient psychiatric facility if the incarcerated individual (a) has been on therapeutic supervision for more than seventy-two (72) hours or (b) is at serious risk of imminent and serious self harm. Once an incarcerated individual has been on therapeutic supervision for forty-eight (48) hours and every twenty-four (24) hours thereafter that the incarcerated individual remains on therapeutic supervision, a QMHP shall inform the incarcerated individual of their right to petition pursuant to G.L. c. 123, §18(a 1/2). A QMHP shall further inform the incarcerated individual that staff will petition on the incarcerated individual's behalf if requested to do so by the incarcerated individual. If the incarcerated individual requests, either orally or in writing, that staff petition pursuant to G.L. c. 123, §18(a 1/2), a QMHP shall file a petition in the appropriate court within twelve (12) hours of the incarcerated individual's request.

b. Discharges

Upon the discharge of an incarcerated individual from a facility of the DMH to MCI-Framingham, the MCI-Framingham Site Mental Health Director shall request from DMH all information which is necessary to ensure continuity of care, including the information set forth in 103 DOC 650.17 (B), Case Identification and Initiation.

Whenever an incarcerated individual returns to a institution from a DMH hospital, the incarcerated individual will be reassessed by a Qualified Mental Health Professional to determine if a new placement on therapeutic supervision is appropriate at that time.

3. Male Incarcerated Individuals

Although G.L. c. 123, §18(a) and (a1/2) also allow for the civil commitment of a male incarcerated individual to a DMH facility, it is rare. The Director of Behavioral Health shall be contacted immediately upon knowledge of a civil commitment of a male incarcerated individual to a DMH facility or the discharge of a male incarcerated individual from a DMH facility to a prison.

Whenever an incarcerated individual returns to a institution from a DMH hospital, the incarcerated individual will be reassessed by a Qualified Mental Health Professional to determine if a new placement on therapeutic supervision is appropriate at that time.

F. Hunger Strikes or Cessation of Nutritional Intake

1. For the purpose of this Section, a "hunger strike" shall mean when an incarcerated individual declares a hunger strike and refuses nourishment (food or supplement) for more than twenty-four (24) hours (four consecutive meals) for reasons other than physical or mental illness.

2. The Mental Health Contractor, in conjunction with the Medical Contractor, shall maintain written procedures governing the management of hunger strikes or cessation of nutritional intake.

3. An incarcerated individual who has declared a hunger strike or who has refused to take food or supplements for twenty-four (24) hours shall be referred for a mental health evaluation pursuant to 103 DOC 650.05 (I), Mental Health Evaluations. Subsequent mental health

assessments shall continue during regular business hours for the duration of the failure to eat behavior. Psychiatric hospitalization shall be considered if the incarcerated individual meets the civil commitment criteria.

4. Mental health clinicians shall cooperate with Department staff and medical staff in the management of the event, including the provision of counseling to the incarcerated individual to resolve the problem.

5. Within three (3) days following the completion of the hunger strike, a Qualified Mental Health Professional shall conduct a follow-up assessment and complete a mental status exam.

650.09 MANAGEMENT OF POTENTIALLY SUICIDAL INCARCERATED INDIVIDUALS AND SELF-DIRECTED VIOLENCE

A. General Policy

Whenever an incarcerated individual is identified as "at risk" for self-destructive behavior, mental health staff shall conduct an immediate evaluation. Correctional staff shall implement precautionary procedures, including continuous monitoring and/or observation, until the evaluation occurs. Correctional staff will engage with the incarcerated individual and encourage cessation of the behavior. The mental health evaluation shall determine the course of action required to provide the incarcerated individual with support and monitoring during the critical period. If the incarcerated individual has attempted suicide or otherwise engaged in self-injurious behavior, the incarcerated individual shall receive immediate medical attention. Notifications of self-directed violence must be made immediately to a Qualified Mental Health Professional. Correctional staff shall be trained in the identification and custodial care of incarcerated individuals with mental illness. All staff who observe and/or discover an incident of self-directed violence will document such incidents in the Inmate Management System with an incident report. Incident reports must be submitted for incidents of self-directed violence, statements about self-harm and/or suicide attempts.

Within twenty-four (24) hours, a Qualified Mental Health Professional will complete a Self-Injurious Behavior Occurrence Report (SIBOR).

B. Referral

The referral process for the potentially suicidal incarcerated individual shall be governed by 103 DOC 650.05 (C), Mental Health Referral, 650.05 (E), Staff Referral and 650.08 (A), Referral for Emergency Mental Health Services.

C. Monitoring

The monitoring process for the potentially suicidal incarcerated individual shall be governed by Section 650.08 (B), Therapeutic Supervision.

Any Self-Injurious Behavior that occurs during a therapeutic supervision will be documented by the officer who was responsible for observing the prisoner. The documentation will describe the self-directed violence as it occurred while the incarcerated individual was on Constant or Close observation watch.

Any incarcerated individual who engages in self-directed violence while on therapeutic supervision will be re-assessed for modification of interventions when clinically indicated.

Within twenty-four (24) hours of any incident of self directed violence, a Qualified Mental Health Professional will conduct an additional assessment and modify the prisoner's treatment plan if clinically appropriate.

D. Treatment

If it is determined that an incarcerated individual is in danger of immediate self-harm, the incarcerated individual shall be placed on a clinically appropriate level of therapeutic supervision as governed by 103 DOC 650.08 (B), Therapeutic Supervision. Emergency mental health treatment may be provided as clinically indicated as governed by 103 DOC 650.08 (B), Therapeutic Supervision. The incarcerated individual's mental health team shall develop and implement a treatment plan to address the incarcerated individual's short term and long term needs.

Following a suicide attempt or self-directed violence incident requiring medical admission, psychiatry will be consulted to determine if it is clinically indicated for the incarcerated individual to be assessed by psychiatry following return to an institution from the medical admission. If the incarcerated individual is not assessed by psychiatry upon return to an institution from the medical admission, the incarcerated individual shall be assessed by psychiatry within 72 hours of return to an institution from the medical admission.

For a person with a history of SDV/SATT, who had a recent non-lethal or non-serious SDV/SATT event, psychiatry shall meet with that person within seven (7) days of the event, if clinically indicated.

E. Discharge from "At Risk" Status

If it is determined that an incarcerated individual is not currently at risk of suicide or self-injurious behavior, the incarcerated individual may be restored to the incarcerated individual's housing unit with follow-up by mental health staff as clinically indicated.

The discharge from therapeutic supervision of the potentially suicidal incarcerated individual shall be governed by 103 DOC 650.08 (B)(8), Duration of Mental Health Restraints.

F. Suicide Prevention Plan

The Program Mental Health Director shall collaborate with the Director of Behavioral Health in establishing a site-specific suicide prevention plan. The suicide prevention plan shall:

1. Identify the warning signs and symptoms of impending suicidal behavior;
2. Provide an understanding of the demographic and cultural parameters of suicidal behavior, including incidence and variations in precipitating factors;
3. Review how to respond to suicidal and depressed incarcerated individuals;
4. Highlight communication between correctional and health care personnel;
5. Outline referral procedures;
6. Review housing observation and suicide watch level procedures;
7. Outline follow-up monitoring protocols for incarcerated individuals who make a suicide attempt;
8. Identify incarcerated individuals who require evaluation for potential suicide risk;
9. Provide for referral, assessment, monitoring, and placement of incarcerated individuals who are at risk for potential suicide;
10. Ensure that communication occurs among mental health, medical and correctional staff regarding the status of incarcerated individuals identified as "at risk" for potential suicide;
11. Establish a protocol for the intervention of a suicide in progress;
12. Establish a protocol for notification of completed and attempted suicides;
13. Provide for the review of completed and attempted suicides; and
14. Establish data collection for completed and attempted suicides and for self-injurious behavior.

G. Training for Correctional Personnel

Subject to collective bargaining agreements and bidding process, correction officers and correctional program officers shall receive annual in-service training of at least two (2) hours per year on mental health issues and suicide prevention. In addition, all correction officer and correctional program officer recruits shall receive an eight (8) hour training as part of pre-service training. This training is established by the Mental Health Authority in conjunction with the institution/program administrator.

1. Training on mental health care, suicide prevention and de-escalation techniques will be provided by trainers using current evidence-based standards on these issues, and will include, if available, video(s) depicting individuals speaking about their own experiences or experiences of their family members who have been on therapeutic supervision.

2. Current policies about observing therapeutic supervision will be posted in visible places on every unit where therapeutic supervision takes place.

3. Such annual training for correction officers and correctional program officers shall include the identification and custodial care of incarcerated individuals with mental illness and shall include:

    a. Suicide intervention strategies, policies and procedures;

    b. Analysis of institution environments and why they may contribute to suicidal behavior;

    c. Potential predisposing factors to suicide;

    d. High-risk suicide periods;

    e. Warning signs and symptoms of suicidal behavior (including the suicide screening instrument and the medical intake tool);

    f. Observing incarcerated individuals on therapeutic supervision (prior to the Mental Health Crisis Assessment/Evaluation) and, if applicable, step- down unit status;

    g. De-escalation techniques;

    h. Case studies of recent suicides and serious suicide attempts;

i. Scenario-based trainings regarding the proper response to a suicide attempt, and lessons learned from past interventions

H. Training for Mental Health Personnel

The Mental Health Contractor shall train mental health clinicians on the prevention and intervention of self-injurious behavior and management of persons experiencing chronic self-injurious behavior and new policies that affect the provision of medical and mental health care. Training shall include, at minimum, an eight (8) hour preservice training and a yearly eight (8) hour, in-house seminar on suicide prevention strategies, actuarial suicide risk assessment tools and structured clinical interviews.

I. Support Persons

1. Support Persons will receive forty (40) hours of pre-service training prior to engaging with incarcerated individuals on therapeutic supervision, which will include training about how to appropriately interact with, and document interactions with, incarcerated individuals on therapeutic supervision. Support Persons will also receive Crisis Intervention Training.

2. A Qualified Mental Health Professional will be on site to oversee the Support Person and provide guidance on appropriate non-clinical activities and ensure there is efficacy in the interactions with the prisoner on therapeutic supervision. Interactions with the Support Person must be determined to be clinically appropriate for each incarcerated individual on therapeutic supervision.

3. The Support Persons will be assigned to work at least six days per week, eight (8) hours per day, on the days and shifts when data indicates that Self-Injurious Behavior is more likely to occur so as to be of the most benefit to incarcerated individuals on therapeutic supervision.

4. At each shift transition, the departing Qualified Mental Health Professional will discuss with the oncoming Qualified Mental Health Professional what kind of Support Person activities are clinically appropriate for each of the incarcerated individuals on therapeutic supervision.

5. Throughout each shift, a Support Person will document all interactions. The Support Person's contacts will be reviewed with the clinical team during the following day's triage meeting.

650.10 MENTAL HEALTH RESPONSE TO REPORTS OF SEXUALLY ABUSIVE BEHAVIOR

A. The mental health response to reports of sexually abusive behavior shall be governed by 103 DOC 519, *Sexual Harassment/Abuse Response Prevention Policy (SHARPP).* The Mental Health Contractor shall establish procedures consistent therewith.

B. The mental health response shall include the following:

1. Any incarcerated individual who reports being physically victimized by sexually abusive behavior shall be brought to the Health Services Unit for emergency medical and mental health treatment as needed.

   a. Unless otherwise precluded by Federal, State, or local law, medical and mental health practitioners shall be required to report sexual abuse pursuant to 650.10(A) and to inform incarcerated individuals of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services.

   b. If the alleged victim is under the age of eighteen (18) or considered a vulnerable adult under a State or local vulnerable persons statute, the agency shall report the allegation to the designated State or local services agency under applicable mandatory reporting laws.

2. The incarcerated individual shall be evaluated by a Qualified Health Care Professional for physical injuries and emergency medical treatment.

3. An emergency mental health referral to the on-site mental health clinician shall be made following the completion of the medical examination. Any reports of physical or verbal abuse of a sexual nature shall be referred to the mental health crisis clinician.

4. The on-site mental health clinician shall conduct an initial assessment to identify any symptoms which may preclude the incarcerated individual's transport to an outside hospital (i.e. gross psychotic symptoms, risk of self-harm) and offer supportive services as needed. If the report of sexually abusive behavior occurs when there are no on-site mental health clinicians, a qualified medical provider shall screen the incarcerated individual and immediately notify the on-call mental health clinician if the

incarcerated individual victim is deemed at risk of harm to self or others.

5. Following the completion of the medical and mental health assessments, the Superintendent, in consultation with medical and mental health clinicians, shall determine whether there is sufficient physical evidence to justify a referral to an outside hospital with a SANE program in accordance with 103 DOC 519, *Sexual Harassment/Abuse Response Prevention Policy (SHARPP),* 519.06(B).

6. Upon the incarcerated individual's return from the outside hospital, the incarcerated individual shall be brought to the HSU for appropriate follow-up care to include a mental health screen by a Qualified Health Care Professional. If the screen indicates that the incarcerated individual is at risk to harm self or others, a mental health clinician shall be immediately notified. Otherwise, the incarcerated individual shall be seen by a Qualified Mental Health Professional within twenty-four (24) hours or no later than the next business day to assess the need for ongoing monitoring and counseling.

7. Unless the allegation has been determined to be unfounded, the facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated.

   Such review shall ordinarily occur within thirty (30) days of the conclusion of the investigation.

   The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners.

C. Specialized PREA Training: Mental Health Care

1. The vendor, in conjunction with the Department, shall ensure that all full- and part-time mental health care practitioners who work regularly in its institutions have been trained in:

   a. How to detect and assess signs of sexual abuse and sexual harassment;

   b. How to preserve physical evidence of sexual abuse;

c. How to respond effectively and professionally to victims of sexual abuse and sexual harassment; and

d. How and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

2. The vendor shall maintain documentation that mental health practitioners have received the training and forward a list of trained staff to the DOC on a quarterly basis.

D. Access to Emergency Medical and Mental Health Services

1. Incarcerated individual victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment.

2. If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, security staff first responders shall take preliminary steps to protect the victim and shall immediately notify the appropriate medical and mental health practitioners.

E. Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers

1. Mental health staff shall offer a mental health evaluation and, as appropriate, treatment to all incarcerated individuals who have been victimized by sexual abuse in any prison.

2. The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other institutions, or their release from DOC custody.

3. A mental health evaluation of all known incarcerated individual-on-incarcerated individual abusers shall be conducted within sixty (60) days of learning of such abuse history and mental health staff shall offer treatment when deemed clinically appropriate.

650.11 PROTECTIVE CUSTODY UNITS

Each incarcerated individual in a protective custody unit shall be screened by a mental health clinician during rounds at least one (1) time per week. Rounds shall include a face-to-face encounter. If the incarcerated individual is unavailable (e.g.,

on recreation status, shower, etc.), an appropriate follow-up shall be determined on the basis of clinical judgment.

Any significant findings shall be documented in the medical record. The mental health clinician shall communicate significant issues to the officer in charge of the unit. Staff and incarcerated individual referrals shall be addressed in accordance with 103 DOC 650.05 (C), Mental Health Referral

650.12 BEHAVIOR ASSESSMENT UNIT

103 DOC 650.12 governs mental health procedures and treatment attendant to the placement of an incarcerated individual in a Behavior Assessment Unit (BAU).

A. Placement in a Behavior Assessment Unit

Upon an incarcerated individual's placement into a BAU, health care staff shall be notified immediately in order for a mental health assessment to be conducted. This assessment shall be documented in IMS in the Inmate Information screen and in the medical record. The assessment shall include a face-to-face with the incarcerated individual. The assessment shall include evaluation for clinical indication that the incarcerated individual is in need of a higher level of care. If a higher level of care is indicated, the incarcerated individual will be referred to the appropriate level of care (including, but not limited to, therapeutic supervision, a Secure Treatment Unit, the Intensive Stabilization Unit, or psychiatric hospitalization).

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1. Subsequent Evaluations of Open Mental Health Cases in BAUs

Each incarcerated individual with an Open Mental Health case who is placed in a BAU shall be evaluated by a Qualified Mental Health Professional at least every thirty (30) days. The evaluation shall include routine treatment per the incarcerated individual's treatment plan and an evaluation if there is an indication to refer the incarcerated individual to a higher level of care.

The Primary Care Clinician shall monitor the incarcerated individual per the Treatment Plan throughout the duration of placement.

2. On-going Assessment of Non-Open Mental Health Cases in BAUs.

Each incarcerated individual who is placed in a BAU and does not have an Open Mental Health Case shall be evaluated upon placement; after thirty (30) days in BAU; and then every three (3) months thereafter. The evaluation will be documented in IMS and in the medical record.

3. Out-of-Cell Interviews

The evaluations described in 103 DOC 650.12 (A)(2), On-Going Assessment of Non-Open Mental Health Cases in BAUs , 650.12 (A) (3), Out-of-Cell Interviews, and the assessment described in 103 DOC 650.12 (A)(4), Behavior Assessment Unit Rounds and Referrals, shall include, absent Exigent Circumstances, a face-to-face interview with the incarcerated individual conducted in a private confidential setting. If the incarcerated individual refuses the face-to-face interview, the clinician shall interview the incarcerated individual at the cell and document in the medical record the incarcerated individual's refusal, behavioral presentation and all attempts made to engage the incarcerated individual in a private interview. A Qualified Mental Health Professional may utilize a private interview for an evaluation described in 103 DOC 650.12 (A)(2) On-Going Assessment of Non-Open Mental Health Cases in BAUs , 650.12 (A) (3), Out-of-Cell Interviews, and the assessment described in 103 DOC 650.12 (A)(4), Behavior Assessment Unit Rounds and Referrals if a private interview is warranted in the clinician's professional judgment.

4. Behavior Assessment Unit Rounds and Referrals

In each BAU, the Qualified Mental Health Professional assigned to the BAU shall make mental health rounds at least one (1) time a week. The presence of mental health staff in BAU is announced and recorded by security staff in the IMS Unit Activity Log. The Qualified Mental Health Professional shall arrange for an out-of-cell meeting with any incarcerated individual for whom a confidential meeting is warranted in the clinician's professional judgment. Custody staff shall provide escorts to facilitate out-of-cell meetings with clinicians, except in Exigent Circumstances and except where the incarcerated individual refuses. If the incarcerated individual is unavailable at the time of the round (e.g., recreation, shower, visit), the Qualified Mental Health Professional shall determine an appropriate follow-up based upon clinical judgment.

The Qualified Mental Health Professional shall document the medical completion of rounds in the BAU log, document significant findings in the record and communicate any significant issues to the officer in charge of the BAU.

The Qualified Mental Health Professional, or in their absence, another mental health clinician shall review daily, or immediately if clinically indicated, referrals from custody staff and medical staff

conducting rounds. The Qualified Mental Health Professional or mental health clinician shall determine the appropriate response based upon clinical judgment. Such referrals shall be reviewed by mental health staff in subsequent triage meetings.

B. Meetings

1. Interdisciplinary Appraisal Team

The site Mental Health Director or designee shall be a member of the Interdisciplinary Appraisal Team and attend meetings as described in 103 DOC 427, *Behavior Assessment Units*, section 427.02, BAU Placement and Retention.

650.13 INTENSIVE STABILIZATION UNIT

A. Purpose

The ISU has been established as a therapeutic, treatment-oriented housing unit for specially referred incarcerated individuals who are unable to effectively progress with placement on therapeutic supervision or general population due to serious mental illness or marked behavioral dysregulation. ISU treatment is for incarcerated individuals who do not meet the statutory criteria required for inpatient hospitalization but who have been on therapeutic supervision and are clinically appropriate for a higher level of care. ISU Services may be also utilized as a clinical intervention for incarcerated individuals returning from an inpatient psychiatric setting as determined clinically indicated to support their placement in a non-ISU setting. While designed as a short-term placement, the ISU focus of treatment is to address immediate clinical needs in an intensive environment restoring safety and stabilizing symptoms while working with the incarcerated individual to identify treatment needs to maintain in a non-ISU environment.

The ISU program utilizes an integrated approach that involves the close collaboration of Mental Health, program and security staff in the development and implementation of a comprehensive behavioral/crisis treatment plan. The program includes both behavioral and cognitive/behavioral treatment modalities. The program includes four phases: Phase 1 (Constant Observation), Phase 2 (Close Observation), Phase 3, and Phase 4. Each incarcerated individual is assigned to treatment groups and interventions in accordance with their individualized treatment plan for an estimated stay of thirty (30) – ninety (90) days. The goal is for incarcerated individual to return to a stabilized state and return to site of origin.

Any other units that are developed to serve the same purpose of the Intensive Stabilization Unit will follow the guidelines enumerated in this policy.

B. Intensive Stabilization Unit Referral and Placement

1. Incarcerated individuals can be referred to the ISU from any male DOC institution within Massachusetts.

2. Intensive Stabilization Unit admissions are referred by the contracted mental healthcare provider based on the incarcerated individual being dysregulated and/or decompensated, and for whom multiple interventions have been ineffective.

3. Duration of symptoms, utilization of therapeutic supervision and implementation of behavior management plans must be considered with the Program Mental Health Director (and medical as needed) prior to referral.

4. Incarcerated individuals should be active participants in the interventions and in their own treatment planning and thus may request to be considered for ISU placement. This self-identification shall be considered, by MDOC's contracted healthcare provider has the ultimate authority over ISU placement.

5. Referral to ISU (Attachment #16) will occur through verbal and written communication with the ISU Director and Director of Behavioral health, that outlines the interventions attempted and the indication for ISU placement. The referral shall contain the incarcerated individual's name, commitment number, referring institution, date of referral, clinical determination, and the date the recommendation was communicated to DOC.

6. Upon notification by the Program Mental Health Director of clinical approval for ISU placement for an incarcerated individual who is not already residing at the institution that houses the ISU, the Classification Division shall effect the transfer of the incarcerated individual as an administrative transfer for documented clinical needs, once informed by the ISU Coordinator that there is an available bed in the ISU.

7. Upon an incarcerated individual's transfer from an ISU to an inpatient psychiatric hospital, the incarcerated individual's bed in

the ISU program shall not be held during the evaluating period prescribed by G.L. C. 123, § 18(a) or 18(a)(1/2). A case conference shall be conducted upon upcoming discharge from the psychiatric hospitalization to determine the appropriate placement for discharge.

C. Intensive Stabilization Unit Programs and Operations

1. Treatment Team

a. The ISUs utilize a multi-disciplinary treatment team. Treatment team membership may include the following: ISU Director; Special Housing Unit Captain; Unit Officer in Charge; alternating correction officers from all shifts; correctional program officer; Qualified Mental Health Professionals, psychiatrists, psychologists, support persons, activities therapists and nurses, as clinically indicated.

b. Support persons will engage in non-clinical interactions with incarcerated individuals, per their individualized treatment plan in the ISU, and will provide supplemental activities and interactions with incarcerated individuals between the offered clinical sessions, and will document these interactions and incarcerated individuals' behavior.

c. Activity Therapists will be used in the ISU to provide one-on – one and group structured and unstructured interactions for ISU participants as determined by the treatment providers per the incarcerated individual's treatment plan.

d. The treatment team shall conduct daily team triage meetings during normal business hours to discuss treatment planning, progress, and continued level of care. During triage, the ISU treatment team will review each incarcerated individual's status and will discuss appropriateness for transition back to general population unit or other treatment unit. The daily team triage meetings shall be chaired by the ISU Director.

2. Treatment Plans

a. Upon admission to the ISU, all incarcerated individuals will be evaluated daily (Monday through Saturday) by the treatment team. The recommended frequency will be

documented on the incarcerated individuals individualized ISU treatment plan.

b. All crisis/individual treatment plans will be reviewed and approved by the ISU Director. If clinically indicated, each incarcerated individual will meet with the ISU treatment team to review the components of the treatment plan and directly participate in the reintegration planning review process. All initial treatment plans must be completed upon admission.

c. The treatment plan shall determine the incarcerated individual's level of clinical monitoring and frequency and modality of treatment interventions. Each treatment plan shall reflect a target goal or clear clinical discussion that directly identifies specific treatment requirements for completion of the ISU program.

d. ISU treatment plans may be reviewed at any time, but at minimum, every seven (7) days. The incarcerated individual shall be requested to participate in the multi-disciplinary treatment team meeting and shall be afforded the opportunity to give input into the incarcerated individual's treatment goals and assigned treatment interventions. The incarcerated individual shall be requested to sign the treatment plan. The incarcerated individual's refusal to sign shall be documented in the treatment plan.

e. Specialized interventions are based on the incarcerated individual's mental health needs, behavioral needs, and level of functioning. Each incarcerated individual will be assigned to treatment and programming in accordance with their individual treatment plan. The primary goals for ISU treatment include the following: stabilizing of primary symptoms necessitating referral, providing a supportive, intensive therapeutic milieu for incarcerated individuals with mental health needs, and preparing each incarcerated individual for reintegration into the general prison population or appropriate long term Treatment Unit offering a reasonable expectation of success given current mental health needs.

3. Orientation Meetings

Within one (1) day of admission to the ISU, each incarcerated individual shall participate in a formal ISU orientation meeting. The purpose of this meeting is to assist incarcerated individuals in making a smooth transition to the ISU. The orientation meeting shall be facilitated by the ISU treatment team and provide incarcerated individuals with an introduction to unit staff and an overview of the ISU rules and regulations, unit schedules and operations, program components, and program completion criteria. All ISU orientation materials and unit program components shall be reviewed by the vendor's Director of Clinical Programs and are subject to approval by the Director of Behavioral Health.

4. Interventions

a. The ISU program utilizes an integrated approach that involves the close collaboration with Mental Health, program and security staff in the development and implementation of a comprehensive behavior/treatment plan.

b. Therapeutic interventions or non-treatment interactions will be used by staff, including support persons and activity therapists prior to initiating a therapeutic supervision when clinically indicated.

c. Each incarcerated individual will be assigned a stabilization clinician from the ISU treatment team.

d. Group Programming will be available in the ISU and incarcerated individuals will be referred based on their progress in treatment and individualized treatment plan. Group programming available will be maintained with rolling admission, allowing incarcerated individuals to enter the group at varying stages of treatment and based on length of stay in the ISU. Assignment to core group treatment modules is at the sole discretion of the ISU treatment team and is based on the incarcerated individuals individualized treatment needs.

e. Incarcerated individuals in the ISU shall be scheduled for twenty (20) hours of structured out of cell activity per week, with no fewer than fifteen (15) hours to be offered, and ten (10) hours per week of unstructured out of cell activity to be

offered, including exercise but not including showers, absent exigent circumstances. For ISU incarcerated individuals who are clinically stable enough for contact with other incarcerated individual's, out of cell activities shall include opportunities for socialization including congregate exercise and dining.

f. Access to all on-unit programming and activities as outlined in the individualized treatment plan and will not restrain incarcerated individuals unless necessary.

g. Individual clinical assessment by a qualified mental health professional at least one (1) time per week.

h. Contact visits and phone privileges commensurate with general population.

i. Meals in the on-unit dining area provided in a group setting unless clinically contraindicated.

j. Clothing and other items are allowed in-cell commensurate with general population.

k. Recreation will be provided in on-unit outdoor and indoor recreation areas.

l. Movement will be restricted to the ISU (other than visits, medical appointments, or other off-unit activities approved by the treatment team).

m. If movement is required off-unit, restraints will not be required unless necessary.

n. Behavior Management Plans will be utilized, when clinically appropriate. These will be implemented by a Qualified Mental Health Professional.

5. The ISU will have a therapeutic de-escalation room for incarcerated individuals.

6. The ISU will have an ISU log, where all movement and out of cell time offered to incarcerated individuals will be documented as accepted or refused.

D. ISU Discipline

ISU incarcerated individuals shall be subject to the disciplinary process. ISU incarcerated individuals may be issued disciplinary reports and be subject to disciplinary sanctions in accordance with 103 CMR 430, *Inmate Discipline*. ISU mental health staff shall provide consultation to the hearing officer in the disciplinary hearing process pursuant to 103 DOC 650.18 (D) (5), *Communication on and Recommendations for Special Needs Incarcerated Individuals.*

E. ISU Discharge

1. An incarcerated individual may be discharged from the ISU for the following reasons:

   a. The incarcerated individual no longer requires the level of service provided in an ISU or requires the level of services provided in a higher or lower level of care.

   b. ISU Discharge for clinical reasons

      i. If the ISU director believes that an incarcerated individual should be discharged, the director shall triage the case with the ISU treatment team. The ISU clinician should submit an ISU discharge form (Attachment #17) to the ISU Director. If the ISU director concurs that the discharge is appropriate, the ISU Director should submit the form to the Program mental health director.

      ii. Once the ISU discharge is approved, the assigned ISU clinician shall document the reason for discharge and any treatment recommendations in a mental health progress note in the medical record and complete a treatment plan review and revision as necessary. The receiving site assigned clinician, Mental Health Director and Psychiatrist shall review the treatment plan update.

      iii. As soon as possible, the ISU Director shall communicate the discharge to Deputy Superintendent of Reentry to effect the return of the

incarcerated individual to their sending institution and notification shall be made to the Director of Behavioral Health.

c. ISU Discharge for Security Reasons

i. If an incarcerated individual continues to require ISU services, but the site superintendent determines that the incarcerated individual can no longer be safely housed within the institution ISU, the Superintendent shall request that the Director of Behavioral Health schedule a case conference to determine the manner in which the incarcerated individual's treatment and safety needs may best be managed.

ii. A case conference shall include, at a minimum, the Superintendent, the Director of Behavioral Health, The Program Mental Health Director, and the ISU Director. Other staff may be requested to attend as appropriate.

iii. The case conference shall make one of the following decisions:

- The incarcerated individual shall remain in the ISU.
- The incarcerated individual shall be referred for placement in an alternative treatment unit.
- The incarcerated individual shall be placed in other housing/another institution with specific treatment plan modifications developed in concert with the receiving institution's mental health team.

iv. The ISU Director shall complete a case conference summary form (attachment) which shall be incorporated in the medical record. In addition, the PCC shall write a mental health progress note in the medical record documenting the discussion regarding RTU retention or discharge with the incarcerated individual and with the receiving institutions Site Mental Health Director.

v. The Director of Behavioral Health shall communicate the disposition of the conference to the relevant divisions, institutions, and contract providers as appropriate.

650.14 SECURE TREATMENT UNITS AND SECURE ADJUSTMENT UNITS

A. Secure Treatment Unit Referral and Placement

An incarcerated individual may be referred to a Secure Treatment Unit following an incident or incidents of significant disruptive behavior which the IAT appraises as warranting placement in a secured intervention and that the incarcerated individual's mental health was, at least, a contributing factor, to the disruptive behavior. Following the appraisal from the IAT that indicates placement in an STU might be appropriate, the contracted mental health vendor shall determine whether referral to an STU is clinically warranted. If such placement is clinically indicated, the contracted mental health vendor determines if the Secure Treatment Program (STP) or the Behavior Management Unit (BMU) is more appropriate and complete an STU Referral Form. The contracted mental health vendor may refer any incarcerated individual to an STU when clinically indicated.

Generally speaking, the STP is indicated for SMI incarcerated individuals with serious and persistent mental illness (e.g., psychotic disorders, bipolar and related disorders, and major depressive disorders, serious trauma and stressor related disorder with dissociation, derealization, or depersonalization features) when the SMI was a contributing factor to the disruptive incident or where the individual requires intensive mental health treatment to ensure a return to a premorbid level of functioning. Additionally, incarcerated individuals with borderline personality disorder are appropriate to refer to the STP.

Generally speaking, the BMU is indicated for incarcerated individuals regardless of SMI status, when a severe personality disorder was a contributing factor to the disruptive behavior. These personality disorders are generally marked by the following, serious assaultive behavior(s), repetitive self-directed violence, or notable mistrust to paranoid ideation regarding authority figures.

1. The STU Referral Form shall be completed by the incarcerated individual's Primary Care Clinician (PCC) and reviewed by the Site Mental Health Director to ensure that the STU Referral Form incorporates all of the pertinent clinical information. The STU Referral Form shall be completed within five (5) days. Following review by the site Mental Health Director, the referral is reviewed

by the Program Mental Health Director to ensure the appropriateness of the referral.

2. The Program Mental Health Director shall immediately notify the Director of Behavioral Health after having ensured that the STU Referral Form has been completed correctly, and that the referral is clinically appropriate.

3. Upon receipt of the STU Referral Form, the Director of Behavioral Health shall convene a meeting of the STU Review Committee, either in person or by a conference call, within five (5) days. The STU Review Committee shall be chaired by the Director of Behavioral Health. Membership shall include the Program Mental Health Director, the Department of Correction administrators assigned to oversee the operation of the STP and BMU, and the Mental Health Vendor's clinical coordinators of the STP and the BMU. The STU Review Committee shall determine which STU is the more appropriate placement. The STU Review Committee shall determine whether STU placement is warranted, whether the incarcerated individual would be more appropriately admitted to an RTU, or whether the incarcerated individual could be appropriately managed by enhanced outpatient treatment, which may include an individualized incentive plan. The STU Review Committee may call upon the Site Mental Health Director or the incarcerated individual's PCC to present the case and provide additional information, upon a determination that such presentation or additional information is necessary.

4. In instances where there is a lack of consensus regarding the placement of an incarcerated individual, the case shall be referred to the Program Mental Health Director, Director of Behavioral Health, and the Assistant Deputy Commissioner, Clinical Services who shall come to consensus within five (5) days regarding the appropriate placement.

5. Upon the final decision to place an incarcerated individual in an STU or an RTU, the Director of Behavioral Health shall notify the Department's Central Classification Division transfer coordinator, who shall affect the prompt classification and transfer of the incarcerated individual to the selected unit.

6. All final decisions pursuant to an STU referral shall be made within thirty (30) calendar days of the receipt of the referral by the Director of Behavioral Health.

B. Secure Treatment Unit Programs and Operation

1. Each STU shall provide a variety of treatment programs and modalities to optimize the overall level of functioning of incarcerated individuals within the correctional environment, and to prepare them for successful reentry into general population or the community.

2. Each STU shall utilize a phase system designed to provide incarcerated individuals with the opportunity to earn incentives and privileges contingent upon behavioral stability and program participation. Each STU shall utilize time frame guidelines for phase progression, but all decisions to move an incarcerated individual between phases shall be made by the STU treatment team.

3. Behavioral programming in each STU shall include incentives to encourage positive behavior. These incentives may include, where appropriate, the opportunity to earn additional privileges and reduce disciplinary sanctions. Substantial rule infractions may result in an immediate reduction of incentives, phase regression, or in extreme cases, program termination. Each STU treatment team shall review incidents of rule infractions and determine an individualized treatment response, which shall be documented in the incarcerated individual's treatment plan.

4. STU incarcerated individuals shall be subject to the disciplinary process as follows. Category 3, and 4 disciplinary offenses, as set forth in 103 CMR 430, *Inmate Discipline*, section 430.24, shall be reduced to an incident report and referred to the STU treatment team for addressing through program incentives and the phase system. Category 1 and 2 disciplinary offenses shall be addressed through the disciplinary system in accordance with 103 CMR 430, *Inmate Discipline*.

5. Criteria for successful participation is based on the individual's treatment plan and shall include, at a minimum, the absence of behavior resulting in disciplinary reports, treatment compliance, clinical stability, and active program participation.

6. Nothing contained herein shall restrict the authority of the Superintendent to address matters of safety and security in the STU.

C. Secure Treatment Unit Out-of-Cell Time

1. Incarcerated individuals in an STU shall be scheduled for fifteen (15) hours of structured out-of-cell activity per week, with no fewer than ten (10) hours to be offered, and ten (10) hours per week of

unstructured out-of-cell activity to be offered, including exercise but excluding showers, absent Exigent Circumstances. The group schedule shall be staggered and ensure access to structured programming is provided across day, afternoon, evening, and weekend hours.

2. For STU incarcerated individuals assigned to a program phase that allows contact with other incarcerated individuals, out-of-cell activities shall include opportunities for socialization including congregate exercise and dining, as determined by the treatment team.

D. Secure Treatment Unit Discharge

1. Upon the successful completion of all phases and requirements of the STU program by an incarcerated individual or at any time prior to the successful completion of the STU program by such incarcerated individual if the STU treatment team determines that the incarcerated individual is appropriate for discharge from the STU, the treatment team shall submit a request to the Director of Behavioral Health for a case conference to review the incarcerated individual's progress and appropriateness for discharge.

2. In assessing the incarcerated individual's appropriateness for STU discharge, the case conference participants shall consider the requirements set forth in 103 DOC 650.14 (D)(2), *Secure Treatment Discharge*. Additionally, the case conference participants shall consider the incarcerated individual's referral goals from the STU referral. The successful achievement of the referral goals shall be the primary factor in determining whether discharge is clinically appropriate If the case conference determines that an RTU level of care is clinically indicated, the incarcerated individual shall be referred for RTU placement. If the case conference determines that an RTU level of care is not clinically indicated, the incarcerated individual's placement upon the incarcerated individual's transition and discharge from the STU shall be affected by the classification process.

F. Termination from a Secure Treatment Unit

Only when every alternative and potential intervention has been exhausted, may an incarcerated individual be considered for termination from an STU. Under no circumstances will incarcerated individuals with SMI be returned to a Behavioral Assessment Unit from an STU prior to completion of the STU program, except in Exigent Circumstances or for program termination as follows:

1. Incarcerated individuals may be considered for termination from an STU prior to completing the program if the incarcerated individual engages in assaultive behavior or presents severe behavioral problems without demonstration of any effort to change and it is the consensus of the STU treatment team that the behavior has not improved and shows no indication of future change. Termination shall not be considered without evidence and documentation of consistent refusal to engage in programs or chronic disruptive behavior that compromises the integrity of the program. The STU treatment team shall meet to determine if further treatment interventions can be expected to produce no or minimal behavior changes. The STU treatment team shall also consider whether transfer to a different STU would be appropriate. If the STU treatment team concludes that termination is warranted, the STU treatment team shall submit a request to the Director of Behavioral Health for a case conference to review the incarcerated individual's status and appropriateness for termination. In conjunction with this case conference, the treatment team shall recommend a discharge plan consistent with the incarcerated individual's needs. Final approval of STU termination shall be made by the STU Review Committee.

2. Pursuant to the procedures established for review of Exigent Circumstances in 103 DOC 650.23(C), Exigent Circumstances, the Department shall periodically reassess incarcerated individuals who have been terminated from an STU and returned to a BAU. The incarcerated individual shall be referred to the same or a different STU if the incarcerated individual's behavior and motivation demonstrably improve. The incarcerated individual shall have a treatment plan designed to motivate him or her to participate in clinically indicated therapeutic programming in an appropriate setting.

F. Secure Treatment Unit Staff Training

Subject to collective bargaining agreements and bidding process, there shall be initial pre-service and annual in-service training of all staff in the STUs regarding mental health and mental illness, medications, co-existing disorders, and programming needs. Training shall be as follows:

1. Upon the opening of any new STU, all security and treatment staff regularly assigned to the unit will receive forty (40) hours of specialized training.

2. New security and treatment staff assigned to a STU after it is open and operational will receive sixteen (16) hours of specialized orientation training at the time of assignment. The Department will endeavor to provide each new staff member with an additional twenty-four (24) hours of structured on-the-job training during the first seventy-five (75) days of assignment.

G. Secure Treatment Unit Documentation

Each STU shall utilize a program manual approved by the Director of Behavioral Health. Program manual changes shall be submitted to the Director of Behavioral Health for review and approval prior to implementation.

Each STU shall also utilize standard instruments approved by the Director of Behavioral Health to document the following:

1. Program schedules;

2. Program participation by unit and by incarcerated individual;

3. Phase and incentives, by unit and by incarcerated individual;

4. Structured out-of-cell programming offered and provided, by unit and by incarcerated individual, including documentation of any instances in which such programming was not provided in accordance with 103 DOC 650.14 (C), Secure Treatment Unit Out-of-Cell Time.

5. Non-structured out-of-cell programming offered and provided, by unit and by incarcerated individual including documentation of any incidents in which such programming was not provided in accordance with 103 DOC 650.14 (C), Secure Treatment Unit Out-of-Cell Time.

6. Outcome measures by unit and by incarcerated individual, as determined by the Director of Behavioral Health.

H. Secure Adjustment Units Referral and Placement

1. Referral and Placement in a Secure Adjustment Unit

An incarcerated individual may be transferred from a BAU to a Secure Adjustment Unit following an Interdisciplinary Appraisal Team (IAT) recommendation and classification board.

Any incarcerated individual being considered for transfer to an SAU who is identified as having a Mental Health Classification of MH-4 shall be referred by the Superintendent or designee to the site Mental Health Director to be screened for contraindications prior to SAU placement. This referral and the results shall be documented on the SAU referral form. If there is a contraindication to an SAU placement, the contracted mental health vendor shall identify an appropriate treatment unit or treatment plan to address the incarcerated individual's needs. If there are no contraindications for SAU placement, the classification process for possible classification to the appropriate SAU shall commence.

Immediately prior to an incarcerated individual's placement in a Secure Adjustment Unit (SAU) a QMHP shall be notified in order for a mental health evaluation to be conducted; the evaluation shall include a face-to-face interview with the incarcerated individual.

Incarcerated individuals in an SAU who do not have an open mental health case shall be assessed as follows: after thirty (30) days in an SAU and then every ninety (90) days thereafter. The assessment shall include an evaluation if there is an indication to refer the incarcerated individual for a comprehensive mental health evaluation. The evaluation shall be documented in the medical record.

2. Treatment Planning for SAU Participants

Qualified Mental Health Professionals shall adjust the incarcerated individual's treatment plan to include goals for symptom reduction and behavioral interventions throughout SAU placement. Incarcerated individuals with an open mental health case shall be seen as per their treatment plan and sooner when clinically indicated.

If placement in a BAU exceeds thirty (30) days, and for all SAUs, a QMHP shall evaluate the incarcerated individual and complete appropriate documentation in incarcerated individual's medical record.

If placement continues beyond the initial thirty (30) day mental health review, the QMHP shall complete a mental health evaluation every three (3) months thereafter. If an incarcerated individual has an identified mental health need, the mental health evaluation shall be completed monthly. More frequent evaluations shall be completed upon the direction of the Mental Health Director and per clinical indication.

650.15 RESIDENTIAL TREATMENT UNITS

A. Purpose

Residential Treatment Units provide an intermediate level of care for general population incarcerated individuals with a mental health classification of MH-4. These individuals do not require inpatient psychiatric hospitalization, but they present with a pervasive pattern of dysfunction and inability to manage themselves appropriately within general population due to a mental disorder which may be evidenced by any of the following:

1. Multiple transfers to an inpatient psychiatric setting;

2. Frequent placement on therapeutic supervision;

3. Frequent reliance on crisis stabilization services/interventions;

4. Frequent episodes of self-injurious behavior;

5. Multiple disciplinary or rule infractions;

6. Inability to follow routine/directions;

7. Inability to participate independently in activities of daily living.

Incarcerated individuals with acute medical needs requiring placement and treatment within an infirmary setting or a Clinical Stabilization Unit are not appropriate for RTU placement.

The mission of every RTU is to significantly reduce emergency crisis referrals, suicide attempts, self-injurious behaviors, psychiatric hospitalizations, serious rule infractions and disciplinary issues through the utilization of group and individual therapy within a residential, therapeutic treatment milieu. Additionally, RTUs may be used as transitional levels of care facilitating step down from a higher level of care (such as an STU, ISU, or inpatient psychiatric hospitalization) to a lower level of care.

B. Residential Treatment Unit Referral and Placement

1. A mental health clinician who believes that an incarcerated individual may benefit from RTU placement shall triage the case with the Site Mental Health Director. Where there is agreement that RTU placement is clinically indicated, the incarcerated individual's

PCC shall complete an RTU referral form (Attachment #3) and submit the form to the Site Mental Health Director for review.

2. If the Site Mental Health Director concurs that RTU referral is appropriate, the Director shall sign and approve the RTU referral. The referral shall then be submitted to the Program Mental Health Director for review and final determination. If the Program Mental Health Director determines that the RTU referral is clinically appropriate and does not require further evaluation to make a determination, the Director shall inform the following within five (5) business days: the Director of Behavioral Health; the Department's Central Classification Division; the RTU coordinators; and the PCC. If the Program Mental Health Director requires further evaluation in order to make a final determination, within ten (10) days, the Director shall conduct a medical record review and a face-to-face evaluation with the incarcerated individual.

3. The mental health classification of an incarcerated individual who is determined to be clinically appropriate for RTU placement shall be designated as MH-4, subject to the review and approval of the Program Mental Health Director pursuant to 103 DOC 650.06 (B)(5), Assignment and Review of Mental Health Codes and Subcodes. If the incarcerated individual is being referred to the RTU as part of a transitional plan from a higher level of care, the MH Code does not need to be MH-4.

4. Upon notification by the Director of Behavioral Health and/or the Program Mental Health Director of clinical approval for RTU placement for a male incarcerated individual who is not already residing at the institution that houses the RTU, the Classification Division shall determine the appropriateness of the transfer under the point based classification system. Unless otherwise indicated, the incarcerated individual shall remain at the sending institution until bed space becomes available in the designated RTU. The RTU admission of an incarcerated individual who is already residing at the institution that houses the designated RTU constitutes an internal placement that does not require review by the Classification Division.

5. Upon an incarcerated individual's transfer from an RTU to an inpatient psychiatric hospital (BSH for males, a DMH facility for females) the incarcerated individual's space in the RTU program shall be held for the entirety of the thirty (30) day evaluation period prescribed by G.L. c. 123, § 18(a). An RTU incarcerated individual who is subsequently civilly committed to an inpatient psychiatric

hospital shall be afforded an RTU placement upon the incarcerated individual's discharge from the hospital if such placement remains clinically indicated.

C. Residential Treatment Unit Programs and Operation

1. Treatment Team

The RTUs utilize a multi-disciplinary treatment team. Treatment team membership may include the following: RTU Coordinator; assigned Captain; Unit Sergeant; assigned Correction Officers from all shifts; Correctional Program Officer; assigned mental health clinicians including the assigned Psychiatrist; and assigned nursing and program staff.

The treatment team shall conduct daily team triage meetings during normal business hours to review each incarcerated individual's status and discuss any identified issues or concerns. The daily team triage meetings shall be chaired by the RTU Coordinator.

The treatment team shall conduct multi-disciplinary treatment team meetings at least every ninety (90) days. Multi-disciplinary treatment team meetings shall include participation of a Psychiatrist, as well as the mental health and correctional staff who are directly involved in the incarcerated individual's care and treatment.

At MCI Framingham, the mental health providers shall conduct a multidisciplinary care annual review of individuals receiving treatment in the Residential Treatment Unit. This review shall include psychiatric treatment of the mental illness, and a summary assessment of the trajectory of her mental illness and treatment needs through a life span review, including her index offense. Communication of needs identified shall be prioritized in administrative and clinical meetings.

2. Treatment Plans

Within thirty (30) calendar days of the incarcerated individual's placement in the RTU, the treatment team shall develop an Initial Treatment Plan, which shall be documented in the incarcerated individual's medical record. While individual members of the treatment team may complete specific items of the treatment plan, approval of the treatment plan shall occur during a multi-disciplinary team meeting.

RTU treatment plans may be reviewed at any time, but at minimum, every ninety (90) days during a multi-disciplinary treatment team review meeting. The incarcerated individual shall be requested to participate in the multi-disciplinary treatment team meeting and shall be afforded the opportunity to give input into the incarcerated individual's treatment goals and assigned treatment interventions. The incarcerated individual shall be requested to sign the treatment plan. The incarcerated individual's refusal to sign shall be documented in the treatment plan.

The treatment plan shall determine the incarcerated individual's level of clinical monitoring and frequency and modality of treatment interventions. Each treatment plan shall reflect a target goal or clear clinical discussion that directly identifies specific treatment requirements for completion of the RTU program.

3. Programs

The RTU shall offer a variety of clinically driven programs and activities. Although RTU incarcerated individuals will not be forced to accept treatment, the incarcerated individual's PCC and the RTU treatment team shall monitor and encourage participation. When an incarcerated individual is reluctant to comply with treatment recommendations, staff efforts to engage the incarcerated individual will be documented.

The primary mode of mental health treatment in the RTU shall consist of evidence-based group programming that offers core treatment modules and elective groups. A portion of the group programming available will be maintained with rolling admission, allowing incarcerated individuals to enter the group at varying stages of treatment and length of stay on the RTU. Assignment to core group treatment modules is at the sole discretion of the RTU treatment team and is based on the incarcerated individual's individualized treatment needs. Elective groups may be assigned based on the input and interest of the incarcerated individual. Attendance records shall be kept for each group conducted and each incarcerated individual's participation and attendance shall be documented in each incarcerated individual's medical record.

4. Orientation Meetings

Within one (1) to two (2) days of admission to the RTU, each incarcerated individual shall participate in a formal RTU orientation meeting. The purpose of this meeting is to assist incarcerated individuals in making a smooth transition to the RTU. The

orientation meeting shall be facilitated by the RTU treatment team and provide incarcerated individuals with an introduction to unit staff and an overview of the RTU rules and regulations, unit schedules and operations, program components, and program completion criteria. All RTU orientation materials and unit program components shall be reviewed by the vendor's Director of Clinical Programs and are subject to approval by the Director of Behavioral Health.

5. Earned Good Time

RTU incarcerated individuals who participate in programming may earn seven and a half (7.5) days of earned good time each month based upon successful compliance with the elements of their Individualized Treatment Plans. Such elements shall include one or more of the following: attendance and participation in structured group or individual activities; absence of threatening or injurious behavior directed at self or others; quality of interactions with staff and peers; work assignments; educational programming.

There shall be no limit to the number of months that an incarcerated individual is eligible to receive earned good time credits, as some incarcerated individuals may require such programming and support in the RTU environment for an extended period of time.

Each incarcerated individual's daily attendance shall be recorded in the IMS Program/Attendance screen for the purpose of tracking the incarcerated individual's program participation for the purpose of determining the incarcerated individual's performance rating and the award of earned good time credits.

At the end of each month, the RTU Coordinator shall convene a treatment team meeting with designated staff to assess each RTU incarcerated individual's compliance with the incarcerated individual's individualized treatment plan. RTU staff shall assess whether the incarcerated individual's degree of compliance was satisfactory, unsatisfactory, or incomplete. The RTU Coordinator shall enter each incarcerated individual's performance rating into the IMS Program/Attendance screen no later than the first business day of the following month. The final earned good time credit rating for each incarcerated individual who receives earned good time credits shall be determined by the institution Director of Treatment and shall be entered into IMS by the sixth day of the following month. The site Deputy Superintendent of Reentry, shall monitor the implementation of this process on a regular basis to ensure that the

earned good time credits are entered in an accurate and timely manner in accordance with 103 CMR 410, *Sentence Computation*.

D. Residential Treatment Unit Discipline

RTU incarcerated individuals shall be subject to the disciplinary process. RTU incarcerated individuals may be issued disciplinary reports and be subject to disciplinary sanctions in accordance with 103 CMR 430. RTU mental health staff shall provide consultation to the hearing office in the disciplinary hearing process pursuant to 103 DOC 650.18 (D)(5), Communications on and Recommendations for Special Needs Incarcerated Individuals.

E. Residential Treatment Unit Discharge

An incarcerated individual may be discharged from an RTU for the following reasons:

1. The incarcerated individual no longer requires the level of service provided in an RTU or requires the level of services provided in a higher or lower security RTU; or

2. The incarcerated individual is no longer clinically appropriate for RTU services; or

3. The incarcerated individual may present security risks that cannot be safely managed in the RTU.

G. RTU Discharge for Clinical Reasons

1. If the RTU coordinator believes that an incarcerated individual should be discharged, the coordinator shall triage the case with the Site Mental Health Director. The RTU Coordinator shall submit an RTU discharge form (Attachment #4) to the Site Mental Health Director.

2. If the Site Mental Health Director concurs that the RTU discharge is appropriate, the RTU discharge form shall be submitted to the Program Mental Health Director for review and final determination. All RTU discharges require approval of the Program Mental Health Director. If the Program Mental Health Director determines that the RTU discharge is clinically appropriate and does not require further evaluation to make a determination, the Mental Health Director shall convey the recommendation to the Director of Behavioral Health. If the Program Mental Health Director requires further evaluation in

order to make a final determination, he/she/they may interview the offender and review pertinent records.

3. Once the RTU discharge is approved, the assigned RTU clinician shall document the reason for discharge and any treatment recommendations in a mental health progress note in the medical record and complete a treatment plan review and revision as necessary. The Site Mental Health Director, and if appropriate, the Psychiatrist, shall review the treatment plan update.

4. As soon as possible, the Site Mental Health Director shall communicate the discharge determination to the institution Superintendent, who shall initiate the determination of an alternative housing assignment.

H. RTU Discharge for Security Reasons

1. If an incarcerated individual continues to require RTU services, but the Superintendent determines that the incarcerated individual can no longer be safely housed within the institution RTU, the Superintendent shall request that the Director of Behavioral Health schedule a case conference to determine the manner in which the incarcerated individual's treatment and safety needs may best be managed.

2. A case conference shall include, at a minimum, the Superintendent, the Director of Behavioral Health, the Program Mental Health Director, the Site Mental Health Director and the PCC. Other staff may be requested to attend as appropriate.

   The case conference shall make one of the following decisions:

   a. The incarcerated individual shall remain in the RTU at the current institution;
   b. The incarcerated individual shall be transferred to an RTU at another institution;
   c. The incarcerated individual shall be referred for placement in an STU;
   d. The incarcerated individual shall be placed in other housing/another institution with specific treatment plan modifications developed in concert with the receiving institution's mental health team.

   The PCC shall complete a Case Conference Summary Form (Attachment #5), which shall be incorporated in the medical record. In addition, the PCC shall write a mental health progress note in the

medical record documenting that the PCC discussed the decision regarding RTU retention or discharge with the incarcerated individual and with the receiving institution's Site Mental Health Director.

3. The Director of Behavioral Health shall communicate the disposition of the conference to the relevant divisions, institutions, and contract providers as appropriate.

650.16 SECTION 35 SERVICES

A. General Provisions

Under G.L. c. 123, § 35, a Massachusetts District Court may order a civil commitment for a period of up to ninety (90) days to MASAC for males or to MCI-Framingham for females, who are dual status only, if the court finds that such person is an individual with an alcohol or substance use disorder and there is a likelihood of serious harm as a result of such disorder. Section 35 defines "alcohol use disorder" as "the chronic or habitual consumption of alcoholic beverages by a person to the extent that (1) such use substantially injures the person's health or substantially interferes with the person's social or economic functioning, or (2) the person has lost the power of self-control over the use of such beverages." Section 35 defines "substance use disorder" as "the chronic or habitual consumption or ingestion of controlled substances or intentional inhalation of toxic vapors by a person to the extent that: (i) such use substantially injures the person's health or substantially interferes with the person's social or economic functioning; or (ii) the person has lost the power of self-control over the use of such controlled substances or toxic vapors." Such civil commitments are admitted to MASAC or to MCI-Framingham (females, who are dual status) and provided infirmary-level detoxification services. Section 35 requires a review of the necessity of the commitment on days thirty (30), forty-five (45), sixty (60) and seventy-five (75) as long as the commitment continues.

The Healthcare Contractor shall provide all Section 35 services set forth herein. The Department may also utilize Section 35 services provided by other Commonwealth agencies.

B. The Massachusetts Alcohol and Substance Abuse Center at MCI-Plymouth

1. The Massachusetts Alcohol and Substance Abuse Center (MASAC) at Plymouth is designated as a minimum-security treatment-focused institution.

2. The Contractor shall provide medical detoxification and related medical services to the civil population and other required medical services to both populations.

3. The Contractor shall provide alcohol and substance use treatment, necessary mental health services, and discharge planning for up to ninety (90) days to the civil population and required mental health services to the minimum-security incarcerated individuals.

   The Contractor shall provide ongoing assessments required by G.L. c. 123, § 35 for the civil commitments to assist the Superintendent in conducting reviews to determine the appropriateness for discharge.

4. Substance use treatment shall be organized according to empirically supported approaches (i.e., based on social learning, cognitive behavioral models, etc.). The Contractor shall employ methodologies that have been proven effective on the basis of random controlled trials and/or meta-analysis, which should be referenced and documented.

5. After the civilly committed individual is cleared by the Contractor from the detoxification process to participate in substance use treatment, the Contractor shall provide each participant with a thorough substance use treatment program with insight oriented, skill building and social activities for a minimum of eight (8) hours per day, seven (7) days per week. At minimum, such programming should focus on:

   - Relapse prevention;
   - Substance use education;
   - Aftercare and discharge planning;
   - Family reunification;
   - Interpersonal skills training;
   - Health and wellness;
   - Creating recovery plans; and
   - 12-step programming.

6. Substance use treatment shall employ an individualized treatment and case management model. Primary Care Clinicians and Substance Use Counselors shall initiate an Individual Treatment Plan for all program participants. The Treatment Plan shall include a schedule of classes and activities. The Treatment Plans shall be reviewed and updated weekly.

C. MCI-Framingham

1. All Section 35 females in DOC custody are under dual status as a civil commitment and pending criminal charges.

2. The Contractor shall provide medical detoxification and other necessary medical treatment to all incarcerated individuals and civil commitments with dual status at MCI-Framingham.

3. The Contractor shall provide necessary Mental Health Services and discharge planning, as well as ongoing assessments required by G.L. c. 123, § 35, to assist the Superintendent in determining the appropriateness for discharge of civil commitments who are not also being held pursuant to the criminal process.

650.17 MENTAL HEALTH REENTRY PLANNING AND PROCEDURES

A. General Policy

The ongoing needs of incarcerated individuals with open mental health cases shall be addressed in anticipation of the incarcerated individual's discharge from the Department of Correction. All incarcerated individuals with open mental health cases who require ongoing services after release shall have a discharge plan, which may include referral for services in the community. Mental health clinicians shall collaborate with Department of Correction staff in the reentry process to ensure the continuity of mental health care.

B. Case Identification and Initiation

Utilizing the institutional release lists, mental health clinicians shall identify incarcerated individuals with open mental health cases who are within one (1) year of discharge or parole and in need of aftercare planning.

At least six (6) months prior to any anticipated discharge, a mental health clinician shall initiate plans to address the incarcerated individual's need for continuing mental health care upon discharge. This shall include the identification of appropriate providers for the continuation and maintenance of medication and therapy as indicated. Documentation of all discharge planning shall be recorded in the medical record and entered in the Release/Aftercare Plan Screen in IMS. Additionally, for any actual placements, information shall be entered in the Release Address screen.

C. Discharge Plan

1. At least forty-five (45) days prior to the anticipated discharge of an incarcerated individual with an open mental health case, or sooner

if required by a short sentence structure, a mental health clinician shall work with the incarcerated individual to complete a Discharge Plan. The Discharge Plan shall identify services available in the community and reflect sufficient details of the incarcerated individual's clinical diagnoses, medications and future needs. Contacts and telephone numbers shall be provided for the incarcerated individual's reference following discharge.

2. All discharge plans shall be updated if the mental health services and/or services for reentry change. Any changes to the discharge plan shall be dated.

3. If the incarcerated individual has been identified as the victim of sexually abusive behavior while incarcerated, a referral for sexual use counseling shall be included in the discharge plan where clinically warranted.

4. The discharge plan shall be signed by the mental health clinician, the incarcerated individual and the Site Mental Health Director or designee. The incarcerated individual's refusal to sign shall be noted in the discharge plan.

5. The discharge plan shall be completed fourteen (14) days prior to the anticipated discharge. The incarcerated individual shall be provided with a copy. A receipt of the mental health record form shall be completed.

6. A copy of the discharge plan shall be placed in the mental health section of the incarcerated individual's medical record.

D. Mental Health Parole Board Contact Sheet

The Site Mental Health Director shall obtain a list of incarcerated individuals scheduled for parole hearings on a monthly basis from the Institutional Parole Officer (IPO). Parole hearing information is maintained on the IMS Institution Schedule Query Screen.

When requested by an IPO, a mental health clinician shall complete the Mental Health Parole Contact Sheet (Attachment #12) in advance of a parole hearing. The mental health clinician shall meet with the incarcerated individual and discuss the information contained on the form and any mental health aftercare needs. Per G.L. c. 127, § 135, the Mental Health Parole Board Contact Sheet shall be submitted to the Institutional Parole Officer (IPO) and include any diagnosis, current medications, current treatment and mental health status and other community services recommended upon release.

E. Department of Mental Health Referral

If an incarcerated individual with an open mental health case has been assessed as meeting the clinical criteria for ongoing Department of Mental Health (DMH) services (as described in 104 CMR 29.04 (3)(a) or (3)(b)) and may be in need of DMH services upon discharge from the Department of Correction, a mental health clinician shall initiate a DMH referral as follows:

1. A mental health clinician shall secure the incarcerated individual's signature on the DMH release form included in the DMH application. The mental health clinician shall then complete the DMH application for Adult Continuing Care and the DMH Adult Clinical Summary Sheet, providing relevant clinical documentation and other information for review by DMH Eligibility Determination Specialists.

2. With the appropriate executed DMH release, the mental health clinician shall share information from the incarcerated individual's mental health record with the DMH representatives to determine the incarcerated individual's eligibility for continuing care services and/or to initiate a community-based service plan.

3. A mental health clinician shall facilitate the entry of DMH representatives to Department institutions to conduct incarcerated individual and staff interviews and review records related to release planning. A mental health clinician shall meet with the DMH Forensic Transition Team Coordinator and/or DMH Case Manager at the incarcerated individual's institution and collaborate with the development of a service plan.

4. Upon DMH determination of eligibility, the mental health clinician shall note the incarcerated individual's eligibility for DMH services in the incarcerated individual's treatment plan.

5. A mental health clinician, in conjunction with other staff participating in transition planning, shall communicate any problems or concerns related to the service plan to the Forensic Transition Team Coordinator. The mental health clinician shall notify the DMH liaison of any change in the discharge date at least one month prior to the anticipated discharge date.

F. Civil Commitment upon Discharge

If an incarcerated individual with an open mental health case is assessed as requiring involuntary civil commitment to an inpatient hospital setting upon the expiration of the incarcerated individual's sentence, the mental health clinician shall proceed as follows:

1. In conjunction with the Site Mental Health Director, the mental health clinician shall consult with the Director of Behavioral Health and the Medical Director of Bridgewater State Hospital.

2. A case conference may be scheduled as needed. The case conference may include participation by the incarcerated individual's Primary Care Clinician, the Site Mental Health Director, the Site Psychiatrist, the Program Mental Health Director, the Director of Behavioral Health, the Department of Correction Mental Health Regional Administrator, the Correctional Program Officer, and other staff as warranted.

3. If at any time during the discharge planning process, the incarcerated individual is deemed in need of immediate civil commitment, the civil commitment process shall proceed in accordance with 103 DOC 650.08(E)(1), Psychiatric Hospitalization.

4. If an incarcerated individual requires commitment to a facility of the Department of Mental Health on the day of the incarcerated individual's discharge from the Department of Correction, a psychiatrist shall file a petition under G.L. c. 123, § 12.

G. Department of Developmental Services Referral

If an incarcerated individual with an open mental health case has been assessed to have a developmental disability that may render the incarcerated individual eligible for services from the Department of Developmental Services (DDS), a mental health clinician shall initiate an application for continuing care services and act as liaison with DDS to facilitate the incarcerated individual's transition to the community.

At least six (6) months prior to anticipated discharge, the assigned Qualified Mental Health Professional will identify the need to complete a DDS application. Consultation with DDS shall commence and, when requested, an eligibility determination packet will be forwarded to the designated DDS liaison with all required releases and clinical documentation.

H. MassHealth Adult Disability Supplement

Three (3) months prior to the anticipated discharge of an incarcerated individual with an open mental health case, a mental health clinician shall initiate the MassHealth Adult Disability Supplement application (long form). The following documentation is required:

1. Twelve (12) months of mental health progress notes, including the incarcerated individual's mental health treatment plan;

2. Twelve (12) months of psychiatric progress notes, including medication updates;

3. The Medication Administration Record (MAR);

4. Discharge summaries from Bridgewater State Hospital if the incarcerated individual has been hospitalized within the past twelve (12) months;

5. Any neuropsychological testing completed within the past twelve (12) months; and

6. Any pertinent medical documentation.

I. Reentry Clinical Case Conference

No later than ninety (90) days prior to the anticipated discharge of an incarcerated individual with an open mental health case, a reentry clinical case conference should be considered if the incarcerated individual is considered at risk for homelessness and has one of the following:

1. Serious cognitive deficits and/or a serious mental health diagnosis (a current DSM 5 diagnosis) which is characterized by the impairment of the individual's normal cognitive, emotional or behavioral functioning in such manner that he/she/they may have difficulty functioning and/or planning appropriate discharge and follow-up care; or

2. A long-term history of substance use or alcohol addiction where the incarcerated individual has not had recent treatment but requires out-patient follow-up care.

J. Discharge Medication

An incarcerated individual receiving psychotropic medication shall be provided with a thirty (30) day prescription and/or the remainder of the incarcerated individual's patient-specific blister pack at the time of discharge in accordance with the incarcerated individual's needs and follow-up care.

The psychiatrist shall determine whether an incarcerated individual should be discharged with a supply of medication or with a written prescription.

650.18 COMMUNICATION REGARDING MENTAL HEALTH STATUS AND NEEDS OF INCARCERATED INDIVIDUALS

A. Intra-Institution Communication

1. Each Superintendent, in conjunction with the Site Mental Health Director, shall establish written site specific procedures to direct, guide and encourage correctional staff to seek and obtain consultation from Qualified Mental Health Professionals when correctional staff have reason to believe that an incarcerated individual may be mentally ill or when mental health status is an issue in the consideration of classification, discipline, program participation, placement or release planning. Such procedures shall require communication to occur at least Monday through Friday between Qualified Mental Health Professionals and the Superintendent or designee in order to review all of the prior day's incident and disciplinary reports for any matter where it is believed that an incarcerated individual's mental status may be in question. Consideration of the incarcerated individual's mental health status as it pertains to the disciplinary process shall be governed by 103 DOC 650.18 (D) (5) (b) Communications on and Recommendations for Special Needs Incarcerated Individuals. Consideration of the incarcerated individual's mental health status as it pertains to housing, program assignments, work, transportation, special equipment and admission to and transfer from the institution shall be governed by 103 DOC 650.18 (D) (2) (c) Communications on and Recommendations for Special Needs Incarcerated Individuals. Meeting minutes of the daily (Monday through Friday) meetings shall be maintained by the Superintendent's office.

2. Institutions that do not have at least five (5) day per week mental health coverage shall be exempt from this required daily (Monday through Friday) meeting, but site specific procedures shall be developed to ensure consultation from Qualified Mental Health Professionals occurs at least weekly, and is sought on an as needed basis, when correctional staff have reason to believe that an incarcerated individual may be mentally ill or when mental health status is an issue in the consideration of classification, discipline, program participation, placement or release planning.

3. Site-specific procedures shall be submitted to the Director of Behavioral Health for approval.

4. The daily (Monday through Friday) meeting shall provide the opportunity for mental health staff to raise specific incarcerated individual related mental health issues that may require some form of increased involvement or monitoring from correctional staff, but does not rise to the level of requiring an incarcerated individual to be placed on therapeutic supervision. This information shall also be documented to ensure that relevant mental health information is communicated to the appropriate correctional or medical staff.

5. The daily meeting shall also provide a forum for senior Department site administration to inform mental health staff of any significant events expected to occur within the day that may have an impact upon an incarcerated individual's overall mental status (e.g. classification hearings, parole hearing, legal decisions, court trips, etc.). When it is suspected that an incarcerated individual will react negatively to such an event, mental health staff shall ensure that the incarcerated individual is evaluated by a Qualified Mental Health Professional upon completion of the event.

6. Mental health staff's input into any of these matters shall be documented within the official minutes of the daily meeting.

B. Inter-Institution Communication

Along with the medical record, a "Health Status Report" shall accompany each incarcerated individual who is transferred from one Department of Correction institution to another. This report shall contain information regarding the incarcerated individual's mental health history including psychiatric hospitalizations, psychotropic medications, any existing Probate Court order(s) regarding medications, suicide attempts and sexual use victimization while incarcerated.

If the Site Mental Health Director at the sending institution believes that the incarcerated individual may suffer a psychiatric emergency or act out during transportation or upon arrival at the receiving institution, the Director shall communicate this belief to the Deputy Superintendent of the sending institution and the Site Mental Health Director at the receiving institution. The Deputy Superintendent of the sending institution shall ensure that this information is communicated to the Central Transportation Unit as well as initiate contact with the Deputy Superintendent of the receiving institution.

C. Inter-System Communication

A Health Status Report pursuant to 103 DOC 607, *Inmate Medical Records*, section 607.02 shall accompany each incarcerated individual who is released from the custody of the Department of Correction to another

correctional or law enforcement agency or to the Department of Mental Health. Mental health participation in the reentry process shall be governed by 103 DOC 650.17, Mental Health Reentry Planning and Procedures.

D. Communications on and Recommendations for Special Needs Incarcerated individuals

1. General Policy

Incarcerated individuals shall be identified who, due to mental illness or developmental disabilities, have special needs regarding housing, program assignments, work, transportation, special equipment and admission to and transfer from the institution. Special needs and any recommendations regarding such special needs shall be documented in the medical record and in the appropriate IMS screens and shall be communicated as necessary and appropriate to medical and mental health clinicians, Department staff and outside hospital staff.

2. Procedure

a. Mental health clinicians shall assess incarcerated individuals for special needs and review the medical record for documentation of special needs upon intake, upon transfer and on an ongoing basis. Thereafter, any special needs shall be reviewed and renewed or discontinued at least annually.

b. Mental health clinical recommendations for housing, program and work assignments, transportation and special equipment shall be documented on the Medical Restrictions Form in IMS (Attachment #10) by a member of the mental health team and forwarded to the site Mental Health Director for review. Special needs shall also be documented in the Problem List (Attachment #11).

c. If the recommendation concerns housing, program and work assignments, and/or transportation, the Site Mental Health Director shall notify and provide the Superintendent with the Medical Restrictions Form. The Superintendent shall initiate appropriate communication and measures. Recommendations concerning transportation shall also be conveyed to the Records Department.

d. If the recommendation requires the provision of special equipment, the site Mental Health Director shall forward the completed Medical Restrictions Form to the Site Medical

Director for review and approval and to the Superintendent or other Department designee for security review within seven (7) days of completion of the form. If the order is not denied by the Site Medical Director or by the Superintendent or designee and further evaluation or testing is not required, the Medical Contractor shall order any equipment within seven (7) days of the Site Medical Director's approval. The equipment shall be provided to or made available for the incarcerated individual within a reasonable time.

e. When invited or included, mental health staff shall participate in Department of Correction meetings in order to alert Department staff as to the special needs of incarcerated individuals and to recommend strategies to address these needs.

f. Completed Medical Restrictions Forms and Problem Lists shall be filed in the "Miscellaneous Section" of the medical record and the information entered into the IMS Medical/Mental Health Restrictions screen.

3. Self-Directed Violence Review Committee

A Self-Directed Violence Review Committee will operate and meet twice per month. This meeting will be led by a member of mental health clinical staff, and include mental health staff, DOC Health Services Division staff, and related clinical disciplines as appropriate.

The Self-Directed Violence Review Committee will review and discuss the Quality Improvement Committee's data regarding Self-Directed Violence, conduct an in-depth analysis of the incarcerated individuals who have engaged in the most Self-Directed Violence over the past month, and conduct timely and adequate multi-disciplinary reviews for all instances of Self-Directed Violence that require an outside hospital trip.

The minutes of these reviews will be provided to all treating staff and senior Department of Corrections staff. Action will be taken to correct any systemic problems identified during these reviews.

4. Incarcerated Individuals with Disabilities and Incarcerated Individuals with Language Barriers

The agency shall take appropriate steps to ensure that incarcerated individuals with disabilities (including, for example, incarcerated

individuals who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual use and sexual harassment. Such steps shall include, when necessary to ensure effective communication with incarcerated individuals who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, the agency shall ensure that written materials are provided in formats or through methods that ensure effective communication with incarcerated individuals with disabilities, including incarcerated individuals who have intellectual disabilities, limited reading skills, or who are blind or have low vision. An agency is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under title II of the Americans with Disabilities Act, 28 CFR 35.164.

5. Mental Health Consultation in the Disciplinary Process

a. Notification to Mental Health – SMI Incarcerated Individuals

Site mental health staff shall be notified prior to service of a disciplinary report on any incarcerated individual with SMI who is charged with a Category 1 or Category 2 disciplinary offense, as defined by 103 CMR 430, *Inmate Discipline* regulation.

b. Superintendent's Review of Disciplinary Reports

During regularly scheduled reviews of recently issued disciplinary reports (103 DOC 650.18(A). Intra-Institution Communication, the Superintendent or designee shall receive consultation from a site mental health staff member regarding mental health issues that may be implicated in the events described by the disciplinary report, and whether there are appropriate alternatives for addressing the matter by means other than the disciplinary process. Upon determination that the case should be managed by means other than the disciplinary process, the Superintendent may order that the disciplinary report be dismissed in whole or in

part. Such dispositions shall be documented in the meeting minutes.

6. Consultation Regarding Disciplinary Disposition

a. Following the entry of a guilty finding on a Category 1 or Category 2 disciplinary offense for an incarcerated individual with a Mental Health Classification of MH-4, the hearing officer, , shall consult with mental health staff. Mental health staff shall render an oral opinion, if pertinent, as to whether there are mental health considerations that may bear on the issues of mitigation and determination of an appropriate sanction. This may include an opinion on the effect of particular sanctions or combination of sanctions on the incarcerated individual's mental health (e.g., loss of visits, canteen, television, etc.). The hearing officer shall indicate by "check off" on the disciplinary hearing form (Attachment #6) that the hearing officer has received an opinion from mental health staff and document any change in the disposition of the case entered pursuant to that opinion.

650.19 DUTY TO WARN

A Qualified Mental Health Professional who, in the course of diagnosing, assessing or treating an incarcerated individual, has reason to conclude that the incarcerated individual poses a threat to a third person, and the clinician is obliged by statute (including G.L. c. 112, § 129A (licensed psychologist), G.L. c. 112, § 135A (licensed social worker), G.L. c. 112, § 172A (mental health counselor) or otherwise obliged to warn a third person or take action to prevent the occurrence of harm, the clinician shall notify the Site Mental Health Director and the Program Mental Health Director, who shall notify and consult with the Director of Behavioral Health. The Director of Behavioral Health may consult with security staff, convene a case conference or take any other appropriate action to address the situation.

650.20 ON-SITE EVALUATIONS BY OUTSIDE QUALIFIED MENTAL HEALTH PROFESSIONALS

The following shall be followed by all institutions whenever a request is received for an incarcerated individual examination or evaluation by an outside Qualified Mental Health Professional (i.e., any Qualified Mental Health Professional who is not currently employed by the Department of Correction or the Department of Correction Mental Health Contractor).

A. Prior to admittance, the outside Qualified Mental Health Professional performing the evaluation or examination shall complete the Request to Perform Outside Mental Health Services Form (Attachment #13), copies of which shall be available in the outer control area.

B. In all cases, the incarcerated individual shall sign an authorization to release medical/mental health information in order for the outside Qualified Mental Health Professional to examine the incarcerated individual's medical and/or mental health record (see 103 DOC 607, *Inmate Medical Records*, Attachment #2).

C. The outside Qualified Mental Health Professional may enter the institution through the normal institution visiting procedure, with any documents related to the evaluation, if the professional indicates on Attachment #13 the nature of the services as one or more of the following:

1. Court-Ordered Evaluation
2. Criminal Responsibility Evaluation (G.L. c. 123, §15(b))
3. Competency Evaluation (G. L. c. 123, § 15(b))
4. Commitment to BSH (G.L. c. 123)
5. Sexual Dangerousness (G.L. c. 123A)
6. Transfer Hearing (G.L. c. 123A)
7. Competency of Witness to Testify (G.L. c. 123, §19)
8. Guardianship/Probate Issues
9. Criminal Defense
10. Bail Hearing (issues of dangerousness) (G.L. c.276, §58A)
11. Commutation of Sentence (120 CMR 901 et seq.)
12. Parole
13. Department of Children and Families or Department of Youth Services
14. Social Security Disability
15. Non-court ordered examination in conjunction with civil claim.

D. Advance notification and approval in the above cases are not required. However, the outside Qualified Mental Health Professional must have a valid license to provide services consistent with the discipline in which the professional is trained to practice. The license, along with the required visiting identification, shall be submitted with the visiting slip.

E. Special accommodations (e.g., attorney room, non-visiting hours, recording equipment, projector) may be requested and may be approved by the Superintendent or designee, if requested in advance of the visit.

F. If the outside Qualified Mental Health Professional indicates, on Attachment #13, that the nature of the service is for any other reason than those cited in 103 DOC 650.20(C) On-Site Evaluations by Outside

Qualified Mental Health Professionals, the following procedure shall be followed:

1. A request must be made in writing to the Superintendent. The request must include on Attachment #13, the specific reason for and nature of the examination, any special accommodations, and a copy of the valid license to provide services.

2. Upon the approval of the Superintendent, the evaluator may enter the institution through the normal institution visiting procedure or via any special accommodations approved by the Superintendent.

G. All outside Qualified Mental Health Professionals shall be subject to the following additional requirements:

1. Outside Qualified Mental Health Professional shall be informed that they may not perform an intrusive examination, nor may the Qualified Mental Health Professional write any orders or notes in any part of the medical or mental health record.

2. The outside Qualified Mental Health Professional shall be informed that neither the Department of Correction nor the Mental Health Contractor is obligated to comply with any consultation recommendations that the Qualified Mental Health Professional makes. The outside Qualified Mental Health Professional may offer a consultation report. The consultation report shall be reviewed by the Site Mental Health Director or the Medical Director at Bridgewater State Hospital and may be included in the incarcerated individual's medical health record.

4. The Director of Behavioral Health shall be notified of any request for an outside mental health consultation where the reason for such consultation concerns an allegation of lack of services within a institution, or inappropriate treatment within a institution, so that the Director may consider proper review, comment or initiate a peer review.

650.21 RECORDS AND CONTINUOUS QUALITY IMPROVEMENT

A. Mental Health Records

Mental health records shall be governed by 103 DOC 607, *Inmate Medical Records*.

B. Peer and Mortality Reviews

Mortality reviews shall be governed by 103 DOC 622, *Death Procedures*.

The Health Contractor and their respective personnel shall participate in peer review, mortality review, case review and other such functions, and shall cooperate with such additional clinicians in achieving the common goal of providing quality health services to incarcerated individuals. Such participation shall include full cooperation in any investigation, mortality review, peer review and case review performed by the Department, the Medical Contractor, the Mental Health Contractor or by any consultant retained by the Department. Full cooperation shall include the provision of any requested information and reports within the time period required by the Director of Behavioral Health. Any findings pertinent to DOC policy or the vendor's internal review shall be shared with the Director of Behavioral Health.

The Director of Behavioral Health shall have timely access to Department of Correction incident and investigation reports necessary to perform a mortality review.

C. Continuous Quality Improvement

1. The Contracted Healthcare Vendor shall engage in a quality assurance program that is adequately maintained and identifies and corrects deficiencies with the provision of supervision and mental health care to prisoners in mental health crisis. A system will be implemented to ensure that trends and incidents are promptly identified and addressed as clinically indicated.

2. Quality Assurance policies and procedures will be drafted to identify trends and incidents in the provision of supervision and mental health care to incarcerated individuals in mental health crisis.

3. The Health Services Division, in collaboration with the Healthcare Vendor Quality Improvement team will track and analyze patterns and trends of reliable data concerning supervision and mental health care to incarcerated individuals in mental health crisis to assess whether measure taken by the Healthcare Vendor are effective and/or continue to be effective in preventing and/or minimizing harm to incarcerated individuals on therapeutic supervision. This data will be reviewed annually to consider whether to modify data tracked and analyzed.

4. The Mental Health Contractor shall include in its Continuous Quality Improvement indicators the examination of high risk/high volume activities, self-injurious behavior and other sentinel events, and special treatment procedures, including but not limited to, the

utilization of therapeutic supervisions, chemical restraints, mental health restraints and court approved treatment.

650.22 SUPPLEMENTAL MENTAL HEALTH POLICIES AND PROCEDURES

A. Department Policies

103 DOC 519, *Sexual Harassment/Abuse Response Prevention Policy (SHARPP),* governs the mental health response to sexually abusive behavior.

103 DOC 652, *Identification, Treatment and Correctional Management of Inmates Diagnosed with Gender Dysphoria*, governs the treatment of Gender Dysphoria.

103 DOC 653, *Identification, Treatment and Correctional Management of Gender Non-Conforming Inmates*, governs the treatment of persons identified as Gender Non-Conforming.

B. Institution Mental Health Policies

Except as set forth herein, the provisions of 103 DOC 650 shall apply to all institutions.

MCI-Shirley shall maintain the therapeutic de-escalation room.

Bridgewater State Hospital, as an accredited psychiatric hospital, establishes hospital-specific policies and procedures. Other institutions shall not adopt site-specific mental health policies except upon the prior approval of, and subject to the review of the Director of Behavioral Health. All site-specific mental health policies shall be consistent with the provisions of 103 DOC 650.

C. Mental Health Treatment Unit Policies

The Director of Behavioral Health, in conjunction with the institution Superintendents, shall draft and update operational procedures and incarcerated individual handbooks for mental health treatment units, including:

1. The Secure Treatment Program (STP)
2. The Behavioral Management Unit (BMU)
3. The MCI-Framingham Intensive Treatment Unit (ITU)
4. The Residential Treatment Units (RTUs)
5. The Intensive Stabilization Unit (ISU)

D. Contractor Policies

The Contractor shall write, update and submit policies and procedures consistent with 103 DOC 650 for review, approval and co-signature by the Assistant Deputy Commissioner of Clinical Services.

650.23 ADMINISTRATIVE PROVISIONS

A. Designees

An action that this policy requires to be taken by an identified official may be taken by that official's designee as circumstances dictate.

B. Temporal References

Unless otherwise provided by this policy, all temporal references to "days" within this policy shall mean calendar days.

C. Exigent Circumstances

1. If a provision of this policy specifically requires a prior determination whether Exigent Circumstances may preclude the occurrence of an act or action, the determination shall be made by the Assistant Deputy Commissioners for the Northern and Southern Sectors. If the Assistant Deputy Commissioners for the Northern and Southern Sectors do not agree whether Exigent Circumstances exist, the matter shall be referred to the Deputy Commissioner, Prison Division for final determination.

2. In all other instances in which an act or action required by this policy does not occur for reason of Exigent Circumstances, notification shall be made to the Assistant Deputy Commissioner for the appropriate sector. In such instance, responsible staff shall attempt to resolve the Exigent Circumstances as soon as possible and the act or action shall be performed as soon as possible after the Exigent Circumstances cease to exist.

Attachment # 1

SICK CALL REQUEST FORM

Date: _____

Name:_____ ID#: _____ Unit #: _____

Date of Birth:_____ Check **ONLY** One Box: ☐ Medical ☐ Dental ☐ Mental Health

Nature of problem or request: _____

_____

_____

I consent to be treated by the healthcare staff for the condition described above.

Incarcerated Individual Signature: _____ Date: _____

********DO NOT WRITE BELOW THIS AREA********
PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA

Date/Time Received:_____

Referred to: ☐ Nurse ☐ Provider ☐ Mental Health ☐ Dental ☐ Other

Institution: _____ Slip Sorted By: _____

☐ Emergency ☐ Urgent ☐ Routine ☐ Administrative

Subjective:

Objective: T _____ P _____R_____B/P _____W/T _____

Assessment:

Plan:

Signature & Title _____ Date: _____ Time: _____

Attachment #2

Mental Health Classification Form

☐ Initial Classification ☐ Classification Change Institution: _____

☐ **MH-5 Severe functional impairment due to a mental disorder (Hospitalization)**
Sub Code(s) : A □ B □ C □ D □

- ❖ Severe debilitating symptoms, such as persistent danger of hurting self or others, recurrent violence, inability to maintain minimal personal hygiene, or gross impairment in communication; severely disorganized thinking and behavior
- ❖ Cannot safely and/or adequately be treated in a prison environment
- ❖ This code is effective once an incarcerated individual is referred to the 18a commitment process.

☐ **MH-4 Serious functional impairment due to a mental disorder (RTU)**
Sub Code(s): A □ B □ C □ D □

- ❖ The incarcerated individual may experience severe impairment in mental health functioning and/or behavioral control that significantly impacts ability to function in a general population setting. (May include recurrent episodes of psychiatric decompensation, frequent reliance on crisis stabilization services, pervasive pattern of self-injury and/or multiple disciplinary infractions, etc.)
- ❖ Psychiatric intervention and/or evaluation required
- ❖ Psychotropic medications may be indicated (regardless of whether incarcerated individual is noncompliant)
- ❖ Incarcerated individual requires structured daily activities and comprehensive mental health programming to maintain stability
- ❖ A multidisciplinary treatment plan review is needed more frequently than every six (6) months

☐ **MH-3 Moderate level of mental health treatment needs (General Population)**
Sub Code(s): A □ B □ C □ D □

- ❖ The incarcerated individual experiences moderate impairment in mental health functioning and/or behavioral control
- ❖ Psychiatric intervention and/or evaluation required
- ❖ Psychotropic medications may be indicated (regardless of whether incarcerated individual is noncompliant)
- ❖ Incarcerated individual must be seen at least monthly by their assigned primary care clinician, but may require more frequent monitoring due to concerns related to self-injury and/or psychiatric decompensation
- ❖ The incarcerated individual is prioritized for group treatment when available and clinically indicated
- ❖ Incarcerated individual is able to function in general population with structured support from mental health staff
- ❖ The incarcerated individual requires a multidisciplinary treatment plan
- ❖ The incarcerated individual may participate in DOC programs as available; there may be program restrictions based on mental health symptoms

☐ **MH-2 Mild level of mental health treatment needs (General Population)**
Sub Code(s): A □ B □ C □ D □

- ❖ The incarcerated individual experiences mild impairment in mental health functioning and/or behavioral control
- ❖ Psychiatric intervention and/or evaluation may be necessary
- ❖ Psychotropic medications may be indicated (regardless of whether incarcerated individual is noncompliant)
- ❖ The incarcerated individual requires assignment of a primary care clinician and must be seen at least monthly for outpatient mental health treatment
- ❖ Group treatment may be provided when available and clinically indicated
- ❖ The incarcerated individual requires a multidisciplinary treatment plan
- ❖ The incarcerated individual can participate in DOC programs as available

☐ **MH-1 Case management needs (General Population)**
Sub Code(s): B □ D □

- ❖ The incarcerated individual experiences mild or minor impairment in mental health functioning
- ❖ The incarcerated individual is stable with treatment provided on an outpatient basis which may include case management and group treatment
- ❖ Psychotropic medications are not indicated
- ❖ The incarcerated individual may require monitoring due to use of psychotropic medications
- ❖ The incarcerated individual's history contains evidence of a suicide attempt or psychiatric hospitalization within the past year
- ❖ The incarcerated individual requires a multidisciplinary treatment plan
- ❖ The incarcerated individual can participate in DOC programs as available

☐ **MH-0 No current mental health treatment needs (General Population)**
Sub Code: D □

- ❖ The incarcerated individual does not demonstrate any identified need for mental health assistance
- ❖ The incarcerated individual may receive crisis intervention services when indicated
- ❖ The incarcerated individual can participate in DOC programs as available

☐ **MH-9 Awaiting evaluation – no classification code**

- ❖ Pending disposition upon completion of mental health evaluation

Glossary of Mental Health Classification Sub Codes

A: Incarcerated individual is designated as SMI (seriously mentally ill) based upon definition.
B: Incarcerated individual is currently prescribed psychotropic medication by a psychiatrist.
C: Incarcerated individual is currently prescribed medication by a psychiatrist that must be administered by nursing staff, requiring a facility with seven (7) day nursing coverage.
D: Incarcerated individual has a history of self-injurious behavior.

ANY INCARCERATED INDIVIDUAL MEETING THE CRITERIA FOR SMI MUST BE CLASSIFIED WITH A DESIGNATION OF AT LEAST A MH-2

Clinician Printed Name:_____

Signature:_____ Date:_____

Attachment #3

RESIDENTIAL TREATMENT UNIT REFERRAL

Name:_____ ID:_____ DOB:_____

Date of Referral:_____

Referring Institution: _____ Housing Unit: _____

Currently in BAU: ☐ Yes ☐ No

If Currently in BAU, please report the following:

- Date Placed in BAU:_____
- Offense Leading to BAU Placement:_____

Referring Clinician and Contact Information: _____

_____

Current Diagnosis:_____

_____

_____

Current Stressors:_____

SMI: ☐ Yes ☐ No

Current MH Classification and Subcode:_____

Criminal Offense:_____

GCD/PE (include both dates): _____

Commitment Expires (BSH ONLY):_____

Prior Incarcerations:_____

_____

Disciplinary/Institution Adjustment:_____

_____

_____

Current Medications and Dosage (and Probate Rogers history):_____

_____

Mental Health History (Include Diagnostic History):

Psychiatric Hospitalizations (Include Dates and Reasons):

Outpatient Mental Health Treatment:

Substance Use History:

Therapeutic Supervisions (Include Dates and Reasons):

Frequency of Crisis Contacts:

History of Suicide Attempts/Self-Directed Violence (Include Dates):

Prior RTU/ISU/STU Treatment:

Current Mental Status:

Current Functional Status:

Current Psychiatric Symptoms that Impair Independent Functioning in General Population:_____

_____

Incarcerated Individual's Perception and Understanding of RTU Placement:_____

_____

RTU Treatment Goals:_____

_____

_____

Potential Barriers for RTU Treatment:_____

_____ _____

Incarcerated Individual's Signature Date

_____ _____

Clinician's Signature Date

_____ _____

Mental Health Director (From Referring Site) Date

Please scan signed copy to Contracted Healthcare Vendor Director of Clinical Programs (or designee):

_____

(PLEASE DO NOT WRITE BELOW THIS LINE)

Date Referral Received:_____

Contacts Regarding this Referral:_____

Result: ☐ Incarcerated Individual Meets Criteria
☐ Incarcerated Individual Does Not Meet Criteria

_____ _____

Director of Clinical Programs (or designee) Date

Recommended RTU Site: (to be issued by DOC Classification)

☐ Old Colony (Max) ☐ Old Colony (Med) ☐ NCCI Gardner ☐ MCI-Framingham

Attachment #4

MA Department of Correction
Health Services Division
Residential Treatment Unit Discharge Summary

Incarcerated Individual Name:_____ ID#:_____
DOB:_____ Institution:_____

Admitted on:	Date of Discharge:
Length of Stay in the RTU:	Multiple RTU Admissions: ☐ Yes ☐ No
Reason for RTU Placement:	
Admitting DSM 5 Diagnosis:	
Reason for RTU Discharge: ☐ Clinically and behaviorally stable. No longer in need of RTU placement (attach any case conference documentation) ☐ After assessment in the RTU the incarcerated individual is deemed not to require RTU level of care (Case conference required. Attach case conference summary).	
Treatment Progress on RTU:	
Current Mental Status:	
Incarcerated Individual compliant with medication? ☐ Yes ☐ No	
Incarcerated Individual placed on mental health watch during the last thirty (30) days? ☐ Yes ☐ No	
Relevant Medical Information:	

Discharge DSM 5 Diagnosis:
Current Medications:
Follow-up Treatment Recommendations:

Incarcerated Individual Signature:	Date
Reason No Incarcerated Individual Signature:	
Primary Care Clinician:	Date
Psychiatrist/Nurse Practitioner:	Date
Mental Health Director:	Date
Other (Title)	Date

Attachment #5

Case Conference Summary Form

Complete & submit this form to DOC Health Services Division by Noon on Friday before IFCC

Incarcerated Individual Name:	Incarcerated Individual ID #:
Date of Case Conference:	Incarcerated Individual's DOB:
Institution(s) Involved:	Form Completed By:

Reason(s) for the Inter-Institution Case Conference/Questions to be addressed:

Past History (brief overview of the incarcerated individual's psychiatric, legal, and DOC history):

Legal status:

Recent History:

Diagnoses:

Medication Regimen (list all medications & dosages):

Medication & Dosage	Indication	Compliance

Probate or District Rogers (include history of Probate and/or District Rogers and dates):

Is incarcerated individual/patient aware of IFCC? (y/n)		Is incarcerated individual/patient aware of clinical plan? (y/n)	

If alternative placement is being considered, is incarcerated individual/patient aware & if so, how receptive is s/he?

Plan (to be completed and submitted within 24 hours of the case conference. Identify all responsible parties and dates for completion of identified tasks. Include all clinical, housing, and classification issues):

Plan:	Responsible Party:
1.	
2.	
3.	
4.	

Attendees (List all individuals on the conference call and in attendance):

Signature:	Printed Name:

Attachment #6

Mental Health Consultation for Disciplinary Disposition

This form is to be completed for all incarcerated individuals designated MH-4 who have been found guilty or who have pled or pleaded guilty to a Category 1 or Category 2 Disciplinary Offense.

Incarcerated Individual Name	Commitment Number
Disciplinary Report Number	

Check One (1) Result:

☐ Guilty Plea

☐ Guilty Finding

Printed Name of Officer	Date of Finding
Printed Name of Mental Health Staff Person Consulted	Date of Disposition Consult

As a result of consulting with mental health staff regarding the above-referenced disciplinary matter and incarcerated individual, the sanction(s) I have imposed has been impacted as indicated:

Part 1

☐ Mental health staff did not recommend a sanction modification.

☐ Mental health staff recommended a sanction modification.

Part 2 (Complete only if mental health staff recommended modification.)

☐ Sanction was not modified.

☐ Sanction modified in whole or in part pursuant to the recommendation.

Signature of Disciplinary Officer or Hearing Officer	Date Completed

Attachment #7

SECURE TREATMENT UNIT REFERRAL

Name:_____ ID:_____ DOB:_____

Date Referral Completed:_____

Referring Institution:_____ Current Housing Unit:_____

Referring Clinician and Contact Information (Email, Phone Number):_____

_____

Summary of Iat Discussion and Recommendation for Referral:_____

_____

Current Diagnosis:_____

Current Medications and Dosage:_____

Recent Medication Changes (Include Date of Changes and Dosages):_____

_____

Medication Compliance:_____

Probate Roger's History (Include Dates and Specifics Regarding Administration of Medications):

_____

Allergies And Known/Reported Side Effects:_____

Significant Medical History (e.g., Traumatic Brain Injury, Insulin Dependent, Requires Inhaler, Etc.):_____

Mental Health History Since Incarcerated (Include Dates and Interventions):_____

_____

Specialized Treatment Interventions (e.g., 18a's, RTU's, Etc., Include Dates and Response to Treatment Interventions):_____

Prior Psych Testing (Include Copy of Testing Results):_____

Psychiatric Hospitalizations (Include BSH Evaluation):_____

Outpatient Mental Health Treatment Prior To Incarceration:

Substance Use History:

Therapeutic Supervision (Past 12 Months):

Frequency of Crisis Contacts (Specify Date, Reason, and Outcome Over the Past 12 Months):

History Of Suicide/Self-Directed Violence (Include Dates and Brief Descriptions of Behaviors for Past 12 Months):

Self-Directed Violence Requiring Outside Medical Attention in The Past 12 Months (Include Dates and Descriptions of Identified Triggers, Behaviors and Interventions):

Location Where Self-Directed Violence Occurred (E.G., In BAU, General Population, Etc.):

Current Functional Status (Please Include Mental Status Exam):

Current Psychiatric Symptoms and/or Behavioral Problems That Impair Independent Functioning In BAU:

Chronic of Psychiatric Symptoms and/or Behavioral Problems That Impair Independent Functioning in General Population:

Treatment Goals:

Incarcerated Individual's Perception and Understanding of STU Placement:

Identified Strengths:

Identified Positive Coping Strategies:

Clinician Signature _____ Date _____

Mental Health Director (From Referring Site) _____ Date _____

Team Recommendation For STU Placement:

☐ Behavior Management Unit

☐ Secure Treatment Program

Please email to Healthcare Vendor Director of Clinical Programs

---

(PLEASE DO NOT WRITE BELOW THIS LINE)

Date Referral Received:_____

Date of STU Review Committee Review:_____

☐ Incarcerated Individual Meets Criteria for Placement in the Behavior Management Unit

☐ Incarcerated Individual Meets Criteria for Placement in the Secure Treatment Program

☐ Incarcerated Individual Does Not Meet Criteria for Placement in A Secure Treatment Unit (Rationale For Decision Provided in a Separate Document)

Director of Behavioral Health (DOC) _____ Date _____

Director of Clinical Programs (Contracted Healthcare Vendor) _____ Date _____

Attachment #8

OBSERVATION CHECK SHEET

Institution:________________________________

Name:___________________________________ Commitment #:_____________________ Unit:________________ Cell:________________ Date:________________

Officer's Name (Print):____ Officer's Signature:____

TIME	STATUS	ACTIVITIES / OBSERVATIONS	COMMENTS	LIGHT
	☐ Close ☐ Constant	☐ Asleep ☐ At door ☐ Using tablet ☐ Exercising ☐ Out of cell ☐ On bed ☐ Reading ☐ Pacing ☐ Talking to peer/staff		☐ Full ☐ Dim
	☐ Close ☐ Constant	☐ Asleep ☐ At door ☐ Using tablet ☐ Exercising ☐ Out of cell ☐ On bed ☐ Reading ☐ Pacing ☐ Talking to peer/staff		☐ Full ☐ Dim
	☐ Close ☐ Constant	☐ Asleep ☐ At door ☐ Using tablet ☐ Exercising ☐ Out of cell ☐ On bed ☐ Reading ☐ Pacing ☐ Talking to peer/staff		☐ Full ☐ Dim
	☐ Close ☐ Constant	☐ Asleep ☐ At door ☐ Using tablet ☐ Exercising ☐ Out of cell ☐ On bed ☐ Reading ☐ Pacing ☐ Talking to peer/staff		☐ Full ☐ Dim
	☐ Close ☐ Constant	☐ Asleep ☐ At door ☐ Using tablet ☐ Exercising ☐ Out of cell ☐ On bed ☐ Reading ☐ Pacing ☐ Talking to peer/staff		☐ Full ☐ Dim
	☐ Close ☐ Constant	☐ Asleep ☐ At door ☐ Using tablet ☐ Exercising ☐ Out of cell ☐ On bed ☐ Reading ☐ Pacing ☐ Talking to peer/staff		☐ Full ☐ Dim
	☐ Close ☐ Constant	☐ Asleep ☐ At door ☐ Using tablet ☐ Exercising ☐ Out of cell ☐ On bed ☐ Reading ☐ Pacing ☐ Talking to peer/staff		☐ Full ☐ Dim
	☐ Close ☐ Constant	☐ Asleep ☐ At door ☐ Using tablet ☐ Exercising ☐ Out of cell ☐ On bed ☐ Reading ☐ Pacing ☐ Talking to peer/staff		☐ Full ☐ Dim
	☐ Close ☐ Constant	☐ Asleep ☐ At door ☐ Using tablet ☐ Exercising ☐ Out of cell ☐ On bed ☐ Reading ☐ Pacing ☐ Talking to peer/staff		☐ Full ☐ Dim
	☐ Close ☐ Constant	☐ Asleep ☐ At door ☐ Using tablet ☐ Exercising ☐ Out of cell ☐ On bed ☐ Reading ☐ Pacing ☐ Talking to peer/staff		☐ Full ☐ Dim
	☐ Close ☐ Constant	☐ Asleep ☐ At door ☐ Using tablet ☐ Exercising ☐ Out of cell ☐ On bed ☐ Reading ☐ Pacing ☐ Talking to peer/staff		☐ Full ☐ Dim
	☐ Close ☐ Constant	☐ Asleep ☐ At door ☐ Using tablet ☐ Exercising ☐ Out of cell ☐ On bed ☐ Reading ☐ Pacing ☐ Talking to peer/staff		☐ Full ☐ Dim
	☐ Close ☐ Constant	☐ Asleep ☐ At door ☐ Using tablet ☐ Exercising ☐ Out of cell ☐ On bed ☐ Reading ☐ Pacing ☐ Talking to peer/staff		☐ Full ☐ Dim

ALL CHECKS SHALL BE MADE AT 15 MINUTE STAGGERED INTERVALS. EACH ENTRY SHALL BE IN INK.

If the assigned officer is changed, this form will be finalized and signed by the out-going officer.
A new form will be utilized by the oncoming officer to continue the observation.

Copy from 103 DOC 520, Instruments of Restraint, Attachment #3 (November 2024)

Attachment #3

Four-Point Restraints Medical Examination Checklist

Institution:_____ **UOF # (if applicable):**_____

Inmate Name:_____

Commitment #:_____

Ordered By (Print Name):_____

Date Restraints Applied:_____ **Time Restraints Applied:**_____

Date Restraints Removed:_____ **Time Restraints Removed:**_____

Time	Qualified Medical Professional Conducting Check	Extremity Circulation Checked, Pulse Present, Movement Adequate	Medical Professional Initials

***** Except in unusual circumstances, the first restraint check shall occur within fifteen (15) minutes of the inmate being secured in Four-Point Restraints. All subsequent restraint checks shall be conducted at intervals not to exceed fifteen (15) minutes in duration. Vital signs shall be taken at each thirty (30) minute interval. *****

Attachment #10

MEDICATION RESTRICTION FORM
(GENERATED BY IMS)

To access the form:

1. Log onto IMS

2. Select the “Medical” tab located at the top of the page.

3. Selected the “Medical Restriction/Special Needs” option from the drop down box.

PROBLEM LIST

_____
Institution

Name:_____ ID#:_____ DOB:_____

Medication Allergies:_____

Date Identified	Significant Health Problems	Healthcare Practitioner Signature	Date Resolved	Healthcare Practitioner Signature

MENTAL HEALTH PAROLE CONTACT SHEET

Incarcerated Individual Name:_____
ID#:_____ DOB:_____

Date **Mental Health** Services Initiated:_____

Date Mental Health Services Terminated:_____

Diagnosis:_____

_____

_____

Current Mental Health Services receiving (why receiving these services, e.g. manage symptoms, adjustment to prison, etc., what has their course of treatment been like; have they been engaged in treatment, etc.):_____

_____

_____

_____

Current Psychiatric Medications:_____

Psychiatric Hospitalization History:_____

Mental Health and other community services recommended by current provider (e.g. Substance Use Treatment, Residential, DMH Services, Employment, Case Management, etc.):_____

_____

_____

_____

DMH Application Status: ☐ N/A ☐ Approved ☐ Denied ☐ Pending ☐ Appeal

Form completed by (Name/Title):_____

(Print):_____

(Signature):_____ Date:_____

REQUEST TO PERFORM OUTSIDE MENTAL HEALTH SERVICES
(PSYCHIATRIST, PSYCHOLOGIST, LICENSED SOCIAL WORKER)

I, _____, agree to perform or cause to perform a mental health evaluation on _____, #_____, an incarcerated individual in the custody of the Department of Correction. In so doing, I understand that neither the Department of Correction, nor any of its agents, officials, or employees, nor the medical/mental health care provider for the Department of Correction, will incur any financial obligation for said services.

Name and Address of Provider:_____
(Please print clearly) _____
_____
_____

NATURE OF SERVICES	CHECK ANY THAT APPLY
Court-ordered	_____
Criminal Responsibility (G.L. c. 123, §15(b))	_____
Competency Evaluation (G. L.c. 123, § 15(b))	_____
Commitment to BSH (G.L. c. 123)	_____
Sexual Dangerousness (G.L. c. 123A)	_____
Transfer Hearing (G.L. c. 123A)	_____
Criminal Defense	_____
Bail Hearing(G.L. c. 276, §58A) (issues of dangerousness)	_____
Commutation of Sentence (120 CMR 901 *et seq.*)	_____
Parole	_____
DCF or DYS	_____
Social Security Disability	_____
Non-court ordered examination in conjunction with civil claim	_____

OTHER: (Please Specify)
1. _____
2. _____
3. _____

Signed:_____ Witness:_____
Title:_____ Date:_____
MA Lic. #:_____
Date:_____

THERAPEUTIC SUPERVISION PROCEDURES

The procedures outlined in this attachment are in addition to the language found in 103 DOC 650 regarding Therapeutic Supervision.

I. Searches

A. Before placement on therapeutic supervision, an incarcerated individual will complete an unclothed search. The search will be followed immediately by a search in a BOSS chair in accordance with 103 DOC 506 *Search Policy*.

B. The cell that the incarcerated individual is to be placed in for Therapeutic Supervision shall be thoroughly searched and inspected in accordance with 103 DOC 506 *Search Policy* and 103 DOC 504 *Security Inspections*.

C. Incarcerated individuals taken out of their cell to see Mental Health are not to have their cell searched, unless there are reasonable circumstances that would require a search, such reasons shall be documented through an IMS incident report.

II. Use of Restraints

A. An incarcerated individual who is actively engaging in self-injurious behavior may be placed into mental health restraints as outlined in 103 DOC 650. Alternatively, if mental health restraints are not deemed to be appropriate, Mental Health staff in conjunction with security staff may determine that the incarcerated individual may be placed into one or more restraint devices as outlined in 103 DOC 507, *Security Equipment*. Any determination for restraints is to be made as an individualized determination for each incarcerated individual on Therapeutic Supervision. Incarcerated individuals placed in restraints shall remain on constant observation until such time the incarcerated individual is removed from restraints and is assessed by mental health.

B. Should an incarcerated individual on Therapeutic Supervision be deemed not at imminent risk to self or others, the use of restraints may be eliminated for transition to therapeutic activities, the shower and other activities as determined by the collaboration of mental health and security.

III. Conditions

A. Visits: In addition to the visits outlined in 103 DOC 650.08 if clinically indicated, incarcerated individuals on Therapeutic Supervision shall be allowed visits in accordance with 103 CMR 483, *Visiting Procedures*, section 483.09, Maximum Security/Special Visiting Inmate Populations.

B. Disciplinary: Unless a contraindication exists as determined by mental health staff, incarcerated individuals on Therapeutic Supervision may be served and processed discipline in accordance with 103 CMR 430, *Inmate Discipline*. Any contraindications shall be noted in the mental health progress notes specific to the incarcerated individual in question.

1. Prior to any visit from Disciplinary Personnel, a Qualified Mental Health Professional shall conduct a clinical assessment and identify the appropriate conditions of the visit, consistent with the incarcerated individual's mental health status, including but not limited to whether the visit should be in cell or out of cell; and the appropriate permissible property, if any (e.g., pen/pencil, whether the incarcerated individual is allowed to maintain disciplinary paperwork in their cell). These conditions shall be entered on the IMS Mental Health Watch screen.

2. If the incarcerated individual is being represented in a disciplinary hearing by a legal representative, the procedures set forth in 103 DOC 650.08 (B)(7), Attorney Visits, shall apply.

3. At the conclusion of all visits from Disciplinary Personnel, a clinician shall follow-up with the incarcerated individual to ensure that the incarcerated individual's mental status has not changed, and note the incarcerated individual's mental status in the incarcerated individual's medical record and on the IMS Mental Health Watch screen.

IV. Procedure for Incarcerated Individuals on Therapeutic Supervision and Ingestion/Insertion of Drugs or Foreign Bodies

A. Notifications

1. Once on therapeutic supervision, if an incarcerated individual is observed ingesting contraband or inserting a foreign object into their body, the officer assigned to the Supervision shall contact the Shift Commander immediately and the Shift Commander shall ensure that medical staff respond to the area. Appropriate medical protocols shall be adhered to. The officer witnessing such ingestion or insertion shall submit an IMS incident report prior to the end of their shift.

2. If the officer assigned to the therapeutic supervision witnesses an inserted foreign object being passed, or if the incarcerated individual is observed to have an implement or weapon and is causing self-harm, the Shift Commander shall be notified immediately to determine the appropriate number of staff necessary to be present prior to the cell being entered either to collect a passed foreign body or to stop self-injurious behavior.

3. If an incarcerated individual on Therapeutic Supervision is on BAU status and such status is rescinded while on supervision, such status change shall be communicated to the officer (s) conducting the supervision and to the incarcerated individual.

Therapeutic Supervision Report

Date:_____

Name:_____ Commit #:_____

Decision:_____ Date:_____
Reviewer Name:_____
Reason for Observation:_____
Location of Therapeutic Supervision:_____
Four Point Restraint:_____
Observation Schedule:_____

Medi Prop Type Desc	Yes/No	Instructions/Comments
Restraints Clinically Contraindicated		
Clothing		
Security Smock		
Blanket		
Mattress		
Meals Out of Cell		
Finger Foods		
Utensils		
Phone		
Visits		
Recreation		
Shower		
Shower Requires Supervision		
Dim Lighting Allowed		
Medical Property Allowed		

Nursing Staff:_____

Mental Health Staff:_____

DOC:_____

Suicide Resistant Cell Check Sheet

Institution:_____

Incarcerated Individual/SDP/Civil Commit's Name:_____

Commitment #:_____ Housing Unit:_____

Therapeutic Supervision Status (circle one): 1:1 TS 15' TS

Cell #:_____ Hayes Compliant Cell: ☐ YES ☐ NO

Date Searched:_____ Date Therapeutic Supervision Initiated:_____

Time Searched:_____ Time Therapeutic Supervision Initiated:_____

The unit OIC shall ensure a suicide resistant cell check sheet is completed prior to an incarcerated individual being placed in the designated cell for Therapeutic Supervision. If a change in cell occurs for any reason, a suicide resistant cell check sheet must be completed prior to the incarcerated individual being placed in the new cell. After an incarcerated individual is removed from a suicide resistant cell, or any cell being utilized as a suicide resistant cell, the suicide resistant cell check sheet will be utilized. The inspection shall be documented on this form.

	Yes	No	N/A	Comments
Is there visibility through the cell door window?				
Are the video cameras operational?				
Is high beam lighting operational?				
Is low beam lighting operational?				
Are all switches and outlets removed/covered?				
Are all towel hooks removed?				
Is the stainless-steel sink/toilet secured?				
Is all the caulking in the seams and joints secure? (include area around camera, light fixtures, mirror, door frame, light switch and vent)				
Are there any areas of paint chipping?				
Are all vents covered with perforated steel?				
Are there gaps around the light fixtures?				
Is the baseboard around the heater secured?				
Is the suicide resistant sprinkler head secure?				
Is the bed secured to the floor?				
Has the cell been searched?				
Is the cell clean (all debris removed)?				
Is there security screen over the bars at window?				

Additional Comments/ Discrepancies Noted:

_____

_____

Completed by:

_____ _____ _____

Printed Name Signature Date

INTENSIVE STABILIZATION UNIT REFERRAL

Name:_____ ID:_____ DOB:_____

Date of Referral:_____ Referring Institution:_____

Referring Clinician and Contact Information:_____

_____

Current Diagnosis:_____

Current Stressors:_____

Current MH Classification and Subcode:_____

Criminal Offense:_____

GCD/PE (Include Both Dates):_____

Prior Incarcerations:_____

_____

Disciplinary/Institution Adjustment:_____

_____

Current Medications and Dosage (Include History Of Probate Rogers):_____

_____

Mental Health History:_____

_____

Psychiatric Hospitalizations (Include Dates and Reasons):_____

_____

Outpatient Mental Health Treatment:_____

_____

Does patient currently have a behavior plan or history of one? _____

If yes, please include dates and attach._____

If a behavior plan has not been initiated, summarize the team's assessment of the contraindications/barriers to implementing one.

_____

_____

Substance Use History:_____

_____

_____

Therapeutic Supervision History (Include Dates and Reasons):_____

_____

_____

Frequency of Crisis Contacts:_____

_____

History of Suicide/Self-Directed Violence (Include Dates):_____

_____

Prior RTU/STU Treatment:_____

_____

Current Mental Status:_____

_____

Current Functional Status:_____

_____

Incarcerated Individual's Perception and Understanding of ISU Placement:_____

_____

ISU Treatment Goals:_____

_____

_____

Potential Barriers for ISU Treatment:_____

_____

_____ _____

Clinician Signature Date

_____ _____

Mental Health Director (From Referring Site) Date

Please scan signed copy to Healthcare Vendor Director of Clinical Programs.

_____

(PLEASE DO NOT WRITE BELOW THIS LINE)

Date Referral Received:_____

Contacts Regarding this Referral:_____

Result: ☐ Incarcerated Individual Meets Criteria
☐ Incarcerated Individual Does Not Meet Criteria

_____ _____
Director of Clinical Programs (or designee) Date

INTENSIVE STABILIZATION UNIT DISCHARGE SUMMARY

Name:_____ DOB:_____ Institution:_____

Admitted On:_____ Date of Discharge:_____

Length of Stay in the ISU:_____ Multiple ISU Admissions: ☐ Yes ☐ No

Reason for ISU Placement: _____
_____
_____
_____

Admitting Mental Health Diagnosis:_____
_____
_____
_____

Reason for ISU Discharge:

☐ Clinically and behaviorally stable. No longer in need of ISU placement (attach any case conference documentation)

☐ After assessment in the ISU the incarcerated individual is deemed not to require ISU level of care (case conference required. Attach case conference summary)

Treatment Progress in ISU:_____
_____
_____
_____

Current Mental Status:_____
_____
_____

Incarcerated individual compliant with medication? ☐ Yes ☐ No

Relevant Medical Information:_____
_____
_____

Discharge Mental Health Diagnosis:_____
_____

Current Medications:_____
_____
_____

Follow-up Treatment Recommendations:_____

_____

_____

_____

Incarcerated Individual's Signature:_____ Date:_____

Reason no incarcerated individual signature: _____

_____

Primary Care Clinician:_____ Date:_____

Psychiatrist/Nurse Practitioner:_____ Date:_____

Mental Health Director:_____ Date:_____

Other (Title):_____ Date:_____