Massachusetts Department Of Corrrection **POLICY**	Effective Date 7/4/2021 Annual Review Date 6/4/2021	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
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Attachments Yes ☒ No ☐	Inmate Library Yes ☒ No ☐	Applicability: Staff
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PURPOSE:

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

RESPONSIBLE STAFF FOR IMPLEMENTATION AND MONITORING OF POLICY:

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 inmates.

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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650.01 POLICY STATEMENT

The Massachusetts Department of Correction (Department) is dedicated to providing quality mental health assessment, care and treatment to all inmates. 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

A. 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.

B. Central Office Restrictive Housing Oversight Committee – The committee charged with developing strategies to reduce the time spent in Restrictive Housing by inmates with Serious Mental Illness (SMI) and conducting monthly reviews of the circumstances of inmates with SMI who have been in Restrictive Housing in Restrictive Housing Units (RHU) or the Department Disciplinary Unit (DDU) for a period exceeding thirty (30) days.

C. Department Disciplinary Unit (DDU) – A restricted area or areas designated by the Commissioner to which an inmate has received a recommended sanction by a Special Hearing Officer in accordance with 103 CMR 430, *Inmate Discipline*.

D. 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.

E. Exigent Circumstances – Circumstances that create an unacceptable risk to the safety of any person. Exigent Circumstances shall not include the opinion of a clinician that notwithstanding an inmate's Serious Mental Illness (SMI), the inmate may remain in Restrictive Housing.

E. Inmate-- A committed offender or other such person as is placed in a Department of Correction Facility or Department of Correction program in accordance with law, including, but not limited to, persons participating in the Transitional Treatment Program. The term Inmate shall not include persons who have been admitted or committed to Bridgewater State Hospital pursuant to G.L. c. 123.

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

G. Inter-System Transfer – The transfer of an inmate between a Department institution and a non-Department facility, 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).

H. Intra-System Transfer – The transfer of an inmate between Department institutions.

I. Mental Health Classification – The system that identifies and codes the level of mental health services that an inmate requires based upon the inmate's mental health need.

J. Medical Contractor – The Department's contract medical vendor.

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

L. Open Mental Health Case (OMH) – An inmate 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 inmate's incarceration, an inmate may become an open mental health case (OMH) based on a mental health crisis, including suicidal threats or self-injurious behavior 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 inmate may also be removed from the active mental health caseload. However, any inmate carrying the Gender Dysphoria (GD) diagnosis will remain an OMH.

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

N. 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 inmates when clinically indicated.

O. 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 inmates when clinically indicated.

P. Psychotropic Medication – Medication prescribed for the treatment of mental illness.

Q. 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).

R. 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.

S. 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 Inmates.

T. Residential Treatment Unit (RTU) – A general population housing unit that provides an intermediate level of care for inmates 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 facility, but who are not so impaired as to require psychiatric hospitalization.

U. Secure Treatment Unit (STU) – A maximum security residential treatment unit that is designed to provide an alternative to Restrictive Housing for inmates diagnosed with a Serious Mental Illness (SMI). The Department

currently operates two STUs: the Secure Treatment Program (STP) and the Behavioral Management Unit (BMU).

V. Secure Treatment Unit Review Committee – The committee convened to review STU referrals regarding inmates with a SMI in Restrictive Housing, or to approve the termination of inmates with SMI from STU's. 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.

W. Restrictive Housing – A placement, whether for disciplinary or non-disciplinary purposes, that requires an inmate to be confined to a cell for more than twenty-two (22) hours per day for the safe and secure operation of the facility. 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 inmate in a Health Services Unit (HSU); the placement of an inmate in a hospital; the placement of an inmate in a medical setting where treatment is being provided; or the placement of an inmate on therapeutic Supervision.

X. Restrictive Housing Unit (RHU) – A separate housing area from general population within institutions in which inmates may be confined to a cell for more than 22 hours per day where:

a. it has been determined that the inmate poses an unacceptable risk to the safety of others, of damage or destruction or property, or to the operation of a correctional facility;
b. the inmate requires protection from harm by others but the inmate has not been classified to a Protective Custody Unit in accordance with 103 DOC 422, *Department Protective Custody Units*; and/or
c. the inmate is serving a disciplinary detention sanction.

Y. Secure Adjustment Unit (SAU) – A highly structured unit that is not Restrictive Housing and that provides access to cognitive behavioral treatment, education, programs, structured recreation, leisure time activities and mental health services for those inmates diverted from or released from Restrictive Housing.

Z. Serious Mental Illness (SMI) – For purposes of assessing whether Restrictive Housing may be clinically contraindicated, or whether an inmate in Restrictive Housing should be placed in an alternative unit, the term "Serious Mental Illness" shall be defined as the following:

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; or

a finding by a Qualified Mental Health Professional that the inmate is at serious risk of substantially deteriorating mentally or emotionally while confined in Restrictive Housing, or already has so deteriorated while confined in Restrictive Housing, such that diversion or removal is deemed to be clinically appropriate by a Qualified Mental Health Professional.

AA. 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 a facility or group of facilities.

650.03 INFORMED CONSENT

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

B. The inmate'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 inmate, other inmates or staff;

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

3. Emergency treatment, including treatment with antipsychotic medication, for an inmate 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 inmate 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 inmate has been made aware of any consequences to his/her/their mental health that may occur as a result of the refusal;

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

650.04 ADMISSIONS

A. Mental Health Screen

Each inmate admitted to a facility by a new commitment or by an Inter-System or an Intra-System Transfer shall receive a mental health screen (Mental Health Status Update Form, refer to Wellpath 39.01) by a Qualified Health Care Professional upon admission.

The Qualified Health Care Professional shall refer the inmate 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 inmate has a history of sexual abuse victimization or may be at risk for sexual abuse victimization while incarcerated; or

3. Screening for risk of victimization and abusiveness:

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

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

   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 inmates for risk of sexual victimization:

      i. Whether the inmate has a mental, physical, or developmental disability;
      ii. The age of the inmate;
      iii. The physical build of the inmate;
      iv. Whether the inmate has previously been incarcerated;

v. Whether the inmate's criminal history is exclusively nonviolent;
vi. Whether the inmate has prior convictions for sex offenses against an adult or child;
vii. Whether the inmate is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;
viii. Whether the inmate has previously experienced sexual victimization;
ix. The inmate's own perception of vulnerability; and
x. Whether the inmate is detained solely for civil immigration purposes.

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

f. An inmate'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 inmate's risk of sexual victimization or abusiveness.

g. Inmates may not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1),(d)(7),(d)(8), or (d)(9) of this section.

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

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

a. If the screening indicates that an inmate has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall ensure that the inmate 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 inmate has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the inmate 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 inmates before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the inmate is under the age of eighteen (18).

B. Psychotropic Medication Prescription

Each inmate newly entering the Department of 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 inmate to be evaluated by a psychiatrist within fourteen (14) days. If the prescription is not verified, the psychiatrist shall schedule an appointment for the inmate to be evaluated by a psychiatrist within fourteen (14) days. If the inmate is an active Department of Mental Health client, the psychiatrist shall schedule an appointment for the inmate to be evaluated by a psychiatrist within seven (7) days.

650.05 NON-EMERGENCY MENTAL HEALTH ASSESSMENTS

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

1. Each inmate admitted to an institution by a new commitment or by an Intra-System transfer shall receive a mental health appraisal (Mental Health Appraisal – refer to Wellpath 35.03) by a Qualified Mental Health Professional within fourteen (14) days of admission. 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 Abuse 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 inmate committed for a term of thirty (30) days or more.

2. The Qualified Mental Health Professional shall refer the inmate 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 appraisal indicates that the inmate has a developmental disability, the Qualified Mental Health Professional

shall refer the inmate 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 inmate 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 inmate's discharge from the Department.

4. If the Qualified Mental Health Professional determines that the inmate has a history of sexual abuse victimization or may be at risk for sexual abuse victimization while incarcerated, the inmate 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 inmate makes a disclosure that requires the issuance of a confidential incident report, the inmate 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 appraisal indicates that the inmate 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 appraisal indicates that the inmate 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 inmate to obtain such records. Information obtained from such records shall be entered in the inmate's medical record and in IMS, as appropriate.

B. Mental Health Appraisal – Inter-System Transfer

Upon an Inter-System Transfer, a Qualified Mental Health Professional shall conduct a mental health appraisal in accordance with 103 DOC 650.05, *Non-Emergency Mental Health Assessment*.

C. Mental Health Referral

Mental health referrals may occur by inmate 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 on IMS. The mental health referral

and the response shall also be documented in the inmate'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 mental health clinician. All mental health referrals that indicate that an inmate 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 mental health clinician on the same day. All mental health referrals that indicate an inmate 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 inmate 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 inmate 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. Inmate Self-Referral

Any inmate 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 correction officer or correctional 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) and (G) *Non-Emergent Mental Health Assessment.* 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 inmate to mental health staff upon a belief that the inmate may be in need of mental health assistance or when an intake or restrictive housing assessment indicates a need.

2. In the event that an inmate 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 inmate to mental health staff to be offered a face-to-face evaluation upon the inmate's return from the EET.

3. If any staff member believes that the inmate is at imminent risk for harm to self or others, the inmate shall be placed under Constant Observation in accordance with 103 DOC 650.08 (B) *Emergency Mental Health Services.* nd the inmate 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 inmate 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 301 DOC 650.08 (B) *Emergency Mental Health Services.* 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 Care 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) *Non-Emergency Mental Health Assessments* followed-up accordingly, and entered in the Sick Call Request/Mental Health Referral log.

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

Absent an emergency, upon the determination that an inmate 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 inmate shall be transported to an institution with on-site mental health staff.

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

1. If an inmate 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 to determine what steps should be - followed. At a minimum, a mental health clinician shall conduct a face-to-face interview with the inmate to determine (1) whether the

inmate is continuing to refuse or not-cooperate, (2) why the inmate is refusing or not cooperating, and (3) whether immediate intervention is required. The inmate's refusal or non-cooperation, along with all subsequent steps taken, shall be documented in the medical record.

2. If an inmate undergoing detoxification refuses or does not cooperate with a mental health appraisal, the inmate 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 inmate again refuses or does not cooperate, the mental health professional shall follow the procedures set forth in 103 DOC 650.03 (D) *Informed Consent* and 103 DOC 650.05 (H) *Non-Emergent Mental Health Assessments.*

I. Mental Health Evaluations

1. If a mental health appraisal reveals that an inmate may require ongoing mental health treatment or services, a Qualified Mental Health Professional shall complete a mental health evaluation (Mental Health Evaluation Forms – refer to Wellpath 35.03) 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, he/she/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 inmate for ongoing assessment for a period up to thirty (30) days from the completion of the mental health evaluation.

3. An inmate may be referred for a mental health evaluation at any time during the inmate'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 inmate 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 inmate requires ongoing mental health treatment or services, the inmate 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 Intra-system* Transfer and 103 DOC 650.05 (B) *Mental Health Appraisal – Inter-system Transfer*, the PCC shall determine and document the inmate'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 inmate's designation as an Open Mental Health Case, the PCC shall develop an Initial Treatment Plan. (refer to Wellpath 35.02).

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

   For SMI inmates, 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;

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

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

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

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 Code 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 inmate prescribed psychotropic medication shall be seen by a psychiatrist every ninety (90) days at a minimum.

K. Procedures for Closing Mental Health Cases of Inmates

1. An SMI inmate 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)
- Psychotic Disorder Not Otherwise Specified

2. If an SMI inmate is diagnosed with Major Depressive Disorder, Bipolar Disorder I, or Bipolar Disorder II in Full Remission (the DSM-V 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:

   The inmate has not been prescribed psychotropic medication for one (1) year; and

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

   a. 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.

   b. Upon approval by the Program Mental Health Director, the treatment team shall complete the case closure form (refer to Wellpath 35.03).

   c. 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 case closures, the procedure shall be as follows:

   a. Prior to closing the case:

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

2. 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 inmate'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.

3. 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 inmate prescribed medication in the prior year. This evaluation shall be documented in a progress note.

4. 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 inmate requires due to the inmate'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 inmate's PCC shall determine an inmate's initial mental health code and subcodes within fourteen (14) days of a mental health appraisal conducted pursuant to 103 DOC 650.04 (A) or (B) *Admissions.*

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.

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.

Sub Codes shall be defined as:

"A" Inmate meets definition for Serious Mental Illness (SMI).

"B" Inmate is actively prescribed psychotropic medication by a provider.

"C" Inmate is actively prescribed a psychotropic medication that requires nursing administration and 7-day per week nursing coverage.

"D" Inmate has a history of self-injurious behaviors.

2. As frequently as the inmate'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 inmate with an Open Mental Health Case. At a minimum, the mental health codes and subcodes shall be reviewed at the time of the inmate's treatment plan update, as set forth in 103 DOC 650.05 (J) *Open Mental Health Cases and Treatment Plans*

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 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. [A subcode of "B" or "D" is permitted; however a subcode of "A" or "C" may not be a MH1 designation.]

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 G.L. c. 123, § 18(a), 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 inmate'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 inmate's mental health classification and/or subcodes shall be entered immediately in the inmate'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 inmate 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 Psychiatrist;

- 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

- 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 inmates 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 inmate (and document that he/she/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 inmate 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.

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 on the IMS Medical Orders Screen and as a mental health classification sub-code on the IMS Mental Health and Substance abuse history screen.

C. Dispensing

1. Medications administered to inmates on therapeutic supervision or in Restrictive Housing 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. Inmates who are on therapeutic supervision shall be removed from their cell prior to medication administration. A complete visual inspection of the inmate's mouth shall be made by correctional staff to insure 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 inmates' 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 inmates who are prescribed anti-psychotic medication.

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

3. For the purpose of determining an inmate'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 inmate's failure to appear to receive prescribed medication shall be noted on the medication administration record (MAR) or medication non-compliance log.

5. An inmate'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 inmates. The list of non-compliant inmates shall be provided to the attending physician and psychiatrist on a bi-weekly basis, unless the situation requires immediate attention.

E. Treatment Non-Compliance and Refusal

1. An inmate who repeatedly refuses his/her/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 inmate 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 inmate continues to engage in non-compliance with the taking of the medication, the inmate shall be requested to sign a refusal of treatment form. If the inmate 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

inmate'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 inmate's symptoms or complaints of medication side effects shall be reported to the Psychiatrist.

3. The Psychiatric provider shall see any Secure Treatment Unit inmate within 30 days of non-compliance with prescribed psychotropic medication.

4. The Site Mental Health Director may request a clinical case conference to consider the inmate'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) *Emergency Involuntary Administration of Psychotropic Medication.*

G. Non-Emergency Antipsychotic Medications for Incompetent Inmates

1. General

a. Court authorization is required for the non-emergency provision of antipsychotic medications to an inmate 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 inmate's legal guardian or health care agent (see 103 DOC 620, *Special Health Care Practices,* 620.12 - Health Care Proxy Guidelines).

b. Court authorization for inmates 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 inmates 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 inmate's medication administration record (MAR).

b. When an inmate is subject to a court-authorized treatment plan, the inmate'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 inmate'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. Inmates 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 inmates attend the medication line and sign formal refusals when medication is not accepted.

b. If an inmate with a court-authorized treatment plan refuses medication, a clinician shall inform the inmate that if he/ she/they refuses to take the medication by mouth, the inmate 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 inmate continues to refuse the medication following counseling by mental health staff, the Psychiatrist may order that the inmate 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 Section 650.08.

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

1. Upon the civil commitment of an inmate 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 inmate 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

Any staff member believing an inmate is at risk shall place an inmate under constant supervision, pending assessment and/or intervention by mental health staff.

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. 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 utilization of therapeutic supervision in a cell outside of the HSU shall require constant observation if the cell has not been designated as suicide resistant. A current listing of the facility'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

Any inmate whose presentation is deemed concerning and warrants some level of increased observation, regardless of the inmate's mental health diagnosis, shall be placed on therapeutic supervision.

3. Level of Supervision

A Qualified Mental Health Professional shall determine the level of supervision indicated for therapeutic supervision. 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 needs of the inmate requiring therapeutic supervision/therapeutic intervention.

There are two levels of therapeutic intervention:

a. Constant Observation utilizes one-to-one supervision;
b. Close observation utilizes checks within fifteen (15) minute intervals.

Constant Observation is indicated for an inmate who is actively suicidal, by threatening or engaging in self-injury and whom mental health staff consider to be at high risk for suicide. An inmate on constant observation shall be observed by a staff member on a continuous, uninterrupted basis. Although the observation itself is constant, the documentation shall occur at fifteen (15) minute intervals or more frequently when and as notable behaviors or events occur.

Close Observation is indicated for the inmate 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 low risk for suicide. In addition, an inmate 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-injury, should be placed under close observation. An inmate on close observation shall be observed by staff at staggered intervals not to exceed every fifteen (15) minutes. Documentation shall occur at fifteen (15) minute intervals as such observation occurs.

Clinical indication for observation also includes other signs and symptoms which may indicate risk of safety.

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

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 inmate on therapeutic supervision shall converse with the inmate. The correctional staff member or the HSU correctional supervisor 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, inmates 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. Goals of such contacts 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 inmate refuses an out-of-cell assessment. A Qualified Mental Health Professional shall complete a progress note documenting an inmate's refusal of an out-of-cell assessment including the stated reason for the refusal and noting the completion of a cell front assessment. To the extent possible, an inmate should 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.

5. Documentation

a. 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 inmate, 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.

b. Inmate Management System – A Qualified Mental Health Professional shall enter the requisite therapeutic supervision information in IMS. The reason for therapeutic supervision shall specify any special considerations for those monitoring such as self-embedding and/or insertion behaviors, self-injurious behaviors 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 / inmate 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. A copy of the completed IMS form shall be filed in the inmate's medical record.

c. Medical Record – A Qualified Mental Health Professional shall place a completed crisis treatment plan (refer to Wellpath 37.03) in the inmate's medical record documenting a suicide risk assessment and the justification for the level of observation. Thereafter, all therapeutic sessions, interventions, activities and daily assessments shall be documented in a 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.

6. Conditions

a. Treatment- Inmates on therapeutic supervision shall receive multiple mental health sessions per day to address the individualized crisis treatment plan goals, address symptomology, increase socialization through individual and congregate activities as clinically indicated. If not clinically contraindicated, a minimum of three out of cell contacts per day shall 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. Clothing – A Qualified Mental Health Professional shall determine if clothing restrictions are clinically indicated and if the issuance of a safety garment is commensurate with the level of the inmate's risk for suicidal or self-injurious behavior.

b. Activities - Inmates on therapeutic supervision shall be allowed all routine activities including family visits, telephone calls, and recreation unless there are security reasons precluding those activities, or if 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.

c. Shower - Inmates on therapeutic supervision shall have shower access commensurate with their security level.

7. Attorney Visits

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

b. Prior to any attorney or other legal visit with an inmate on therapeutic supervision, a Qualified Mental Health Professional shall conduct a clinical assessment and identify the appropriate conditions of the visit, consistent with the inmate'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 Mental Health Watch screen.

c. The Superintendent shall determine the location and conditions of any legal visit for an inmate on therapeutic supervision based upon the recommendations of the Site Mental Health Director and also upon the facility'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 facility. 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 Inmate 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 inmate to ensure that his/her/their mental status has not changed, and note the inmate's mental status in the inmate's medical record and on the IMS Mental Health Watch screen.

8. Duration and Discharge

a. Therapeutic supervision shall be no longer in duration than necessary to deal with the mental health crisis that caused the inmate to be placed under observation. The goal is to safely discharge the inmate from therapeutic supervision to the inmate's housing unit within ninety-six (96) hours; however, any decision to discharge the inmate from therapeutic supervision shall be determined solely on the clinical judgment of mental health staff.

b. In the event that an inmate is maintained on therapeutic supervision for more than seventy-two (72) hours and every seventy-two (72) hours thereafter, the Director of Behavioral Health and Program Mental Health Director shall be notified and consulted until the inmate is discharged from therapeutic supervision.

c. An inmate shall not be discharged from a therapeutic supervision without an out of cell, face to face assessment with a qualified mental health professional and without a treatment team discussion of his/her/their case during mental health staff's daily team meeting or a discussion with the Mental Health Director on Saturday and Sunday. There must be documentation that the inmate's case was discussed with the MH team and/ or the Mental Health Director prior to the inmate being discharged from therapeutic supervision. Should there be a medication related issue, such as decompensation or non-compliance, the prescriber must be consulted and that consultation must be documented.

d. An inmate 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 inmate has been placed on constant observation solely for the reason that the watch 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 inmate's clinically assessed risk level indicates only a close observation.

e. A Qualified Mental Health Professional shall complete a Crisis Treatment Plan Discontinuation Form (refer to Wellpath 37.03) prior to discharging an inmate from therapeutic supervision. The discontinuation form must be completed citing the course of therapeutic supervision, the rationale for discontinuation, as well as the treatment plan and recommendations for the inmate. The form shall be filed in the medical record. The termination of the therapeutic supervision shall be entered on the IMS Mental Health Watch screen.

f. After being discharged from therapeutic supervision, an inmate shall be assessed by a Qualified Mental Health Professional on the day 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 and then again within seven (7) days, and a Mental Status Update form shall be completed (refer to Wellpath 39.01). If an inmate who has been discharged from therapeutic supervision is not on the active open mental health caseload, s/he 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 inmate 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 the treatment modality. However, mental health restraints may be ordered as a treatment modality only after determining that other available 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 facility 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 inmate 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 for mental health restraints are not permitted.

3. Forms of Mental Health Restraints

a. Padded leather restraints may be used to secure an inmate 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 inmate 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 facility'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 inmate in mental health restraints. The Shift Commander shall direct the correctional staff in placing the inmate 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 inmate and other inmates.

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

i. Staff shall always maintain observation of a restrained inmate 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 inmate's back, chest or abdomen while the inmate is in restraints.

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

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

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

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

6. <u>Medical Review of Inmates in Mental Health Restraints</u>

a. Immediately following the placement of an inmate in mental health restraints, medical staff shall conduct an

examination of the inmate 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 inmate in mental health restraints.

b. Inmates 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 inmate's vital signs at a minimum of every thirty (30) minutes while the inmate is awake or at least once per shift while the inmate 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 inmate'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 inmate 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 inmate may be allowed to exercise her/his/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 inmate 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 inmate 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 inmate 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 inmate shall be transferred to the appropriate psychiatric facility at the earliest possible time.

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

h. All inmates 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 inmate behavior during the designated time period.

9. Feeding

a. Meals shall not be withheld from inmates in mental health restraints. The on-site/on-call medical director or Site Mental Health Director shall determine whether the inmate 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 inmate'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 inmate and staff shall be reviewed and approved by the Shift Commander.

11. Programs

Inmates in mental health restraints shall not be allowed participation in any programs, including visitation. The inmate 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 inmate poses a clear and immediate threat to harm him/herself or others; or to prevent the immediate, substantial and irreversible deterioration of a serious mental illness of an inmate 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 inmate's medical record:

a. The inmate'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 inmate 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 inmate'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 inmates 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.

b. Discharges

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

Inmates discharged from BSH State Sentenced Units will be accompanied by at least two (2) copies of the most recent Section 18(a) evaluation or discharge note and a Discharge Summary Form. These documents shall be transported with the inmate and delivered to the Superintendent and Health Services staff.

Prior to the discharge of a civilly committed BSH State Sentenced inmate to a prison, an inter-facility 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.

2. Department of Mental Health

a. Civil Commitment

G.L. c. 123, §18(a) provides that a court may order the admission of female inmates 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.

b. Discharges

Upon the discharge of an inmate from a facility of the Department of Mental Health 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 650.16 (B) *Mental Health Reentry Planning and Procedures.*

3. Male Inmates

Although G.L. c. 123, §18(a) also provides for the civil commitment of a male inmate 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 inmate to a DMH facility or the discharge of a male inmate from a DMH facility to a prison.

F. Hunger Strikes or Cessation of Nutritional Intake

a. For the purpose of this Section, a "hunger strike" shall mean when an inmate 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.

b. 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.

c. An inmate 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) *Non-Emergency Mental Helth Assessment.* 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 inmate meets the civil commitment criteria.

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

e. Three (3) days following the completion of the hunger strike, a mental health clinician shall conduct a follow up assessment and complete a mental status update.

650.09 MANAGEMENT OF POTENTIALLY SUICIDAL INMATES AND SELF-INJURIOUS BEHAVIOR

A. General Policy

Whenever an inmate 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. The mental health evaluation shall determine the course of action required to provide the inmate with support and monitoring during the critical period. If the inmate has attempted suicide or otherwise engaged in self-injurious behavior, the inmate shall receive immediate medical attention. Correctional staff shall be trained in the identification and custodial care of inmates with mental illness.

B. Referral

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

C. Monitoring

The monitoring process for the potentially suicidal inmate shall be governed by Section 650.08 (B) (Therapeutic supervision).

D. Evaluation

The evaluation of the potentially suicidal inmate shall be governed by 103 DOC 650.05 (I) *Non-Emergency Mental Health Assessment*. The evaluation of a potentially suicidal inmate shall include an assessment of the following:

- Inmate's mental status;
- Inmate's self-report and reports of others regarding the behavior resulting in the referral;
- Current suicide 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 and goals of behavior;
- History of suicidal behavior/ideation, including frequency, methods used or contemplated, reasons why, consequences of prior attempts and gestures;
- Inmate's report of his/her/their potential for suicidal behavior;
- Inmate's capacity to seek mental health help if needed and expressed intent to do so.
- Actuarial assessment utilizing evidence based suicide risk assessment tool.

Mental health staff shall consult with a psychiatrist if necessary for the evaluation.

E. Treatment

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

F. Discharge from Therapeutic supervision

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

The discharge from Therapeutic supervision of the potentially suicidal inmate shall be governed by 103 DOC 650.08 (B) (8) *Emergency Mental Health Services*(Duration and Discharge).

G. 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:

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

H. Training for Correctional Personnel

1. 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. This training is established by the Mental Health Authority in conjunction with the facility/program administrator.

2. Such annual training for correction officers and correctional program officers shall include the identification and custodial care of inmates with mental illness and may include:

   a. Interpreting and responding to symptomatic behaviors, and communication skills for interacting with inmates with mental illness with emphasis on SMI;

   b. Recognition of signs and symptoms of mental illness, violent behavior, and acute chemical intoxication and withdrawal;

   c. Methods for accessing health/mental health staff during a mental health crisis;

   d. Recognizing and responding to indications of suicidal thoughts and implementation of suicide/self-injurious prevention interventions;

   e. Conducting a proper observation for individuals on therapeutic supervision who engage in self-injurious behaviors and warning signs of potential self-injury;

   f. Responding to mental health crises, including suicide intervention and cell extractions;

   g. Recognizing common side-effects of psychotropic medications;

   h. Professional and humane treatment of inmates with mental illness;

   i. Trauma informed care;

   j. Crisis Intervention Training including De-escalation techniques; and alternatives to discipline and use of force when working with inmates with mental illness;

   k. Appropriate Interaction with persons on Therapeutic supervision;

   l. Procedures for placement of inmate in a level of care in accordance with their mental health needs.

I. 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. Training shall include, at minimum, a yearly eight hour, in-house seminar on suicide prevention strategies, actuarial suicide risk assessment tools and structured clinical interviews.

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 inmate 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 paragraph (A) of this section and to inform inmates 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 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 inmate 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 inmate'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 inmate and immediately notify the on-call mental health clinician if the inmate 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 inmate's return from the outside hospital, the inmate 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 inmate is at risk to harm self or others, a mental health clinician shall be immediately notified. Otherwise, the inmate 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 facilities 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. Inmate 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 inmates 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 facilities, or their release from DOC custody.

3. A mental health evaluation of all known inmate-on-inmate 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 inmate 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 inmate 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 inmate referrals shall be addressed in accordance with 103 DOC 650.5 (C) *Non-Emergency Mental Health Assessment.*

650.12 RESTRICTIVE HOUSING

103 DOC 650.12 (A) *Restrictive Housing* governs mental health procedures and treatment attendant to the Restrictive Housing of an inmate in a Restrictive Housing Unit (RHU). 103 DOC 650.12 (B) *Restrictive Housing* overns mental health procedures and treatment attendant to Restrictive Housing in the DDU. 103

DOC 650.12 (C) *Restrictive Housing* governs other twenty-two-hour per day cell Restrictive Housing. 103 DOC 650.12 (D) *Restrictive Housing* governs meetings attendant to Restrictive Housing in the RHU and DDU.

A. Restrictive Housing in RHU.

1. Pre-Restrictive Housing Screen
Before placement in a Restrictive Housing Unit, an inmate shall be screened by a Qualified Mental Health Professional to determine if the inmate has a serious mental illness (SMI) or to determine if Restrictive Housing is otherwise clinically contraindicated based on clinical standards adopted by the department of correction and the qualified mental health professional's clinical judgment. A medical chart review shall be conducted prior to placement in any Restrictive Housing environment.

2. The screening and assessment shall be conducted by the Qualified Mental Health Professional. If the inmate is currently designated as SMI, a clinical evaluation to determine SMI need not be performed. The Qualified Mental Health Professional shall document the evaluation in a Mental Status Update Form (refer to Wellpath 39.01) and in IMS.

An inmate shall not be held in Restrictive Housing if the inmate has been determined to have a serious mental illness or a finding has been made by a Qualified Mental Health Professional that Restrictive Housing is clinically contraindicated unless, not later than seventy-two (72) hours after the Restrictive Housing placement or finding, the Commissioner or a designee certifies in writing:

(1) the reason why the inmate may not be safely held in the general population;
(2) that there is no available placement in a Secure Treatment Unit;
(3) that efforts are being undertaken to find appropriate housing and the status of the efforts; and
(4) the anticipated time frame for resolution.

3. Subsequent Restrictive Housing Evaluations of Open Mental Health Cases in RHUs.

Each inmate with an Open Mental Health Case who is placed in an RHU shall be evaluated by a Qualified Mental Health Professional every thirty (30) days following such placement to determine (1) whether the inmate has an SMI, and/or (2) whether there are any acute medical or mental health contraindications to Restrictive housing. For inmates placed in an RHU, the evaluation shall be conducted by the Qualified Mental Health Professional assigned to the RHU. If the inmate is currently designated as SMI, a clinical evaluation to determine SMI need not be performed. The Qualified

Mental Health Professional shall document the evaluation in a Mental Status Update Form (refer to Wellpath 39.01) and in IMS.

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

4. On-going Restrictive Housing Assessment of Non-Open Mental Health Cases in RHUs.

Each inmate without an Open Mental Health Case who is placed in an RHU shall be assessed by the Qualified Mental Health Professional assigned to the RHU within thirty (30) days of initial placement, and not less than once every thirty (30) days thereafter, to determine (1) whether the inmate has an SMI, and/or (2) whether there are any acute medical or mental health contraindications to Restrictive Housing. The Qualified Mental Health Professional shall document the evaluation in a Mental Status Update Form (refer to Wellpath 39.01) and in IMS.

5. Out-of-Cell Interviews

The evaluations described in 103 DOC 650.12 (A) (2) and (3) *Restrictive Housing* and the assessment described in 103 DOC 650.12 (A) (4) *Restrictive Housing* shall include, absent Exigent Circumstances, a face-to-face interview with the inmate conducted in a private confidential setting. If the inmate refuses the face-to-face interview, the clinician shall interview the inmate at the cell and document in the medical record the inmate's refusal, behavioral presentation and all attempts made to engage the inmate 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) and (3) *Restrictive Housing* and the assessment described in 103 DOC 650.12 (A) (4) *Restrictive Housing* if a private interview is warranted in the clinician's professional judgment.

6. Restrictive Housing Unit Rounds and Referrals

In each RHU, the Qualified Mental Health Professional assigned to the RHU shall make mental health rounds at least two (2) times a week. The presence of mental health staff in Restrictive Housing 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 inmate 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 inmate refuses. If the inmate 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 RHU log, document significant findings in the record and communicate any significant issues to the officer in charge of the RHU.

The Qualified Mental Health Professional, or in his/her/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.

7. Removal of Inmates from Restrictive Housing Units

Except in Exigent Circumstances, when any inmate in an RHU is determined to have an SMI, he/she/they shall be referred to a Secure Adjustment Unit, referred to the STU Review Committee, or referred to an RTU. During such time as the inmate remains in the RHU, the inmate shall be provided with additional mental health services in accordance with 103 DOC 650.12 (A) (8) *Restrictive Housing*

Except in Exigent Circumstances, if the Program Mental Health Director determines that continued placement in an RHU will pose an imminent risk of substantial deterioration to an inmate's mental health, the inmate shall be, referred to the STU Review Committee or to an RTU. During such time as the inmate remains in the RHU, the inmate shall be provided with additional mental health services in accordance with 103 DOC 650.12 (A) (8) *Restrictive Housing.*

8. Additional Mental Health and Out-of-Cell Services for SMI Inmates in Restrictive Housing Units

Except in Exigent Circumstances, at a minimum, SMI inmates confined in an RHU shall be offered the following mental health and other services:

a. Less than Thirty (30) Days

If the SMI inmate has a Mental Health Classification of MH-1, MH-2 or MH-3, one (1) session of structured out-of-cell individual or group mental health per week, commencing in the first week of Restrictive Housing, and which shall be part of a treatment plan; the opportunity to speak to a mental health clinician at least five (5) days per week, and in-cell programming. A Qualified Mental Health Professional will review the mental health classification of

each SMI inmate in Restrictive Housing every thirty (30) days, and more frequently if dictated by the inmate's mental health needs to ensure that the inmate is appropriately classified.

An SMI inmate with a Mental Health Classification of MH-4 shall be offered two (2) sessions of structured out-of-cell individual or group activity per week. These sessions shall be part of a treatment plan and shall include at least one (1) session with a mental health clinician. The length of the out-of-cell clinical sessions shall be determined by the clinician on a case-by-case basis.

In addition to the minimum of five (5) hours of out-of-cell leisure activity already offered to inmates in Restrictive Housing, an SMI inmate with a Mental Health Classification of MH-4 shall be offered two (2) additional hours of out-of-cell leisure activity per week. These extra hours may be provided either by offering additional out-of-cell sessions or by extending the period of existing out-of-cell sessions.

b. Over Thirty (30) Days

After thirty (30) days in Restrictive Housing, the amount of weekly out-of-cell services offered to an MH-4 SMI inmate shall be increased to four (4) sessions of structured out-of-cell individual or group activity per week and, in addition to the minimum of five (5) hours out-of-cell leisure activity already offered to inmates in restrictive housing, four (4) additional hours of out-of-cell leisure activity. For purposes of this section, placement of the inmate on therapeutic supervision shall not be deemed to interrupt the duration of time in Restrictive Housing.

B. Department Disciplinary Unit

1. Pre-DDU Placement Evaluations

At the time of the filing of a DDU referral, every inmate shall be seen and receive a comprehensive assessment by a Qualified Mental Health Professional to determine whether the inmate has an SMI and/or whether there are any acute mental health contraindications to DDU placement. Acute mental health contraindications to DDU placement include that the inmate appears acutely psychotic, is actively suicidal or has made a recent serious suicide attempt, or is otherwise in need of immediate placement on therapeutic supervision. The comprehensive assessment shall include a thorough record review, and face to face interview. Documentation regarding the findings shall be included

in the medical record and submitted to the Director of Behavioral Health.

If the inmate is currently designated as having an SMI, or if the inmate is determined to have an SMI, the matter shall proceed in accordance with 103 DOC 650.12 (A) (1) *Restrictive Housing.*

2. Day of Admission Evaluation

On the day of placement in the DDU, all inmates will receive a face to face clinical interview documented on a Mental Status Update form (refer to Wellpath 39.01). If the inmate does not have an SMI, but the evaluation is positive for an acute mental health contraindication to DDU placement, the inmate shall be placed on therapeutic supervision in the DDU. The inmate shall be further evaluated to determine whether he meets the criteria for transfer to Bridgewater State Hospital State Sentenced Units and whether he has an SMI. If the inmate does not meet the criteria for transfer to Bridgewater State Hospital State Sentenced Units and does not have an SMI, he may be placed in the DDU after the acute contradiction to DDU placement has passed and it is determined by the Site Mental Health Director that the inmate is discharged from therapeutic supervision in accordance with 301 DOC 650.08 (B) (8) *Restrictive Housing.* The Qualified Mental Health Professional shall document the evaluation and result in the medical record and communicate any significant issues to the Superintendent, or during non-business hours, to the Shift Commander.

3. Subsequent DDU Evaluations

Each inmate placed in the DDU shall be assessed by a Qualified Mental Health Professional after thirty (30) days of initial placement and not less than once every thirty (30) days thereafter. The evaluation shall be documented in the medical record and in the IMS Mental Health/Substance Abuse screen. This evaluation shall include, absent Exigent Circumstances, a face-to-face interview with the inmate conducted in a private confidential setting. If the inmate refuses the face-to-face interview, the Qualified Mental Health Professional shall interview the inmate at the cell and document in the medical record the inmate's refusal, behavioral presentation and all attempts made to engage the inmate in a private interview.

4. DDU Rounds and Referrals

The Qualified Mental Health Professional(s) assigned to the DDU shall make mental health rounds at least two (2) times a week. The Qualified Mental Health Professional shall arrange for an out-of-cell meeting with any inmate 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 or where the inmate refuses. If the inmate 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 completion of rounds in the DDU log, document significant findings in the medical record and communicate any significant issues to the senior DDU officer.

The Qualified Mental Health Professional, or in his/her/their absence, another mental health clinician, shall address mental health referrals from custody staff and medical staff conducting rounds in accordance with 103 DOC 650.12 (A) (5) and (6) *Restrictive Housing*. The Qualified Mental Health Professional shall determine the appropriate response based upon clinical judgment. Such referrals shall be reviewed by mental health staff in subsequent triage meetings.

5. DDU Exclusion of SMI Inmates and Additional Services for Pre-Program SMI Inmates

Inmates with SMI shall not be housed in the DDU except in Exigent Circumstances or as set forth below.

If there is not an appropriate alternative placement for an SMI inmate with a DDU sanction currently available, and the inmate has been approved for STU placement pursuant to 103 DOC 650.13 (A) *Secure Treatment Units and Secure Adjustment Units* after approval by the Deputy Commissioner of Clinical Services and Reentry and the Assistant Deputy Commissioner, Clinical Services, the Department may confine an SMI inmate in the DDU pending the availability of an STU bed. Such inmates shall be considered to be "pre-program inmates." The Department shall address the placement of pre-program inmates on a case by case basis, taking into account the length of time that each pre-program inmate has been awaiting STU placement and the inmate's clinical needs. Placement in a Secure Adjustment Unit (SAU) shall be considered.

At a minimum, pre-program inmates in the DDU shall be offered additional mental health and other services, consisting of the following:

a. Less Than Thirty (30) Days

- Two (2) out-of-cell sessions of structured individual or group activity per week shall be offered. These sessions shall be part of a treatment plan and shall include at least one (1) session with a mental health

clinician. The length of the out-of-cell clinical sessions shall be determined by the clinician on a case-by-case basis.

- In addition to the five (5) hours of out-of-cell leisure activity already offered to DDU inmates, two (2) additional hours of out-of-cell leisure activity per week shall be offered. These extra hours may be provided either by offering additional out-of-cell sessions or by extending the period of existing out-of-cell sessions.

- Upon entering the DDU from an RHU, pre-program inmates shall be offered the level of visitation, radio, and telephone privileges that had been provided in the RHU prior to DDU placement. Pre-Program inmates shall also be eligible to earn all privileges available to DDU inmates, contingent upon compliance with the Department's, institutional, and DDU rules.

b. Over Thirty (30) Days

After thirty (30) days in the DDU, the amount of weekly out-of-cell services offered to a pre-program inmate with a mental health classification of MH-4 shall be increased to four (4) sessions of structured out-of-cell individual or group activity and, in addition to the five (5) hours of out-of-cell leisure activity already offered to DDU inmates, four (4) additional hours of out-of-cell leisure activity. A Qualified Mental Health Professional will review the mental health classification of each pre-program inmate in the DDU every thirty (30) days, and more frequently if dictated by the inmate's mental health needs to ensure that the inmate is appropriately classified. For purposes of this section, placement of the inmate on therapeutic supervision shall not be deemed to interrupt the duration of time in the DDU.

C. Other Twenty-two Hour Restrictive Housing

Each inmate with an Open Mental Health Case who is placed in other twenty-two (22) hour Restrictive Housing (i.e., cell confinement other than DDU or RHU confinement) shall be evaluated by a Qualified Mental Health Professional within twenty-four (24) hours to determine (1) whether the inmate has an SMI, and/or (2) whether there are any acute medical or mental health contraindications to other twenty-two hour Restrictive Housing cell confinement. The evaluation shall be conducted by the inmate's PCC or other member of the mental health team. If the inmate has an SMI, such other twenty-two (22) hour cell confinement shall be subject to the provisions of 103 DOC 650.12 (A) (7) and (A) (8) *Restrictive Housing.*

D. Meetings

1. Facility Restrictive Housing Committee

At each facility at which inmates are held in an RHU or other twenty-two (22) hour Restrictive Housing, the Site Mental Health Director shall participate in the facility RHU Placement Reviews that are conducted every Monday, Wednesday, and Friday in accordance with 103 CMR 423, *Restrictive Housing*, for the purpose of reviewing the status of such inmates to determine the reason(s) for Restrictive Housing and whether alternatives exist. Such review may include a review of pending investigation status, classification status, mental health developments, and disciplinary status. The Site Mental Health Director shall provide input regarding mental health issues and concerns of RHU inmates.

2. Central Office Restrictive Housing Oversight Committee

Membership of the Central Office Restrictive Housing Oversight Committee shall include the Deputy Commissioner, Prison Division; the Deputy Commissioner, Clinical Services and Reentry Division; the Assistant Deputy Commissioners for the Northern and Southern Sectors, the Director of the Central Inmate Disciplinary Unit; the Director of Behavioral Health; and a mental health professional from the Mental Health Vendor.

The role of the Central Office Restrictive Housing Oversight Committee shall include:

- Developing strategies to reduce time spent in Restrictive Housing by inmates with SMI, including reducing time on awaiting action or identifying alternatives to Restrictive Housing for such inmates; and expansion of privileges for SMI inmates remaining in Restrictive Housing; and

- Conducting a monthly review of the circumstances of inmates with SMI, including pre-program inmates, who have been in Restrictive Housing for a period exceeding thirty (30) days as of the date of the monthly review. The review shall include consideration of facilitating the inmate's discharge from Restrictive Housing, assessment of the inmate's mental health classification level, and whether additional out-of-cell time is clinically indicated. For purposes of this review, placement of the inmate on therapeutic supervision or temporary placement in a Health Services Unit shall not be deemed to interrupt the duration of time in Restrictive Housing.

The Central Office Restrictive Housing Oversight Committee shall maintain minutes that document reviews and actions taken, with the reasons for the Committee's decision and the potential alternatives for Restrictive Housing considered.

650.13 SECURE TREATMENT UNITS AND SECURE ADJUSTMENT UNITS

A. Secure Treatment Unit Referral and Placement

1. The Director of Behavioral Health shall be notified: (1) By the Director of Inmate Discipline upon a determination pursuant to 103 CMR 430, *Inmate Discipline*, 430.08 that a DDU hearing shall be held for an inmate with SMI, or upon the imposition of a DDU sanction for an inmate with SMI; and (2) By the Program Mental Health Director that an inmate housed in the DDU has been diagnosed with an SMI, or that an inmate with an SMI without a DDU sanction may require placement in an STU.

2. Upon any such notification, the Director of Behavioral Health shall contact the Program Mental Health Director who shall ensure that an STU Referral Form (Attachment #7) is initiated and completed at the site where the inmate is currently housed. The STU Referral Form shall be completed by the inmate'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. In instances where an inmate who is not awaiting a DDU hearing is referred for placement in an STU, such referral shall be generated by the inmate's PCC, reviewed by the Site Mental Health Director and then reviewed by the Program Mental Health Director to ensure the appropriateness of the referral.

3. 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.

4. 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. In instances in which an inmate has been referred for STU placement without a pending DDU hearing, the STU Review Committee shall determine whether STU placement is warranted, whether the inmate would be more appropriately admitted to an RTU, or whether the inmate 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

inmate's PCC to present the case and provide additional information, upon a determination that such presentation or additional information is necessary.

5. In instances in which the STU Review Committee has determined that an inmate pending placement pursuant to a DDU hearing is appropriate for placement in an STU but is unable to reach consensus regarding whether the BMU or STP is more appropriate, the case shall be referred to the Program Mental Health Director for a final recommendation regarding the placement of the inmate. This must occur within five (5) days. In instances where there is a lack of consensus regarding the placement of an inmate who was not referred pursuant to a pending DDU hearing, the case shall be referred to the Program Mental Health Director and the Assistant Deputy Commissioner, Clinical Services who shall come to consensus within five (5) days regarding the appropriate placement.

6. Upon a clinical recommendation to place the inmate in an STU, the Director of Behavioral Health shall forward the determination to the Assistant Deputy Commissioner, Clinical Services and the Assistant Deputy Commissioners for the Northern and the Southern Sectors, who shall review the referral information to determine whether there are any security concerns raised by the STU placement recommendation and if so, whether Exigent Circumstances may require the rejection of the STU placement recommendation. This review shall occur within five (5) days. If the Assistant Deputy Commissioners for the Northern and Southern Sectors disagree whether Exigent Circumstances exist, the matter shall be referred to the Deputy Commissioner, Prison Division, for a determination whether Exigent Circumstances exist. If the STU placement recommendation is affirmed, the Director of Behavioral Health shall effect the final disposition. If the STU placement recommendation is rejected, the determination shall be communicated by the Assistant Deputy Commissioner of Clinical Services to the Director of Behavioral Health, who shall reconvene the STU Review Committee within five (5) days to consider possible alternative placements (e.g., placement of the inmate in the STP instead of the BMU or vice versa, RTU placement.). If an alternative placement is recommended, the Director of Behavioral Health shall convey such recommendation to the Assistant Deputy Commissioner of Clinical Services and the Assistant Deputy Commissioners for the Northern and the Southern Sectors, who shall again review the referral information to re-determine whether Exigent Circumstances warrant the denial of the alternative placement recommendation. In the event that no alternative placement is recommended or that the alternative placement recommendation is rejected, the case shall be referred to the Deputy Commissioner, Prison Division, who shall make the final placement determination.

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

8. 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 inmates with SMI 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 inmates 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 inmate 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 inmate's treatment plan.

4. STU inmates shall be subject to the disciplinary process as follows. Category 3 and 4 disciplinary offenses, as set forth in 103 CMR 430, *Inmate Discipline*, 430.24, may be reduced to an informal 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.

5. DDU time for STU inmates serving DDU sanctions shall continue to run. STU treatment teams may recommend up to a thirty (30) day DDU time cut as an individual incentive for every ninety (90) days of successful participation. Criteria for successful participation shall include, at a minimum, the absence of behavior resulting in disciplinary reports, treatment compliance and active program participation for the designated time period. Time cut recommendations shall be submitted to the Deputy Commissioner, Prison Division, for determination.

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. Inmates 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.

2. For STU inmates assigned to a program phase that allows contact with other inmates, 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. STU Discharge Upon the Completion of a DDU Sentence

a. Subject to 103 DOC 650.13(D)(2) *Secure Treatment Units and Secure Adjustment Units*, the minimum length of time that an inmate who is admitted with a DDU sentence resides in an STU shall be defined by the inmate's DDU sentence. Upon the expiration of an inmate's DDU sentence prior to the inmate's successful progression through all phases of the STU program, subject to 103 DOC 650.13(D)(1)(c) and (d) *Secure Treatment Units and Secure Adjustment Units*, the inmate shall be referred for another placement commensurate with the inmate's mental health treatment needs and the inmate's behavioral and security needs.

b. The STU treatment team shall request a case conference to be held, within ninety (90) days prior to the inmate's anticipated completion of the inmate's DDU sentence in order to determine the most appropriate aftercare placement. The STU treatment team shall determine whether an RTU level of care is clinically indicated, and if so, the inmate shall be referred for RTU placement. If an RTU level of care is not clinically indicated, the inmate's placement upon the inmate's discharge from the STU shall be effected by the classification process.

c. Upon an inmate's request to remain in an STU after the completion of the inmate's DDU sentence, the STU treatment team shall recommend whether continued STU placement is clinically appropriate. The recommendation shall be conveyed to the Director of Behavioral Health and

a case conference convened to determine the appropriate disposition. A determination that voluntary continued STU placement is clinically indicated shall be conveyed to the Central Classification Division for scheduling a classification board.

d. Notwithstanding an inmate's expressed desire to be discharged from the STU upon the completion of the inmate's DDU sentence, the STU treatment team may recommend that the inmate remain in the STU based upon the extent to which the inmate's SMI contributes to the inmate's potential threat to staff and/or other inmates. The treatment team shall consider the inmate's history of predatory or assaultive behavior, the inmate's use of weapons, and the extent of any serious injury that the inmate has caused or is likely to cause in the future. The treatment team shall recommend specific security or classification criteria, setting conditions that would warrant consideration of the inmate's discharge from the STU. Such conditions shall include, but not be limited to, consistent psychiatric and behavioral stability as indicated by remaining free from Category 1 and 2 disciplinary offenses; significant and consistent reduction in the incidence of self-injury and/or threats of self-injury; and engagement in programming and compliance with mental health treatment. The treatment team shall review and monitor the inmate's compliance with such treatment and behavioral criteria on a quarterly basis.

2. <u>STU Discharge Prior to Completion of a DDU Sentence</u>

a. If an STU inmate successfully completes all phases and requirements of the STU program prior to the completion of the inmate's governing DDU sentence, and if the STU treatment team determines that the inmate 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 inmate's progress and appropriateness for discharge.

b. The requirements for STU discharge consideration prior to completion of a DDU sentence shall include, but not be limited, to the following:

- Successful completion of all program phases;
- Achievement of 90% participation in group programming during the previous twelve (12) months;
- Achievement of 90% participation in individual programming during the previous twelve (12) months;
- No Category 1 and Category 2 disciplinary offenses for the previous twelve (12) months;

- No negative incidents reports for the previous nine (9) months;
- No instances of self-injury for the previous twelve (12) months; and
- No placement on accountability status for the previous twelve (12) months.

c. If the case conference produces a recommendation that the STU inmate be discharged prior to completion of the inmate's DDU sanction, the Director of Behavioral Health shall submit such recommendation to the Deputy Commissioner, Prison Division, for a determination whether the remaining DDU sentence should be suspended and the inmate transitioned from the STU to another placement.

d. If the Deputy Commissioner, Prison Division determines that the remaining DDU sentence should be suspended and the inmate should be transitioned from the STU to another placement, the Director of Behavioral Health shall convene a case conference to determine an appropriate placement and formulate a transition plan. If the prior case conference had determined that an RTU level of care is clinically indicated, the inmate shall be referred for RTU placement. If the prior case conference had determined that an RTU level of care is not clinically indicated, the inmate's placement upon the inmate's transition and discharge from the STU shall be effected by the classification process.

e. The DDU sanction of an inmate who is discharged from an STU prior to completing the DDU sanction shall be suspended for the remaining period of such DDU sanction. During the period of suspension, if such inmate commits another disciplinary offense that is subject to a DDU referral, the inmate shall be returned to an STU for the period remaining on the suspended sanction, plus the period of any new DDU sanction that may be imposed for the new offense. However, if such inmate is no longer determined to have an SMI, or if the Deputy Commissioner, Prison Division determines that Exigent Circumstances warrant DDU placement, the inmate shall be placed in the DDU to serve the DDU sanction(s).

3. <u>Secure Treatment Unit Discharge for Inmates Admitted Without DDU Sanctions</u>

a. Upon the successful completion of all phases and requirements of the STU program by an inmate who was admitted to the STU without a governing DDU sanction, or at any time prior to the successful completion of the STU program by such inmate, if the STU treatment team

determines that the inmate 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 inmate's progress and appropriateness for discharge.

b. In assessing the inmate's appropriateness for STU discharge, the case conference participants shall consider the requirements set forth in 103 DOC 650.13 (D) (2) (b) *Secure Treatment Units and Secure Adjustment Units.*. If the case conference determines that an RTU level of care is clinically indicated, the inmate shall be referred for RTU placement. If the case conference determines that an RTU level of care is not clinically indicated, the inmate's placement upon the inmate's transition and discharge from the STU shall be effected by the classification process.

D. Termination from a Secure Treatment Unit

Only when every alternative and potential intervention has been exhausted, may an inmate be considered for termination from an STU. Under no circumstances will inmates with SMI be returned to Restrictive Housing from an STU prior to completion of the STU program, except in Exigent Circumstances or for program termination as follows:

1. Inmates may be considered for termination from an STU prior to completing the program if the inmate 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 inmate's status and appropriateness for termination. In conjunction with this case conference, the treatment team shall recommend a discharge plan consistent with the inmate'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 650.22 (C) *Administrative Provisions,* the Department shall periodically reassess inmates who have been terminated from an STU and returned to Restrictive housing. The inmate shall be referred to the same or a different STU if the

inmate's behavior and motivation demonstrably improve. The inmate 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:

- Program schedules;
- Program participation by unit and by inmate;
- Phase and incentives, by unit and by inmate;
- Structured out-of-cell programming offered and provided, by unit and by inmate, including documentation of any instances in which such programming was not provided in accordance with 103 DOC 650.13 (C) *Secure Treatment Units and Secure Adjustment Units* (Exigent Circumstances);
- Non-structured out-of-cell programming offered and provided, by unit and by inmate including documentation of any incidents in which such programming was not provided in accordance with 103 DOC 650.13 (C) *Secure Treatment Units and Secure Adjustment Units* (Exigent Circumstances);
- Outcome measures by unit and by inmate, 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 inmate may be transferred from Restrictive Housing to a Secure Adjustment Unit following a Placement Review and finding by the Superintendent or designee, made in accordance with 103 CMR 423, *Restrictive Housing*, or following a Placement Review and finding by the Deputy Commissioner, Prison Division, in accordance with 103 CMR 430, *Inmate Discipline*, that the inmate no longer requires Restrictive Housing but cannot be placed in general population.

Any inmate 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 Director of Mental Health to be screened for contraindications prior to SAU placement. This referral and the results shall be documented on the SAU referral form. If there are no contraindications for SAU placement, the Superintendent or designee shall submit a completed Secure Adjustment Unit transfer request form to the Classification Division. The Classification Division shall then identify a bed in an appropriate SAU and effect such transfer.

2. Treatment Planning for SAU participants

Qualified Mental Health Professionals shall adjust the inmate's treatment plan to include goals for symptom reduction and behavioral interventions throughout SAU placement.

650.14 RESIDENTIAL TREATMENT UNITS

A. Purpose

Residential Treatment Units provide an intermediate level of care for general population inmates with a mental health classification of MH-4. These inmates 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:

- Multiple transfers to an inpatient psychiatric setting;
- Frequent placement on therapeutic supervision;
- Frequent reliance on crisis stabilization services/interventions;
- Frequent episodes of self-injurious behavior;
- Multiple disciplinary or rule infractions;
- Inability to follow routine/directions;
- Inability to participate independently in activities of daily living.

Inmates 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.

B. Residential Treatment Unit Referral and Placement

1. A mental health clinician who believes that an inmate 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 inmate'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, they 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 inmate.

3. The mental health classification of an inmate 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) *Mental Health Classification.*

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 inmate who is not already residing at the facility that houses the RTU, the Classification Division shall determine the appropriateness of the transfer under the point based classification system. Unless otherwise indicated, the inmate shall remain at the sending institution until bed space becomes available in the designated RTU. The RTU admission of an inmate who is already residing at the facility that houses the designated RTU constitutes an internal placement that does not require review by the Classification Division.

5. Upon an inmate's transfer from an RTU to an inpatient psychiatric hospital (BSH for males, a DMH facility for females) the inmate'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 inmate who is subsequently civilly committed to an inpatient psychiatric hospital shall be afforded an RTU

placement upon the inmate'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 inmate'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 inmate'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 inmate's placement in the RTU, the treatment team shall develop an Initial Treatment Plan, which shall be documented in the inmate'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 inmate shall be requested to participate in the multi-disciplinary treatment team meeting and shall be afforded the opportunity to give input into the inmate's treatment goals and assigned treatment interventions. The inmate shall be requested to sign the treatment plan. The inmate's refusal to sign shall be documented in the treatment plan.

The treatment plan shall determine the inmate'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 inmates will not be forced to accept treatment, the inmate's PCC and the RTU treatment team shall monitor and encourage participation. When an inmate is reluctant to comply with treatment recommendations, staff efforts to engage the inmate 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 inmates 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 inmate's individualized treatment needs. Elective groups may be assigned based on the input and interest of the inmate. Attendance records shall be kept for each group conducted and each inmate's participation and attendance shall be documented in each inmate's medical record.

4. Orientation Meetings

Within one (1) to two (2) days of admission to the RTU, each inmate shall participate in a formal RTU orientation meeting. The purpose of this meeting is to assist inmates in making a smooth transition to the RTU. The orientation meeting shall be facilitated by the RTU treatment team and provide inmates 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 inmates 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 inmate is eligible to receive earned good time credits, as some inmates may require such

programming and support in the RTU environment for an extended period of time.

Each inmate's daily attendance shall be recorded in the IMS Program/Attendance screen for the purpose of tracking the inmate's program participation for the purpose of determining the inmate'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 inmate's compliance with the inmate's individualized treatment plan. RTU staff shall assess whether the inmate's degree of compliance was satisfactory, unsatisfactory, or incomplete. The RTU Coordinator shall enter each inmate'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 inmate who receives earned good time credits shall be determined by the facility 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 Deductions*.

D. Residential Treatment Unit Discipline and Restrictive housing

RTU inmates shall be subject to the disciplinary process. RTU inmates may be issued disciplinary reports and may be required to serve a disciplinary detention sanction in a Restrictive Housing cell. RTU mental health staff shall provide consultation to the hearing office in the disciplinary hearing process pursuant to 103 DOC 650.17 (D) (5) *Communications Regarding Mental Health Status and Needs of Inmates.*

RTU inmates who are placed in a Restrictive Housing cell shall be assessed at least four (4) times weekly by a Qualified Mental Health Professional during two (2) Restrictive Housing rounds and during two (2) required out of cell individual contacts. The out of cell contact or an inmate's refusal of out of cell contact shall be documented in the medical record.

E. Residential Treatment Unit Discharge

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

- The inmate 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
- The inmate is no longer clinically appropriate for RTU services; or
- The inmate may present security risks that cannot be safely managed in the RTU.

1. RTU Discharge for Clinical Reasons

If the RTU coordinator believes that an inmate 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.

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.

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.

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

2. RTU Discharge for Security Reasons

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

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:

- The inmate shall remain in the RTU at the current facility;
- The inmate shall be transferred to an RTU at another facility;
- The inmate shall be referred for placement in an STU;

- The inmate shall be placed in other housing/another facility with specific treatment plan modifications developed in concert with the receiving facility'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 inmate and with the receiving facility's Site Mental Health Director.

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

650.15 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 Substance Abuse and Addiction Center at MCI-Plymouth

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

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 abuse 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 inmates.

   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 abuse 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 civil commitment is cleared by the Contractor from the detoxification process to participate in substance abuse 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 abuse education;
   - Aftercare and discharge planning;
   - Family reunification;
   - Interpersonal skills training;
   - Health and wellness;
   - Creating recovery plans; and
   - 12-step programming.

6. Substance abuse 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. <u>MCI-Framingham</u>

1. All Section 35 females 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 inmates 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.

650.16 MENTAL HEALTH REENTRY PLANNING AND PROCEDURES

A. General Policy

The ongoing needs of inmates with open mental health cases shall be addressed in anticipation of the inmate's discharge from the Department of Correction. All inmates 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 inmates 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 inmate'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 inmate with an open mental health case, or sooner if required by a short sentence structure, a mental health clinician shall work with the inmate to complete a Discharge Plan (refer to Wellpath 44.01). The Discharge Plan shall identify services available in the community and reflect sufficient details of the inmate's clinical diagnoses, medications and future needs. Contacts and telephone numbers shall be provided for the inmate'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 inmate has been identified as the victim of sexually abusive behavior while incarcerated, a referral for sexual abuse counseling shall be included in the discharge plan where clinically warranted.

4. The discharge plan shall be signed by the mental health clinician, the inmate and the Site Mental Health Director or designee. The inmate'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 inmate 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 inmate's medical record.

D. Mental Health Parole Board Contact Sheet

The Site Mental Health Director shall obtain a list of inmates 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 inmate 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 inmate 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 inmate'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 inmate's mental health record with the DMH representatives to determine the inmate'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 facilities to conduct inmate 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 inmate's facility and collaborate with the development of a service plan.

4. Upon DMH determination of eligibility, the mental health clinician shall note the inmate's eligibility for DMH services in the inmate'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 inmate with an open mental health case is assessed as requiring involuntary civil commitment to an inpatient hospital setting upon the expiration of the inmate'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 inmate'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 inmate is deemed in need of immediate civil commitment, the civil commitment process shall proceed in accordance with 103 DOC 650.08(E)(1).

4. If an inmate requires commitment to a facility of the Department of Mental Health on the day of the inmate'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 inmate with an open mental health case has been assessed to have a developmental disability that may render the inmate 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 inmate's transition to the community.

At least six (6) months prior to anticipated discharge, the assigned 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 inmate 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:

- Twelve (12) months of mental health progress notes, including the inmate's mental health treatment plan;
- Twelve (12) months of psychiatric progress notes, including medication updates;
- The Medication Administration Record (MAR);
- Discharge summaries from Bridgewater State Hospital if the inmate has been hospitalized within the past twelve (12) months;
- Any neuropsychological testing completed within the past twelve (12) months; and
- Any pertinent medical documentation.

I. Reentry Clinical Case Conference

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

- 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

- A long-term history of substance abuse or alcohol addiction where the inmate has not had recent treatment, but requires out-patient follow-up care.

J. Discharge Medication

An inmate receiving psychotropic medication shall be provided with a thirty (30) day prescription and/or the remainder of the inmate's patient-specific blister pack at the time of discharge in accordance with the inmate's needs and follow-up care. The psychiatrist shall determine whether an inmate should be discharged with a supply of medication or with a written prescription.

650.17 COMMUNICATION REGARDING MENTAL HEALTH STATUS AND NEEDS OF INMATES

A. Intra-Facility 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 mental health professionals when correctional staff have reason to believe that an inmate 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 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 inmate's mental status may be in question. Consideration of the inmate's mental health status as it pertains to the disciplinary process shall be governed by 103 DOC 650.17 (D) (4) (b) *Communication Regarding Mental Health Status and Needs of Inmates*. Consideration of the inmate's mental health status as it pertains to housing, program assignments, work, transportation, special equipment and admission to and transfer from the facility shall be governed by 103 DOC 650.17 (D) (2) (c) *Communication Regarding Mental Health Status and Needs of Inmates*. Meeting minutes of the daily (Monday through Friday) meetings shall be maintained by the Superintendent's office.

2. Facilities 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 mental health professionals occurs at least weekly, and is sought on an as needed basis, when correctional staff have reason to believe that an inmate 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 inmate 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 inmate 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 inmate's overall mental status (e.g. classification hearings, parole hearing, legal decisions, court trips, etc.). When it is suspected that an inmate will react negatively to such an event, mental health staff shall ensure that the inmate 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-Facility Communication

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

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

C. Inter-System Communication

A Health Status Report pursuant to 103 DOC 607, *Inmate Medical Records*, 607.02(1) shall accompany each inmate 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 650.16 *Mental Health Reentry Planning and Procedures*.

D. Communications on and Recommendations for Special Needs Inmates

1. General Policy

Inmates 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 facility. 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 inmates 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 inmate within a reasonable time.

m. 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 inmates 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. Inmates with Disabilities and Inmates with Language Barriers

The agency shall take appropriate steps to ensure that inmates with disabilities (including, for example, inmates 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 abuse and sexual harassment. Such steps shall include, when necessary to ensure effective communication with inmates 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 inmates with disabilities, including inmates 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.

4. Mental Health Consultation in the Disciplinary Process

a. Notification to Mental Health – SMI Inmates

Site mental health staff shall be notified prior to service of a disciplinary report on any inmate 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 650.17(A) *Communication Regarding Mental Health Status and Needs of Inmates*, 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.

5. Consultation Regarding Disciplinary Disposition

a. Following the entry of a guilty finding on a Category 1 or Category 2 disciplinary offense for an inmate with a Mental Health Classification of MH-4, the hearing officer, if not recommending a DDU sanction, 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 inmate'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.

b. In the event that an inmate with a Mental Health Classification of MH-4 charged with a Category 1 or 2 disciplinary offense pleads guilty to disciplinary charges, prior to the imposition of disciplinary detention, other than a sanction of "time served," the hearing officer or disciplinary officer shall consult with mental health staff with respect to dispositional recommendations and document any such change in disposition as provided in 103 DOC 650.17(D)(5) *Communication Regarding Mental Health Status and Needs of Inmates*.

650.18 DUTY TO WARN

A mental health clinician who, in the course of diagnosing, assessing or treating an inmate, has reason to conclude that the inmate 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.

650.19 ON-SITE EVALUATIONS BY OUTSIDE MENTAL HEALTH PROFESSIONALS

The following procedure shall be followed by all facilities whenever a request is received for an inmate examination or evaluation by an outside mental health professional (i.e., any 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 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 inmate shall sign an authorization to release medical/mental health information in order for the outside mental health professional to examine the inmate's medical and/or mental health record (see 103 DOC 607, *Inmate Medical Records*, Attachment #2).

C. The outside mental health professional may enter the facility through the normal facility 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 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 mental health professional indicates, on Attachment #13, that the nature of the service is for any other reason than those cited in 103 DOC 650.19(C) *On-Site Evaluations by Outside 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 facility through the normal facility visiting procedure or via any special accommodations approved by the Superintendent.

G. All outside mental health professionals shall be subject to the following additional requirements:

1. Outside mental health professional shall be informed that he/she/they may not perform an intrusive examination, nor may the mental health professional write any orders or notes in any part of the medical or mental health record.

2. The outside 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 mental health professional makes. The outside 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 inmate's medical health record.

H. 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 facility, inappropriate treatment within a facility, inappropriate Restrictive Housing or inappropriate DDU placement so that the Director may consider proper review, comment or initiate a peer review.

650.20 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 inmates. 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 Mental Health Contractor shall fully participate in Continuous Quality Improvement (CQI) initiatives that are defined and required by the Health Services Division, from planning through study completion, reporting, monitoring and follow-up.

2. The Mental Health Contractor shall develop and provide planned, systematic and ongoing comprehensive quality improvement processes for monitoring, evaluating and improving the quality and appropriateness of mental health care provided to Inmates. The Mental Health Contractor shall identify indicators to monitor the quality and appropriateness of the important aspects of care, and organize the data collected for each such indicator in a manner to facilitate the identification of situations in need of more detailed evaluations of the quality or appropriateness of care. Upon identification of such problems, the respective Mental Health Contractor shall take actions to correct problems or improve the quality of care and incorporate the findings into the Department's education and training activities.

3. The Mental Health Contractor shall provide the Director of Behavioral Health with documentation of an appropriate Continuous Quality Improvement program for its subcontractors.

3. 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.

650.21 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. Facility Mental Health Policies

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

Bridgewater State Hospital, as an accredited psychiatric hospital, establishes hospital-specific policies and procedures. Other facilities 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 facility Superintendents, shall draft and update operational procedures and inmate handbooks for mental health treatment units, including:

- The Secure Treatment Program (STP)
- The Behavioral Management Unit (BMU)
- The MCI-Framingham Intensive Treatment Unit (ITU)
- The Residential Treatment Units (RTUs)

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.

650.22 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.

SICK CALL REQUEST FORM

Name: _____ **ID#:** _____ **Unit #:** _____

Date of Birth: _____ **Date:** _____ **Check** ONLY **One Box:** □ **Medical** □ **Dental**

Nature of problem or request: _____ □ **Mental Health**

_____

_____

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

Inmate 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:** _____

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 inmate 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 inmate 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 inmate is noncompliant)
❖ Inmate requires structured daily activities and comprehensive mental health programming to maintain stability
❖ A multidisciplinary treatment plan review is needed more frequently than every 6 months
☐ **MH-3 Moderate level of mental health treatment needs (General Population)** **Sub Code(s) A ☐ B ☐ C ☐ D ☐**
❖ The inmate 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 inmate is noncompliant)
❖ Inmate 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 inmate is prioritized for group treatment when available and clinically indicated
❖ Inmate is able to function in general population with structured support from mental health staff
❖ The inmate requires a multidisciplinary treatment plan
❖ The inmate 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 inmate 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 inmate is noncompliant)
❖ The inmate 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 inmate requires a multidisciplinary treatment plan
❖ The inmate can participate in DOC programs as available
☐ **MH-1 Case management needs Sub Code B ☐ D ☐ (General Population)**

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

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

- ❖ The inmate does not demonstrate any identified need for mental health assistance
- ❖ The inmate may receive crisis intervention services when indicated
- ❖ The inmate 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: Inmate is designated as SMI (seriously mentally ill) based upon definition
B: Inmate is currently prescribed psychotropic medication by a psychiatrist
C: Inmate is currently prescribed medication by a psychiatrist that must be administered by nursing staff, requiring a facility with 7 day nursing coverage
D: Inmate has a history of self-injurious behavior

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

Clinician Printed Name: _____

Signature: _____ Date: _____

DEPARTMENT OF CORRECTION
RESIDENTIAL TREATMENT UNIT REFERRAL

NAME: ID: DOB:

DATE OF REFERRAL:

REFERRING FACILITY:

HOUSING UNIT:

CURRENTLY IN RESTRICTIVE HOUSING (yes/no):

If currently in restrictive housing please report the following:

- Date placed in RHU:
- Offense leading to RHU 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:

MENTAL HEALTH HISTORY:

Diagnosis:

PSYCHIATRIC HOSPITALIZATIONS (include dates and reasons):

OUTPATIENT MENTAL HEALTH TREATMENT:

SUBSTANCE ABUSE HISTORY:

MENTAL HEALTH WATCHES (include dates and reasons):

FREQUENCY OF CRISIS CONTACTS:

HISTORY OF SUICIDE/SELF-INJURIOUS BEHAVIOR (include dates):

PRIOR RTU TREATMENT:

CURRENT MENTAL STATUS:

CURRENT FUNCTIONAL STATUS:

CURRENT PSYCHIATRIC SYMPTOMS THAT IMPAIR INDEPENDENT FUNCTIONING IN GENERAL POPULATION:

INMATE'S PERCEPTION AND UNDERSTANDING OF RTU PLACEMENT:

RTU TREATMENT GOALS:

POTENTIAL BARRIERS FOR RTU TREATMENT:

_____

INMATE SIGNATURE/DATE

_____

CLINCIAN SIGNATURE/DATE

_____

MENTAL HEALTH DIRECTOR/DATE (FROM REFERRING SITE)

Please scan signed copy to:
Neal Norcliffe, LICSW, Program Mental Health Director at NNorcliffe@wellpath.us
Karen Collins, LICSW, Assistant Program Mental Health Director at KMCollins@wellpath.us

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(PLEASE DO NOT WRITE BELOW THIS LINE)

Date Referral Received:

Contacts Regarding this Referral:

RESULT: □ **INMATE MEETS CRITERIA** □ **INMATE DOES NOT MEET CRITERIA**

_____ _____

Director of Clinical Programs (or designee) **Date**

RECOMMENDED RTU SITE: (TO BE ISSUED BY DOC CLASSIFICATION)

□ **Old Colony (Maximum)** □ **Old Colony (Medium)** □ **NCCI Gardner** □ **MCI-FRAMINGHAM**

MA Department of Correction
Health Services Division

RESIDENTIAL TREATMENT UNIT DISCHARGE SUMMARY

Inmate Name	#	DOB:	Facility:

Admitted on: Length of Stay in the RTU:	Date of Discharge: 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 inmate is deemed not to require RTU level of care (Case conference required. Attach case conference summary).	
Treatment Progress on RTU:	
Current Mental Status:	
Inmate compliant with medication? ☐ Yes ☐ No	
Inmate placed on mental health watch during the last 30 days? ☐ Yes ☐ No	
Relevant Medical Information:	
Discharge DSM 5 Diagnosis:	
Current Medications:	

Follow-up Treatment Recommendations:

Inmate Signature:	Date
Reason no inmate signature:	
Primary Care Clinician:	Date
Psychiatrist/Nurse Practitioner:	Date
Mental Health Director:	Date
Other (Title)	Date

MA Department of Correction
Health Services Division
Inter-Facility Clinical Case Conference Form

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

Inmate Name: Date of Case Conference: Facilities Involved:	Inmate ID #: Inmate DOB: Form completed by:

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

Past History (brief overview of the inmate'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):

N/A

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

If alternative placement is being considered, is inmate/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.	Mike will follow up on this
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 inmates designated MH-4 who have been found guilty or who have pled or pleaded guilty to a Category 1 or Category 2 Disciplinary Offense who are not sanctioned with a Department Disciplinary Unit (DDU) sanction.

_____ _____
Inmate Name Commitment Number

_____
Disciplinary Report Number

Check One 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 inmate, 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.

_____ _____
Date Completed Signature of Disciplinary Officer or Hearing Officer

MASSACHUSETTS DEPARTMENT OF CORRECTION
HEALTH SERVICES

SECURE TREATMENT UNIT REFERRAL

NAME: ID: DOB:

DATE REFERRAL COMPLETED:

REFERRING FACILITY: CURRENT HOUSING UNIT:

REFERRING CLINICIAN AND CONTACT INFORMATION (email, phone number):

LENGTH OF DDU SENTENCE:

DISCIPLINARY INFRACTION THAT RESULTED IN DDU PLACEMENT:
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 ABUSE HISTORY:

MENTAL HEALTH WATCHES (PAST 12 MONTHS):

FREQUENCY OF CRISIS CONTACTS (SPECIFY DATE, REASON, AND OUTCOME OVER THE PAST 12 MONTHS):

HISTORY OF SUICIDE/SELF-INJURIOUS BEHAVIOR (INCLUDE DATES AND BRIEF DESCRIPTIONS OF BEHAVIORS FOR PAST 12 MONTHS):

SELF-INJURIOUS BEHAVIOR REQUIRING OUTSIDE MEDICAL ATTENTION IN THE PAST 12 MONTHS (INCLUDE DATES AND DESCRIPTIONS OF IDENTIFIED TRIGGERS, BEHAVIORS AND INTERVENTIONS):

LOCATION WHERE SELF-INJURIOUS BEHAVIOR OCCURRED (e.g., IN RESTRICTIVE HOUSING, GENERAL POPULATION, ETC.):

CURRENT FUNCTIONAL STATUS (PLEASE INCLUDE MENTAL STATUS EXAM):

CURRENT PSYCHIATRIC SYMPTOMS AND/OR BEHAVIORAL PROBLEMS THAT IMPAIR INDEPENDENT FUNCTIONING IN RESTRICTIVE HOUSING:

CHRONIC OF PSYCHIATRIC SYMPTOMS AND/OR BEHAVIORAL PROBLEMS THAT IMPAIR INDEPENDENT FUNCTIONING IN GENERAL POPULATION:

TREATMENT GOALS:

INMATE'S PERCEPTION AND UNDERSTANDING OF STU PLACEMENT:

IDENTIFIED STRENGTHS:

IDENTIFIED POSTIVE COPING STRATEGIES:

_____

CLINCIAN SIGNATURE/DATE

_____

MENTAL HEALTH DIRECTOR/DATE (FROM REFERRING SITE)

TEAM RECOMMENDATION FOR STU PLACEMENT:

□ BEHAVIOR MANAGEMENT UNIT

□ SECURE TREATMENT PROGRAM

Please email to nnorrliffe@wellpath.us

(PLEASE DO NOT WRITE BELOW THIS LINE)

DATE REFERRAL RECEIVED:

DATE OF STU REVIEW COMMITTEE REVIEW:

□ INMATE MEETS CRITERIA FOR PLACEMENT IN THE BEHAVIOR MANAGEMENT UNIT

□ INMATE MEETS CRITERIA FOR PLACEMENT IN THE SECURE TREATMENT PROGRAM

□ INMATE 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 (MHM)/DATE:

OBSERVATION CHECK SHEET

NAME: _____ CELL: _____ DATE:_____ COMMITMENT #:_____

TIME	AWAKE	ASLEEP	COHERENT	ENGAGEMENT/ INTERACTION*	DISPOSITION	COMMENTS	OFFICER'S INITALS

ALL NOTATIONS SHALL BE MADE AT 15 MIN INTERVALS, EACH ENTRY SHALL BE IN INK

***Comments regarding officer/inmate engagement and interaction shall be noted in this field and include descriptions such as if the inmate is talkative and/or receptive.**

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

OFFICER'S NAME (PRINT NAME) **OFFICER'S SIGNATURE**

FOUR POINT RESTRAINT MEDICAL EXAMINATION CHECKLIST

TYPE RESTRAINTS UTILIZED

4 Point Soft Posey Restraints _____
4 Point metal Restraints_____
Security Restraint Chair _____

Inmate Name:_____ Commitment #:_____

ORDERED BY_____
(PRINT)

DATE STARTED _____ TIME STARTED_____

DATE ENDED _____TIME ENDED _____

TIME	CHECKED BY HSU STAFF NAME	EXTREMITY CIRCULATION CHECKED, PULSE PRESENT, MOVEMENT ADEQUATE

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 (MH) / Parole Contact Sheet

Inmate Name:_____ Date of Birth:_____

DOC#:_____

Date MH services initiated:_____ Axis I diagnosis:_____

Date MH services terminated:_____ Axis II diagnosis:_____

Axis III diagnosis:_____

MH services inmate currently receives:

_____

_____

Predominated symptoms / reason for service:

_____

_____

_____

Current medications:

_____

_____

# of 18 (a)'s:_____

Is inmate seen as a potential DMH client?:_____
Is inmate seen as a potential DDS client?:_____

Services to be addressed upon release (circle all that apply):

1. DMH application for continuing care: filed / not filed / not applicable
2. Outpatient referral for meds / counseling
3. Substance abuse treatment
4. Housing / employment
5. Case management
6. Other:_____

Acknowledgement and Release

I have read the information contained in this form, or have had it read to me, and I hereby give my permission to Wellpath and its agents or assigns to release any and / or all of the information contained in this form to the Parole Board, its members and staff.

In signing this Acknowledgement and Release, I agree that information from this form may be used to coordinate my aftercare treatment.

Inmate signature:_____ Date:_____

Clinician signature:_____ Date:_____

MASSACHUSETTS DEPARTMENT OF CORRECTION
Health Services Division
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 inmate 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: _____

MASSACHUSETTS DEPARTMENT OF CORRECTION
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

1. Before placement on Therapeutic Supervision, an inmate 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*.

2. The cell that the inmate 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*.

3. Inmates 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 inmate 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 inmate 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 inmate on therapeutic supervision. Inmates placed in restraints shall remain on constant observation until such time the inmate is removed from restraints and is assessed by mental health.
b. Should an inmate 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, inmates on therapeutic supervision shall be allowed visits in accordance with 103 CMR 483.09 *Maximum Security/Special Visiting Inmate Population*.
B. Disciplinary: Unless a contraindication exists as determined by mental health staff, inmates 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 inmate in question.

a. 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 inmate'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 inmate is allowed to maintain disciplinary paperwork in their cell). These conditions shall be entered on the IMS Mental Health Watch screen.
b. If the inmate is being represented in a disciplinary hearing by a legal representative, the procedures set forth in 103 DOC 650.08 (B) Attorney Visits shall apply.
c. At the conclusion of all visits from Disciplinary Personnel, a clinician shall follow-up with the inmate to ensure that the inmate's mental status has not changed, and note the inmate's mental status in the inmate's medical record and on the IMS Mental Health Watch screen.

IV. Procedure for inmates on Therapeutic Supervision and ingestion/Insertion of Drugs or Foreign Bodies:

A. Notifications

1. Once on Therapeutic Supervision, if an inmate 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 inmate 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 inmate on therapeutic supervision is on RHU 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 inmate.