MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

HUMAN RIGHTS HANDBOOK

JUNE 2005
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DEPARTMENT OF MENTAL HEALTH
HUMAN RIGHTS HANDBOOK
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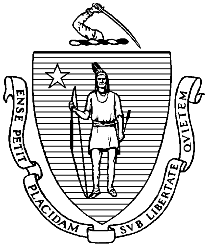

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Dear Colleagues,

Over the past several years, the Department of Mental Health has taken a close look at the Human Rights structure, the protection of Human Rights and how integral this is to our mission. The Human Rights Policy, revised in January 2003, is an important outcome of that effort. The policy and this handbook clarify and strengthen the mechanisms by which we protect clients' rights. They serve as an important resource as the Department strives to integrate these values into the day-to-day delivery of DMH services.

In addition to revising the policy, the Department has examined the sometimes complex dynamics that arise while ensuring the protection of rights and delivering quality clinical care. I firmly believe that excellent care is congruent with respecting clients' rights. As the policy clearly states: ". . . the protection and enhancement of Human Rights is a common objective to be shared by all. Senior staff and managers have a responsibility to provide the leadership and model the values necessary to proactively implement this policy, and to ensure that DMH maintains a service environment that promotes respectful and responsive interactions with Clients."

Thank you for your shared commitment to the mission of the Department of Mental Health and your dedication to the continued protection of human rights.

Sincerely,

Elizabeth Childs, M.D.
Commissioner

II. ACKNOWLDEDGEMENTS

We first want to thank Bill Crane, former DMH Special Assistant for Human Rights who wrote the original Human Rights (“pink”) handbook on which this one is based, that has been an invaluable resource to many people over the years.

We also wish to acknowledge the assistance of many individuals who helped in rewriting this handbook.

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Linda Barlow, Kathleen Callan, John Ceruolo, Mary Connelly, Marion Freedman-Gurspan, Marianne Greeno, Joan Kerzner, Stephen Kiley, and Stephen Shull.

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If we have forgotten to mention anyone who contributed to this project, we apologize and ask that you contact the Human Rights Office.

Bernadette Drum
Director of Human Rights for Children and Adolescents

Carol O’Loughlin
Former Director of Human Rights for Adults

III. HOW TO USE THE HUMAN RIGHTS HANDBOOK

The Human Rights Handbook is meant to be a companion to the Human Rights Policy (Appendix 1). On pages five through seven of the policy there is a chart of rights that is in alphabetical order. The handbook is designed to define and explain the regulations, statutes and policies establishing the rights listed on those pages.

In the Human Rights Policy, the topics are listed as either applying to a facility or a community program. In this handbook, the table of contents will direct you to the page where a specific right is discussed. You will first read a general statement about a right and then it will explain how it applies to the facility, community and DMH child/adolescent programs licensed by DEEC.

Section V of the handbook explains the Human Rights Infrastructure. Section VI, the Appendix, contains relevant materials mentioned in the handbook such as the Human Rights Policy, the Five Fundamental Rights Law, as well as contact information for legal, educational, and advocacy resources.

As laws, regulations and DMH policies change, this handbook will be revised.

We hope the handbook proves to be a useful resource to you. For copies of DMH regulations or policies or if you have any questions that are not readily answered in this handbook, please feel free to contact the Human Rights Office.

Bernadette Drum
Children/Adolescents Director of Human Rights
617-626-8150

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IV. HUMAN RIGHTS AND RESPONSIBILITIES OF CLIENTS

A. ACCESS TO ATTORNEY OR LEGAL ADVOCATE

(See Appendix 2a and 2b -"Five Fundamental Rights" Law)

1. <u>Facility and community: general</u>

A program or facility must ensure access to a client by his/her attorney and/or legal advocate working under the supervision of an attorney, at any reasonable time. Every client must be provided with reasonable assistance in contacting and receiving visits or telephone calls from attorneys or legal advocates. Whenever possible, such visits and telephone calls shall occur in private areas. The client also has the right to refuse a visit or telephone call from an attorney or legal advocate. An attorney or legal advocate who represents a client must be given access to the client, the client's record, the hospital staff responsible for the client's care and treatment and any meetings concerning treatment or discharge planning where the client would be or has the right to be present.[1] The program or facility may ask an attorney, or legal advocate working under the supervision of an attorney, to verify that he or she, in fact, is representing the client.

2. <u>Facility</u>

In a facility, a client:

a. has the right to receive or refuse visits and telephone calls from his/her attorney or legal advocate, physician, psychologist, clergy or social worker at any reasonable time, regardless of whether the patient initiated or requested the visit or telephone call.

b. upon admission and upon request at any time thereafter, must be provided with the name, address, and telephone number of the Mental Health Legal Advisors Committee, Committee for Public Counsel Services, and authorized Protection and Advocacy organizations, and shall be provided with reasonable assistance in contacting and receiving visits or telephone calls from attorneys or legal advocates from such organizations; provided that the facility shall designate reasonable times for unsolicited visits and for the dissemination of educational materials to patients by such attorneys or legal advocates.[2] (See Appendix 3 for a listing of legal and advocacy resources.)

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[1] M.G.L.c. 123,§ 23(e); 104 CMR 27.17(6)(b); and 104 CMR 28.09(1)(b)

[2] 104 CMR 27.13(5)(e) and (f)

3. **Community**

In a community program, a client:

a. has the right to receive or refuse visits and telephone calls from an attorney or legal advocate, physician, psychologist, clergy or social worker at any reasonable time, regardless of whether the client initiated or requested the visit or telephone call; and

b. has the right to be represented by an attorney or legal advocate of his/her own choice, including the right to meet in a private area at the program with the attorney or legal advocate.[3]

4. **Community: DMH child/adolescent programs licensed by DEEC**

When contracting with a child/adolescent program licensed by the Department of Early Education and Care (DEEC), DMH must insure that the Program allows DMH child/adolescent clients to have access to an attorney or legal advocate in accordance with the Five Fundamental Rights Law.[4]

5. **Attorneys for clients regarding commitment or guardianship and/or Rogers matters** (See also section of Handbook entitled "Informed Consent" (Section IV.O. p. 25)

An attorney who represents a client in a commitment or guardianship and/or Rogers matter must be given access to:

a. the client;
b. the client's record;
c. the hospital staff responsible for the care and treatment of the client; and
d. any meetings concerning treatment planning or discharge planning where the client would be or has the right to be present.[5]

6. **Attorneys or legal advocates from protection and advocacy organizations**

Upon admission to a facility or program and upon request at any time thereafter, the facility or program must provide clients with the name, address and telephone number of the following organizations:

a. Disability Law Center (Massachusetts Mental Health Protection and Advocacy Project);
b. Mental Health Legal Advisors Committee;
c. Committee for Public Counsel Services; and

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[3] 104 CMR 28.03(1)(d)(3) and (1)(e)
[4] Id.
[5] M.G.L. c. 123 § 23(e); 104 CMR 27.17(6)(b); and 104 CMR 28.09(1)(b)

d. Any other legal service agencies funded by the Massachusetts Legal Assistance Corporation, under the provisions of chapter 221A, to provide free legal services.[6]

In addition, the Massachusetts Mental Health Protection and Advocacy Project may have additional rights of access to the client or the client's record under federal or state law.

B. CIVIL AND FORENSIC COMMITMENTS AND OTHER ADMISSIONS

(See Appendix 4, Massachusetts General Laws Chapter 123-Commitments and Other Admissions)

1. Involuntary admission for adults and minors

The term "individual" in this section refers to both adults and minors.

a. If an individual is admitted against his/her will to a facility under the provisions of M.G.L. c. 123, §12 ("Section 12"), he/she has the right to meet with an attorney appointed to represent him/her by the Committee for Public Counsel Services (CPCS) Mental Health Litigation Unit (1-617-482-6212). Upon admission, the facility must advise the individual of this right and the facility will contact CPCS if the individual so requests. CPCS is required to appoint an attorney who shall meet with the person promptly. The individual, of course, may decline to have CPCS contacted on his/her behalf.[7]

b. If an individual is sent to a facility on a "Section 12," he/she may be admitted involuntarily if the admitting physician (who must be a designated physician in accordance with DMH regulations)[8] thinks that he/she suffers from a mental illness and, because of such illness, would be dangerous to him/herself or others if not admitted.[9] The individual may be held for examination and treatment for up to three (3) business days. Within this time, the facility must release him/her, accept his/her conditional voluntary admission, or petition the local District Court for a commitment. If the individual thinks that his/her involuntary admission arises from abuse or misuse of the prescribed process, he/she may seek an emergency hearing in the District Court. Such hearings are required to take place on the next business day. The admitting facility should be prepared to supply forms for emergency petitions to the individual and/or his/her attorney. A facility is entitled to respond to such petitions.

c. If the facility files a petition for the individual's commitment, under the provisions of M.G.L. c.123, sec. 7, the court must hold the hearing within

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[6] M.G.L. c. 123 § 23(e)
[7] M.G.L. c. 123, § 12(b)
[8] 104 CMR 33.03
[9] 104 CMR 27.05(1) defines mental illness and M.G.L. c. 123, §1 defines likelihood of serious harm.

five (5) business days after the petition is filed, unless the patient agrees to a delay. The initial order of commitment after a hearing will be for a period of up to six (6) months. If the facility files a petition for further commitment after the initial six (6) month period, the hearing must be held within fourteen (14) days after the petition is filed, unless the individual agrees to a delay. The second or any subsequent commitment(s) will be for a period of up to twelve (12) months.[10]

d. If the facility files a petition for commitment, the individual must remain at the facility until the hearing is held and a judge has decided the matter. Although judges usually decide the cases quickly, a judge has up to 10 days after the hearing ends to make his/her decision. If the judge orders the individual committed, the individual has a right to appeal.

2. Voluntary admission

a. Persons age 16 years or older - Any individual 16 years of age or older, or his/her Legally Authorized Representative (LAR), has the right to apply for voluntary admission to a psychiatric facility. A voluntary admission is granted when the individual meets the clinical criteria for admission and there is not a likelihood that serious harm would result if the individual left the facility. As a general rule, only unlocked psychiatric facilities accept patients voluntarily without conditions on their admissions. An individual on a voluntary admission status may leave the facility at any time.

b. Individuals under the age of 16 years - Only the parent(s) or LAR of a child/adolescent under the age of 16 years has the right to apply for voluntary admission of the individual. The parent(s) or LAR may remove the child/adolescent from the facility at any time.

3. Conditional voluntary admission

a. Individuals age 16 years or older - An individual 16 years of age or older has the right to apply for a conditional voluntary admission to a psychiatric facility.[11] He/she may consult a lawyer or legal representative before taking this action. In general, locked psychiatric facilities only accept voluntary admissions with the conditions described in this section. This is because locked psychiatric facilities generally treat patients who present a concern or a likelihood of serious harm if they leave the facility. If the individual meets the criteria for admission and is found competent to make that decision, the application for conditional voluntary status should be accepted. A person on conditional voluntary status must give the facility three (3) business days notice of his/her intention to leave. By the end of the three (3)-day period, the facility must either discharge him/her

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[10] M.G.L. c. 123, sec. 8

[11] M.G.L. c. 123, § 10

or, if the facility thinks he/she is mentally ill and dangerous, petition the court for the individual's commitment.

The parent(s) or LAR of individuals age 16 and 17 also has the right to:
a) sign for a conditional voluntary admission on behalf of the child; and
b) provide notice of intent to remove the child from a facility.

b. Individuals under the age of 16 - Only the parents or LAR of a child under the age of 16 are authorized to apply for a conditional voluntary admission, and to provide notice of intent to remove the child from a facility.

4. Right to a hearing and representation

A lawyer will be appointed by the Committee for Public Counsel Services (the public defender's office) to represent the individual, unless the individual has a private lawyer or wishes to represent him/herself. The attorney should meet with the individual promptly after his/her appointment and should explain the individual's rights in the court proceeding, including the right to seek a psychiatric examination and testimony from an independent expert.

Whenever a court hearing is held under the provisions of M.G.L. c. 123 for the commitment or further retention of an individual with conditional voluntary status in a facility, the individual has the right to a timely hearing and representation by counsel under the law.[12]

5. Forensic commitments

Under Massachusetts General Laws, Chapter 123, §§15-18, courts with appropriate jurisdiction may order certain pre-trial criminal defendants, criminal defendants after a finding on a criminal charge, and state prison or county house of correction inmates, to be committed to a state operated mental health facility, or in some instances, to Bridgewater State Hospital for a period of evaluation for competence to stand trial, criminal responsibility, or aid in sentencing, or for treatment following a finding of not guilty by reason of insanity or incompetence to stand trial, or for treatment upon transfer from a place of detention. **These commitment sections are described briefly on the table of legal sections found in Appendix 4, Massachusetts General Laws Chapter 123-Commitments and Other Admissions.**

[12] M.G.L. c. 123, §§ 5 and 7; and 104 CMR 27.13(9)

C. CLIENT FUNDS

1. Facility and community: general

In general, an adult client has the unrestricted right to manage and spend his/her own money unless he/she has a guardian, conservator or representative payee.[13]

Whenever possible, client funds maintained by a facility or program should be deposited in an interest-bearing account. If the amount of the funds exceeds one thousand dollars ($1,000), then the client's name must be entered onto the account.[14]

Assistance should be provided to a client to allow the client maximum independence and control over his/her funds, consistent with his/her ability.[15] The client or his/her fiduciary may request and obtain an accounting of how his/her funds were spent.[16]

Note: A Representative Payee is authorized to manage only federal benefits such as SSI and SSDI funds. A guardian of the estate or a conservator usually is authorized to manage all of a client's funds.

2. Facility: general

A facility director has the ultimate responsibility for the management and expenditure of all dependent funds .[17] In a facility, including Intensive Residential Treatment Programs (IRTPs) and Behaviorally Intensive Residential Treatment Programs (BIRTs) for patients 18 years of age or older, an evaluation of the patient's ability to manage his/her funds must take place within thirty (30) days of admission. The patient must receive notice of the evaluation and an explanation of the evaluation process at least seven (7) days in advance. He/she has the right to be assisted by a person of his/her choice during the evaluation process. He/she also must be informed as to the availability of legal assistance and/or the Human Rights Officer as resources for such assistance. In addition, a facility must have procedures for conducting emergency evaluations when the seven (7) days notice is not required, that is when a patient's use of his/her funds presents a significant risk to the patient, others, or the funds themselves. [18]

DMH Policy #97-6, concerning patient funds in facilities, states: "...(t)he fact that a patient may make 'bad' fiscal decisions is not a proper basis for determining

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[13] 104 CMR 30.02(3)(a)(4) and (5); DMH Policy #97-6, (V)(1)(C) and (V)(3)(A) and (B)
[14] 104 CMR 30.02(7)(a) and 30.03(5)(d) and (e); and DMH Policy # 97-6, (V)(1)(B)
[15] 104 CMR 30.03(5)(b)
[16] 104 CMR 30.02(7)(d) and 104 CMR 30.03(5)(e)
[17] 104 CMR 30.02(6)(a)
[18] 104 CMR 30.01(3)(a-d)

that he/she is unable to manage and spend his/her funds; only if the patient's fiscal judgment is significantly impaired…should such a determination be made." [19]

Dependent funds are those funds belonging to a patient which are located at a facility or received by a facility if:

a. the patient is unable to manage these funds as determined by an evaluation in accordance with 104 CMR 30.01(3);
b. the patient is unable to manage these funds as determined by a court in a guardianship or conservatorship proceeding;
c. the patient is unable to manage these funds as determined by the Social Security Administration or Veterans Administration in accordance with their requirements;
d. the funds were received as dependent funds from a guardian, conservator or representative payee, or other representative of the patient; or
e. the funds belong to a patient who is a minor.[20]

Independent funds are defined as, "all of a patient's funds which are located at the facility and which are not dependent funds."[21]

A facility may use dependent funds only for purposes directly beneficial to the client, taking into consideration the client's needs and desires. (See 104 CMR 30.02(6) for the standards for managing and spending these client funds.) If the evaluation determines that a client is able to manage part or all of his/her money that has been turned over to the facility, the client has the unrestricted right to manage and spend part or all of this money.[22]

3. Community: general

In community programs, the program director may hold funds given to him/her by a client, or the client's fiduciary, and the client has an unrestricted right to manage and spend these funds unless the client is a minor or has a legal guardian, conservator or representative payee.[23] However, if a clinical evaluation determines that the client is not capable of managing part or all of his/her funds, the program must develop procedures to advise and assist the client to manage and spend these funds, in accordance with the client's needs and interests.[24]

Programs operated, contracted for, or licensed by DMH and at which a client earns or maintains funds must have written procedures for the shared or delegated management of client funds. The purpose of the procedures is to advise and assist those clients who have been deemed incapable of managing or spending any part

[19] DMH Policy #97-6, (V)(2)(B) (p. 3)
[20] 104 CMR 30.02(3)(a); See also DMH Policy #97-6, (IV)(1) (p. 2)
[21] 104 CMR 30.02(3)(c) and DMH Policy #97-6, (IV)(5) (p. 2)
[22] 104 CMR 30.01(3)
[23] 104 CMR 30.03(5)(a)
[24] 104 CMR 30.03(5)(b)

of their funds and who do not have a fiduciary.[25] DMH regulations set forth other requirements applicable to managing client funds in the community. See 104 CMR 30.03(5)(c)(1)(7).

4. Community: DMH child and adolescent programs licensed by DEEC

Child/adolescent community programs, including Clinically Intensive Residential Treatment Programs (CIRTs), must provide opportunities for the child/adolescent in their care for more than 45 days to learn the value of money through earning, spending, giving and saving.[26] The programs also must have written policies that address allowances.[27]

5. Financial Custodians

a. Guardians - A guardian is appointed by a court to make personal and/or financial decisions for the client if the client is not competent to make these decisions him/herself. A guardian can have general or limited authority. To determine the extent of a guardian's authority, the court decree or order appointing the guardian must be carefully reviewed. The kinds of limitations include: person only, estate only, specific treatment authority, etc. A guardian of a person can only make personal decisions (e.g., medical) for the individual. A guardian of the estate can only make financial decisions for the individual.

A guardianship can be temporary or permanent. To determine if a guardianship is still valid, the decree or order should be reviewed and/or legal counsel consulted. A temporary order, unless otherwise stated in the decree or order, expires ninety (90) days after the date of appointment.

For clients under the age of 18 years, the parent(s) is the custodian of the client unless a court determines that someone else should be the client's guardian. Once a client reaches the age of 18 years, he/she is considered legally competent and the law no longer considers his/her parent(s) a custodian, absent court appointment of the parent(s) as guardian of the person and/or estate. The client's change to legal adulthood happens automatically on the client's 18th birthday whether or not he/she is competent.

b. Conservators - A conservator's authority is limited to control over the client's financial resources. DMH does not have the authority to pursue a conservatorship, but some clients may have a conservatorship in place. A guardian of the estate has the same authority over a client's financial resources as a conservator. A conservatorship can be temporary or permanent. To determine if a conservatorship is still valid, the court order

[25] 104 CMR 30.03(5)(c)
[26] 102 CMR 3.07(8)(a)
[27] 102 CMR 3.07(8)(b)

or decree appointing the conservator should be reviewed and/or legal counsel consulted.

c. Representative Payees - A Representative Payee is appointed by the Social Security Administration (SSA) or the Veterans Administration (VA) to handle a client's Social Security or Veterans' benefits, which have been deemed dependent funds.

An adult who is unhappy with his/her Representative Payee can request that someone else be appointed. Such a request must be in writing and should be sent to the SSA or VA. It is best to have a replacement Representative Payee in mind, but the SSA or VA will provide assistance in locating a payee if the client has no one identified and is unable to locate an appropriate substitute Payee.

In the case of **minors**, the parent(s) with custody of the minor is the preferred Representative Payee. However, in some instances, another person will be appointed.

An adult who feels he/she no longer needs a Representative Payee may ask the SSA or VA to pay him/her directly. To become independent of a Representative Payee, a person must submit evidence to the SSA or VA demonstrating that he/she no longer needs assistance to manage his/her funds. Evidence may be in the form of a letter from his/her doctor or counselor stating that he/she can manage money to provide for his/her basic needs.

Any suspected abuse of a client's funds by a Representative Payee should be reported directly to the SSA or VA, in addition to other applicable reporting entities, such as the DMH or Disabled Persons Protection Commission or Elder Affairs. If fraud is suspected, the fraud office of the Inspector General can be contacted at 617-565-2662.

D. CLOTHING

1. Facility and community (DMH): general

A client in a facility or program has the right to wear his/her own clothing. However, a facility director or his/her designee may limit this right for good cause.[28] A statement of the reason(s) for limiting the right must be entered into the individual client's treatment record.[29]

[28] M.G.L. c.123, § 23
[29] *Id.*

2. Community: DMH child/adolescent programs licensed by DEEC

DEEC licensed child and adolescent residential programs must furnish residents with clean, adequate, and seasonable clothing as required for health, comfort and physical well being.[30] In addition, a minor in a program is entitled to participate in the selection and wearing of his/her own clothes that are appropriate to age, sex, and individual needs. Upon discharge, the minor may keep this clothing.[31]

E. COMMERCIAL EXPLOITATION

1. Facility and community: general

Commercial exploitation of clients is not acceptable.[32]

Commercial exploitation occurs when someone other than the client stands to gain from the use of a client's image(s) in advertising or other publications.

Before using the client's name, image, or personal information in commercial publications, mass media, and/or other types of publications, express written permission from the client and, if applicable, his/her guardian, must be obtained. Publications for the purpose of research, fund-raising and publicity also are subject to this rule.

2. Community: DMH child/adolescent programs licensed by DEEC

These programs shall not allow a client to participate in any activities unrelated to the client's service plan without the written consent of the parents or a person other than the parent with custody of the child, and the written consent of the client if over 14 years of age. Among the activities to which this applies are research, fund-raising and publicity, including photographs and/or mass media communications.[33]

F. COMPLAINTS/ INVESTIGATIONS AND REPORTING ABUSE

1. Facility and community: general

DMH complaint, investigation and reporting regulations apply to DMH operated, licensed and contracted for facilities and programs.[34] The regulations define the "person in charge" as the person with day-to-day responsibility for the facility or program or his/her designee.

[30] 102 CMR 3.07(4)
[31] 102 CMR 3.07(4)(c) and (d)
[32] 104 CMR 28.03(1)(f) and DMH Policy #03-1, (V)(C)(1) (p. 7)
[33] 102 CMR 3.06(10)
[34] 104 CMR 32.01(1)(a)

2. Informal resolution of complaints

If a client, family member or other person has a human rights concern, that individual may file a formal complaint with the person in charge of the program or facility or may seek to address the concern informally.

The client (or other person acting on behalf of the client) may seek the assistance of the Human Rights Officer for advice or advocacy in resolving a concern informally. The role of the Human Rights Officer is to advocate for the client. In some situations, the Human Rights Officer may be able to negotiate a resolution satisfactory to the client. For example, the Human Rights Officer may be able to determine whether the client has a particular right under DMH regulations or policy and if so, then he/she may be able to educate the staff regarding this right. Also, the Human Rights Officer may be able to discuss an issue separately with staff and find out whether there may be an alternative solution satisfactory to both the client and the staff.

However, regardless of what informal mechanisms are available to the client, the client always retains the right to file a formal complaint with the person in charge of the program or facility regarding any matter which the client believes is dangerous, illegal or inhumane. A complaint should always be filed regarding an allegation of abuse or other serious human rights violation so that any necessary corrective action can be taken. The Human Rights Officer and other program and facility staff should be available to help a client file a complaint.

3. Filing a complaint with the person in charge

A client (regardless of age or competence) or any other person, at any time, may make an oral or written complaint to the person in charge of the program/facility, alleging a dangerous, illegal or inhumane incident or condition**. (** See Appendix 5, the DMH complaint form). The form is also available on the DMH website. The use of this form is not required.

The regulations further provide that an employee has a responsibility to file a complaint with the person in charge, if the employee has reason to believe that there has been a dangerous, illegal or inhumane incident or there exists a dangerous, illegal or inhumane condition.[35]

The person in charge of the program/facility must ensure the complaint forms and appeal forms are available at well-identified locations and are provided to individuals upon request.[36] A notice of the availability and general content of the DMH complaint process must be "conspicuously posted" at the program or facility and must be given to each client and any guardian upon admission.[37]

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[35] 104 CMR 32.05(1)(c)
[36] 104 CMR 32.05(2)(b)
[37] 104 CMR 32.05(2)(a)

The DMH regulations provide that the program/facility's Human Rights Officer has a responsibility to assist clients in filing complaints and must use best efforts to ensure that an incapable client's interests are protected through representation by an independent attorney or advocate, if necessary or appropriate.[38] The regulations require that staff help clients file complaints upon the client's request.[39] Employees have this responsibility regardless of their views about the appropriateness of a complaint.

4. Complaint procedure under the DMH regulations

(Refer to the Office of Investigation diagram on the complaint process in Appendix 6.)

a. Person in charge - Once a complaint is filed, the DMH regulations require the person in charge of the facility/program or his/her designee to **either**:

   i. conduct the necessary fact finding, and issue a written decision within ten (10) days[40] (The decision must notify the parties of the right to request reconsideration and the right to appeal); **or**
   ii. refer the complaint to the DMH Central Office, if the complaint falls within any one of the following seven categories:
      - medicolegal death;
      - sexual assault or abuse;
      - physical assault or abuse;
      - attempted suicide which results in serious physical injury;
      - commission of a felony;
      - restraint or seclusion practice not in accordance with DMH regulations which results in serious physical injury; or
      - the person in charge believes that the complaint is sufficiently serious or complicated as to require an investigation by the DMH Office of Investigations even though the complaint does not fall within one of the other six categories listed above.[41]

b. Central Office - The complaints referred to the DMH Central Office are sent to either**:**

   i. the Office of Investigations (if the complaint involves a program or facility operated or contracted by DMH) or
   ii. the Director of Licensing (if the complaint involves a facility that is licensed by DMH, but not under contract with DMH). The Director of

[38] 104 CMR 32.05(3)

[39] 104 CMR 32.05(1)(a)

[40] 104 CMR 32.05(2)(c)

[41] 104 CMR 32.05(2)(d)

Licensing coordinates the investigation of these complaints with the Office of Investigations.[42]

These complaints must be investigated within 30 days (unless an extension is granted).[43] An Area Director, Assistant Commissioner of Child and Adolescent Services, or Director of Licensing will issue a written decision on the complaint within 10 days of the receipt of the investigation report.[44]

c. Reconsideration - After the person in charge (DMH Area Director, Assistant Commissioner of Child/Adolescent Services or Director of Licensing) makes a written decision regarding the complaint, any party to the complaint may request in writing, reconsideration of the written decision. The request must be made within ten days of receipt of the decision. The request for reconsideration must assert that there was a failure either to interview an essential witness or to consider an important fact or factor.[45]

d. Right to appeal - In addition, the client or any individual or entity acting on behalf of a client may appeal the written decision to DMH. The person within DMH to whom the client may appeal will vary depending on who issued the written decision.[46] See Appendix 6 for a diagram of the complaint process.

5. Retaliation prohibited

The regulations explicitly prohibit retaliation against any person who files a complaint with DMH pursuant to 104 CMR 32.00.[47] The DMH Human Rights Policy #03-1 (p.13) describes the process that is to be followed if retaliation is believed to have occurred.

6. Other reporting of abuse and neglect

In addition to filing a DMH complaint, many staff who work in a mental health facility or program are required to report immediately any alleged incidents of abuse and neglect to certain state agencies. (See the section in this Handbook entitled "Mistreatment" (p. 33) for additional information regarding what might constitute abuse.)

a. Adults 18 - 59 - All DMH staff must report to the **Disabled Persons Protection Commission (DPPC)** any act or omission which results in

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[42] 104 CMR 32.03(3)
[43] 104 CMR 32.05(5)
[44] 104 CMR 32.05(6)(b)
[45] 104 CMR 32.03(5)
[46] 104 CMR 32.03(6)
[47] 104 CMR 32.03(7)

serious physical or emotional injury to a client aged 18 through 59, inclusive. A written report also must be filed. [48]
(**The 24-hour DPPC hotline phone number is 1-800-426-9009, or call DPPC at 1-617-727-6465** during regular business hours.)

b. Minors (under age 18) - All DMH staff working in children's units or programs must report the abuse or neglect of minors to the **Department of Social Services** (**1-800-792-5200).** A written report also must be filed.[49]

Sometimes an adult client will provide information regarding the abuse of a child. Certain staff working with adult clients are mandated reporters of the abuse or neglect of minors, if their work falls into a specific category including, but not limited to: hospital personnel engaged in examination, care or treatment; psychologists; nurses; social workers; allied mental health and human services professionals; and psychiatrists. A written report also must be filed.[50]

If the work of a DMH employee who works with adult clients does not fall into one of the categories specified in the statute, this does not mean that information regarding abuse should be ignored. The employee should speak with his/her supervisor, and it may be helpful to contact the DMH Legal Office.

c. Adults 60 or older **-** The statute authorizes and requires mandated reporters to contact the **Executive Office of Elder Affairs (1-800-922-2275)** regarding the abuse, neglect or financial exploitation of persons aged 60 and over. Mandated reporters are employees holding certain specific job titles, including, but not limited to, the following: social worker, physician, nurse and licensed psychologist. **Mandated reporters also must file written reports**.[51]

Note: Any other person (i.e., a client, family member, advocate or friend) also may file a complaint of abuse or neglect with the agencies listed above.

Community: DMH child/adolescent programs licensed by DEEC

In addition to the above DMH process, any person may file a complaint that affects the health, safety or welfare of a minor in an DEEC licensed program. To find out which regional licenser to contact, call the DEEC at 1-617-988-6600.

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[48] M.G.L. c. 19C, §§ 1 and 10

[49] M.G.L. c. 119, § 51A
[50] *Id.*
[51]M.G.L. c. 19A, §§ 14 and 15

Privacy Complaints[52]

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law (Public Law 104-191) that, in part, protects both an individual's right to keep and/or transfer his/her health insurance when moving from one job to another, and the privacy of the individual's Protected Health Information (PHI). In addition to HIPPA, there are state statutes and regulations that protect the privacy of client information. In some instances, these are more restrictive than HIPPA as to how information can be used.[53]

Questions regarding privacy can be directed to the DMH Privacy Officer who can be reached by e-mail at PrivacyOfficer@DMH.state.ma.us or by telephone at 1-617-626-8160. Also, additional information regarding privacy can be found in Section IV. X. of this Handbook (entitled "Record Access").

An individual whose Protected Health Information (PHI) is created and/or maintained by DMH or his/her Personal Representative may file a Privacy Complaint at any time concerning:

a. DMH's response to his/her request:
   i. to access PHI;
   ii. for restrictions on the use and/or disclosure of PHI;
   iii. for confidential communications;
   iv. to amend PHI; and/or
   v. to receive an audit trial of the disclosures of PHI made by DMH.
b. DMH's PHI privacy policies and procedures; and
c. DMH's compliance with its PHI privacy policies and procedures including, but not limited to, concerns about the maintenance and unauthorized uses and/or disclosures of PHI.

Any individual whose PHI is created and/or maintained by DMH or his/her personal representative may file a Privacy Complaint. All complaints must be in writing. The DMH 104 CMR 32.00 complaint form may be used to file a Privacy Complaint. A Privacy Complaint may be filed at any DMH Area or Site Office, Facility or State-operated Program or with the DMH Privacy Officer. All Privacy Complaints will be treated as 104 CMR 32.00 complaints until determined to be a Privacy Complaint only. If a Privacy Complaint also is a 104 CMR 32.00 complaint and/or is filed in conjunction with a 104 CMR 32.00 complaint, the Privacy Officer, or designee, will work with the applicable 104 CMR 32.00 investigator and will follow 104 CMR 32.00 timelines for investigating and responding to the complaint. Similarly, if a privacy portion of a complaint is substantiated, the Privacy Officer, or designee, will coordinate decisions regarding the corrective actions to be taken with the applicable

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[52] Detailed information can be located in DMH's Privacy Handbook. The privacy complaint process is addressed in Chapter 16 of said handbook.
[53] Key state provisions for programs and facilities are M.G.L. c. 123, §36; 104 CMR 27.17 (facilities); and 104 CMR 28.09 (programs)

104 CMR 32.00 decision-maker.

With regard to a complaint that is a Privacy Complaint only, the DMH Privacy Officer or designee will determine if a violation of the DMH's privacy policies and procedures occurred; and/or if the DMH policies and procedures are inconsistent with state or federal law; and what course of action is to be taken in response to a Privacy Complaint. The time frames for processing 104 CMR 32.00 complaints shall be used for processing all Privacy Complaints. A privacy complaint shall not be deemed "out of scope" until after a fact-finding or investigation occurs. It is believed that most Privacy complaints will require fact-finding rather than an investigation.

Complaint Outcomes:

At the completion of the fact-finding or investigation, the Person in Charge shall consult with the DMH Privacy Officer as to whether a privacy violation occurred and if so, the appropriate sanctions and /or corrective actions that should be taken.

The Person in Charge shall send a decision letter to the complainant. The decision letter will serve as both DMH's response to the Privacy Complaint and, where applicable, a 104 CMR 32.00 complaint A copy of the decision letter concerning a Privacy Complaint must be sent to the DMH Privacy Officer.

Written notice of the findings and corrective action(s) to be taken shall be given to all appropriate DMH managers and officers, including, but not limited to, any appointed fact finder. Written notice also shall be provided to the individual or Personal Representative who filed the Privacy Complaint.

Privacy Complaints also may be filed with the Secretary of Health and Human Services, Office for Civil Rights, U.S. Department of Health and Human Services, JFK Federal Building, Room 1875, Boston, MA 02203. The procedures for filing a complaint with the U.S. Department of Health and Human Services and a copy of its complaint form can be found at http://www.hhs.gov/ocr/privacyhowtofile.htm.

Retaliation is prohibited against any party for filing a Privacy Complaint or for exercising rights under the provisions of HIPAA and/or DMH Policy #03-02 (Management of Protected Health Information).

G. CONTRACT

Facility and community: general

An adult client has the right to enter into a contract unless a court has limited the right and/or declared the client to be incompetent.

State law and regulation prohibit deeming an individual incompetent to enter into a contract based solely on the fact that the individual has been admitted to a program or admitted or committed to a facility.[54]

H. DIET

Facility and community: general

DMH Policy #03-1 states that programs and facilities that provide meals as part of their service are responsible for providing a nutritious diet consistent with medical requirements and the clients' religious and cultural beliefs and, to the extent possible, in accordance with personal preferences.

I. DISCRIMINATION

1. Facility and community: general

Every client has the right to be free from any unlawful discrimination including, but not limited to, discrimination on the basis of race, color, national origin, religion, gender, sexual preference, language, age, veteran status, disability or HIV status.[55]

A person may not be excluded, denied opportunities or benefits, or otherwise discriminated against because he/she had, currently has, or is regarded as having a mental illness or physical disability. Federal and state laws prohibit disability-based discrimination in housing, employment, places of public accommodation (such as restaurants, movie theatres and banks), health care facilities and other services and benefits generally offered to the public. **Persons who feel they may have been discriminated against should be referred to a legal advocacy organization for assistance.**

2. Housing

A landlord may not deny housing to someone because of the individual's mental illness, history of mental illness or physical disability. Federal law also protects

[54] MGL 123, § 24; 104 CMR 27.13(1); and 104 CMR 28.10(1)
[55] DMH Human Rights Policy #03-1, (V)(A) (p.5)

persons from housing discrimination. [56] The landlord has a responsibility to make a reasonable accommodation to its rules, policies, practices, services and the premises if necessary to allow the tenant full use and enjoyment of the apartment. The landlord does not have to make an accommodation if it would impose an undue hardship on the landlord.[57]

An accommodation, when reasonable, might include relocating the tenant within the building, inserting soundproofing materials in the apartment, educating security persons regarding any special needs of a tenant with mental illness, allowing the tenant sufficient time and opportunity to obtain counseling or other assistance, or making a reasonable modification to the normal rules or expectations in the apartment building. With an accommodation, the tenant must be able to meet the usual requirements of tenancy, such as timely payment of rent.

<u>Community Residence Tenancy Act:</u> This law is intended to ensure that clients are protected from inappropriate evictions from community residential programs that are outside the traditional landlord-tenant relationship. The law provides clients with a hearing before an impartial hearing officer who must determine whether a proposed eviction is proper. [58] (See appendix 7 for more information on this policy and when this law can be applied.)

3. Employment

State and federal laws also prohibit discrimination against people with mental illness, history of mental illness or physical disability in regard to employment. To be protected, the person must be able to perform the essential functions of the job he/she desires or holds with or without a reasonable accommodation. The employer need not make an accommodation if it would impose an undue hardship on the employer or other employees.[59] An accommodation might include restructuring the job, allowing a job coach to assist the employee, allowing employees to modify work schedules, or permitting the employee additional time off to seek counseling or other treatment or assistance. Medication monitoring is not considered a reasonable accommodation, so an employee cannot be forced to take medicine or face workplace discipline. Asking that a current supervisor modify supervision methods may be a reasonable accommodation, but asking for a new supervisor is not considered reasonable. To seek reasonable accommodation, a person need not use that term, but may express his/her need for a workplace adjustment. An applicant or employee may be asked to document the disability and the need for reasonable accommodation. If an applicant or

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[56] M.G.L. c. 151B, § 4(6-7), prohibiting discrimination in all rental housing other than owner-occupied two-family housing; Federal Fair Housing Act, 42 U.S.C. 3601 et seq.

[57] M.G.L. c. 151B, § 4subs.7A

[58] M.G.L. c. 186, § 17A

[59] M.G.L. c. 151B, § 1(16-17) and § 4(16). This law does not cover employers with fewer than 6 employees. M.G.L. c. 151B, § 1(5); See also the Americans with Disabilities Act.

employee with a mental illness does not need reasonable accommodation, he/she is not required to share information regarding his/her condition.

4. Places of public accommodation

All public buildings are required to comply with the Americans with Disabilities Act (ADA) with regard to wheelchair accessibility. In a facility or in a program, clients and their visitors need to be able to meet in private in a space that accommodates a wheelchair.

J. EDUCATION

1. Facility and community: general

Every client under the care of DMH has the right to education and training, as specifically defined below.

2. Instruction and education

In cooperation with other state agencies, DMH shall arrange for instruction and education for clients in its facilities as may be appropriate for such persons to undertake, especially if the person is unable to engage in programs for patient-trainees.[60]

3. Patients under the age of 22

Individuals under the age of 22 who are in DMH facilities shall receive education and training appropriate to their needs in accordance with M.G. L. 71B and the related regulations.[61] See also Appendix 3 for educational advocacy resources.

4. Community: DMH child/adolescent programs licensed by DEEC

Residency programs licensed by DEEC must describe in writing a plan for identifying and meeting the educational needs of the residents served. The program must arrange for the education of each resident, in compliance with federal, state and local law, as appropriate to the needs of each resident and consistent with the individual education plan.[62]

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[60] M.G.L. c. 123, § 29
[61] 104 CMR 27.13(4)
[62] 102 CMR 3.06(5)

K. HABEAS CORPUS

Any person involuntarily committed to a facility who believes, or has reason to believe, he/she no longer should be retained may make written application to the Superior Court for a judicial determination of the necessity of continued commitment pursuant to M.G.L. c. 123, §9(b).[63]

L. HEALTH CARE PROXY

Facility and community: general

Any competent person **18 years of age or older** is allowed to make a health care proxy. A health care proxy is a legal document, but it does not have to be drafted or executed by a lawyer to be valid. However, it must conform to the requirements of M.G.L. c. 201D. By the proxy, the client names a health care agent who will make decisions for the client regarding medical and psychiatric care, if and when the client is not competent or able to communicate his/her own wishes and/or decisions.[64]

A client may revoke his/her appointment of a health care agent at any time.

A proxy can be specific or general. A client can give his/her health care agent specific instructions, general guidance, or no instructions or guidance in the proxy. For example, a client may inform the health care agent what his/her specific preferences are regarding antipsychotic medications. Also, a client may inform the health care agent about the kinds of treatment he/she wants to receive if he/she becomes terminally ill.

The decisions regarding whether or not to have a health care proxy and who is to be designated as the health care agent are entirely up to the client. In addition, the client may or may not choose to specify treatment preferences as part of his/her proxy. However, if no restrictions are in a proxy, a health care agent can make all health care decisions that otherwise could have been made by the client. This may include voluntary admission to a psychiatric hospital.[65]

Therefore, when completing a health care proxy, it is important for a client to discuss medical and psychiatric health care treatments, as well as voluntary psychiatric admission with his/her proposed health care agent. The client also should specify on the form whether or not he/she wants to limit the authority of the agent. **A client may object to a health care decision that is made by his/her agent. The client's decision will prevail unless the client is determined to lack capacity to make health care decisions by court order.[66]**

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[63] *See also* 104 CMR 27.13(8)
[64] M.G.L. c. 201D
[65] Cohen v. Bolduc, 435 Mass. 608 (2002)
[66] M.G.L. c. 201D

A health care agent may be a relative, a friend, or anyone on whom the client feels he/she can rely on who is willing to follow the client's choices and make decisions for the client when he/she cannot make them for him/herself. **Staff cannot be named as a client's health care agent.**

For more information about health care proxies, clients may contact the Human Rights Officer at a program or facility or DMH's Office of Consumer and Ex-Patient Relations: 1-800-221-0053. They can assist a client in obtaining a health care proxy form or contacting someone else knowledgeable about a health care proxy.

M. HOLD AND CONVEY PROPERTY

Facility and community: general

An adult client has the right to hold and convey property unless a court has limited the right and/or declares the client to be incompetent.

State regulation and the DMH Human Rights policy prohibit deeming a client incompetent to hold and convey property based solely on the fact that the client has been admitted to a program or admitted or committed to a facility.[67]

N. HUMANE PSYCHOLOGICAL AND PHYSICAL ENVIRONMENT

(See Appendices 2a and 2b "Five Fundamental Rights" Law)

Facility and community: general

Every client in a facility or a residential program has the right to a humane psychological and physical environment, such as living quarters and accommodations which afford privacy and security in resting, sleeping, dressing, bathing and personal hygiene, reading, writing, and toileting. Nothing in this section shall be interpreted to require individual sleeping quarters.[68]

Every client should experience an environment where he/she is treated skillfully, professionally and with dignity and respect. Clients' values and differences, including cultural, sexual and religious preferences need to be respected. Clients may not be verbally, physically, psychologically or sexually abused or neglected. Clients also have the right to not be humiliated. The strengths of clients should be emphasized while fostering their dignity and autonomy.

Humane physical quarters include facilities and programs that are not overcrowded and meet, or exceed, applicable state code standards for housing.

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[67] 104 CMR 27.13(1) and DMH Policy #03-1, (V)(A) (p. 4)

[68] M.G. L. c. 123, § 23(d)

Community: DMH child/adolescent programs licensed by DEEC

When contracting with a child/adolescent program, DMH must insure that the program allows the DMH child/adolescent the right to a humane psychological and physical environment in accordance with the Five Fundamental Rights Law.

O. INFORMED CONSENT

1. Facility and community: general

Every client has the qualified right to control his/her own treatment and services and to request alternative or additional treatment or services.

DMH is committed to the universal application of the practice of informed consent to safeguard human rights and to promote an optimal health care environment.

The doctrine of informed consent, clearly set forth in DMH regulation and policy, means that the acceptance or rejection of treatment must be based upon a voluntary and informed decision. Informed decision-making is based upon a person's ability to understand the risks and benefits of the proposed treatment as well as the alternatives, including no treatment.

To be voluntary, a decision must be made freely, without coercion or threats. Every adult is presumed competent to make an informed decision. A minor (excluding emancipated and/or mature minors), by reason of age, is presumed incompetent except in very limited situations (See #6, p. 28, Minors). A competent client may make treatment decisions on his/her own behalf. For a client deemed legally incompetent by reason of age or mental status, informed consent to treatment must be obtained through an alternative process, which may involve parents, guardians or, in some circumstances, a judicial determination.

Every consent form signed by a client shall be placed in his/her record. A copy of the consent form must be given to the client. If the client gives verbal consent, this must be noted on the consent form by the clinician.[69]

2. When informed consent must be obtained

According to DMH policy, no psychiatric treatment can be administered or performed without a client's informed consent, or that of his/her legally authorized representative, or with court approval.[70]

Specific informed consent must be obtained from the client, his/her legally authorized representative, or a court of competent jurisdiction for treatment with antipsychotic medication, electroconvulsive treatment (ECT), psychosurgery,

[69] DMH Policy #96-3R (p.5)
[70] 104 CMR 27.10(1)(a) (inpatient) and 104 CMR 28.03(1)(j) (community)

involuntary sterilization or abortion, and other highly intrusive or high-risk interventions.[71] In the case of an adult client incapable of giving informed consent, these interventions may not be administered or performed without prior review and approval by a court or without the consent of a client's legally authorized representative, who must have been granted specific authority by a court to authorize such treatment(s) or procedure(s).

3. Right to refuse psychiatric treatment

Absent a determination by a judge that a client is incompetent, court approval of his/her treatment, or appointment of a guardian to consent to the client's treatment, a client retains the right to accept or refuse treatment. A client temporarily may lose the right to refuse treatment only in rare circumstances where a clinician determines that the client is incompetent and that the treatment is necessary to prevent an immediate, substantial, and irreversible deterioration of his/her mental illness.[72]

While the DMH regulations described above require informed consent for antipsychotic medications, DMH Policy #96-3R extends these same informed consent principles to all psychiatric medications. This policy applies to all DMH-operated and contracted facilities and programs.

Finally, DMH expects that the client and clinician will discuss all proposed treatments, even if a court or a legally authorized representative is providing the informed consent.

4. Obtaining valid informed consent

According to the DMH Informed Consent Policy, the informed consent process must include the following elements:

a. an assessment of the client's ability to appreciate and have insight into the fact that he/she has a mental illness, to understand that there is a treatment that might help, and to have the capacity to recognize and report side effects;
b. a description of the condition being treated;
c. an explanation of the proposed treatment;
d. an explanation of the risks, side effects and benefits of the proposed treatment;
e. an explanation of alternatives to the proposed treatment as well as the risks, benefits and side effects of the alternatives to the proposed treatment;
f. an explanation of the right to freely consent to or refuse the treatment without coercion, retaliation or punishment, including loss of privileges, threat/use of restraints, discharge, guardianship or Rogers orders. Such

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[71] 104 CMR 27.10(1)(b) (inpatient) and 104 CMR 28.03(1)(j)(1) (community); *See also* Rogers v. Commissioner of the Department of Mental Health, 390 Mass. 489 (1983)
[72] 104 CMR 27.10(1)(d)

interventions only may be utilized in accordance with applicable legal and clinical standards. When a competent client refuses a recommended treatment, a clinically appropriate alternative treatment that is acceptable to the client, including no treatment, shall be explored and offered where possible;

g. an explanation of the right to withdraw one's consent to treatment, orally or in writing, at any time; and
h. a set of materials provided to the client that are written in common, everyday language, and explain the benefits, risks and side effects of the prescribed medication.[73]

5. Routine and preventive treatment

Routine and preventive treatments include standard medical examinations, clinical tests, standard immunizations and treatment for minor illnesses and injuries.

a. Facility DMH regulations provide that a client who is capable of giving informed consent regarding routine and preventive treatment has the right to refuse such treatment. However, the facility director, without special court authorization, may override the refusal when the treatment consists of:
   i. a complete physical examination and associated routine laboratory tests, required by law to be conducted upon admission and at least annually thereafter; or
   ii. immunizations or treatment required by law or necessary to prevent the spread of infection or disease.[74]

b. Community: general DMH regulations provide that if the client has been found to be incapable at his/her last periodic review and has no legally authorized representative, the program director may consent to routine or preventive medical care, including standard medical examinations, clinical tests, standard immunizations and treatment for minor illnesses and injuries. However, such medical care may only be authorized upon recommendation by the treating physician that such care is necessary and appropriate, and provided that:
   i. the client agrees to such care;
   ii. the client is not a minor or under guardianship; [75]

[73] DMH Policy #96-3R, (V)(B) (pp.3-4)
[74] 104 CMR 27.10(3)
[75] 104 CMR 28.03(1)(j)(2)

6. Minors

a. General Parents of **minors** retain the authority to give informed consent on behalf of their child, unless the court has appointed someone else as guardian.

b. Electroconvulsive treatment Electroconvulsive treatment is prohibited for clients under the age 16 years unless the DMH Commissioner or designee authorizes its use.[76]

c. Consent of guardian – exceptions Consent for the treatment of clients under 18 years of age must be obtained from the Legally Authorized Representative (LAR) with the following exceptions:

i. Mature Minor - Pursuant to the "mature minor" rule, a facility or program may administer treatment on the basis of a minor's (rather than the parents') consent and must honor the minor's right to refuse treatment unless there is an emergency or court order. The "mature minor" rule was first articulated by the Supreme Judicial Court of Massachusetts when it concluded that where the minor is "capable of giving informed consent to treatment," and it is not in the best interests of the child to notify the parents of the intended treatment, the "mature minor" rule may apply. [77]

Note: This determination rarely is made and only should be made in consultation with legal counsel.

ii. Emancipated Minor –An "emancipated minor" is considered an adult for purposes of the informed consent rule. According to state law, an "emancipated minor" is a person under the age of 18 who is:

- married, widowed or divorced; or
- the parent of a child; or
- a member of the armed forces; or
- pregnant or believes herself to be pregnant; or
- living separate and apart from a parent or legal guardian and managing his/her own financial affairs; or
- has or reasonably believes he/she has a disease dangerous to the public health or is drug-dependent. Minors in this category may consent only to medical care related to the specific disease or drug dependency.[78]

Required by law - In certain circumstances, state law specifically allows minors to give consent to treatment (e.g. HIV testing). See M.G.L. c.112,

[76] 104 CMR 27.10(2)(a)
[77] Baird v. Attorney General, 371 Mass. 741 (1977) and 104 CMR 25.03
[78] M.G.L. c. 112, § 12F

§§12E and F. Additionally, as discussed in Section IV.B.3. of this Handbook, 16 and 17-year-olds have the right to sign themselves in and out of psychiatric facilities.

Community: DMH child/adolescents programs licensed by DEEC

A resident of these programs age 12 and older, consistent with his/her ability to understand, must be informed of the treatment, risks and any potential side effects of anti-psychotic medications that have been prescribed for that resident.[79]

7. Guardianship

A guardianship is a legal relationship between a court-appointed individual (guardian) and an individual (ward) who was deemed by the court to be legally incompetent to manage his/her own personal and/or financial affairs. The authority of a guardian depends on the court order or decree appointing him/her. A guardianship remains in effect until vacated by the Court or the death of the ward. See Section IV.C. 5 (p. 11) of the Handbook for more information on guardians.

8. Rogers Monitors

A Rogers monitor is appointed when a Probate and Family Court judge authorizes the use of antipsychotic medication after a finding that the client is incapable of giving informed consent for the use of antipsychotic medications. The monitor's duty it is to ensure that the antipsychotic medication treatment plan approved by the Court is followed. A review of the treatment plan is done on a periodic basis at which time the treatment plan is extended, amended, and/or revoked by the Court.[80]

9. 8B authorizations to treat (facility only)

An 8B Authorization to Treat is an order of a District Court made after entry of an order for involuntary commitment and a finding by the Court that the client is incapable of giving informed consent (incompetent) to the administration of antipsychotic medication or other medical treatment for mental illness. It is limited to the Court's authorization of a specific treatment plan designed to treat the person's psychiatric condition. The authority of this treatment order dissolves upon the client's discharge from the facility or upon conversion of the client's legal status to "voluntary" while at the facility. [81]

[79] 102 CMR 3.06(4)(k)(3)(e)
[80] M.G.L. c. 201, §§ 6 and 14
[81] M.G.L. c. 123, § 8B

P. INTERPRETER SERVICES

1. Facility: general

DMH is committed to providing services that are culturally and linguistically appropriate at all times. Each facility must provide competent interpreter services for every non-English speaking, deaf or hard-of-hearing client.[82]

2. Definitions

a. Facility means:
   i. DMH-operated hospital; or
   ii. DMH-operated Community mental health center with inpatient unit; or
   iii. DMH-operated psychiatric unit within a public health hospital; or
   iv. DMH licensed psychiatric hospital; or
   v. DMH licensed psychiatric unit within a general hospital.[83]

b. Competent interpreter services means interpreter services performed by a person who is:
   i. fluent in English and in the language of a non-English speaker; and
   ii. trained and proficient in the skill and ethics of interpreting; and
   iii. knowledgeable about the specialized terms and concepts that need to be interpreted for purposes of receiving care or treatment.[84]

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

3. Additional guidelines

a. Family members or friends are not encouraged to act as interpreters and minor children shall not be used as interpreters other than in exceptional circumstances.

b. There must be written notification and a posting in the client's primary language of the right to and availability of interpreter services.

c. The Americans with Disabilities Act (ADA) requires that reasonable accommodations be made for individuals with disabilities. With regard to interpreter services, the ADA does *not* apply to LEP (Limited English Proficiency) individuals who need a spoken language interpreter for communication. It *does* apply to individuals who are deaf or hard-of-hearing and who need a sign language interpreter or an assistive device for communication.

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[82] M.G.L. c. 123, § 23A
[83] 104 CMR. 27.18(1)(b)
[84] 104 CMR 27.18(1)(a)

d. Section 504 of the Rehabilitation Act of 1974 also applies to individuals who are deaf or hard-of-hearing.

Note: For general information regarding available translations and interpreters (both spoken and sign language), contact the DMH Office of Multicultural Affairs at 617-626-8134.

Q. LABOR

1. Facility and community: general

Although clients may be asked to carry out tasks and activities related to daily living, they may not be required to perform unpaid labor. Clients may choose to perform additional work that is to be compensated according to applicable state and federal laws. Examples of daily tasks for which clients are not required to be compensated include maintaining a neat and clean living space and doing one's own laundry when facilities are available.

2. Facility

State law authorizes DMH to establish programs at its facilities for patients who would benefit from performing work/tasks. Such work and tasks are to be compensated according to payment schedules established by DMH in its regulations.[85]

3. Community: adult

a. In an adult program, no client shall be required to perform labor that involves the essential operations and maintenance of the program or the regular care, treatment or supervision of other clients, provided that,

i. in community residential or alternative programs, clients may be required to perform normal housekeeping and home maintenance functions; and

ii. clients may perform labor in accordance with a planned and supervised program of vocational and rehabilitation training as set forth in the client's treatment plan. Such labor shall be compensated to the extent of its economic value.[86]

b. Federal and state laws relating to wages, hours of work, workmen's compensation and other labor standards are to be followed to the extent that they apply to such required and voluntary labor.[87]

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[85] M.G.L. c.123, § 29
[86] 104 CMR 28.07
[87] *Id.*

4. Community: DMH child/adolescent programs licensed by DEEC

Programs must have a written plan that addresses meeting residents' vocational preparation needs. Programs must assist each child in their care for more than 45 days, assessing his/her vocational needs.[88] Each child must be fully involved in his/her vocational evaluation and the development of a vocational plan.[89]

R. LICENSES: PROFESSIONAL, OCCUPATIONAL OR VEHICLE

1. Facility and community: general

Every client has the right to hold professional, occupational and driver's licenses unless age, limitation by the licensing agency or order of a court of competent jurisdiction precludes the exercise of this right.

State law and regulation prohibit considering an individual incompetent to hold a professional, occupational or driver's license, based solely on the fact that the individual has been admitted to a program or admitted or committed to a facility. [90]

S. MAIL

(See Appendices 2a and 2b-"Five Fundamental Rights" Law)

1. Facility and community: general

According to the Five Fundamental Rights Law, every client has the right to send and receive sealed, unopened, uncensored mail. In addition, every client must be provided with a reasonable amount of writing materials and postage, and reasonable assistance in writing, addressing and mailing letters and other documents, upon request.[91]

2. Facility

a. Limiting this right in a facility

Only the director of a facility or designee may limit this right when there is good cause to believe that the mail may contain contraband. In this instance, facility staff, for the sole purpose of preventing the transmission of contraband, may open and inspect the item of mail **in front of the patient.** Staff may not read the content of the correspondence.[92] There must be documentation of specific facts in the patient's record if this right is limited.

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[88] 102 CMR 3.06(6)
[89] 102 CMR 3.06(6)(b)
[90] M.G.L. c.123, § 24; 104 CMR 27.13; and 104 CMR 28.10(1)
[91] M.G.L. c. 123, § 23
[92] *Id.*

b. <u>Contraband</u>

Although not specifically defined in the law, DMH policy defines contraband as "any substance or article that is likely to cause harm to the patient or others, that violates facility infection control requirements, or otherwise is illegal."[93] Facilities must have procedures for disposing of or returning contraband. [94]

3. Community: general

The right to send and receive unopened and uncensored mail cannot be restricted in community programs.

4. Community: DMH child/adolescent programs licensed by DEEC

When contracting with a child/adolescent program licensed by DEEC, DMH must insure that the program allows DMH child/adolescent clients to send and receive sealed, unopened, uncensored mail in accordance with the Five Fundamental Rights Law.

T. MARRIAGE

1. Facility and community: general

Adult clients retain the right to marry unless a court of competent jurisdiction makes a determination to the contrary.[95] In general, a person must be 18 years or older to marry in Massachusetts. However, there are exceptions that would allow a minor to marry, such as with parental or guardian permission or a court order. Contact legal counsel for clarification.

State regulation prohibits deeming a client incompetent to marry based solely on the fact that the client has been admitted to a program or admitted/committed to a facility.[96]

U. MISTREATMENT

1. Facility and community: general

Program and facility staff may not mistreat a client or permit mistreatment of a client by staff, other clients or others. Mistreatment includes any intentional or

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[93] DMH Policy #98-3, (p. 1)
[94] *Id.(p.6)*
[95] 104 CMR 27.13(1) and DMH Policy #03-1(V)
[96] *Id.*

negligent act or omission that exposes a client to a serious risk of physical or emotional harm.[97]

DMH Community Regulations and DMH Policy #03-1 explicitly prohibit mistreatment of clients. Mistreatment includes, but is not limited to:

a. Corporal punishment or any unreasonable use, threat, or degree of force or coercion;
b. Infliction of mental or verbal abuse such as abusive screaming or name calling;
c. Incitement or encouragement of clients or others to mistreat a client;
d. Transfer or the threat of transfer of a client for punitive reasons;
e. The use of restraint as punishment or primarily for the convenience of staff; and/or
f. Any retaliation against a client for reporting any violation as defined in the DMH complaint regulations.[98]

Allegations of mistreatment must be treated and investigated as a DMH complaint.[99]

2. <u>Community: DMH child/adolescent programs licensed by DEEC</u>

DEEC regulations state: "[n]o program employee, member of the child care staff nor any other person with unsupervised access to residents shall inflict any form of physical, emotional or sexual abuse, or neglect upon a resident while in the program's care and custody."[100]

3. <u>Mandatory reporting of abuse and neglect</u>

See Section IV.F.6 of this Handbook entitled, COMPLAINTS/REPORTING ABUSE for additional information regarding reporting mistreatment. (p. 16)

V. PERSONAL POSSESSIONS

1. <u>Facility and community: general</u>

Every client has the right to his/her own possessions, barring a threat to client safety. Massachusetts law affords clients the right to keep and use their own personal possessions, including toilet articles, and to have access to client storage spaces for private use.[101]

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[97] DMH Policy #03-1, (p.8)
[98] 104 CMR 28.04(1) and DMH Policy #03-1, (p. 7)
[99] 104 CMR 28.04(2) and DMH Policy #03-1, (p. 7)
[100] 104 CMR 3.07(1)
[101] M.G.L. c. 123, § 23

2. Facility

The facility director or designee may deny these rights for good cause. The good cause must be related to the likelihood of harm resulting from the client's having access to the possession. This determination must be made on an individual basis. The reasons for any such denial must be entered into the treatment record of the client whose possessions are being limited.[102]

3. Community: general

Regulations state that a program may not interfere with the right of the client to acquire, retain, and dispose of personally owned property unless:

a. the client is a minor, under guardianship or conservatorship, or has had a representative payee appointed; in accordance with the provisions of 104 CMR 30.03 (client funds in community programs); or
b. the client possesses contraband or any item prohibited by law; or
c. ordered by a court of competent jurisdiction; or [103]
d. possession poses an imminent threat of serious physical harm to the client or others.

In the event of a restriction of possession by a program on the grounds of imminent and serious physical harm, the program must issue a receipt to the client and safely store the object. Any restriction shall be documented in the client's record and subsequently reviewed and monitored by the Human Rights Officer and Human Rights Committee.

4. Community: DMH child/adolescent programs licensed by DEEC

Each individual in a residential program licensed by DEEC must be provided with personal grooming and hygiene articles.[104] He/she also must have accessible storage areas for these and other personal possessions[105]

W. PHYSICAL EXERCISE AND OUTDOOR ACCESS

1. Facility and community: general

Every client has the right to a reasonable opportunity for physical exercise and access to the outdoors consistent with requirements for safety.[106] Access to fresh air and exercise should be valued not only as a right, but also as a vital aid to a person's mental and physical health.

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[102] *Id.*
[103] 104 CMR 28.08(1)
[104] 102 CMR 3.07(5)(a)
[105] 102 CMR 3.08(7)(i)
[106] DMH Human Rights Policy #03-1, (p. 8)

2. Facility

Although this right applies to all settings, access to the outdoors is an issue that arises most often for clients in the inpatient setting. For individual safety reasons, an individual's access to the outdoors may be limited temporarily. Limits on outdoor access must be determined on an individual basis.

As soon as an individual's safety level is determined, increased freedom of movement should occur in accordance with the person's ability to safely manage it. Refer to DMH Policy #96-1, Patient Privileges, for additional guidance regarding increasing individuals' freedom of movement in facilities.

In addition, indoor alternatives for exercise, such as access to exercise equipment and/or groups that encourage movement and activity, should be made available to clients.

Staff convenience should not be a factor in limiting physical activities and outdoor access. Although DMH policy is not specific on this issue, it is recommended that any restriction to outdoor access be evaluated daily. At a minimum, daily access to the outdoors should be facilitated and consistent with assessed individual safety.

3. Community: DMH child/adolescent programs licensed by DEEC

DEEC licensed residential programs that serve clients for more than 72 hours must have a written plan that addresses meeting the recreational needs of the residents.[107]

X. RECORD ACCESS

1. In general

Clients, in general, have a right to access their records created and maintained by DMH. Also, clients have a right of privacy regarding said records, which are considered confidential. However, neither right is absolute; there are circumstances when a client's right to access may be limited and/or such records may be accessed by third parties.

In response to the Federal Health Insurance Portability and Accountability Act (HIPAA), DMH issued a policy on Management of Protected Health Information and developed a DMH Privacy Handbook.[108] Both the policy and the Handbook provide greater details on the material contained in this section of the DMH Human Rights Handbook. The policy and the Handbook also explain how state law, in some instances, supersedes HIPAA because state law offers more protection or more privacy.

[107] 102 CMR 3.06(7)
[108] *See* DMH Policy #03-2 and the DMH Privacy Handbook

2. Access by client to his/her records

a. Facility: Adult and Child/Adolescent A patient, or his/her Personal Representative (PR), has a right (subject to certain limitations) to access his/her record.[109] A PR is someone who is authorized to make healthcare decisions on behalf of the patient. Examples of a PR include a health care agent, a guardian, a parent, or the Department of Social Services (DSS), when they are authorized to make healthcare decisions.[110] Examples of information which may not be accessible are psychotherapy notes, "information compiled in reasonable anticipation" of court or administrative proceedings[111], forensic reports and records not used to make decisions about the patient.[112]

Denial of Access

A patient or his/her PR is allowed access to the patient's records absent a determination by the Commissioner or designee (who must be a licensed health care professional) that:

i. the inspection by the patient is reasonably likely to endanger the life or physical safety of the patient or another person;

ii. the record makes reference to another person (other than the health care provider) and is reasonably likely to cause substantial harm to such other person; or

iii. inspection by the legally authorized representative is reasonably likely to cause substantial harm to the patient or another person.[113]

If access to a record is denied based on one of the above criteria, the patient or PR shall be informed of the right to appeal. The individual making a determination on appeal must be a licensed health care professional, and such determination shall be final.[114]

There are some other circumstances under which an individual/PR does not have the right to access PHI. See DMH Privacy Handbook, chapter 11, II. B. 1. pp.1–2. These denials cannot be appealed.

[109] 45 CFR 164.524(a) and DMH Privacy Handbook c. 5(I)
[110] 104 CMR 25.03 (Definitions)
[111] 45 CFR 164.524(a) and the DMH Privacy Handbook c. 11(II)(B)(1)(c)
[112] DMH Privacy Handbook c. 5(II)(B)(1)&(3)
[113] 104 CMR 27.17(6)(c)(1-3)
[114] 104 CMR 27.17(6)(c)(3)

b. Facility: Child/Adolescent.
A facility director may require the PR's consent before permitting a patient under the age of 18 to inspect his/her own records. However, if the patient is 16 or 17 years old and admitted him/herself to the facility pursuant to M.G.L. c.123 §§ 10 and 11, then the patient may inspect records of the admittance without consent of the PR. [115] Also, a minor who, because he/she is emancipated is a mature minor pursuant to 104 MR 25.04, or by law consented to a treatment, has the right to access the PHI that DMH maintains relevant to such treatment.[116] Emancipated minor and mature minor are discussed under Informed Consent (p.28)

c. Staff Assistance:
Clinical staff of a facility may offer to read or interpret a record to a patient or PR. However, access may not be denied solely on the basis of a patient or PR declining the offer. [117]

d. Access to records in the community:
Records are available (or may be denied) to a client or his/her PR in the community to the same extent they are available (or denied) to a patient in a facility. (See above). [118]

3. Access by 3rd parties to records created or maintained by DMH

DMH records are private and not open to inspection by a third party except:

- upon a proper judicial order
- by an attorney of the patient or client
- when the Commissioner or designee makes a determination that it is in the best interest of the patient or client to permit inspection or disclosure
- certain disclosures to persons involved in the care of the individual
- certain instances involving whistleblowers or workforce members who are victims of crime
- as authorized by the individual
- disclosure for health oversight activities
- certain disclosures for research
- as required by law[119]

a. Proper judicial order. This term is defined in DMH regulations as "an order signed by a justice or special justice of a court of competent jurisdiction, or a clerk or assistant clerk acting upon instruction of such a justice."[120] A subpoena is **not** considered a proper judicial order and, therefore, is not sufficient authority to release Protected Health Information

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[115] *Id.*
[116] 104 CMR 25.04 and the DMH Privacy Handbook c.11(C)
[117] 104 CMR 27.17 (6)(c)(3)
[118] 104 CMR 28.09(1) and the DMH Privacy Handbook c.11(I)
[119] See M.G.L. c.123, § 36; 104 CMR 27.17(6); and 104 CMR 28.09(2)
[120] 104 CMR 27.17(6)(a) (facility) and 104 CMR 28.09(2)(a) (community)

(PHI).[121] If a subpoena for PHI is received, the DMH Legal Office should be consulted.

b. Attorney. An attorney for a patient/client may have access to the records of said patient/client. If the records are at a facility, the attorney should provide a written request for the individual's records as well as appropriate verification of the attorney-client relationship.[122] If the records are in the community, the attorney may be required to provide written authorization from the client or PR, if any, or a letter of appointment from the Court.[123]

c. Best interest determination: The Commissioner or designee may allow access to records to a third party based upon a "best interest determination." However, such access may only be given if the requirements of 104 CMR 27.17 or 28.09 are met. Such determination may only be made for treatment, payment or healthcare operation purposes. Examples of when a best interest determination could be made include:

   i. from a sending facility to a receiving facility for purposes of transfer pursuant to M.G.L. c. 123, § 3.[124];
   ii. to a physician or other health care provider who requires such records for the treatment of a medical or psychiatric emergency, provided that the patient/client is given notice of access as soon as possible;
   iii. to a medical or psychiatric facility currently caring for the patient/client, where the disclosure is necessary for the safe and appropriate treatment and discharge of the individual;
   iv. to persons involved in treatment or service where the individual has provided consent;
   v. between DMH and a contracted vendor regarding individuals being served by the vendor for purposes related to services provided under the contract;
   vi. to persons authorized by DMH to monitor quality control of services provided;
   vii. to enable patient/client, or someone acting on his/her behalf, to obtain benefits, protective services, or third party payment for services so rendered;
   viii. to persons conducting an investigation pursuant to 104 CMR 32.00;
   ix. to persons engaged in research if approved by DMH under 104 CMR 31.00;
   x. to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other accrediting bodies;

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[121] *Id.*; *See also* DMH Privacy Handbook c. 6(IV)(A)(5)(Note)
[122] 104 CMR 27.17(6)(b)
[123] 104 CMR 28.09(1)(c)
[124] 104 CMR 27.17(6)(g)(1)

xi. to DPH or local board of health consistent with 105 CMR 300.00 *et.seq*. regarding reports of communicable or other infectious diseases; and

xii. to coroner, medical examiner or funeral home director, in case of death.[125]

Information disclosed based upon a best interest determination must be limited to the minimum information necessary to achieve the purpose of the disclosure.[126]

Prior to making a best interest determination, "the Commissioner or designee shall have made a determination that it is not possible or practicable to obtain the informed written consent of the individual" or PR, if any.[127]

d. Required by law

Records may be disclosed if required by law. Disclosures that DMH or its workforce members are required to make include but are not limited to, the following:

i. Crimes Committed Upon Persons in care of Mental Health Facilities. MGL c.19, §10
ii. Transfer Notices. M.G.L. c.123, §3
iii. Periodic Review Notices. M.G.L. c.123, §4
iv. Commitment Petitions/Appeals. M.G.L. c.123, §§7, 8, 9, 15 and 16
v. Petition for Medical Treatment Orders. M.G.L. c.123, §8B
vi. Emergency Hospitalizations. M.G.L. c.123, §12
vii. Forensic Reports. M.G.L. c123, §§15,16, 17, 18
viii. Guardian or Conservator Appointments. M.G.L c.123, §25 and M.G.L. c.201, §§6, 6A, 6B, 7, 14, 16B, 17, 21
ix. Unclaimed Funds Notice. M.G.L c.123, §26
x. Administration of estate of deceased inpatient or resident by DMH. M.G.L. c.123, §27
xi. Violent or Unnatural Death of DMH Clients. M.G.L c.123, §28
xii. Unauthorized Absence of DMH Clients. M.G.L. c.123, §30
xiii. Gun Licensing Authority Access to Mental Health Records. M.G.L. c.140, §§129B and 131
xiv. Mental Health Legal Advisor's Committee access to records. M.G.L c.221, §34E
xv. Medication Communications. 104 CMR 28.06
xvi. Abuse of Elderly Person. M.G.L. c.19A, §15, 104 CMR 32.06
xvii. The Disabled Person Protection Commission. M.G.L. c.19C, §15, 104 CMR 32.06

[125] 104 CMR 27.17(6)(g) and 104 CMR 28.09(2)(d)
[126] 104 CMR 27.17(6)(h) and 104 CMR 28.09(2)(f)
[127] 104 CMR 27.17(6)(f) and 104 CMR 28.09(2)(c)

xviii. DSS-Persons required to report Cases of Injured, Abused or Neglect Children. M.G.L c.119, §51A

xix. Persons Having Knowledge of Death to Notify Medical Examiner. M.G.L. c.38, §13, 104 CMR 32.06

xx. Sex Offender Registry Law. M.G.L. c.6, §§178C through 178O

xxi. Disclosures to the U.S. Secretary of Health and Human Services, if required by the Secretary in investigating DMH's compliance with HIPAA. 45 CFR 164.505(a)(2)

xxii. Protection and Advocacy. 42 USC 10806.[128]

e. Written authorization – by individual or PR

Inspection of records or parts thereof by third parties are permitted "upon the written authorization of the individual" or PR, "provided that such written authorization meet the requirements for authorization set forth in the federal HIPAA regulations (45 CFR 164.508)."[129] A valid authorization must be in writing and contain the following elements:

- a description of the information to be disclosed;
- a description of the purpose of each use or disclosure;
- the identification of the requester and recipient of this information;
- the identification of the entity authorized to release the information
- an expiration date, or event, for the authorization;
- a statement indicating the individual's right to revoke the authorization;
- a statement indicating that the information may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws; and
- the signature of the individual or personal representative (and in the case of the PR, a description of the PR's authority to act for the individual).[130]

f. Persons involved in the care of an individual

Certain personal information may be disclosed to a family member, or other persons involved in the care, or payment for care, of a patient/ client if the patient/ client has agreed, verbally or in writing, to such disclosure, or who has been notified and has not objected to such disclosure.[131]

g. Whistleblowers or workforce members who are victims of crime

Certain personal information may be disclosed by a workforce member, if the workforce member believes in good faith that DMH has engaged in

[128] *See* DMH Privacy Handbook c.6(V)(B)(5)
[129] 104 CMR 27.17(6)(d) and 104 CMR 28.09(2)(b)
[130] 45 CFR 164.508(c)(i–viii)
[131] *See* DMH Privacy Handbook c.6(V)(B)(10)

conduct that is unlawful or otherwise violates professional or clinical standards or that the care, services or conditions provided by DMH potentially endangers one or more individuals and the disclosure is made to (i) a public health authority, health oversight agency, or healthcare accreditation organization authorized to investigate or oversee the conduct at issue, or (ii) an attorney retained by the Workforce Member for the purpose of determining legal options of the Workforce Member with regard to said conduct. In addition the disclosure of the personal information must be necessary to accomplish the intended purpose and the amount of personal information that is used must be limited to the amount to that which is necessary for the intended purpose.[132]

h. Health oversight activities

DMH is a health oversight agency for psychiatric facilities and residential programs that it licenses. In such role, DMH has the right to access personal information retained by such facilities and programs without authorizations. Such access, disclosures and exchanges are required by law. However, DMH must safeguard PHI that it obtains during health oversight activities in a manner consistent with federal and state laws and regulations, and DMH policies and procedures relating to PHI. [133]

i. Research

Certain personal information retained by DMH may be disclosed for research purposes, but only with approval of the DMH Central Office Research Review Committee (CORRC), which "officially must waive the authorization requirement as part of its approval of a research protocol…"[134]

Community: DMH child/adolescent programs licensed by DEEC

In residential programs for children and adolescents that are licensed by the Office for Child Care Services (DEEC), "Records shall be the property of the licensee who shall have written procedures which provide for," among other things,

i. accessing a resident's records by resident (taking into account his/her capacity to understand), parent(s), a person other than the parent who has custody or a person not directly related to the service plan;
ii. identifying person(s), if any, whose consent(s) is required before information in a resident's records may be released;
iii. releasing information contained in a resident's record; and
iv. making available summaries of progress reports in lieu of the entire case record.[135]

[132] *See* DMH Privacy Handbook c.6(V)(B)(12)
[133] *See* DMH Privacy Handbook c.6(VII)
[134] *See* DMH Privacy Handbook c.6(V)(B)(6)
[135] 102 CMR 3.10(5)(a),(b),(d) and (e)

"The licensee shall explain all service plans, reviews and discharge plans to all child care personnel responsible for implementing the service plan on a daily basis, to the child's family or guardian, as appropriate, and to the resident in a manner consistent with her or his maturity and capacity to understand."[136]

The regulations reflect basic standards for operation of residential programs serving children and teen parents, but DEEC licensure "shall not relieve facilities of their obligation to comply with any other applicable state or federal regulatory requirements or requirements set forth in their contracts with the referral sources."[137]

4. **Notice requirements**

Under HIPAA, DMH is required to provide a Notice of Privacy Practices to each patient in a DMH facility and DMH client in the community.[138]

5. **Privacy complaint**

If a client or patient believes that his/her privacy rights regarding records have been violated, the individual may file a complaint with DMH or with the Secretary of Health and Human Services.[139] For more information, contact the Human Rights Officer or the DMH Privacy Officer. (See also Section IV.F.p.18 for more information on privacy complaints).

Y. RELIGION

1. **Facility and community**

Every client in a facility or program has the freedom to practice his/her religion of choice without compulsion.[140]

2. **Community: DMH child/adolescent programs licensed by DEEC**

Programs must make religious opportunities available to residents upon request and must respect their religious preferences.[141]

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[136] 102 CMR 3.05(4)(e)
[137] 102 CMR 3.11(1)
[138] *See* DMH Privacy Handbook, Notice of Privacy Practices, c. 4
[139] *See* DMH Privacy Handbook c. 16(I)
[140] 104 CMR 28.03(1)(b) and DMH Policy #03-1
[141] 102 CMR 3.06(8)

Z. RESEARCH

1. In general

Any research project that involves DMH clients as subjects (unless the research is not in any way related to DMH or a facility or program operated by DMH) must meet specific requirements as determined by the DMH Central Office Research Review Committee (CORRC). Any client choosing to participate in such a research project must do so voluntarily and may discontinue his/her participation at any time for any reason. DMH regulations specify the requirements established to protect clients who may participate in DMH approved research. These regulations address, in detail, the process of informed consent. The regulations also apply when any DMH employee, as an employee, participates as a research investigator or subject.

2. Institutional review board

Many research safeguards are in place to protect clients who choose to participate voluntarily in a DMH approved research project or when research involves the disclosure of DMH data. CORRC serves as the Institutional Review Board (IRB), complying with federal regulations for research. The requirements for the approval of research projects by the IRB clearly are articulated under federal regulation, ensuring strong regulatory oversight of all research involving human subjects.[142]

All such research approved by CORRC is subject to monitoring on an ongoing basis. CORRC's primary responsibility is to protect the rights and welfare of research subjects.[143]

3. Selected requirements

Proposals for research must address a number of points including, but not limited to, the following:

- the expected benefits of the research to the subjects, direct and indirect;
- identification of all foreseeable risks;
- how the care and treatment of subjects may be affected during and after the research;
- safeguards for maintaining confidentiality, including the manner in which the data is disposed at the termination of the research. [144]

At a minimum, CORRC must consider the impact the research may have on subjects in terms of health and physical safety, confidentiality and privacy, human dignity, self-determination, freedom of choice, right to adequate care and

[142] 45 CFR 46
[143] 104 CMR 31.05(2)(a)
[144] 104 CMR 31.04(e),(j),(l) and (n)

treatment, freedom from undue discomfort, distress and deprivation, and right to fair and equal treatment without discrimination.[145]

CORRC cannot approve research involving a drug that has not been approved for trial in human beings by the FDA.[146]

4. **Informed consent**

The informed consent process for participation in research is well defined in the regulations. Informed consent is defined as "...knowing consent given by a subject, or if the subject is legally incompetent (e.g., a minor), by the subject's legally authorized representative or by a court of competent jurisdiction. The subject, or legally authorized representative, must be able to exercise free power of choice to participate in research without undue inducement or any element of force, deceit, duress or other forms of constraint or coercion. The subject or legally authorized representative must have the capacity to understand and weigh the risks and benefits of the proposed research for the research subject." [147]

An individual's participation in a research project is entirely voluntary and must cease if the individual objects verbally or non-verbally, even when that individual is considered incompetent to consent and has a legally authorized representative who has consented.[148]

5. **Children/Adolescents as subjects**

DMH regulations require that if CORRC reviews any research involving children, at least one member of CORRC must be knowledgeable about and experienced in working with children.[149]

Although a minor is considered incompetent to give consent to participate in research, as with all adult subjects, his/her participation in a research project must cease if he or she objects, verbally or non-verbally, even though the legally authorized representative (i.e. parent or guardian) has consented on his/her behalf.[150]

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[145] 104 CMR 31.05(2)(a)
[146] 104 CMR 31.05(1)(a)
[147] 104 CMR 31.02
[148] 104 CMR 31.05(5)(e)
[149] 104 CMR 31.03(4)(d)
[150] 104 CMR 31.05(5)(e)

6. **Community: DMH child/adolescent programs licensed by DEEC**

DEEC-licensed programs serving children and adolescents shall not allow clients to participate in any activities unrelated to the client's service plan without the written consent of the parent(s) or a person other than the parent with custody of the child and the resident if over 14 years of age. Among the activities to which this applies are research, fund-raising and publicity, including photographs and/or mass media.[151]

7. **Complaints**

"Any person may file a complaint about a research project with the chairperson of the CORRC that approved the research."[152] In addition, if applicable, a client may file a complaint through the DMH complaint process.

AA. SEARCHES

1. **Facility and community: general**

Clients in community programs and facilities have the right to be free from unreasonable searches of their person or property.

2. **Facility**

DMH Policy #98-3 regarding searches at Inpatient Facilities serves as the policy for all DMH operated or contracted for facilities, including all DMH operated units at a DPH setting, and all IRTPs and BIRTs. Such facilities must establish procedures for searches of patients, their possessions and patient areas as well as for the inspection of visitors' possessions. The procedures must be consistent with DMH Policy #98-3.
According to the DMH Policy #98-3, "All searches must be reasonably related to the objective of protecting the health and safety of all patients, staff and visitors, while at the same time respecting the importance of the privacy and dignity of the individual who is subject to a search." [153]

a. Definitions

Reasonable cause is defined in DMH Policy #98-3 as "a combination of facts and circumstances that would warrant a reasonable person to believe that a patient or visitor is holding or hiding contraband on his/her person or in his/her possessions. Reasonable cause exists if, in the opinion of the person authorized to approve the search, it is more likely than not that the patient or visitor is in possession of contraband. Reasonable cause cannot

[151] 102 CMR 3.06(10)
[152] 104 CMR 31.06(1)
[153] DMH Policy #98-3(IV), (p. 2)

be merely an opinion or hunch. The person must consider all facts and circumstances known to him/her." [154]

Contraband is defined in DMH Policy #98-3 as "any substance or article that is likely to cause harm to the patient or others, that violates Facility infection control requirements, or otherwise is illegal."[155]

b. Requirements

Each facility must include information about searches into written patient notices handed out to patients regarding patients' rights.[156]

If a search is permitted under a facility policy, a patient's consent to conduct a search is not required, however, every effort shall be made to inform the patient about the reasons for the search and obtain the patient's cooperation, absent a compelling reason. Before the search, the patient must be told why the search is being conducted and given the opportunity to surrender the suspected contraband. The patient should be given the opportunity to be present during the search.[157] If a search is conducted without a patient first being told about it, the person who authorized the search must ensure that the patient is notified about it as soon as possible.

The Human Rights Officer must be notified prior to a search whenever possible so that he/she may be present during the search.[158]

The search must be documented according to DMH Policy #98-3. This includes the reason for the search and the result, and if conducted without prior notice to the patient, the compelling reasons that made it necessary. Specific requirements for the following types of searches are explicitly described in DMH Policy #98-3:

- Common area searches
- Searches of bedrooms and other areas with patient possessions
- Pat, wand and metal detector searches of possessions
- Non-invasive body searches
- Invasive body searches
- Possessions brought in by visitors[159]

c. Visitors

A facility's procedures must address the inspection of possessions brought by visitors:

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[154] DMH Policy #98-3(III), (p. 2)
[155] DMH Policy #98-3(III), (p. 2)
[156] DMH Policy #98-3(IV), (p. 2)
[157] DMH Policy #98-3(VII), (p. 4)
[158] DMH Policy #98-3(VII), (p. 4)
[159] *See* DMH Policy #98-3(VI-XI), (pp.4-7)

- Staff may request that visitors allow staff to inspect anything being brought onto the unit. If a visitor refuses the request, staff may ask the visitor to leave or staff may monitor the visit.
- In addition, if the staff person in charge of the unit at the time has reasonable cause to believe that a visitor is holding or hiding contraband, staff may request that the visitor's outer clothing (for example, a jacket or coat) be left outside the unit or, if the visitor prefers, that the outer clothing be inspected by staff. If a visitor refuses the request, staff may ask the visitor to leave or staff may monitor the visit.[160]

3. <u>Community: adult</u>

Each program must develop a written policy, consistent with applicable law and 104 CMR 28.08, regarding client possessions and the implementation of searches and seizures within the program. Clients shall be informed of the policy prior to their admission to the program. The policy, at a minimum, must require that in all except emergency circumstances, clients must:

a. be informed of a search prior to the search;
b. be provided an opportunity to consent to the search; and
c. be present during the search of their property.

If a search of a client's property needs to be performed in an emergency, to avoid imminent risk of harm, and the client is not present during the search, the nature of the emergency and the reasons that the client is not present should be documented in the client's record.[161]

4. <u>Community: DMH child/adolescents programs licensed by DEEC</u>

Programs licensed by DEEC are required to develop a written statement defining the policies, procedures and circumstances for the search of residents and their personal belongings. A copy of the written policy must be provided to a resident within 24 hours of his/her admission to the program and to the resident's parent(s) or guardian within 72 hours.[162]

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[160] DMH Policy #98-3(XI), (p. 7)
[161] 104 CMR 28.08(3)
[162] 102 CMR 3.07(11)

BB. SECLUSION AND RESTRAINT

DMH is committed to eliminating the use of restraint and seclusion in its facilities, which includes all DMH-operated and contracted hospitals, intensive residential treatment programs (IRTPs) and behaviorally intensive residential treatment programs (BIRTs) and its licensed facilities.[163] However, DMH recognizes that in an emergency situation involving imminent risks of harm, where less restrictive alternatives have failed, the use of restraint and seclusion may be necessary to prevent harm. In these situations, staff must use these interventions for the least amount of time and the least restrictive ways, taking into consideration patient history, preference and perspective.[164] DMH regulations[165] set forth stringent requirements for when and how restraints may be used.[166]

See also Section V. of this Handbook on the roles of the Human Rights Officers and Human Rights Committees regarding monitoring the use of restraint and seclusion (p. 70).

1. Facilities must have plans for the reduction of Restraint and Seclusion 104 CMR 27.12(1)

Every facility authorized to use restraint or seclusion must develop and implement a plan to reduce and whenever possible eliminate the use of such. Every plan must include the ten elements set forth in 104 CMR 27.12(1).

2. Individual Crisis Prevention Plans 104 CMR 27.12(3)

As soon as possible after admission to a facility, staff is to work with each patient and his/her legally authorized representatives to develop and implement an individual crisis prevention plan. The plan is to include at a minimum the following: (a) triggers that signal or lead to agitation or distress in the patient; (b) identification of the particular approaches that are most helpful to the patient in reducing agitation or distress; and (c) to minimize the trauma if restraint or seclusion is used, the identification of the patient's preference, such as type of intervention, positioning, gender of staff who administer and monitor the restraint or seclusion and supportive interventions that may have a calming effect on the patient. If a patient refuses or is unable to participate in the initial development of the plan, the staff is to make continuing efforts to include the patient's participation in the review and revision of the plan. A plan is to be updated as necessary to reflect changes in triggers and strategies and reviewed at each treatment plan review.

Facility staff must be aware of and have easy access to all individual crisis prevention plans of the patients in their care.

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[163] DMH Policy #07-02, *Restraint and Seclusion (*Appendix 8)
[164] DMH Policy #07-02, *Restraint and Seclusion* (Appendix 8)
[165] 104 CMR 27.12
[166] See also DMH Policy #07-02. This Policy only applies to DMH operated and contracted facilities.

3. Definitions of Restraint and Seclusion from DMH regulation 104 CMR 27.12(5)(a)

a. Restraint: restraint means a behavioral restraint, including medication restraint, mechanical restraint and physical restraint. Restraint means bodily physical restriction, mechanical devices, or medication that unreasonably limit freedom of movement.

b. Mechanical Restraint: when a device is used to restrain a person by restricting the movement of a person or the movement or normal function of a portion of his/her body.

c. Medication Restraint: occurs when, with certain exceptions, a client is given medications involuntarily for the purpose of restraint.

d. Physical Restraint: occurs when bodily physical force is used to limit a person's freedom of movement or normal access to his/her body. A person may be held with no more force than is necessary to safely limit the person's movement. Physical Restraint does not include: (i) non-forcible guiding or escorting of a patient to another area of the facility; (ii) taking reasonable steps to prevent a patient at imminent risk of entering a dangerous situation from doing so with a limited response to avert injury; or (iii) in the case of an IRTP briefly holding a patient without undue force in order to calm him/her; provided, however, that the facility shall document such brief holds in the patient record and consider the need for post-intervention review.

e. Seclusion: occurs when a person is involuntarily confined in a room and is prevented from leaving, or reasonably believes that he/she will be prevented from leaving. Seclusion does not include a voluntary decision agreed upon by the patient and staff to separate from a group or activity for the purpose of calming the patient.

4. General Requirements for the Use of Restraint or Seclusion in a Facility 104 CMR 27.12(5)

a. Emergency Use Only. Restraint and seclusion only may be used in an emergency, to keep clients from serious and immediate harm.[167] "Emergency" is defined as the occurrence or serious threat of extreme violence, personal injury, or attempted suicide. Emergencies only include situations where there is a substantial risk of, or occurrence of, serious self-destructive behavior, or serious physical assault. A "substantial risk" includes only the serious, imminent threat of bodily harm, where there is the present ability to effect such harm. [168]

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[167] 104 CMR 27.12(5)(b)
[168] 104 CMR 27.12(5)(b)

Restraint or seclusion may not be used if less restrictive alternatives can be used to address the risk of harm.[169] No PRN (as often as necessary) or "as required" authorization of restraint or seclusion may be written.[170]

b. **Use Must Meet the Requirements of 104 CMR 27.12(5).** If an emergency condition exists that justifies the use of a restraint or seclusion, such use must conform to all applicable requirements of 104 CMR 27.12. These requirements include, but are not limited, to the following:

   i. **Authorization:** A restraint or seclusion may only be authorized by an authorized physician or staff person as defined in 104 CMR 27.12(5)(a) and as set forth in 104 CMR 27.12(5)(d) (Medication Restraint) or 104 CMR 27.12(5)(e) (Mechanical Restraint, Physical Restraint and Seclusion).

   ii. **Duration:** A restraint or seclusion may only be used for the period of time necessary to accomplish its purpose, but in no event beyond the periods established in 104 CMR 27.12(5)(e) (time periods for initiation), 104 CMR 27.12(5)(f) (time periods for renewals) and104 CMR 27.12(5)(g) (overall time periods limits).

   iii. **Monitoring and Assessment of Patients in a Mechanical or Physical Restraint or Seclusion 104 CMR 27.12(5)(h):** A staff person must specifically be assigned one-on-one to monitor a person who is in a mechanical or physical restraint or seclusion. A patient in physical or mechanical restraint or seclusion is to be continually monitored for readiness for release. In addition, assessments of physical and psychological comfort, vitals signs and readiness for release must be done by authorized staff persons (as defined in 104 CMR 27.12(5)(a)) at least every thirty (30) minutes.

   iv. **Personal Dignity/Comforts and Needs 104 CMR 27.12(5)(c):** Patients in restraint or seclusion must be fully clothed consistent with patient safety and the restraint devices used. The restraint device used shall afford patients maximum personal dignity. Appropriate attention is to be given to the personal needs of the patient including access to food and drink and toileting. Patients in physical or mechanical restraints are to be placed in a position that allows airway access and does not compromise respiration. A face-down position is not to be used unless very specific conditions are met.

   v. **Physical Environment 104 CMR 27.12(5)(c):** The physical environment is to be as conducive as possible to facilitating early release, with attention to calming the patient with sensory interventions

[169] 104 CMR 27.12(5)(b)(1)
[170] 104 CMR 27.12(5)(b)(3)

where possible and appropriate. Any room used to confine a person in seclusion must allow for complete visual observation of the patient.

vi. **<u>Debriefing 104 CMR 27.12(4):</u>** Each facility is to develop procedures to ensure that debriefing activities occur after each episode of restraint or seclusion in order to determine what led to the incident, what might have prevented or curtailed it and how to prevent future incidents. Debriefing activities are to be documented, used in treatment planning, the revision of the individual crisis prevention plan and ongoing facility–wide restraint and seclusion prevention efforts. At a minimum, the debriefing activities are to include the following:

(a) **<u>Patient Debriefing 104 CMR 27.12(4)(b):</u>** Within 24 hours of the end of a restraint or seclusion, a patient must be asked to debrief and comment on the episode. They must be given a copy of the restraint/seclusion order form with an attached patient debriefing and comment form. The patient is to be encouraged to provide comment on the episode, the circumstances leading to it, staff or patient actions that may have helped to prevent it, the type of restraint or seclusion used, and any physical or psychological effects he/she may have experienced from the episode.

Staff must provide the patient with any necessary assistance in completing the debriefing and comment form. If the patient does not complete the form, but provides verbal or other response to the incident, the staff shall document such on the comment form. The patient must be informed of DMH's complaint procedures and the Human Rights Officer must meet with a patient who has expressed a response to an episode that suggest a possible rights violation or other harmful consequences.

(b) **<u>Staff Debriefing 104 CMR 27.12(4)(a):</u>** As soon as possible after an episode of restraint and seclusion supervisory staff and the staff involved in the episode must convene a debriefing. The debriefing must at a minimum address the items set forth in 104 CMR 27.12(4)(a).

vii. **<u>Administrative Reviews 104 CMR 27.12:</u>** The review of restraint and seclusions are required at a variety of different levels.

(a) **<u>Facility Senior Administrative Review 104 CMR 27.12(4)(c):</u>** There must be a facility senior administrative review by the next business day following an episode of restraint and seclusion that (1) involves a patient or staff member experiencing significant emotional or physical injury; (2) exceeded six hours or episodes of restraint and/or seclusion for a patient exceeded 12 hours in the aggregate in any 48 hour period; (3) involved an exception to the restrictions of mechanical restraints being used on minors; (4)

appears to be part of a pattern warranting review, (5) was marked by unusual circumstances, (6) resulted in a complaint or a reportable incident; and/or (7) resulted in the staff involved requesting such a review.

(b) **Commissioner Review 104 CMR 27.12(5)(i)(2):** The Commissioner, or designee, is to review the aggregate statistical data that facilities are required to submit monthly and a sampling of the restraint and seclusion forms that facilities are also required to submit each month.

(c) **Human Rights Committee/Human Rights Officer Review 104 CMR 27.12(5)(i)(3):** The Human Rights Committee or the Human Rights Officer is to receive copies of all restraints and seclusion forms that the facility sent to the Commissioner. The committee or Human Rights Officer have the authority to (1) review all pertinent data concerning the behavior that necessitated the restraint or seclusion; (2) obtain information about the patient's need from the appropriate staff, relatives and other persons with direct contact or special knowledge of the patient; (3) monitor the use of the individual crisis prevention plan and consider all less restrictive alternatives to restraint and seclusion in meeting the patient's needs; (4) review and refer to the person in charge for action in accordance with 104 CMR 32.00 all complaints that the rights of patients are being abridged by the use of restraint and seclusion; (5) generally monitor the use of restraint and seclusion in the facility.

viii. **Documentation Requirements 104 CMR 27.12(5)(i):** Each restraint and seclusion must be documented on the DMH Restraint and Seclusion Order Form. In addition, the Patient Debriefing and Comment Form (104 CMR 27.12(4)) must be attached to the DMH Restraint and Seclusion Order Form. Copies of the Restraint and Seclusion Order Form, at a minimum, are to be distributed to: the patient's record; the patient with a copy of the Patient Debriefing and Comment Form; the Commissioner; and the Human Rights Committee or Human Rights Officer.

5. Special Rules Applicable to Children and Adolescents in a Facility 104 CMR 25.12(5)(g)

- No order for the restraint or seclusion of a minor under the age of nine (9) may exceed one (1) hour.
- No minor under the age of nine (9) shall be in seclusion or restraint for more than one (1) hour in any twenty-four (24) hour period.
- No minor age nine (9) through seventeen (17) shall be in seclusion for more than two (2) hours in any twenty-four (24) hour period.

- No minor under the age of thirteen (13) may be placed in mechanical restraint unless the specific conditions of 104 CMR 27.12(5)(g)(5) are met.

6. **Staff Training 104 CMR 12.12(2)**

Every facility must provide training at orientation to unit staff and all other staff that that may be involved in restraint and seclusion regarding the prevention and minimal use of restraint and seclusion. The training must meet the requirements set forth in 104 CMR 27.12(2)(a) and (b).

Additional training is required for staff who may be directly involved in authorizing, ordering, administering or applying, monitoring, or assessing for release from restraint and seclusion. This training must include: (a) applicable legal and clinical requirements for restraint and seclusion; (b) the safe and appropriate initiation of physical contact and application and monitoring of restraint and seclusion; and (c) approaches to facilitate the earliest possible release from restraint or seclusion. Staff may not participate in a restraint or seclusion prior to receiving such training and they must be re-trained annually. Staff members must demonstrate competencies in all areas of training.

7. **Community Adults 104 CMR 28.05**

Adult Community programs cannot use medication or mechanical restraints or seclusion. Use of physical restraint and other limitations of movement may only be utilized to the extent the requirement of 104 CMR 28.05 are met. Physical restraint can only be used in an emergency situation limited to; (a) substantial risk of serious self-destructive behavior; (b) occurrence of serious self-destructive behavior; (c) substantial risk of serious physical assault or; (d) occurrence of serious physical assault.

8. **Community DMH Child/Adolescent Programs Licensed by the Department of Early Education and Care (DEEC)**

A Child/Adolescent community program licensed by DEEC can not use locked time out rooms unless the program is a "locked secure detention or treatment program." [171] The program must submit a clear and precise written plan that addresses when locks can be used and the plan must meet the specific requirements set forth in DEEC regulations regarding bedrooms [172] and time-out rooms.[173]

DEEC allows for the use of physical restraint in the residential programs it license, when the resident is demonstrating that he/she is dangerous to him/herself or others and no other intervention has been or is likely to be effective in averting the danger. Unless the residential program obtains a variance prior to

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[171] 102 CMR 3.07(7)(l) and (n)
[172] 102 CMR 307(7)(n)(2)
[173] 102 CMR 3.07(7)(n)(3)(a and b)

implementation, the use of any form of restraint other than physical restraint is prohibited.[174]

STORAGE SPACE

Facility and community: general

Every client has the right to have access to individual storage space for private use.[175] However, a facility director or his/her designee may limit this right for good cause.[176] A statement of the reason(s) for limiting the right must be entered into the individual client's treatment record.[177]

DD. TELEPHONE ACCESS

(See Appendices 2a and 2b,"Five Fundamental Rights" Law)

1. Facility and community: general

a. According to the Five Fundamental Rights Law, every client, regardless of age, has the right to reasonable access to a telephone to make and receive confidential calls and to receive assistance when desired and necessary. However, such calls cannot constitute a criminal act or represent an unreasonable infringement of another person's right to make and receive telephone calls.[178]

b. Every client has the right to receive or refuse to receive, telephone calls from his/her attorney or legal advocate, physician, psychologist, clergy member or social worker, at any reasonable time, regardless of whether the client initiated or requested the telephone call.[179] This right cannot be suspended.

2. Facility

a. Suspending the right to telephone calls from those other than the professionals listed above.

In an inpatient facility, a patient's right to reasonable access to a telephone may be temporarily suspended only if the director or acting director of the facility, or his/her designee, concludes that, based on the experience of the patient's exercise of the right to a telephone, further access in the

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[174] 102 CMR 3.07(7)(j)
[175] M.G.L. c. 123, § 23
[176] M.G.L. c.123, § 23
[177] *Id.*
[178] M.G.L. c. 123, § 23
[179] 104 CMR 27.13(5)(e)

immediate future would present a substantial risk of serious harm to the patient or others, and less restrictive alternatives either have been tried and failed or would be futile to attempt. The suspension shall last no longer than the time necessary to prevent the harm.

The imposition of the suspension shall be documented with specific facts in the patient's record.[180]

b. Requirements when restricting rights

DMH Human Rights Policy #03-1 specifies the steps to be taken when restrictions to a right are considered. The relevant points applying to the restriction of telephone are summarized below:

i. Duration of restriction: All telephone restrictions are considered temporary. In all instances where telephone access has been restricted, access shall be restored immediately when determination is made that the risk no longer justifies the restriction.

ii. Time period for review: A restriction concerning telephone access in a facility must be reviewed and approved by the Facility Director or designee and documented daily by clinical staff for the first 14 days of the restriction. If the restriction is continued for more than 14 days, the Facility Director or designee must review and approve the continuation and, if continued, the reasons for the restriction shall be considered a treatment issue and must be incorporated into the client's treatment plan. The facility director or designee shall review all such restrictions monthly.

iii. Notification: The Human Rights Officer and the client's LAR, if any, shall be notified of the restriction as soon as possible, and no later than 24 hours after it is imposed.

iv. Documentation: Imposition of the restriction shall be documented with specific facts as to the reason for the restriction in the client's record. If a restriction is made due to a restraining order or other court order, then a copy of the restraining or other court order should be retained in the client's record. Such documentation also must include the less restrictive alternatives that were tried and failed or would be futile to attempt, as well as criteria for lifting the restriction.[181]

3. Facility: child/adolescent

In determining serious harm, a Facility Director or designee may take into consideration the age and developmental level of such minor, as well as family and cultural issues relevant to his/her treatment. The Facility Director or designee

[180] M.G.L. c. 123, § 23
[181] DMH Policy #03-1(VI)(B), (pp. 9-10)

may rely upon information supplied by the minor's legally authorized representative (i.e., parent, DSS, guardian), records and information from prior treatment providers, or other sources of reliable information.[182]
DMH Commissioner's Directive # 16, (Appendix 9) regarding Children/Adolescents in DMH facilities who are in DSS custody, states that M.G.L. c. 123 §23, which includes the right to access a telephone, is applicable to children/adolescents who are both in DSS custody and in a DMH facility. The Directive states that, in such cases, the child/adolescent's inpatient treatment team should take into consideration information DSS has concerning the child/adolescent's telephone use, and DMH must always comply with a court order. However, the child/adolescent has the right to make and receive confidential telephone calls in a facility, though that right may temporarily be suspended in accordance with the provisions of the law.[183]

4. **Community: DMH child/adolescent programs licensed by DEEC**

When contracting with a child/adolescent program, DMH must insure that the program allows DMH child/adolescent clients to have telephone access in accordance with the Five Fundamental Rights Laws.[184]

EE. TREATMENT AND SERVICES

1. **Receipt of treatment and services**

a. Facility and Community: General Clients of DMH facilities and community programs shall receive quality treatment and services that are individualized and appropriate to their needs, which respect their dignity and support their functioning at the highest level of independence possible.

b. Facility: DMH regulations state: "Each patient admitted to a facility shall, subject to his or her giving informed consent, receive treatment suited to his or her needs which shall be administered skillfully, safely, and humanely, with full respect for dignity and personal integrity." [185]

c. Community. DMH is responsible for providing or arranging for DMH continuing care services to adults with serious and long term mental illness, and children and adolescents with serious emotional disturbance who are determined eligible and are prioritized for such services.[186] Services shall be provided to eligible clients subject to the availability of

[182] *Id.*
[183] DMH Commissioner's Directive #16
[184] M.G.L. c. 123 §23
[185] 104 CMR 27.13(3)
[186] 104 CMR 29.03(1)

services, funding, and DMH's determination of the priority of the client's need for services.[187]

2. Participation in treatment planning

a. General. The DMH Human Rights Policy emphasizes the importance of client participation in treatment planning. Clients and their LARs have the right to participate as fully as possible in the development and modification of their treatment plan (facility) or the Individual Service Plan (ISP) (community). The policy states "When clinically and age appropriate, all clients, including those with a LAR, shall have the opportunity to participate in and contribute to their treatment planning to the maximum extent possible." For both the community and inpatient setting, clients may request individuals of their choosing, including their attorney, to attend treatment and service planning meetings.[188]
A client may request a modification to his/her treatment and/or service plan. In addition, a client may request a change in his/her facility, program, and treating physician or other clinician or case manager. According to the Human Rights policy, "best efforts shall be made to accommodate the request, consistent with (i) the clinical appropriateness of the request, (ii) the ability of the Facility or Program to grant the request, (iii) the need to provide treatment in an emergency situation, and (iv) the client's eligibility for admission to another service provider or agency (e.g., Veterans' Administration or Massachusetts Rehabilitation Commission)."[189]

b. Community.

Individual Service Plan (ISP) development

DMH community regulations specify the following steps for encouraging client participation in the development of his/her ISP.

All clients, including those who have a LAR, shall be given the opportunity to participate in and contribute to their individual service planning to the maximum extent possible:

i. The client must be present at the service and treatment planning and review meetings unless the client is unwilling or unable to attend.
ii. The client must be encouraged to identify and discuss his/her goals and preferred services and programs during these meetings and otherwise shall be supported to participate in a meaningful way in the discussions and decision-making process.

[187] 104 CMR 29.03(2)
[188] DMH Policy #03-1, (p. 8)
[189] *Id.*

When a client is unable or unwilling to take part in a meaningful way in the service planning process, the case manager, with the assistance of the treatment team, must take steps to minimize obstacles to participation in service planning activities. This must include, but not be limited to:

i. developing a plan for increasing the ability of the client to participate;
ii. modifying the schedule or structure of the meetings or making other accommodations designed to increase the client's participation;
iii. educating the client in order to facilitate and increase his/her participation;
iv. continuing to engage the client in ways that assist him/her to make choices regarding his/her care and treatment to the maximum extent possible.[190]

Acceptance or rejection of the ISP

Every community client who is not under a guardianship, or the LAR of a client under guardianship, has the right to reject and appeal part or all of the contents of any community based service plan.[191] The client or LAR may also request modification of a community based service plan.[192]

No modification of a community treatment plan, service, service plan, or service provider may be made without acceptance of the client or LAR. However, in an emergency or when necessary to comply with state contracting requirements, a treatment plan or service plan may be modified (and services or service providers changed) without acceptance by the client or LAR. An emergency exists only if a modification is necessary to avoid a serious or immediate threat to the health, mental health or safety of the client or other persons.[193]

Any objection to the service plan should be made within 20 days of the date when the individual service plan is received. If the client (or his/her LAR) fails to object within 20 days, the service plan is considered to be accepted by the client and/or LAR.[194]

If an objection is made and cannot be resolved satisfactorily, the client (or LAR) may appeal the service plan.[195]

[190] 104 CMR 29.03(4)
[191] 104 CMR 29.09(1) & 29.15(1)
[192] 104 CMR 29.11(1)
[193] 104 CMR 29.11(3)
[194] 104 CMR 29.09(1)(b)
[195] 104 CMR 29.09(1)(d)

3. **<u>Periodic/annual review</u>**

a. <u>Facility</u>. Each facility must conduct an initial assessment at admission and must conduct periodic reviews of clients who are there beyond 90 days after the first 90 days, the second 90 days and annually thereafter.[196]

<u>For child and adolescent inpatient units,</u> the periodic review must be conducted quarterly for the duration of the admission.[197]
The Facility Director or designee must give reasonable advance written notice of the review to each patient, his/her LAR, and, unless the patient knowingly objects, to the nearest relative, giving the date of the review and requesting his/her participation in the review.[198]

The inpatient regulations also specify that, at minimum, the following areas are to be covered during the initial examination and periodic review: a thorough clinical examination, an evaluation of competency and consideration of alternatives to hospitalization.[199]

The written record of each initial and periodic review becomes part of the patient's permanent medical record.

b. <u>Community</u>. A review of the client's ISP, and the client's related Program Specific Treatment Plans (PSTPs) must be initiated by the case manager no later than 12 months after the ISP was completed or substantially modified, and annually thereafter.[200] At least fifteen (15) days prior to the annual review, the case manager must contact the client, the LAR, if any, the involved family and/or the involved others [with the client or LAR's approval], and the representatives of each of the client's service providers.[201] The regulations have provisions for waiving the annual review meeting if all parties agree.[202]

<u>Community: DMH child/adolescent programs licensed by DEEC</u>

In addition, for DEEC licensed programs, each client's progress, needs and service plan must be reviewed at least every six months.[203]

4. **<u>Behavior management: child/adolescent facilities –Please note there are draft regulations currently being proposed-March 2005-that may change these Behavior management regulations</u>**

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[196] MGL c. 123, § 4 and 104 CMR 27.11(1)
[197] MGL c. 123, § 4 and 104 CMR 27.11(1)
[198] MGL c. 123, § 4 and 104 CMR 27.11(2)
[199] MGL c. 123, § 4 and *See* 104 CMR 27.11(3-6) for detailed requirements.
[200] *See* 104 CMR 29.10 for the specific requirements for the annual review.
[201] 104 CMR 29.10(1)(b)
[202] 104 CMR 29.10(2)
[203] 102 CMR 3.05(5)(a)

a. Facilities: DMH has behavior management regulations which apply to facilities licensed by DMH that serve **children and adolescents** (i.e., acute or continuing care inpatient units and IRTPs and BIRTs). The regulations address behavior management planning for this group only. These regulations require child-serving facilities that intend to use behavior management to develop a plan for its use in each setting. The plan must be approved by DMH, and reviewed by the facility's Human Rights Officer and, where applicable, the facility's Human Rights Committee.[204]

   The regulations set out parameters for individual behavior management plans. They provide guidance for and limitations to the range of interventions facilities can develop. Key requirements are listed below:

   i. No behavior modification techniques, which involve corporal punishment, infliction of pain or physical discomfort, or deprivation of food or sleep, may be used.
   ii. Seclusion and restraint may not be used for behavior management and may only be used in accordance with 104 CMR 27.12. See Seclusion and Restraint Section of this Handbook. (IV.BB.) (p. 49)
   iii. The treatment plan for each client for whom behavior management will be employed must contain specific individualized behavior management interventions, consistent with the program's behavior management plan. The treatment plan, including behavior management interventions, may not be instituted without the consent of the client or his/her LAR.
   iv. Each behavior management plan must describe behavior management interventions that may be used.
   v. When feasible and appropriate, clients must participate in the establishment of rules, policies and procedures for behavior management.
   vi. Upon admission, the facility must provide clients and their legally authorized representatives with a copy of the facility's behavior management plan.
   vii. The DMH regulations further provide that any facility behavior management plan which provides that a client may be separated from the group or facility activities must include at least:
      - guidelines for staff in the utilization of such procedures;
      - the persons responsible for implementing such procedures;
      - the duration of such procedures, including provisions for approval by the Facility Director or his/her designee of a period longer than 30 minutes;
      - a requirement that clients be observable at all times and that staff shall be in close proximity at all times;
      - a procedure for staff to directly observe the client every 15 minutes;

[204] 104 CMR 27.10(7)

- a means of documenting the use of such procedures if used for a period longer than 30 minutes including, at a minimum, length of time, reasons for this intervention, who approved the procedure and who directly observed the client at least every 15 minutes;
- a time out room may not be locked; and
- any room or space used for the practice of separation must be physically safe.[205]

Community: DMH child/adolescent programs licensed by DEEC

DEEC requires that child/adolescent community programs which separate a child or adolescent from the group or program activities have a behavior management policy, which contains the following elements:

i. guidelines for staff utilizing such procedures;
ii. persons responsible for implementing such procedures;
iii. the duration of such procedures, including procedures for the approval of the chief administrative person or designee for a period longer than 30 minutes;
iv. a requirement that the client is observable at all times and in all parts of the room and that staff must be in close proximity at all times;
v. a procedure for staff to directly observe the client at least every 15 minutes; and
vi. a means of documenting the use of such procedures if used for a period longer than 30 minutes including, at a minimum, length of time, reasons for this intervention, who approved the procedure and who directly observed the client at least every 15 minutes.[206]

There are additional DEEC regulations concerning the use of time out rooms at DEEC licensed programs.[207]

5. **Privileges: facility only**

a. General: “Privileges are considered to be therapeutic aspects of inpatient hospital treatment and are never used for punitive purposes. While issues of safety remain of paramount importance, gradual increases in privileges, as clinically appropriate, encourage increased patient autonomy, self-esteem, quality of life, as well as provide a more normalized treatment environment in which to prepare for life after discharge”.[208]

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[205] 104 CMR 27.10(7)
[206] 102 CMR 3.07(7)(k)
[207] 102 CMR 3.07(7)(n)(1-3)
[208] DMH Patient Privileges Policy # 96-1, (p. 1)

b. Definition of privilege: a level of movement off the unit authorized for a patient. Privilege levels range from restricted to the inpatient unit (the most restricted privilege level) to authorization for the patient to leave the buildings and grounds without escort for a specified period of time (the least restrictive privilege level).[209]

c. Patient participation: The determination of the patient's privilege level should include as much participation from the patient as possible. In the case of a minor, the determination should include as much participation from the LAR and child/adolescent in keeping with his/her developmental level.

Note regarding three day notices: A facility should not have a practice of automatically restricting the current privilege level of a patient on a Conditional Voluntary status when he/she files a three-day notice. Rather, any decision to restrict should be individualized based upon compelling safety concerns, and must have documentation in the patient's record concerning the need for the restriction.

Special requirements concerning adult forensic patients: DMH Policy #00-1, Mandatory Forensic Review (MFR), establishes the procedures for determining privileges for certain adult forensic patients in DMH operated and contracted facilities. The Department's Division of Forensic Services through MFRs provides risk assessments and recommendations for appropriate risk management to aid treatment teams in making decisions concerning the granting of certain privileges and discharge. MFRs are performed according to the DMH policy and by forensic consultants appointed by the Assistant Commissioner for Forensic Services. A patient who has been charged with a serious violent offense (as specified in the policy) or has been transferred to a DMH facility following a commitment to Bridgewater State Hospital must have an MFR done prior to being granted supervised off- ground privileges, unsupervised privileges (either on or off-grounds) and/or the discharge from the facility.

The MFR consists of a review of selected portions of the patient's clinical file, a clinical interview with the patient, consultation with the treatment team and a comprehensive written report assessing the risk management aspects of the privilege or discharge plan. A senior forensic supervisor, appointed by the Assistant Commissioner for Forensic Services, finalizes the findings and submits the report as well as an advisory letter to the patient's treatment team. The evaluation and report must be submitted within 25 business days of the MFR referral completion date.

The report and letter are **advisory** only. The treatment team makes final decisions regarding privileges and discharge.

It is important to note that if a court, when committing an individual to a facility, orders that the individual be restricted to the building grounds of

[209] *Id*.

the facility, such restrictions cannot be removed without the approval of the court.

FF. VISITORS

(See Appendix 2a and 2b -"Five Fundamental Rights" Law)

1. Facility and community: general

According to the Five Fundamental Rights law, a DMH client or resident, regardless of age, has the right to receive, at reasonable times, visitors of his/her own choosing daily and in private.[210]

a. Visiting hours may be limited only for the purpose of protecting privacy of other persons and avoiding serious disruptions in the normal functioning of the facility or program. Visiting hours shall be sufficiently flexible to accommodate individual needs and desires of clients and visitors.[211]

b. Every client has the right to receive or refuse to receive at any reasonable time, visits from his/her attorney or legal advocate, physician, psychologist, clergy or social worker even if not during normal visiting hours and regardless of whether the patient initiated or requested the visit.[212] This right cannot be suspended.

2. Facility

a. Suspending the right to visitors in a facility other than from the professionals listed in 1(b) above: In a facility, the right to receive visitors of one's choosing may be temporarily suspended only if the director or acting director of the facility or his/her designee concludes that, based on experience of the patient's exercise of the right, further such exercise of this right in the immediate future would present a substantial risk of serious harm to that person or others, and less restrictive alternatives either have been tried and failed or would be futile to attempt. The suspension shall last no longer than the time necessary to prevent the harm and its imposition shall be documented with specific facts in such a person's record.[213]

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[210] M.G.L. c. 123, § 23
[211] 104 CMR 27.13(5)(c)
[212] 104 CMR 27.13(5)(e)
[213] 104 CMR 27.13(6)

b. Requirements when restricting rights. DMH Human Rights Policy #03-1 specifies the steps to be taken when restrictions to a right are considered. The relevant points applying to the restriction of visits are summarized below:

i. Duration of restriction: All restrictions to visitors other than the professionals listed in 1 (b) above are considered temporary. In all instances where visitor access has been restricted, access shall be restored immediately when the determination is made that the risk no longer justifies the restriction.

ii. Time period for review: A restriction concerning visitor access in a facility must be reviewed and approved by the Facility Director or designee and documented daily by clinical staff for the first 14 days of the restriction. If the restriction is continued for more than 14 days, the Facility Director or designee must review and approve the continuation and, if continued, the reasons for the restriction shall be considered a treatment issue and must be incorporated into the client's treatment plan. The Facility Director or designee shall review all such restrictions monthly.

iii. Notification: The Human Rights Officer and the client's LAR, if any, shall be notified of the restriction as soon as possible and no later than 24 hours after it is imposed.

iv. Documentation: Imposition of the restriction shall be documented with specific facts as to the reason for the restriction in the client's record. If a restriction is made due to a restraining order or other court order, then a copy of the restraining or other court order should be retained in the client's record. Such documentation shall also include the less restrictive alternatives that were tried and failed or would be futile to attempt, as well as criteria for lifting the restriction.[214]

3. Facility: child/adolescent

In determining serious harm, a facility may take into consideration the age and developmental level of such a minor, as well as his/her family and cultural issues relevant to his/her treatment. In addition, the facility may rely upon information and records supplied by the minor's legally authorized representative (i.e., parent, DSS, guardian) from prior treatment providers or other reliable sources.

DMH Commissioner's Directive #16,(See Appendix 9), regarding Children/Adolescents in DMH facilities that are in DSS custody, states that the five fundamental rights law is applicable to children/adolescents who are both in DSS custody and in DMH facilities. The directive states that, in such cases, the child/adolescent's inpatient treatment team must abide by a court decree and should consider information that DSS has concerning certain visitors. Just as with

[214] DMH Policy #03-1 (VI)(B)

adults, a child/adolescent has the right to visitors in a facility, though that right temporarily may be suspended in accordance with the provisions of the law.[215]

4. Community: DMH child/adolescent programs licensed by DEEC

When contracting with a child/adolescent program licensed by DEEC, DMH must insure that the Program allows DMH child/adolescent clients to have visitor access in accordance with the Five Fundamental Rights Law.

GG. VOTING

1. Facility and community: general

Every client who is 18 years of age or older is presumed to be legally competent and has the right to vote. State law and regulation prohibit deeming an individual incompetent to vote based solely on the fact that the individual has been admitted to a program or admitted or committed to a facility.[216]

Unless that right has been specifically restricted by the Probate Court, a client under guardianship may vote.[217]

Staff in facilities and programs must provide reasonable assistance to a client to register and vote and must do so in a non-coercive and non-partisan manner.[218]

2. The National Voter Registration Act

This law, in part, requires that state agencies which provide services to persons with disabilities take proactive steps to ensure that clients applying for and receiving services from the agency have the opportunity to register and vote.[219] Such proactive steps include:

- Provision of voter registration forms to all clients who may desire such a form;
- Provision of assistance in completing the forms; and
- Forwarding of the forms to the appropriate state officials.

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[215] DMH Commissioner's Directive #16
[216] MGL c. 123, § 24; 104 CMR 27.13(1); 104 CMR 28.03(1)(c); and 28.10(1)
[217] 104 CMR 28.03(1)(c)
[218] *Id*.
[219] Federal Voter Registration Act of 1993 (42 U.S.C. 1973)

HH. WILLS

Facility and community: general

Every client who is 18 years of age or older is presumed to be legally competent and has the right to make a will. According to state law, no person shall be deemed to be incompetent to make a will solely by reason of his/her admission to a program or admission or commitment in any capacity to a facility.[220]

However, the validity of the will may depend on whether or not the person making it understands the extent of his/her estate, understands who are his/her legal heirs and significant others, and understands that he/she is giving instructions that will govern how his/her estate is dispersed after death. That is, it must be a "knowing" decision. The fact that someone has a guardian does not necessarily mean that he/she cannot make a valid will. In addition, the fact that a person is not under guardianship does not necessarily mean that he/she is competent to make a valid will.

[220] M.G.L. c. 123, § 24; 104 CMR 27.13(1); and 104 CMR 28.10(1)

V. HUMAN RIGHTS INFRASTRUCTURE

A. GENERAL

DMH Policy #03-1 requires that DMH and its facilities and programs create and maintain a structure for protecting clients' rights. DMH has established the Office of Human Rights and the Human Rights Advisory Committee. For detailed information, see Appendix 1, the DMH Human Rights Policy, Section VII.

This handbook further describes the functions of the Area Human Rights Coordinators, Human Rights Officers and Human Rights Committees.

B. AREA HUMAN RIGHTS COORDINATOR

DMH Human Rights Policy #03-1 establishes the role of Area Human Rights Coordinator as the person responsible for overseeing human rights compliance within each DMH Area. The primary activities that the Coordinator is responsible for are the following:

1. Monitoring compliance with DMH regulations and policies governing Human Rights among all adult and child/adolescent client programs in the Area. These activities include, but are not limited to:
   - ensuring that each program location has a Human Rights Officer who is staff to a Human Rights Committee, which maintains rules of organization, keeps minutes of meetings and conducts annual site visits at all programs;
   - collecting and reviewing human rights committee minutes and responding to documented individual issues or trends;
   - ensuring that human rights training plans are developed and implemented; and
   - ensuring that, on an ongoing basis, all clients are offered education addressing their human rights;
2. Organizing and facilitating Area and/or Site-based Human Rights Officer training.
3. Meets bi-monthly with DMH Directors of Human Rights and the other Area Human Rights Coordinators to work on state-wide Human Rights agenda, including development of Human Rights Officer training curriculum, assisting with planning of state-wide conference and providing input into the policies which impact human rights.
4. Evaluating the need to establish additional forums for exploring human rights issues and offering support for Human Rights staff.
5. Providing consultation and technical assistance to DMH Area and Site offices, Mental Health Center(s), Human Rights Committees and provider agencies as required.
6. Addressing human rights issues as they relate to case management.
7. Serving on relevant Area committees.
8. Reviewing relevant data and reports to identify and address systemic human rights issues.

C. HUMAN RIGHTS OFFICER

1. In general

DMH regulations require that a Human Rights Officer be assigned to each facility that is operated, licensed or contracted for by DMH, as well as any community program that is operated, licensed or contracted for by DMH.

DMH Policy #03-1 provides that DMH and its facilities and programs must provide support for Human Rights staff. The Human Rights Officer must spend sufficient time at the program/facility site so that clients at the program/facility have regular and frequent opportunities to come in contact with and request assistance from the Human Rights Officer. Compliance with this provision may occur by appointing as Human Rights Officer either a staff person who works at the program/facility site or a staff person who visits the program/facility on a regular and frequent basis. However, the head of the program/facility may not be the Human Rights Officer.

The Human Rights Officer must have no day-to-day duties that are inconsistent with his/her responsibilities as a Human Rights Officer, including carrying out fact-finding activities under 104 CMR 32.00, DMH's investigation regulations.[221]

It is recommended that a Human Rights Officer for inpatients have no clinical responsibilities for patients of the facility. This is because an inpatient client's human rights concerns or complaints often involve decisions made by his/her clinicians.

2. Qualifications.

According to DMH Policy #03-1, it is preferable that a Human Rights Officer meet one or more of the following experience requirements prior to appointment as a Human Rights Officer by a Facility or Program:

(i) The Human Rights Officer has been employed by the facility or program for at least three months, or
(ii) The Human Rights Officer has been an advocate for clients' human rights for at least three months in any program or facility.

In addition, the Human Rights Officer must demonstrate a commitment to the protection and advocacy of clients' human rights. He/she must be able to work collaboratively and effectively with facility or program staff and the Human Rights Committee to ensure that clients' human rights are respected. [222]

[221] DMH Policy #03-1, (p.15)
[222] DMH Policy #03-1, (p.15)

3. Responsibilities of the Human Rights Officer

The Human Rights Officer must work closely with the facility or program leadership to ensure that the procedures and protections in place are in compliance with DMH policies and regulations in order to promote full respect and protection of clients' human rights.

DMH regulations and policy outline the specific responsibilities of the Human Rights Officer. Perhaps the most important responsibility is "to inform, train and assist clients served by the program/facility in the exercise of their rights."[223] More specifically, the Human Rights Officer role involves the following:

a. Assisting clients in exercising their rights.
The Human Rights Officer has the responsibility to advocate for and assist any person served by the program/facility whose human rights allegedly have been, are being or are at risk of being denied. The Human Rights Officer should use whatever internal program/facility procedures and communications may be available to seek protections of the individual's rights. These mechanisms include, but are not limited to:

- making inquiry into allegations of the denial of rights;
- meeting with appropriate clinical and administrative staff;
- negotiating on behalf of a person served by the program/facility;
- assisting an individual in filing a complaint or filing a complaint on his behalf; or
- filing an individual service plan appeal.

Assistance may vary depending on the ability of the client. The Human Rights Officer should make a special effort to monitor and assist persons who are not capable of making a request for assistance to the Human Rights Officer or who are not capable of advocating for themselves. For those clients who are able to advocate for themselves, the Human Rights Officer may find it best to empower the client to advocate for him/herself by providing information and encouragement rather than acting on behalf of the client.

b. Monitoring clients' rights. Working with the Human Rights Committee, the Human Rights Officer should monitor any limitations on rights. The Human Rights Officer should review all complaints and written decisions regarding complaints to understand the concerns of clients and to identify potential human rights violations. The Human Rights Officer may also monitor all accident and injury reports, incident reports, treatment plans, and other reports or documents reflecting a limitation on or an alleged violation of a client's rights.

[223] 104 CMR 27.14(1)(b) (facility) and 104 CMR 28.11(7)(c) (community)

c. Informing clients of their rights. The Human Rights Officer should take the steps necessary to inform all of the persons served by the program/facility of their human rights, including the opportunity to file complaints and the availability of the Human Rights Officer to assist them. This should include the distribution to newly admitted individuals of written materials (in language which a lay person can easily understand) describing their human rights and identifying the Human Rights Officer. It also should include periodically attending community meetings to discuss human rights, reminding clients of the role of the Human Rights Officer, advising individuals of their rights upon request and posting a notice of human rights and the name of the Human Rights Officer in a conspicuous place.

d. Resource regarding privacy rights. The Human Rights Officer in a program or facility is also a resource to clients and guardians for information regarding the facility or the program's privacy policy (in accordance with the federal requirements under HIPAA and state law).[224]

e. Training clients. In addition to informing clients of their rights on an informal and an *ad hoc* basis as described in item c. above, the Human Rights Officer (or another person) should develop and implement a plan to train all of the program/facility's clients regarding their human rights. Training assistance from persons both within and outside the program/facility may be useful.

f. Training staff. The Human Rights Officer (or another qualified person) should also educate staff regarding the rights of persons served by the program/facility. This training should occur as part of an annual staff orientation as well as at other formal and informal educational opportunities as appropriate.

g. Referrals for legal information, advice and representation. DMH regulations provide that a Human Rights Officer 's responsibilities include assisting clients "...in obtaining legal information, advice and representation through appropriate means, including referral to independent attorneys or legal advocates", when appropriate.[225] The Human Rights Officer should develop and maintain a current referral list of attorneys and legal advocates. Such a list appears in Appendix 3, Legal and Educational Resources.

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[224] DMH Policy #03-1

[225] 104 CMR 27.14(1)(c) (facility) and 104 CMR 28.11(7)(d) (community)

h. Human rights training participation. The regulations require the Human Rights Officer to "participate in training programs for Human Rights Officers offered by DMH."[226]

i. Knowledge of the rights of clients: To satisfy their responsibilities, Human Rights Officers must have a comprehensive knowledge of the rights of clients and how those rights may be exercised. Training programs can assist the Human Rights Officer in this regard, as well as provide needed collegial and professional support.

j. Staff to the Human Rights Committee**:** DMH regulations provide that the Human Rights Officer is to serve as staff to the facility's/ program's Human Right's Committee (HRC).[227] The Human Rights Officer should attend meetings of the HRC responsible for the program/facility. At HRC meetings, the Human Rights Officer should report his/her human rights activities and any particular human rights concerns or issues pertaining to the program/facility (for example, difficult individual human rights issues or program policies/practices impacting human rights). The Human Rights Officer may also perform certain tasks for the HRC (i.e. reviewing of restraint reports, suggesting agenda items for meetings and assisting with recruitment of new committee members) and may serve as a liaison between the committee, the head of the program/facility and other staff. However, as staff to the HRC, the Human Rights Officer is not a voting member of the committee.

k. Additional responsibilities related to restraint and seclusion: In settings where restraint or seclusion (R/S) is used, the Human Rights Officer has additional responsibilities regarding restraint and seclusion, and other forms of room restriction. The Human Rights Officer must:

1. promptly review a copy of each R/S form, including the client comment sheet, and follow through with clients and/or staff to address Human Rights concerns identified on R/S forms and client comment sheets;
2. monitor extended use of R/S for individual clients and follow through with clinical and/or administrative staff to address any particular concerns;
3. participate in the multidisciplinary team review of the assessments and treatment plans of clients who have experienced R/S;
4. provide the HRC with the facility's aggregate data regarding R/S; and participate in efforts to reduce R/S; [228] and
5. consider whether or not a complaint should be filed on behalf of a patient related to a restraint, in accordance with DMH seclusion/restraint regulations.[229]

[226] 104 CMR 27.14(1)(a) (facility) and 104 CMR 28.11(7)(a) (community)

[227] 104 CMR 27.14(1)(c) (facility) and 104 CMR 28.11(7)(b) (community)

[228] DMH Human Rights Policy #03-1, p.16

[229] 104 CMR 32.05 (2)(d)6

4. Facility only

Resource regarding the Sex Offender Registry Board

The Human Rights Officer, in DMH operated facilities, is to act as a resource to clients to clarify procedures related to registration with the Sexual Offender Registry Board.[230]

D. HUMAN RIGHTS COMITTEE (HRC)

1. In general (facility and community)

Each program and facility operated or funded by DMH must have a HRC. The HRC serves as an advisory committee to the head of the program/facility in order to help the program/facility protect the human rights of its clients.

2. Membership

Committee membership shall include a minimum of five people, the majority of whom must be consumers of mental health services, family members of consumers, or advocates. The membership should reflect the diversity of the communities served by the facility/program and, if possible, include other interested parties, such as clinicians, attorneys and guardians.

No member shall have any direct or indirect financial or administrative interest in the facility/program or in DMH. Membership on a DMH citizen advisory board or the board of trustees or board of directors of a facility/program shall not constitute such a financial or administrative interest. Neither receiving services from the facility/program nor being a family member of a client of the facility/program shall constitute such a financial or administrative interest.

A family member, guardian or attorney who represents one or more clients served by the facility/program may be a member of the HRC. However, neither the family member nor the guardian may participate as a committee member in any discussions or decisions regarding his/her family member or ward, and the attorney may not participate as a committee member in any discussions or decisions regarding his/her client's human rights, which are the subject of the attorney's representation.[231]

Potential members for committees which monitor DMH-operated facilities or programs must agree to a Criminal Offender Information (CORI) check before

[230] Commissioner's Directive #15 "Procedure for Implementation of Sex Offender Registry Law for DMH Inpatient Facilities" (October 1, 2002)
[231] 104 CMR 27.14(3); 104 CMR 28.11(5); and DMH Policy #03-1, (p. 17)

being appointed.[232] Programs contracting with DMH are encouraged, but not required, to conduct CORI checks of potential committee members.[233]

3. **Appointment**

a. Facility: The DMH Commissioner or his/her designee appoints members for the committees of facilities operated by or under contract with DMH.[234]

b. Program: For community programs, the program director shall appoint members to the committee.[235]

4. **Rules of operation**

Pursuant to 104 CMR 27.14 and 28.11, each HRC shall develop operating rules and procedures that include specific reference to quorum requirements, respecting client confidentiality, and dismissal of members. The term of office for HRC members is three years. No member shall be appointed to serve more than two consecutive three-year terms. A person must wait for at least one year after completing a second consecutive three-year term before becoming eligible for reappointment.[236]

The HRC is to meet as often as necessary upon the call of the chairperson or upon request of any two members, but no less often than quarterly. Minutes of all meetings are to be maintained and provided to DMH upon request.[237]

5. **Responsibilities**

The overall responsibility of each committee is to monitor the activities of the facility/program with which it is affiliated, in relation to the rights of clients the facility/program serves.[238] More specifically, a HRC must:

- Review and inquire about complaints related to allegation of mistreatment, harm or other alleged violations of a client's rights, in keeping with DMH's complaint regulations;
- Review the use of any form of restraint or other limitations on movement that are allowed under regulation for the facility/program; (See 104 CMR 27.12 for facilities and 104 CMR 28.05 for community programs)

[232] DMH policy 97-2 and DMH Policy 98-7
[233] DMH Policy 97-2
[234] 104 CMR 27.14(2)
[235] 104 CMR 28.11(1)
[236] DMH Policy # 03-1, (p.18)
[237] 104 CMR 28.11(5)
[238] 104 CMR 27.14(4) and 104 CMR 28.11(3).

- Review and monitor the facility/program's methods of informing clients and staff of clients' rights and of ensuring that clients have opportunities to exercise their rights to the fullest extent of their interests and capabilities;
- Recommend any improvements to the facility/program that enhance understanding and enforcement of clients' rights; and
- Visit the facility/program at least annually with or without notice (the latter, when good cause exists).[239]

6. <u>Multiple site committees allowed</u>

A single HRC may oversee multiple program sites and/or multiple programs in the facility or community, provided that the number, geographic separateness or programmatic diversity of the programs and sites are not so great as to limit the effectiveness of the HRC.[240]

7. <u>Child/Adolescent state-wide committee</u>

The continuing care units, IRTPs, BIRTs and CIRTs participate in a state-wide child/adolescent human rights committee. Membership includes providers, parents, professionals, advocates and current or past residents from the facilities/programs

[239] 104 CMR 27.14(4)(a-e); 104 CMR 28.11(3)(a-e); and DMH Policy #03-1.
[240] 104 CMR 28.11(2), 104 CMR 27.14(2)

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DMH POLICY

Title: Human Rights	Policy #: 03-1 Date Issued: January 10, 2003 Effective Date: January 10, 2003
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I. PURPOSE.

This policy establishes standards and procedures to ensure that the Department of Mental Health (DMH or Department) and its Programs and Facilities respect, support and protect the fundamental human, civil, constitutional and statutory rights of Clients. It repeals and replaces DMH policies #90-3, #95-4 and #95-5R.

The Human Rights framework of DMH is set forth in various statutes and regulations, including, among others, M.G.L. c. 123, §23 and 104 CMR 27.00 and 104 CMR 28.00. This policy explains and further defines the terms, standards and principles relevant to Human Rights, as set forth in those statutes and regulations. It is not an exhaustive description of all Human Rights, but shall serve as guide for respecting all Human Rights, even if not specifically mentioned herein.

DMH expects all staff to work together in a cooperative and collaborative manner to ensure that Human Rights standards are understood and respected, and are integrated within the treatment and philosophy of care of DMH and each Facility or Program. Although this policy articulates the special role of Human Rights Officers and Human Rights Committees to protect the Human Rights of Clients, the protection and enhancement of Human Rights is a common objective to be shared by all. Senior staff and managers have a responsibility to provide the leadership and model the values necessary to proactively implement this policy, and to ensure that DMH maintains a service environment that promotes respectful and responsive interactions with Clients.

II. SCOPE

This policy applies to DMH and its Facilities and Programs, as those terms are defined in Part III below. When special requirements apply only to Facilities or only to Programs or only to a particular kind of Facility or Program, or only to Minors, this is noted explicitly. This policy does not create an obligation to provide services or to create rights that are inconsistent with the type of service provided in a given setting. For example, a work program not designed to provide meals is not obligated by this policy to provide for such. Nothing herein shall be construed to require DMH or its Facilities and Programs to permit or facilitate Client behavior that is dangerous or illegal.

III. DEFINITIONS

Client: a person who receives case management from DMH or a service from a DMH Facility or Program. This definition is broader than the regulatory definition of Client in that it includes individuals in DMH Facilities who may receive services from DMH who are not DMH clients.

Facility: a hospital, inpatient unit, inpatient unit of a community mental heath center, psychiatric unit within a public health hospital or intensive residential treatment program for adolescents (including Behaviorally Intensive Residential Treatment programs), that is operated or contracted for by DMH.

Facility Director: the superintendent, chief operating officer or other head of a Facility.

Human Rights: values and fundamental principles intended to support and promote the worth, full respect and dignity of each individual. In addition to constitutional and statutory rights, Human Rights include the standards and rights set forth in DMH regulations (e.g., 104 CMR 27.13, 104 CMR 28.02 and 28.03) and this Policy.

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

Minor: a person under the age of 18 years.

Program: an organization or other entity that provides one or more community-based services that are contracted for or operated by DMH, including, but not limited to, outpatient, supported housing, residential, staffed apartments, day, emergency, respite and Clinically Intensive Residential Treatment programs. Program does not include case management, which is a DMH function.

Program Director: the person with day-to-day responsibility for a Program.

IV. HUMAN RIGHTS STANDARDS

DMH, and its Facilities and Programs, shall provide services that promote:

A. human dignity;
B. humane and adequate care and treatment;
C. self-determination and freedom of choice to an individual's fullest capacity;
D. the opportunity to receive services which are to the maximum extent possible consistent with the individual's needs and desires, and least restrictive of the individual's freedom;
E. the opportunity to move toward independent living;
F. the opportunity to undergo normal experiences, even though such experiences may entail an element of risk; provided, however, that the individual's safety or well-being or that of others shall not be unreasonably jeopardized;
G. the opportunity for individuals from all cultural backgrounds or with particular linguistic needs to participate to the maximum extent possible in activities and services, with the assistance of staff who possess appropriate cultural understanding and language skills or interpreters in accordance with applicable federal and state laws and DMH regulations;
H. the opportunity for individuals with physical disabilities to participate in activities and services;
I. an environment that protects individuals from physical, verbal and sexual abuse; and
J. the opportunity for individuals to engage in activities or styles of living according to individual desires and consistent with requirements of safety and the consideration of the Human Rights of others.

V. HUMAN RIGHTS AND RESPONSIBILITIES OF CLIENTS

A. Human Rights - General

Clients enjoy the same federal and state constitutional and statutory rights as any other person residing in Massachusetts, except insofar as the exercise of such rights has been limited by a court of competent jurisdiction, or is otherwise limited by the Client's legal status (for example, as a Minor, non-citizen or convicted felon). These rights, encompassed within the definition of Human Rights, include the right to manage one's own affairs, to contract, to hold professional, occupational or vehicle operator's licenses, to pursue judicial actions, to make a will, to marry, to hold or convey property and to vote in local, state and federal elections. Human Rights cannot be abridged solely by virtue of admission or commitment to an inpatient psychiatric hospital or because an individual is a Client. In cases where there has been an adjudication that a Client is incompetent and a guardian or conservator has been appointed for such Client, such appointment limits the Client's Human Rights only to the extent of the guardian or conservator's legal authority.

All Clients have the right to be free from any unlawful discrimination, including, but not limited to, discrimination on the basis of race, creed, national origin, religion, gender, sexual preference, language, age, veterans status, disability, HIV status or ability to pay. Where certain Human Rights may be restricted, they may be restricted only as enumerated in this policy, or as provided in an applicable statute or regulation.

B. Human Rights - Massachusetts General Law Chapter 123 (M.G.L. c.123), DMH Regulations (104 CMR) and Policies

M.G.L. c.123 and DMH regulations and policies enumerate some, but not all, of Clients' Human Rights. The following is a list of some of the Human Rights that are often inquired about, and their sources in the statute, regulations and policies. Attachment I contains a more comprehensive list of Human Rights covered by DMH regulations, other state and federal statutes and regulations, DMH policies, and other legal sources. Some Human Rights may be applicable only in a Program or only in a Facility.

NOTE: The regulations set forth in 104 CMR 28.00 et seq. are not applicable to Programs serving Minors licensed by the Office for Child Care Services (DEEC). Applicable DEEC regulations are set forth in 102 CMR 3.07. These Programs, however, are subject to the provisions of M.G.L. c.123, §23, and Section VII of this policy.

TOPIC	**FACILITY**	**COMMUNITY**
Access to Attorney or Legal Representative	**M.G.L. c.123 §23** 104 CMR 27.13(5)(e) and (f)	**M.G.L. c.123 §23** 104 CMR 28.03(1)(d)3 and (e)
Client Funds	**M.G.L. c.123§§4, 23 and 26** 104 CMR 27.13(2) and 30.00 DMH Policy #97-6	**M.G.L. c.123§ 23** 104 CMR 28.10 and 30.00
Clothing	**M.G.L. c.123 §23**	**M.G.L. c.123 §23**
Commercial Exploitation	This Policy, Section V.C., below	104 CMR 28.03(1)(f)
Complaints	104 CMR 27.13(5)(f) and 32.00	104 CMR 28.03(1)(i), 28.04(2) and 32.00
Contract, to enter into	**M.G.L. c.123 §24** 104 CMR 27.13(1)	104 CMR 28.10(1)
Court Hearings (Commitments)	**M.G.L. c.123 §§5-12 and 15-18** 104 CMR 27.13(9)	
Diet	This Policy, Section V.C., below	This Policy, Section V.C., below
Discrimination	This Policy, Section V.A.	104 CMR 28.03(a) This Policy, Section V.A.
Education	**M.G.L. c.123 §29** 104 CMR 27.13(4)	
Habeas Corpus	**M.G.L. c.123 §9** 104 CMR 27.13(8)	
Health Care Proxy	This Policy, Section V.C., below	This Policy, Section V.C., below
Hold and Convey Property	104 CMR 27.13 (1) This policy, Section V.A.	
Humane Psychological and Physical Environment	**M.G.L. c.123 §23** 104 CMR 27.13(5)(d)	**M.G.L. c.123 §23** 104 CMR 28.03(1)(h)
Informed Consent	104 CMR 27.10(1) and (3) 104 CMR 31.02 and 31.05(5) DMH Policy #96-3R	104 CMR 28.03(1)(j) and 28.10 104 CMR 31.02 and 31.05(5) DMH Policy #96-3R
Interpreter Services	**M.G.L. c.123 §23A** 104 CMR 27.18	
Labor	**M.G.L. c.123 §29**	104 CMR 28.07

TOPIC	FACILITY	COMMUNITY
Licenses, Professional, Occupational or Vehicle	**M.G.L. c.123 §24** 104 CMR 27.13(1) This Policy, Section V.A.	104 CMR 28.10(1) This Policy, Section V.A.
Mail	**M.G.L. c.123 §23** 104 CMR 27.13(5)(b)	**M.G.L. c.123 §23** 104 CMR 28.03(1)(d)2
Marriage	104 CMR 27.13(1)	This Policy, Section V.A.
Mistreatment	This Policy, Section V.C., below	104 CMR 28.04
Personal Possessions	**M.G.L. c.123 §23**	**M.G.L. c.123 §23** 104 CMR 28.08
Physical Exercise and Outdoor Access	This Policy, Section V.C., below	This Policy, Section V.C., below
Record Access	**M.G.L. c.123 §36** 104 CMR 27.17 For HIV/AIDS See DMH Policy #99-2	104 CMR 28.09 For HIV/AIDS See DMH Policy #99-2
Research Subject	104 CMR 31.05(3) (4) and (5)	104 CMR 31.05(3) (4) and (5)
Religion	This Policy, Section V.C., below	104 CMR 28.03(1)(b)
Searches	104 CMR 27.13(7) DMH Policy #98-3	104 CMR 28.08(2) and (3)
Seclusion and Restraint	**M.G.L. c.123 §21** 104 CMR 27.12 DMH Policy #93-1	104 CMR 28.05
Storage Space	**M.G.L. c.123 §23**	**M.G.L. c.123 §23**
Telephone Access	**M.G.L. c.123 §23** 104 CMR 27.13(5)(a) and (6)	**M.G.L. c.123 §23** 104 CMR 28.03(1)(d)1 and (d)3

TOPIC	FACILITY	COMMUNITY
Treatment and Services • **Behavior Management Plan (Children and Adolescents only)** • **Development and appeals of Treatment and Service Plans** • **Periodic/Annual Review of Treatment/Service Plan** • **Receipt of Treatment and Services** • **Privileges**	**M.G.L. c.123 §4** 104 CMR 27.10, 11 and 13 This Policy, Section V.C., below	104 CMR 29.00 This Policy, Section V.C., below DMH Policy #96-1
Visitors	**M.G.L. c.123 §23** 104 CMR 27.13(5)(c) and (e) and (6)	**M.G.L. c.123 §23** 104 CMR 28.03(1)(d) 3. and (g)
Vote	104 CMR 27.13(1)	104 CMR 28.03(1)(c) and 28.10(1)
Wills	**M.G.L. c.123 §24** 104 CMR 27.13(1)	104 CMR 28.10(1)

C. Human Rights – Extension of Certain Human Rights

Some Human Rights are specifically addressed in DMH's regulations for Community Programs but not for Facilities. Through this policy, DMH extends certain of these Human Rights to Clients in Facilities as set forth below. In addition, certain Human Rights are not specifically covered by DMH's regulations. Through this policy, DMH clarifies that these additional Human Rights extend to Clients as set forth below.

1. **Commercial Exploitation**. As in Programs, utmost care shall be taken by Facilities to protect Clients from commercial exploitation.
2. **Mistreatment**. As in Programs, no Facility shall mistreat or permit the mistreatment of a Client by its staff. Mistreatment, as defined in 104 CMR 28.04, includes any intentional or negligent action or omission that exposes an individual to a serious risk of physical or emotional harm. Mistreatment includes but is not limited to:
   a) Corporal punishment or any unreasonable use or degree of force or threat of force or coercion;
   b) Infliction of mental or verbal abuse such as abusive screaming or name calling;
   c) Incitement or encouragement of Clients or others to mistreat a Client;
   d) Transfer or the threat of transfer of a Client for punitive reasons;
   e) The use of restraint as punishment or primarily for the convenience of staff;
   f) Any act in retaliation against a Client for reporting any violation of the provisions of 104 CMR to DMH.

   The Facility Director shall investigate or report to DMH allegations of mistreatment in accordance with the requirements of 104 CMR 32.00.

3. **Participation in Treatment Planning.** When clinically and age-appropriate, all Clients, including those with a LAR, shall have the opportunity to participate in and contribute to their

treatment planning to the maximum extent possible. As in Programs, Clients in Facilities may request individuals of their choosing, including their attorney, to attend treatment and service planning meetings. Facilities shall make reasonable efforts to accommodate such requests.

4. **Religion.** As in Programs, Clients in Facilities have the right to religious freedom and practice without compulsion according to the preference of the Client.

5. **Physical Activities and Access to the Outdoors**. To the maximum extent possible, all Clients have the right to an opportunity for physical exercise and access to the outdoors consistent with requirements for safety.

6. **Health Care Proxy**. All adult Clients have the right to execute a Health Care Proxy consistent with and subject to the provisions of M.G.L. c.201D.

7. **Diet.** A Client in a Facility, or in a Program that is required to furnish meals, has the right to an appropriate and nourishing diet consistent with medical requirements and the Client's religious and cultural beliefs and, to the extent possible, in accordance with personal preferences.

8. **Changes to Treatment or Service Plans.** All Clients and their LAR, if any, have the right to request changes to their treatment and service plans (including a request for a change in their Facility, Program, treating physician or other clinician, or case manager). Best efforts shall be made to accommodate the request, consistent with (i) the clinical appropriateness of the request, (ii) the ability of the Facility or Program to grant the request, (iii) the need to provide treatment in an emergency situation, and (iv) the Client's eligibility for admission to another service provider or agency (e.g., Veterans Administration or Massachusetts Rehabilitation Commission). Under certain circumstances, the DMH Area of Responsibility Policy #99-1, or any successor policy, may also apply. See also, Inpatient 104 CMR 27.10(1)(Consent to Treatment), Community 104 CMR 29.03, 29.06-29.11 (Service Planning).

9. **Voting.** Facilities shall provide reasonable assistance to Clients to register and vote, similar in manner to Programs' responsibilities under 104 CMR 28.03 (1)(c).

D. Human Rights - Responsibilities

1. Every Client shall be responsible for respecting the Human Rights of staff and other Clients.

2. Every Client shall be responsible for following the operational rules and procedures applicable to DMH and its Facilities and Programs.

3. Every Client shall be responsible for respecting the property of other Clients, staff, DMH and its Facilities and Programs.

VI. RESPONSIBLITIES OF DMH, FACILITIES AND PROGRAMS

A. Support and Protect Human Rights

1. It is the responsibility of DMH and its Facilities and Programs to ensure that Clients may exercise their Human Rights without harassment or reprisal, including the denial of appropriate and available treatment and services. DMH and its Facilities and Programs must ensure that their staffs comply with all applicable regulations, policies and procedures.

2. Every DMH staff person and all staff in Facilities and Programs are responsible for supporting and protecting Clients' Human Rights. This responsibility includes, but is not limited to, identifying a Client's need for assistance regarding his/her Human Rights, taking appropriate steps to ensure that Human Rights are fully respected, and assisting Clients in gaining access to Human Rights resources outside DMH.

B. Requirements When Restricting Human Rights

In limited circumstances it may be necessary for a Facility or Program to restrict a Client's exercise of a right. A right may be restricted only if permitted by, and in accordance with, law, regulation or policy. Furthermore, no right shall be restricted unless less restrictive alternatives have been tried and have failed or would be futile to attempt. Some Human Rights cannot be restricted; for instance, pursuant to M.G.L. c.123, §23, visits and phone calls from or to a Client's attorney, legal advocate, physician, psychologist, clergy member or social worker cannot be restricted. Questions as to whether a right can be restricted and under what standard should be addressed to the applicable HRO or legal counsel. For children in the custody of the Department of Social Services (DSS), see Commissioner's Directive #16.

Note: In Facilities only, rights to telephone or visitor access may be restricted pursuant to 104 CMR 27.13(6). In determining if the standard for restricting a right is met with respect to a Minor, a Facility may take into consideration the age and developmental level of such Minor, as well as family and cultural issues relevant to his or her treatment, and may rely on information supplied by the Client's LAR, records and information from prior treatment providers, or other sources of reliable information.

If any right is restricted, the following procedures must be followed:

1. Review. All restrictions are considered temporary and, at a minimum, shall be reviewed at least at the time of the treatment plan modification or review.

Note: If the restriction concerns telephone or visitor access in a Facility, then it must be reviewed and approved by the Facility Director or designee and documented daily by clinical staff for the first 14 days of the restriction. If the restriction is continued for more than 14 days, the Facility Director must review and approve the continuation and, if continued, then the reasons for the restriction shall be considered a treatment issue and must be incorporated into the Client's treatment plan. The Facility Director shall review all such restrictions monthly. In all instances where telephone or visitor access has been restricted, access shall be restored immediately when determination is made that the risk no longer justifies the restriction.

2. Time Period. The length of a restriction of any right must be related to an identified risk of harm or an identified good cause.

3. Notification. The Human Rights Officer and the Client's LAR, if any, shall be notified of the restriction as soon as possible, but not later than 24 hours after it is imposed.

4. Documentation. Imposition of the restriction shall be documented with specific facts as to the reason for the restriction in the Client's record. If a restriction is made due to a restraining order or other court order, then a copy of the restraining or other court order shall be retained in the Client's record.

   Note: Where the restriction concerns telephone or visitor access in a Facility, such documentation also shall include the less restrictive alternatives that were tried and failed or would be futile to attempt, as well as criteria for lifting the restriction.

C. Informing Clients of Human Rights and Responsibilities.

1. **Postings**.

   Pursuant to M.G.L. c.123, §23, 104 CMR 27.13(12) and 28.03(2), DMH shall provide, and each Facility, Program, DMH Area and Site Office shall post, a summary of Clients' Human Rights and responsibilities, a notice of availability of the HRO (and how to contact him or her), an explanation of how to access legal representation, DMH's toll-free information and referral line (1-800-221-0053), and an explanation of the applicable DMH, Disabled Persons Protection Commission (DPPC), DSS and Executive Office of Elder Affairs (EOEA) complaint processes, where applicable.

   The required postings shall be placed in appropriate and conspicuous locations to which Clients and LARs have access, including in each Facility's admitting room and inpatient unit and at outpatient and day activity programs. However, a Client living independently and receiving services from a DMH supported housing Program may decide not to have such postings displayed.

2. **Written Materials**.

   In addition to the postings, every Facility and Program shall distribute written materials to each Client and LAR, if any, upon admission of the Client to the Facility or entrance into a Program, at least annually thereafter and upon request, that contains:

   - a summary of Clients' Human Rights and responsibilities;

- the role, responsibilities and availability of the HRO and HRC and how to contact the applicable HRO;
- notice of the Client's right to an interpreter at no cost to the Client (Facility only);
- contact information for legal assistance (e.g., Massachusetts Mental Health Protection and Advocacy Project, the Mental Health Legal Advisors Committee, the Committee for Public Counsel Services, and other legal services agencies funded by the Massachusetts Legal Assistance Corporation);
- the toll-free number for the DMH information and referral line (1-800-221-0053);
- the procedures for filing a DMH complaint under 104 CMR 32.00;
- the procedures for filing a complaint of abuse or neglect with the DPPC (for persons aged 18 through 59), DSS (for persons under the age of 18) and EOEA (for persons over the age of 59).

If a Client receives only case management from DMH, the Site Office shall be responsible for providing the above referenced written materials.

In addition, every Facility, Program, Area and Site Office shall ensure that DMH complaint forms are readily available to Clients and LARs.

3. **Language**.

The postings and written materials shall be in words understandable and age-appropriate to Clients and LARs and, to the extent possible, translated into appropriate languages. They also shall be made accessible to individuals who are visually impaired.

D. Develop and Implement a Human Rights Training Plan

1. Each Area, Facility and Program shall develop and fully implement a training plan to ensure that staff, HROs, HRCs, Clients and LARs are informed about Clients' Human Rights. The training plan shall be in writing and updated as needed. The plan shall include a description of the training, how frequently it will be offered, and the intended audience. At a minimum, the plan must ensure that:

a) All staff are trained at orientation and annually thereafter on:
   - the value of Human Rights;
   - the DMH Human Rights policy;
   - the role of the LAR in relationship to the Human Rights of Minors and others under guardianship; for staff responsible for Minors, this also shall include (as appropriate) applicable DSS, DEEC and Department of Education regulations;
   - the role and responsibilities of the HROs, HRCs and Area Human Rights Coordinator;
   - all applicable complaint procedures;
   - mental illness and stigma;
   - the role of culture, language and religion in the provision of services; and
   - the role of staff in promoting and protecting Clients' Human Rights.

b) Clients are given materials and/or instruction designed to help them understand and protect their Human Rights.

c) LARs are given materials and/or instruction aimed at helping them understand Clients' Human Rights.

d) HRC members are given materials and/or instruction so they can understand the Human Rights of the Facility's or Program's Clients, and their role in the protection of these Human Rights.

To the extent possible, Facilities and Programs shall include Clients, former Clients, family members and Human Rights staff in developing the plans and in the training.

2. The Office for Human Rights shall develop a plan for training all Central Office staff at orientation and annually on the structure and content of the DMH's Human Rights program.

E. Law Enforcement Investigations

Each Facility and Program shall establish a protocol that provides for advance notice, when possible, to the HRO or other designated staff, of any police interview or investigation of a Client so that appropriate assistance can be offered to the Client. No such protocol shall be construed to interfere with the conduct of a lawful police investigation.

VII. HUMAN RIGHTS INFRASTRUCTURE.

A. Create and Maintain a Human Rights Infrastructure.

1. DMH and its Facilities and Programs must create and maintain an infrastructure for protecting Clients' Human Rights that includes, where applicable, the appointment of a Human Rights Advisory Council (HRAC) pursuant to 104 CMR 26.04(6), and Human Rights Officers (HROs) and Human Rights Committees (HRCs) as set forth in 104 CMR 27.14 and 28.11, this Subsection C of Section VI. and Section VII. of this Policy.

2. DMH and its Facilities and Programs must provide support for Area Human Rights Coordinators, HROs and HRCs. Each Area, Facility and Program must provide its Area Human Rights Coordinator or HRO(s), respectively, with adequate time, resources and support from senior staff to carry out their responsibilities. If Human Rights responsibilities are assigned to a staff person in addition to his/her principal duties, these other duties shall be modified to accommodate the Human Rights responsibilities. No duties shall conflict with the Human Rights staff person's primary Human Rights responsibilities. For example, the Human Rights staff person should not be responsible for conducting fact-finding activities pursuant to 104 CMR 32.00. Each staff person with specific Human Rights responsibilities shall have a job description that includes all duties (including Human Rights responsibilities) the person is expected to perform.

Furthermore, each Area, Facility and Program shall ensure an environment where Area Human Rights Coordinators, HROs, members of a HRC and other staff who pursue Human Rights complaints on behalf of a Client can function without fear of retaliation from any individual employed by the Area, Facility or Program. Any person who believes that this standard has been violated should first seek to resolve the issue within the Area, Facility or Program unless the person believes that such a process will not satisfactorily address the issue. Any alleged violation of this standard may then be reported to the applicable Area Director or designee, who shall take appropriate action, including

considering whether the issue is a licensing or contract violation. If resolution is not achieved, the matter shall be referred to the DMH Office for Human Rights for further review.

3. Where appropriate, DMH and its Facilities and Programs shall solicit input from Human Rights personnel (i.e., HROs, and HRAC and HRC members) when developing policies or procedures that may impact Clients' Human Rights.

Note: When a Program operates more than one site with multiple HROs, the Program shall appoint a staff person, who may be one of the Program's HROs, who shall train, support and coordinate the work of the Program's various HROs. This individual shall ensure the availability of HRO assistance to Clients.

B. Office for Human Rights

There shall be an Office for Human Rights within the DMH Central Office to oversee the protection of Human Rights. The Commissioner shall determine the staffing complement, which generally will include a Director of Human Rights for Adults and a Director of Human Rights for Children and Adolescents. The Director of Human Rights for Adults shall supervise DMH-operated hospital HROs, and support and assist other Facility and Program HROs. The Director of Human Rights for Children and Adolescents shall support and assist child and adolescent Facility and Program HROs. The Office for Human Rights shall support and assist the Area Human Rights Coordinators and provide ongoing training and curriculum development and support for the DMH Human Rights Advisory Committee.

C. Area Human Rights Coordinators

Each Area Director shall designate a staff person to be the Area Human Rights Coordinator to assist the Area in implementing this policy. The Area Human Rights Coordinator shall provide or arrange regular training and information-sharing meetings, as necessary, for the Area and Site Offices, for HROs from Programs and DMH-operated CMHCs, and for HRC members. The Area Human Rights Coordinator also shall serve as a consultant concerning Human Rights issues to staff at the Area and Site Offices, Programs and DMH-operated CMHCs. In addition, the Area Human Rights Coordinator shall address Human Rights issues as they relate to case management.

D. Human Rights Officers (HRO)

1. **In General**. Each Facility or Program shall have a HRO. A HRO shall have no duties, such as acting as a fact-finder as part of the complaint process, that conflict with his or her responsibilities as a HRO. The HRO may not be the head of the Facility or Program, or the head of a local service site (e.g., a residence or day Program).

Facility:

a) Each state hospital, including the psychiatric units located within a public health hospital, shall employ a person full-time to serve as a HRO. The HRO shall be appointed by the Commissioner or designee, and shall be supervised by the Director of Human Rights for Adults.

b) Each Community Mental Health Center shall employ a person either full-time or part-time to serve as a HRO. The HRO shall be appointed by the Commissioner or designee, shall be supervised by a staff person from that Facility and shall receive support from the DMH Office for Human Rights. An alternate HRO shall be appointed to assist any Client for whom the principal HRO has direct clinical responsibility.

c) Each Intensive Residential Treatment Program (IRTP) and Behaviorally Intensive Residential Treatment program (BIRT) and the Western Massachusetts Area adult contracted inpatient unit shall employ a person either full-time or part-time to serve as a HRO. The HRO shall be appointed by the Facility Director and supervised by a staff person from that Facility. The HRO for IRTPs and BIRT programs shall receive support from the DMH Director of Human Rights for Children and Adolescents, and the HRO for the contracted inpatient unit shall receive support from the DMH Office for Human Rights. An alternate HRO shall be appointed to assist any Client for whom the principal HRO has direct clinical responsibility.

Program:

Each Program shall have a person employed by or affiliated with the Program to serve as a HRO. The HRO shall be appointed by the Program Director, supervised by a staff person from the vendor or Program and receive support from the DMH Office of Human Rights. The HRO's schedule shall allow sufficient time for regular and frequent contact with Clients. An alternate HRO shall be appointed to assist any Client for whom the principal HRO has direct clinical responsibility.

2. **Role and Responsibilities of a Human Rights Officer:**

The HRO must demonstrate a commitment to the protection and advocacy of Clients' Human Rights. He or she must be able to work collaboratively and effectively with Facility or Program staff and the HRC to promote respect for the Human Rights of Clients. The HRO shall make affirmative efforts to assist Clients who may not be capable of making a request to the HRO for assistance.

a) <u>Duties</u>. Facility HROs are responsible for those duties set forth in 104 CMR 27.14(1) and Program HROs for those duties set forth in 104 CMR 28.11(7).

b) <u>Qualifications</u>. It is preferable that a HRO meet one of the following experience requirements prior to appointment as a HRO by a Facility or Program:

(i) the HRO has been employed by the Facility or Program for at least three months; or

(ii) the HRO has been an advocate for Clients' Human Rights for at least three months in any Program or Facility.

c) <u>Training</u>. Prior to assuming his or her duties as a HRO, the person shall receive training by the Program, Facility or DMH, designed around a set of basic competencies established by DMH. HROs also shall participate in any applicable training programs for HROs offered by DMH.

d) <u>Representing the perspective of the Client</u>. The HRO should clearly and consistently act to ensure that the points of view of the Clients served by the Facility or Program are understood and respected, whether addressing a policy issue or assisting an individual Client. The expectation is not that a particular Client's perspective will always prevail since, for example, what the Client wants might be impossible to achieve or might conflict with the Human Rights of another Client. However, the goal of the HRO is continually to seek resolution of Human Rights issues consistent with the Client's perspective.

e) Law enforcement investigations. In the event of any police interview or investigation of a Client, the HRO or staff person designated by the Facility or Program shall contact the Client to determine whether the Client wants or needs assistance in accordance with the Facility's or Program's protocol.

f) Monitoring Clients' Human Rights. The HRO, with the assistance of the HRC, shall monitor the Facility's or Program's compliance with its Human Rights practices and procedures and with this policy. The HRO shall ensure that complaints are filed as necessary to address any illegal, dangerous or inhumane incident or condition. The HRO also shall review and monitor the complaint process (including all complaints and written decisions), any searches for contraband (see DMH Policy # 98-3 or any successor policy), incident reports, treatment plans, citizen monitoring reports and any other policies or practices which may infringe upon Clients' Human Rights.

g) Monitoring of Restraint and Seclusion.

(i) In a Facility**,** areas to be monitored include individual incidents of restraint and seclusion (R/S). The HRO shall:

- promptly review a copy of each R/S form, including the Client comment sheet, and follow through with Clients and/or staff to address Human Rights concerns identified on R/S forms and Client comment sheets;
- monitor extended use of R/S for individual Clients and follow through with clinical and/or administrative staff to address any particular concerns;
- participate in the multidisciplinary team review of the assessments and treatment plans of Clients who have experienced R/S;
- provide the HRC with the Facility's aggregate data regarding R/S;
- participate in efforts to reduce R/S.

(ii) In a Program licensed by DMH, the HRO shall review a copy of each restraint form, including the Client comment sheet and assist the HRC in reviewing each incident of physical restraint.

E. Human Rights Advisory Committee

The Commissioner shall appoint a statewide Human Rights Advisory Committee (HRAC), pursuant to 104 CMR 26.04(6), whose duty it shall be to advise the Commissioner on all matters pertaining to the Human Rights of Clients served by the Department.

F. Human Rights Committees

1. **In General.** Each Facility or Program shall maintain a HRC. The general responsibility of the HRC shall be to monitor the Facility or Program with regard to the exercise and protection of the Human Rights of Clients and to advise the Facility or Program regarding how it might improve the implementation of Human Rights. The HRC shall:

a) Meet regularly, but not less often than quarterly, to understand the Facility's or Program's support of Human Rights and advise the Facility or Program Director on Human Rights. The HRC shall make recommendations to the Facility or Program and to DMH to optimize the degree to which the Human Rights of Clients are understood and upheld.

b) Monitor Human Rights Processes and Procedures. The HRC shall review and make inquiry into complaints and allegations of Client mistreatment, harm or violation of a Client's Human Rights and may act on behalf of a Client pursuant to 104 CMR 32.00. The HRC also shall review and monitor the use of restraint and seclusion and review, where applicable, incident reports and other relevant documents, such as treatment plans, that limit or allegedly violate a Clients' Human Rights. The HRC shall review and monitor the methods utilized to inform Clients and staff of Clients' Human Rights, train Clients in the exercise of their Human Rights, and provide Clients with opportunities to exercise their Human Rights to the fullest extent of their capabilities and interests. The HRC shall be familiar with the written information provided to Clients.

   The HRC shall collaborate with the HRO and have access to Clients and their LARs, Client records, incident reports, Facility and Program policies, and staff in order to carry out their responsibilities. The HRC shall respect the privacy and confidentiality of any information it receives that identifies a particular Client.

c) The HRC may file a complaint or an appeal on behalf of an individual Client or group of Clients. By filing a complaint, the HRC becomes a party to that complaint. The HRC may become a party to an existing complaint by filing a notice to intervene in the complaint process pursuant to 104 CMR 32.02.

d) Visit the Facility or Program: The HRC shall visit the Facility or Program at least once per year with prior notice, or without notice provided good cause exists. The purpose of the site visit is to familiarize HRC members with the Facility or Program and to monitor the protection of Human Rights within the Facility or Program.

e) Review and provide feedback to DMH, the Facility or Program concerning relevant policies and procedures.

2. **Membership:** In addition to meeting the HRC membership requirements set forth in 104 CMR 27.14(3) and 28.11(5) concerning consumers, family members and advocates, membership of the HRC should reflect the diversity of the communities served by the applicable Facility and Program and, if possible, include other interested parties, such as clinicians, attorneys and guardians.

   No member shall have any direct or indirect financial or administrative interest in the Facility or Program or in DMH. For purposes of this policy, membership on a DMH citizen advisory board or the board of trustees or board of directors of a Facility or Program shall not constitute such a financial or administrative interest. Neither shall receiving services from the Facility or Program or being a family member of a Client of the Facility or Program constitute such a financial or administrative interest.

   A family member, guardian or attorney who represents one or more Clients served by the Facility or Program may be a member of the HRC. However, neither the family member nor guardian may participate as a committee member in any discussions or decisions regarding his/her family member or ward, and the attorney may not participate as a committee member in any discussions or decisions regarding his/her client's Human Rights which are the subject of the attorney's representation.

3. **Appointment of Members**.

(a) Facility: The Commissioner or designee appoints members of HRCs. When vacancies occur, the Commissioner or designee shall appoint successors from nominations forwarded by both the HRC and the Facility Director. This includes the child and adolescent HRC that covers adolescent inpatient, IRTP, BIRT and CIRT programs.

(b) Program: The Program Director appoints members of HRCs. When vacancies occur after the initial appointments, the Program Director shall appoint successors from nominations made and approved by both the HRC and the Program Director.

4. Pursuant to 104 CMR 27.14 and 28.11, each HRC shall develop operating rules and procedures that include specific reference to: quorum requirements; respecting client confidentiality; and dismissal of members. The term of office for the HRCs is three years. No member shall be appointed to serve more than two consecutive three-year terms. A person must wait for at least one year after completing a second consecutive three-year term before becoming eligible for reappointment.

VIII. POLICY IMPLEMENTATION

The Commissioner or designee shall ensure that the Central Office meets the requirements within this policy.

The Area Director or designee shall monitor the Area and Site Offices as well as each Facility and Program in its Area to ensure that it meets the requirements within this policy regarding its Area Human Rights Coordinator, HRO(s), HRC, Human Rights practices and procedures and Human Rights training plan, except as provided below.

The Assistant Commissioner for Child and Adolescent Services or designee shall monitor the statewide child and adolescent Facilities and Programs to ensure they meet the requirements of this policy.

Any Program subject to this policy that is licensed by DMH shall be monitored for its compliance with this policy as part of the DMH licensing process.

IX. REVIEW OF THIS POLICY

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

ATTACHMENT #I

References to Statutes, Regulations, Accreditation Standards and Relevant Policies

The following references are presented as a guide to facilitate the identification of relevant standards and policies. Each reference cited below should be consulted to determine its exact scope and content, and to determine whether any revision has been issued after the issuance of this policy. If any reference has been replaced with a successor provision, the successor provision should be used.

A. Statutory References

Massachusetts General Laws, Department of Mental Health Statutes:

M.G.L. c.123, §4 (Periodic Review)
M.G.L. c.123, §9 (Review of Matters of Law; Application for Discharge)
M.G.L. c.123, §12(b) (Hospital Admission)
M.G.L. c.123, §23 (Rights and Privileges of Patients)
M.G.L. c.123 §23A (Interpreter Services)
M.G.L. c.123, §24 (Commitment as Affecting Legal Competency of Persons)
M.G.L. c.123, §26 (Deposit of Funds Held in Trust for Inpatients or Residents)
M.G.L. c.123, §29 (Education and Work Programs)

Other State and Federal Statutes:

M.G.L. c.19A, §15 (Mass. Executive Office of Elder Affairs - Abuse of Elderly Persons Reporting)
M.G.L. c.19C (Mass. Disabled Persons Protection Commission - Enabling Act)
M.G.L. c.66A (Mass. Fair Information Practices)
M.G.L. c.71B (Mass. Dept. of Education - Children with Special Needs)
M.G.L. c.111, §70E (Mass. Dept. of Public Health - Patients' and Residents' Rights)
M.G.L. c.119, §51A (Mass. Dept. of Social Services -Child Abuse Reporting)
M.G.L. c.151B (Mass. Anti-Discrimination Laws)
M.G.L. c.201D (Health Care Proxies)
20 USC 1400 et seq. (Federal Special Education Act)
29 USC 201, et seq. (Federal Fair Labor Standards Act)
42 USC 12101, et seq. (Federal Americans with Disabilities Act)
42 USC 10801, et seq. (Federal Protection and Advocacy for Persons with Mental Illness)
42 USC 1320d-1329d-8 (Federal Privacy - Health Insurance Portability and Accountability Act of 1996)

B. Regulatory References

Massachusetts Department of Mental Health Regulations:

104 CMR 27.05 (General Admission Procedures)
104 CMR 27.06 (Voluntary and Conditional Voluntary Admission)
104 CMR 27.07 (Four Day Involuntary Commitment)
104 CMR 27.08 (Transfer of Patients)
104 CMR 27.09 (Discharge)
104 CMR 27.10 (Treatment)
104 CMR 27.11 (Periodic Review)
104 CMR 27.12 (Restraint and Seclusion)
104 CMR 27.13 (Human Rights)

104 CMR 27.14 (Human Rights Officer; Human Rights Committee)
104 CMR 27.15 (Visit)
104 CMR 27.16 (Absence Without Authorization)
104 CMR 27.17 (Records)
104 CMR 27.18 (Interpreter Services)
104 CMR 28.02 (Standards to Promote Client Dignity)
104 CMR 28.03 (Legal and Human Rights of Clients)
104 CMR 28.04 (Protection from Mistreatment)
104 CMR 28.05 (Physical Restraint)
104 CMR 28.06 (Medication)
104 CMR 28.07 (Labor)
104 CMR 28.08 (Possessions)
104 CMR 28.09 (Access to Records and Record Privacy)
104 CMR 28.10 (Legal Competency, Guardianship and Conservatorship)
104 CMR 28.11 (Human Rights Committee; Human Rights Officer)
104 CMR 28.12 (Termination from Program)
104 CMR 29.00 (Service Planning)
104 CMR 30.02 (Funds Belonging to Patients in Facilities)
104 CMR 30.03 (Client Funds in Community Programs)
104 CMR 30.04 (Charges for Care)
104 CMR 32.00 (Investigation and Reporting Responsibilities)

Other State and Federal Regulations:

102 CMR 1.01 et seq. (Mass. Department of Early Education and Care)
110 CMR 11.04(2) (Mass. Dept. of Social Services - Routine Medical Care, Consent)
603 CMR 28.00 (Mass. Dept. of Education - Special Education)
42 CFR 51.41 (Federal Regulations Applicable to Protection and Advocacy Programs)
45 CFR Parts 160 and 161 (Federal Regulations Applicable to Privacy)

C. Judicial Decisions

Rogers v. Commissioner of Mental Health, 390 Mass. 489 (1983) and other related decisions of the Massachusetts Supreme Judicial Court regarding special treatment decisions and patients' rights to refuse treatment.

D. Accreditation Standards

JCAHO Accreditation Manual for Mental Health Chemical Dependency, and Mental Retardation/Developmental Disabilities Services Rights and Responsibilities
JCAHO Accreditation Manual for Hospitals, Patient Rights

E. Department of Mental Health Policies

DMH Policy 93-1 (Seclusion and Restraint)
DMH Policy 99-2 (HIV/AIDS)
DMH Policy 96-1 (Patient Privileges)
DMH Policy 96-3R (Informed Consent)

DMH Policy 97-6 (Patient Funds)
DMH Policy 98-1 (Charges for Care)
DMH Policy 98-3 (Searches)

FIVE FUNDAMENTAL RIGHTS

Mass. Ann. Laws ch. 123, § 23 (2001)

§ 23. Rights and Privileges of Patients.

This section sets forth the statutory rights of all persons regardless of age receiving services from any program or facility, or part thereof, operated by, licensed by or contracting with the department of mental health, including persons who are in state hospitals or community mental health centers or who are in residential programs or inpatient facilities operated by, licensed by or contracting with said department. Such persons may exercise the rights described in this section without harassment or reprisal, including reprisal in the form of denial of appropriate, available treatment. The rights contained herein shall be in addition to and not in derogation of any other statutory or constitutional rights accorded such persons.

Any such person shall have the following rights:

(a) reasonable access to a telephone to make and receive confidential telephone calls and to assistance when desired and necessary to implement such right; provided, that such calls do not constitute a criminal act or represent an unreasonable infringement of another person's right to make and receive telephone calls;

(b) to send and receive sealed, unopened, uncensored mail; provided, however, that the superintendent or director or designee of an inpatient facility may direct, for good cause and with documentation of specific facts in such person's record, that a particular person's mail be opened and inspected in front of such person, without it being read by staff, for the sole purpose of preventing the transmission of contraband. Writing materials and postage stamps in reasonable quantities shall be made available for use by such person. Reasonable assistance shall be provided to such person in writing, addressing and posting letters and other documents upon request;

(c) to receive visitors of such person's own choosing daily and in private, at reasonable times. Hours during which visitors may be received may be limited only to protect the privacy of other persons and to avoid serious disruptions in the normal functioning of the facility or program and shall be sufficiently flexible as to accommodate individual needs and desires of such person and the visitors of such person.

(d) to a humane psychological and physical environment. Each such person shall be provided living quarters and accommodations which afford privacy and security in resting, sleeping, dressing, bathing and personal hygiene, reading and writing and in toileting. Nothing in this section shall be construed to require individual sleeping quarters.

(e) to receive at any reasonable time as defined in department regulations, or refuse to receive, visits and telephone calls from a client's attorney or legal advocate, physician, psychologist, clergy member or social worker, even if not during normal visiting hours and regardless of whether such person initiated or requested the visit or telephone call. An attorney or legal advocate working under an attorney's supervision and who represents a client shall have access to the client and, with such client's consent, the client's record, the hospital staff responsible for the client's care and treatment and any meetings concerning treatment planning or discharge planning where the client would be or

has the right to be present. Any program or facility, or part thereof, operated by, licensed by or contracting with the department shall ensure reasonable access by attorneys and legal advocates of the Massachusetts Mental Health Protection and Advocacy Project, the Mental Health Legal Advisors Committee, the committee for public counsel services and any other legal service agencies funded by the Massachusetts Legal Assistance Corporation under the provisions of chapter 221A, to provide free legal services. Upon admission, and upon request at any time thereafter, persons shall be provided with the name, address and telephone number of such organizations and shall be provided with reasonable assistance in contacting and receiving visits or telephone calls from attorneys or legal advocates from such organizations; provided, however, that the facility shall designate reasonable times for unsolicited visits and for the dissemination of educational materials to persons by such attorneys or legal advocates. The department shall promulgate rules and regulations further defining such access. Nothing in this paragraph shall be construed to limit the ability of attorneys or legal advocates to access clients records or staff as provided by any other state or federal law.

Any dispute or disagreement concerning the exercise of the aforementioned rights in clauses (a) to (e), inclusive, and the reasons therefor shall be documented with specific facts in the client's record and subject to timely appeal.

Any right set forth in clauses (a) and (c) may be temporarily suspended, but only for a person in an inpatient facility and only by the superintendent, director, acting superintendent or acting director of such facility upon such person; concluding, pursuant to standards and procedures set forth in department regulations that, based on experience of such person's exercise of such right, further such exercise of it in the immediate future would present a substantial risk of serious harm to such person or others and that less restrictive alternatives have either been tried and failed or would be futile to attempt. The suspension shall last no longer than the time necessary to prevent the harm and its imposition shall be documented with specific facts in such person's record.

A notice of the rights provided in this section shall be posted in appropriate and conspicuous places in the program or facility and shall be available to any such person upon request. The notice shall be in language understandable by such persons and translated for any such person who cannot read or understand English.

The department, after notice and public hearing pursuant to section 2 of chapter 30A, shall promulgate regulations to implement the provisions of this section.

In addition to the rights specified above and any other rights guaranteed by law, a mentally ill person in the care of the department shall have the following legal and civil rights: to wear his own clothes, to keep and use his own personal possessions including toilet articles, to keep and be allowed to spend a reasonable sum of his own money for canteen expenses and small purchases, to have access to individual storage space for his private use, to refuse shock treatment, to refuse lobotomy, and any other rights specified in the regulations of the department; provided, however, that any of these rights may be denied for good cause by the superintendent or his designee and a statement of the reasons for any such denial entered in the treatment record of such person.

FIVE FUNDAMENTAL RIGHTS, G.L. c. 123 § 23

RIGHTS	INPATIENT FACILITY	COMMUNITY PROGRAM
MAIL	right to send and receive sealed, unopened, uncensored mail with the exception that: if "good cause" exists, the facility director or designee can authorize staff to open and inspect an individual's mail *in the presence of the individual for the sole purpose of preventing the transmission of contraband*. Staff must document the specific facts justifying the mail inspection in the individual's record and staff *may not read* the mail.	right to send and receive sealed, unopened, uncensored mail
TELEPHONE	right to reasonable access to make and to receive confidential phone calls, with the exceptions that: (a) the calls cannot constitute a criminal act; (b) the calls cannot unreasonably infringe on another person's access to the telephone; and (c) **this right may be temporarily suspended** by the facility director or designee *only if* there is a determination that, based on the person's exercise of such right, further exercise of the right in the immediate future would present a substantial risk of serious harm to the person or others, and less restrictive alternatives have been tried and failed or would be futile to try. Any suspension must be documented, and the suspension can last only as long as necessary to prevent the harm.	right to reasonable access to make and to receive confidential phone calls, with the exceptions that: (a) the calls cannot constitute a criminal act; and (b) the calls cannot unreasonably infringe on another person's access to the telephone
GENERAL VISITORS	right to receive visitors of one's own choosing, daily and in private, at reasonable times. "Reasonable times" means that the hours during which visits can occur must be sufficiently flexible to accommodate an individual's needs and desires, and that the hours may be limited only to protect the privacy of other clients and to avoid serious disruptions in the functioning of the facility. **This right may be temporarily suspended** by the facility director or designee *only if* there is a determination that, based on the person's exercise of such right, further exercise of the right in the immediate future would present a substantial risk of serious harm to the person or others, and less restrictive alternatives have been tried and failed or would be futile to try. Any suspension must be documented, and the suspension can last only as long as necessary to prevent the harm.	right to receive visitors of one's own choosing, daily and in private, at reasonable times. "Reasonable times" means that the hours during which visits can occur must be sufficiently flexible to accommodate an individual's needs and desires, and that the hours may be limited only to protect the privacy of other clients and to avoid serious disruptions in the functioning of the program.

RIGHTS	INPATIENT FACILITY	COMMUNITY PROGRAM
VISITS OR PHONE CALLS WITH ATTORNEY, LEGAL ADVOCATE, PHYSICIAN, SOCIAL WORKER, PSYCHOLOGIST OR CLERGY	right at any reasonable time to receive or to refuse to receive visits and telephone calls from one's attorney, legal advocate, physician, psychologist, clergy, or social worker, even if not during normal visiting hours.	right at any reasonable time to receive or to refuse to receive visits and telephone calls from one's attorney, legal advocate, physician, psychologist, clergy, or social worker, even if not during normal visiting hours.
HUMANE ENVIRONMENT	right to a humane psychological and physical environment, including living quarters which provide privacy and security in resting, sleeping, dressing, bathing, personal hygiene, reading, writing and toileting. However, this right does not require that there be individual sleeping quarters.	right to a humane psychological and physical environment, including living quarters which provide privacy and security in resting, sleeping, dressing, bathing, personal hygiene, reading, writing and toileting. However, this right does not require that there be individual sleeping quarters.

Prepared 9/02 by Leigh Mello, Staff Attorney, Disability Law Center.

Legal, Educational and Advocacy Resources

Disability Advocacy Agencies

Disability Law Center (DLC)
11 Beacon Street, Suite 925
Boston, MA 02108

Tel. (617) 723-8455
(800) 872-9992 (voice)
TTY (617) 227-9464
TTY (800) 381-0577
Fax (617) 723-9125

Western Mass Office
Disability Law Center
30 Industrial Park Drive East
Northampton, MA 01060

Tel. (413) 584-6337
(800) 222-5619
TTY (413) 582-6919
Fax (413) 584-2976

The Disability Law Center (DLC) is the Protection and Advocacy agency for Massachusetts. DLC provides free legal advocacy to individuals with disabilities. Areas of representation include: rights in inpatient facilities and community residences; right to community living; informed consent; access to DMH/DMR or assistive technology services; special education; and discrimination in employment, housing, transportation, medical care and other public accommodations.

Center for Public Representation (CPR)

22 Green Street
Northampton, MA 01060
Tel. (413) 587-6265

and

246 Walnut Street
Newton, MA 02160
Tel. (617) 965-0776

CPR specializes in the legal rights of persons with mental illness and discrimination.

Mental Health Legal Advisors Committee (MHLAC)
399 Washington Street, 4th floor
Boston, MA 02108
Tel. (617) 338-2345
1-800-342-9092
Intake Hours: Mondays and Wednesdays 10AM-1PM ONLY

MHLAC specializes in the legal rights of persons with mental illness.

Mental Health Unit of the Public Defender's Office

Persons involved in commitment or Rogers proceedings have the right to an attorney, which is furnished by the Committee for Public Counsel Services.
For more information call (617) 482-6212.

Legal Services Programs

Local legal services programs provide free legal assistance to low-income persons in regard to housing, Social Security Disability and SSI issues, other welfare benefits, and (in some instances) domestic relations matters and mental health issues. To locate the legal services office nearest you, call the Legal Advocacy and Resource Center at (617) 742-9179.

Special Education Services

Mass Association of Special Ed (MASSPAC)
(617) 962-4558

Special Needs Advocacy (SPAN)
(508) 655-7999

Children's Law Center
(781) 581-1977

Mass Advocacy Center
(781) 891-5009

Disability Law Center
(617) 723-8455

Education Advocacy for parents and professionals working with children with mental health issues
Contact: Carol Gramm
617-542-7860x202
cgramm@ppal.net

Federation for Children with Special Needs
(617) 236-7210

Parent Support and Advocacy Services

DMH funds Parent Coordinators throughout the state to provide information, advice and advocacy on children's mental health issues including accessing services and special education. For the parent coordinator in your area contact the
Professional Parent Advocacy League (PAL)
59 Temple Place
Suite 664
Boston, MA 02111
Tel. (617) 542-7860

Parent Resource Network (PRN)
59 Temple Place
Suite 664
Boston, MA 02111
Tel. (866) 815-8122

National Alliance for the Mentally Ill (NAMI): A grassroots, family-based advocacy, education and support organization dedicated to improving the quality of life for people affected by mental illness.
e-mail: namimass@aol.com
Tel. (781) 938-4048
(800) 370-9085

M-Power: (Massachusetts People/Patients Organized for Wellness, Empowerment and Rights) A member-run organization of mental health consumers and current and former psychiatric patients. M-Power advocates for political and social change within the mental health system and the community, city and state-wide.
Tel. (617) 929-4111

MASS. GENERAL LAWS CHAPTER 123-COMMITMENTS AND OTHER ADMISSIONS

SECTION	DESCRIPTION	DURATION	TIMEFRAMES
7&8	Civil Commitment : Involuntary commitment to a facility of an individual who is mentally ill and for whom discharge from such facility would create a likelihood of serious harm	Up to six months for first order; up to 12 months thereafter	File for recommitment on or before expiration of current order or discharge.
8B	8-B authorization to treat: An order of a District Court made after entry of an order for involuntary commitment and a finding by the Court that the client is incapable of giving informed consent (incompetent) to the administration of antipsychotic medication or other medical treatment for mental illness	Coincides with underlying commitment. Dissolves upon the client's discharge from the facility or upon conversion of the client's legal status to voluntary while at the facility	File for new 8B with petition for recommitment
10&11	Conditional Voluntary (CV) Admission to a suitable facility of an individual in need of care & treatment	Length of treatment varies according to individual's assessed needs; terminated by 3 day notice given by individual, or discharge by facility.	Periodic Review: Assess for competence to remain on CV. 3-day: File for commitment before 3 days expire or discharge. Do not count weekends or holidays.
12(a) 12(b)	Emergency admission ("pink paper"): a physician, qualified psychiatric nurse, mental health clinical specialist, qualified court psychologist or police officer may apply to hospitalize person against will. Involuntary commitment of a person following a 12(a) examination. The facility must offer, upon admission, to contact the committee for Public Counsel Services (CPCS) who shall appoint an attorney upon request. Also provides for an emergency - hearing in the district court for a person who believes that his/her admission is the result of an "abuse or misuse" of the civil commitment law.	Up to 3 days (do NOT count Saturday, Sunday or holiday in time computation)	Accept CV, file for commitment before 3 days expire, or discharge. Do not count weekends or - holidays.

12(e)	Court-ordered civil commitment of a person after court has heard evidence that failure to hospitalize person would create likelihood of serious harm due to mental illness. Person is appointed counsel.		
15(b) & 15(e); 15(f)	Evaluation for competence to stand trial or criminal responsibility (15(b)) Aid to sentencing (15(e)); 15(f) authorizes admission of juveniles for similar evaluations	20 days--may be extended an additional 20 days--15(b) and 15(f) Up to 40 days--15(e)	Prepare report of evaluation(s) and assessment of need for further hospitalization for return to court on expiration of 20 days.
15(b)/17(a) *remand*	"Voluntary" court ordered hospitalization of competent patient during pendency of criminal matter	Indeterminate; reviews established by criminal court.	Give court notice if either patient -. or hospital decides to terminate hospitalization.
16(a)	Evaluation of incompetency or Not Guilty by Reason of Mental Illness (NGI) for purposes of further commitment	Period not to exceed 50 days combined with 15(b)	Prepare report of assessment for return to court on or before expiration of commitment period
16(b)&(c)	Forensic commitment of defendant found incompetent to stand trial or Not Guilty by Reason of Mental Illness (NGI)	Up to six months for first order (16(b)); up to 12 months thereafter (16(c))	30-day notice of intent to discharge to District Attorney & Court Notice to Court upon restoration of competence (17(a)). File for recommitment on or before expiration of current order.
18(a)	Forensic commitment for evaluation of an inmate in - need of hospitalization; subsequent order of treatment	Initial evaluation: up to 30 days. Initial treatment order up to six months; subsequent treatment order up to 12 months thereafter.	Prepare report of assessment and petition for commitment for return to court on expiration of assessment. File subsequent petitions before order- or sentence expires.

104 CMR 32.00

DEPARTMENT OF MENTAL HEALTH

COMPLAINT FORM

For Department Use Only
Date Received: ____/_____/_____
Received By: ______________________
Log #: _____________________________

1. NAME OF COMPLAINANT(S)	STATUS*	ADDRESS & TELEPHONE # (OR PROGRAM)
a.		
b.		
c.		

2. Client(s)Thought to be Harmed by Matter Complained of (if any and if known)	ADDRESS & TELEPHONE # (OR PROGRAM)
a.	
b.	
c.	

3. NAME(S) OF PERSON(S) COMPLAINED OF (if any and if known)	STATUS*	ADDRESS & TELEPHONE # (OR PROGRAM)
a.		
b.		
c.		

4. PERSON FILLING OUT FORM (if other than above):

____

____

5. WHEN DID MATTER COMPLAINED OF OCCUR [Date(s) and Time(s)]?

____

____

6. WHERE DID MATTER COMPLAINED OF OCCUR?

____

____

* STATUS: C=Client; E=Employee; H=Human Rights Committee; R=Relative; O=Other (Specify)

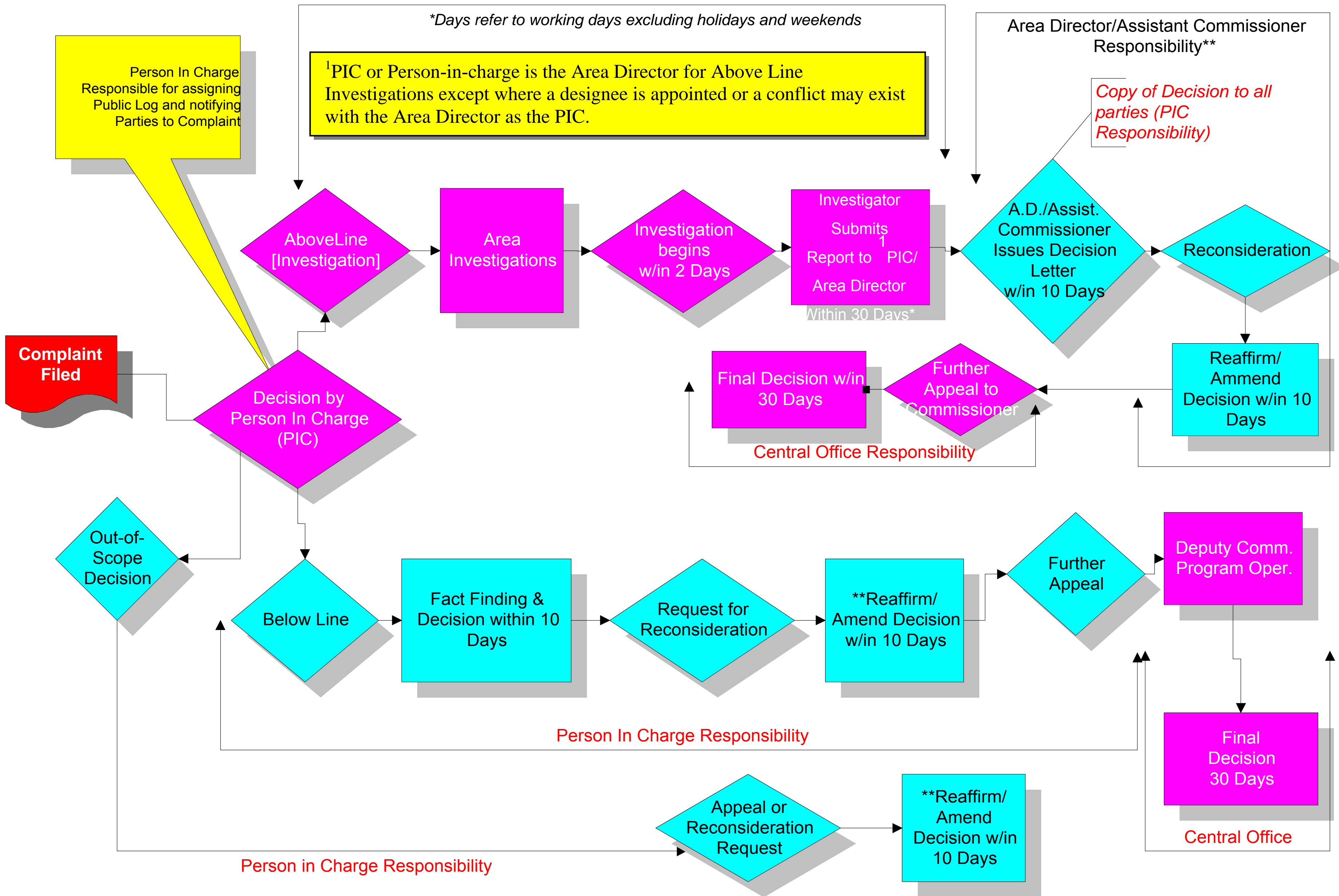
7. Describe what happened:

[ ] Check here if there are any attachments

IF YOU ARE BETWEEN THE AGE OF 18 AND 59 (INCLUSIVE) AND HAVE BEEN SUBJECT TO PHYSICAL
OR EMOTIONAL ABUSE YOU CAN CALL THE DISABLED PERSONS PROTECTION COMMISSION 24 HOUR HOTLINE AT (800) 426-9009.

EMPLOYEES OF THE DEPARTMENT OF MENTAL HEALTH AND OF PRIVATE AGENCIES PROVIDING SERVICES TO DISABLED PERSONS WHO HAVE REASON TO BELIEVE A DISABLED PERSON BETWEEN THE AGE OF 18 AND 59 HAS BEEN PHYSICALLY OR EMOTIONALLY ABUSED ARE REQUIRED BY LAW TO IMMEDIATELY REPORT ABUSE TO THE DISABLED PERSONS PROTECTION COMMISSION 24 HOUR HOTLINE AT (800) 426-9009. A WRITTEN REPORT SHOULD BE FILED WITH DPPC WITHIN 48 HOURS OF THE ORAL REPORT.

DATE **COMPLAINANT SIGNATURE**


*Days refer to working days excluding holidays and weekends
[1]PIC or Person-in-charge is the Area Director for Above Line Investigations except where a designee is appointed or a conflict may exist with the Area Director as the PIC.
Area Director/Assistant Commissioner Responsibility**
Person In Charge Responsible for assigning Public Log and notifying Parties to Complaint
Copy of Decision to all parties (PIC Responsibility)
Complaint Filed
AboveLine [Investigation]
Area Investigations
Investigation begins w/in 2 Days
Investigator Submits Report to PIC/[1] Area Director
Within 30 Days*
A.D./Assist. Commissioner Issues Decision Letter w/in 10 Days
Reconsideration
Reaffirm/ Ammend Decision w/in 10 Days
Further Appeal to Commissioner
Final Decision w/in 30 Days
Central Office Responsibility
Decision by Person In Charge (PIC)
Out-of-Scope Decision
Below Line
Fact Finding & Decision within 10 Days
Request for Reconsideration
**Reaffirm/ Amend Decision w/in 10 Days
Further Appeal
Deputy Comm. Program Oper.
Final Decision 30 Days
Person In Charge Responsibility
Central Office
Appeal or Reconsideration Request
**Reaffirm/ Amend Decision w/in 10 Days
Person in Charge Responsibility

COMMUNITY RESIDENCE TENANCY ACT (CRT)

WHEN DOES THIS LAW APPLY?

Do I live in a group residence that is owned, operated, or funded by the Department of Mental Health (DMH)?

NO

CRT law does not apply

YES

Is my residential provider telling me I must leave the residence?

YES

CRT law applies to me, and provider must follow the formal process below:

PROCESS:

Provider must give written notice to me and to DMH.

The written notice must include:

(1) the grounds for my eviction;
(2) the facts (evidence) supporting these grounds;
(3) the sources of these facts;
(4) my right to a hearing within 4 - 14 days;
(5) my right to be represented at the hearing (to be arranged for by the client); and
(6) my right to look at my file to prepare for the hearing.

GROUNDS FOR EVICTION:
There are only 2 possible grounds for eviction.

(1) Provider alleges that I have SUBSTANTIALLY violated an ESSENTIAL provision of a WRITTEN OCCUPANCY AGREEMENT; or

(2) Provider alleges that I am likely, IN SPITE OF REASONABLE ACCOMMODATION, to impair the emotional or physical well-being of other occupants, program staff or neighbors.

AT THE HEARING, the provider must present evidence of at least one of the above 2 grounds for my eviction. The provider must prove its case by a preponderance of evidence. Preponderance of evidence means "more likely than not."

AFTER THE HEARING, the hearing officer will issue a written decision.

IF I LOSE, I must leave the residence. If this means that I will be homeless, then DMH must help me find housing in the least restrictive setting appropriate to meet my needs. Also, I may have grounds to appeal the decision and/or to ask for a stay.

IF I WIN, I may stay in the residence. However, the provider may have grounds to appeal.

Prepared 2/04 by Leigh Mello, Consulting Attorney, Disability Law Center

DMH POLICY

Title: Restraint and Seclusion	**Policy #: 07-02** **Date Issued: 9/18/07**
	Effective Date: 9/18/07

Approval by Commissioner

Signature: Barbara A. Leadholm, M.S., M.B.A. **Date:**

I. PURPOSE

The Department of Mental Health (DMH) is committed to eliminating the use of restraint and seclusion. For the purposes of this policy, "restraint" means medication restraint, mechanical restraint and physical restraint. DMH's regulations at 104 CMR 27.12 set forth the minimum requirements that all facilities must implement to further the goal of preventing the use of Restraint/Seclusion, as well as the legal requirements concerning the use of restraint and seclusion when it is necessary. This policy establishes *additional* requirements for DMH-operated and contracted facilities and programs beyond those established in 104 CMR 27.00. It modifies and incorporates DMH's March 26, 2004 Philosophy Statement on Restraint and Seclusion. DMH Policy #93-1 is hereby repealed.

II. SCOPE

This policy is applicable to all DMH facilities, which includes DMH-operated and contracted facilities, intensive residential treatment programs (IRTPs) and behaviorally intensive residential treatment programs (BIRTs), that are permitted, pursuant to 104 CMR 27.00, to use restraint or seclusion in emergency situations.

III. PHILOSOPHY STATEMENT

DMH is committed to eliminating the use of restraint or seclusion in its facilities and programs. This goal is consistent with a mental health system that treats people with dignity, respect and mutuality,

protects their rights, provides the best care possible, and supports them in their recovery. DMH understands that achieving this goal may require changes in the culture of the clinical environment and the ways in which the physical environment is utilized.
Some individuals enter the mental health system for help in coping with the aftermath of traumatic experiences. Others enter the system in hope of learning how to control symptoms that have left them feeling helpless, hopeless and fearful. Many enter the system involuntarily. Any intervention that recreates aspects of previous traumatic experiences or that uses power to punish is harmful to the individuals involved. In addition, using power to control an individual's behavior or to resolve arguments can lead to escalation of conflict and can ultimately result in serious injury or even death.

DMH recognizes that many individuals who have been recipients of mental health services consider restraint and seclusion abusive, violent and unnecessary. For more than 35 years, the consumer/survivor movement has continuously voiced its opposition to restraint and seclusion in documents, forums and protests. This movement has consistently championed the development of gentle, voluntary, empowering and holistic alternatives.

To accomplish the goal of eliminating the use of restraint and seclusion in its facilities and programs, DMH endorses and promotes a public health model that values input from patients, families, staff and advocates, and that emphasizes:

- *Primary Prevention*: *preventing* the need for restraint or seclusion;
- *Secondary Prevention*: *early intervention* which focuses on the use of creative, least restrictive alternatives, tailored to the individual, thereby *reducing* the need for restraint or seclusion; and
- *Tertiary Prevention*: *reversing* or *preventing* negative consequences when, in an emergency, restraint or seclusion cannot be avoided.

Furthermore, the public health model uses feedback from each stage to inform and improve subsequent actions. This is a strength-based, patient-driven approach that focuses on enhancing self-esteem, thereby promoting each individual's goals toward recovery. DMH strongly believes this approach is essential in establishing a culture that is proactive, responsive and collaborative, rather than reactive. Comprehensive training, education, modeling, mentoring, supervision and ample support mechanisms foster a therapeutic and healing environment for patients and a supportive environment for staff.

Such a therapeutic and healing environment must take into account the experiences of the patients and staff. Staff must be given opportunities to increase their empathy for and awareness of the patient's subjective and objective experience, including that of mental illness and the physical and emotional impact of restraint and seclusion.

At the same time, while acknowledging the patient's perspective concerning the use of restraint and seclusion and the Department's goal of eventually eliminating their use, and emphasizing that restraint and seclusion are not considered forms of treatment, DMH recognizes that in an emergency situation where less restrictive alternatives have failed, the judicious and humane use of restraint or seclusion may be necessary to prevent the imminent risk of harm. In these instances, staff must use these interventions for the least amount of time and in the least restrictive way, taking into consideration the patient's history, preferences and cultural perspective.

DMH is committed to the continuous evaluation of restraint and seclusion data, and to the ongoing use of targeted performance improvement initiatives. These actions will reinforce the prevention model, improve practice, lead to better outcomes and support the goal of eliminating the use of restraint and seclusion in DMH facilities and programs.

IV. DEFINITIONS

Centers for Medicare and Medicaid (CMS): The federal agency that sets standards for and certifies health care facilities, including mental health facilities for receipt of payment from Medicaid and Medicare.

Health Care Agent: An adult with authority to make health care decisions for another adult under M.G.L. c. 201D.

The Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations or JCAHO): A national, private accrediting body for health care organizations, including mental health facilities.

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

V. POLICY

The policy elements below are designed to facilitate achievement of DMH's goal to reduce and eventually eliminate the use of restraint and seclusion.

A. Physical Space: A room used for restraint and/or seclusion must be calm, quiet, have appropriate lighting, and afford comfort and maximum privacy to the patient. The facility must assure reasonable bathroom access and provide a reasonable way for the patient to mark the passage of time.

B. Dignity, Privacy and Safety: Staff must make every effort to respect the patient's dignity and privacy, (e.g., maintain the patient's dignity and privacy while he or she is using the bathroom) and ensure the patient's safety while he or she is in restraint or seclusion. The patient should not be observable by visitors or other patients, must be clothed or covered appropriately at all times, and may be attended only by staff who have been trained in accordance with 104 CMR 27.12(2)(b). The patient must be provided with adequate food, hydration and access to toileting, including feminine hygiene products as needed, and any ingestion of food or liquids must be monitored carefully to avoid the risk of choking and/or aspiration. Interpreter services, including American Sign Language (ASL), shall be provided if necessary and if the patient communicates using ASL, he or she shall, to the extent practical, be placed in a position where he or she is able to see staff and use his or her hands to communicate during the restraint or seclusion.

C. Use of Mechanical and Physical Restraints: The determination as to which mechanical and/or physical restraints should be used must take into consideration a number of factors, including patient preference, the patient's individual crisis prevention plan, medical safety and comfort.

Only staff with specific, current training and demonstrated competency as required in Section V.E. below in the use of these restraints or techniques may be involved in their application. Listed below are descriptions of specific primary and specialty restraints and techniques which can be used under certain conditions. These are the only restraints and techniques that have been approved by DMH for use pursuant to this policy. Improved restraints or techniques developed subsequent to the date of this policy may be used if approved by the Commissioner or his or her designee.

Primary Mechanical Restraints: A mechanical restraint of five (5) points or less, a Safety Coat or a Papoose Board are the primary mechanical restraints to be used when a mechanical restraint is authorized by a physician or nurse pursuant to 104 CMR 27.12.

Specialty Mechanical Restraints Requiring Prior Approval: If the primary restraint has not been effective or the patient has special safety needs which cannot be met by the primary restraint, specialty mechanical restraints may be used. These include the Posey Vest, Geri Chair and Mitts, but specifically exclude **Protective Ambulatory Devices (PADS).** Prior approval for the use of specialty mechanical restraint must be obtained except in situations where the immediate use of a specialty mechanical restraint is necessary to maintain the safety of patients or staff. Prior approval requires the attending psychiatrist or designee to: (1) obtain approval from the Area Medical Director, Facility Medical Director, COO/Center Director and Director of Nursing or each of their designees; (2) consult with the facility's Human Rights Officer (HRO) and Peer Specialist, if available; and (3) document this process in the patient's treatment plan and Individual Crisis Prevention Plan. The reasons for the use of specialty mechanical restraint without prior approval as described in this paragraph must be documented in the patient's medical record and reported to Area Medical Director, Facility Medical Director, COO/Center Director and Director of Nursing or each of their designees and the facility's HRO and Peer Specialist; prior approval must be sought for possible future use. Approval obtained from the parties listed above for use of a specialty mechanical restraint shall remain in force until or unless it is revoked by one or more of those authorized to give approval or their designees. If the facility's HRO and Peer Specialist were unavailable for prior consultation, the approval of use of specialty mechanical restraints should be reported to them by the next business day after such approval is obtained. Specialty mechanical restraints require the same degree of monitoring and documentation as primary mechanical restraints.

Physical Restraint: DMH will determine which physical restraint techniques may be used. Such techniques will be included in training for all staff who may be directly involved in a physical restraint. DMH regulations, the Joint Commission and CMS standards will be used to determine what constitutes *physical restraint*. For the purposes of this policy, physical restraint *does not* include:

- holding a patient when necessary for routine physical examinations and/or tests for orthopedic, surgical and other similar medical treatment purposes;
- providing support for the achievement of functional body positioning or proper balance;
- protecting a patient from falling out of bed;
- holding a patient in a way that permits the patient to participate in ongoing activities without the risk of physical harm;
- holding a patient without undue force for the purpose of providing comfort;
- non-forcible holding of a patient's hand/arm to safely escort him/her from one area to another;
- holding a patient when necessary to implement a mechanical or medication restraint;
- holding a patient when necessary to implement a court-ordered treatment (e.g., District Court Section 8B or Probate Court Rogers Order);
- taking reasonable steps to prevent a patient at imminent risk of entering a dangerous situation from doing so with a limited response to avert injury, such as blocking a blow, breaking up a fight, or preventing a fall, a jump, or a run into danger.

Note: Certain of the above may be subject to non-behavioral restraint requirements set forth by the Joint Commission or CMS and may only be used in accordance with those requirements.

D. Procedures and Forms: Each facility must develop and implement procedures to ensure that the following activities and forms are completed and reviewed. Information from these forms (both

individual and aggregate) shall be used, as appropriate, to improve clinical practices and administrative processes. The forms shall be distributed and documented in accordance with the regulations and this policy. The procedures must ensure that the Senior Administrative and Clinical Review requirements of 104 CMR 27.12(4)(c) are met. The forms previously used to document "Physician Delay" and "No Specials" are no longer required.

1. *Individual Crisis Prevention Plan*: As soon as possible after admission, as a part of the initial and ongoing assessment and treatment planning process, and in accordance with the procedures developed pursuant to Section D., each facility will collaborate with patients, their LAR, their Health Care Agent, if any, and, where appropriate and authorized, other sources, to identify individual age and patient-specific information for the development of an Individual Crisis Prevention Plan (sometimes referred to as a "Safety Tool"). Each facility may develop its own format for this plan to meet its particular environment and needs as long as it contains the elements listed below.

   The plan shall include, but not be limited to relevant clinical data, such as medical risk factors, physical, learning or cognitive disability, communication needs such as sign language or interpreter, and the patient's history of trauma. At a minimum, each plan shall include the following elements:

   - Identification of triggers that signal or lead to agitation or distress in the patient and, if not addressed, may result in the use of restraint or seclusion;
   - Identification of the particular patient-specific approaches and strategies that are most helpful to the patient in reducing agitation or distress (e.g., environmental supports, physical activity, sensory interventions); and
   - Identification of patient preferences concerning restraint and seclusion, including type of procedure and positioning, gender of staff that administer and monitor the restraint or seclusion, and supportive interventions that may have a calming effect on the patient.

   If a patient chooses not to or is unable to participate in the development of the plan, staff shall develop a plan based on available information until such time as the patient is willing or able to participate in the review and revision of the plan. Staff shall make continuing efforts to include the patient as well as information from other collateral sources in the development of the plan.

   The plan shall be revised as necessary to reflect changes in the required elements and shall be reviewed at each treatment plan review and after each incident of restraint or seclusion. Revisions shall include pertinent information from the patient's previous (patient and staff) debriefing form(s), if any. The Individual Crisis Prevention Plan shall be incorporated into the multidisciplinary treatment plan, which shall be revised accordingly.

   Distribution

   The facility shall ensure that all staff on all shifts are aware of and have ready access to the Individual Crisis Prevention Plans for their patients. A copy of the plan and all revisions and updates shall be placed in the patient's medical record. The facility also shall provide each patient with a copy of his or her Individual Crisis Prevention Plan.

2. *The Emergency Restraint or Seclusion Form* (Part A) shall be completed each time a restraint or seclusion is initiated or renewed. All data elements, including names and signatures on the form, must be completed at the time of the event. Use of Part A is required for all types of restraints, including medication only. *The Monitoring and Assessment Form* (Part B), which is required for use during a mechanical or physical restraint, or seclusion, shall be completed by the nurse/trained

staff assigned to the patient's care during the time restraint or seclusion is in process. Although not required, use of Part B is encouraged during a medication (only) restraint.

Distribution
A copy of the form (Parts A and B) shall be filed in the patient's medical record, one copy shall be attached to the Patient Debriefing and Comment Form, and one copy shall be sent to the Commissioner or designee and HRO as part of the facility's monthly reporting requirements (104 CMR 27.12 (5)(i) 2 and 3). The forms must be distributed as required by each facility's procedures.

3. *The Patient Debriefing and Comment Form*: Within 24 hours of the conclusion of the restraint or seclusion event, the patient must be offered an opportunity to debrief and comment on the episode. Patients may include others of their choosing (e.g., a family member, friend, HRO or advocate) in the debriefing process. At a minimum, staff will give the Patient Debriefing and Comment Form, with the Emergency Restraint and Seclusion Form attached, to the patient, and provide the patient with the necessary assistance to help the patient complete it, either in writing or verbally. The Patient Debriefing and Comment Form will be used to document the components of 104 CMR 27.12 (4)(b). If the patient chooses not to respond initially, staff will re-offer the form at least one more time within the 24-hour time frame. If the patient ultimately chooses not to respond, this decision must be documented on the form. Observance of the 24-hour timeframe to complete the form should not preclude continuing clinically appropriate efforts by staff to engage patients in the process of talking about the incident.

   Distribution
   Upon completion of the debriefing and comment process with the patient, the form shall be placed in the patient's medical record with copies forwarded to the Treatment Team and HRO and, in addition, shall be distributed in accordance with regulatory and facility procedures. The Treatment Team and HRO shall use the form for further planning, modification of the treatment plan and future restraint prevention.

   Additional Forms and Opportunities
   A facility may choose to develop and provide additional forms and/or opportunities for patient debriefing and comment and shall develop processes and procedures for doing so. The purpose of all debriefing and comment activities is to ensure appropriate feedback to clinicians, staff, and the patient; however, the process must be carried out in such a way as to minimize re-traumatization. Patients may include others of their choosing (e.g., a family member, friend, HRO or advocate) in these additional debriefing opportunities.

4. *Staff Debriefing Form:* Each facility must develop procedures and a form to ensure that Staff Debriefing occurs and is documented as soon as possible after the restraint or seclusion event. The content of this form shall be approved by the Facility Administration and include all the components identified in 104 CMR 27.12(4)(a).

   Distribution: The Staff Debriefing form shall be kept with other restraint-related performance review documents, a copy shall be forwarded to the patient's Treatment Team, and additional copies shall be distributed in accordance with the facility's procedures developed in accordance with this Section. A copy of this form shall not be included in the patient's record.

E. Documentation: Each facility must develop a standardized protocol for documenting an incident of seclusion or restraint that meets the regulatory requirements set forth in 104 CMR 27.12(5)(i). The protocol, at a minimum, must include use of the following standard forms:

(1) the DMH-approved "Emergency Restraint or Seclusion (R/S) Form A" and "Emergency Restraint or Seclusion (R/S) Form B;"

(2) the DMH-approved "Patient Debriefing and Comment Form" or for contracted facilities, a comment and debriefing form for client use that has been approved by the Commissioner;

(3) a “Staff Debriefing Form;”

In addition, the protocol must include standards for the content of documentation of the following:

(4) Senior Administrative Review, if required by 104 CMR 27.12(4)(c) or the facility’s performance improvement plan;

(5) progress note;

(6) physician's order;

(7) any information management system designed to track and report on restraint and seclusion data (e.g., MHIS, ORYX);

(8) analysis and recommendations pursuant to the facility’s performance improvement plan.

F. Performance Improvement: Each facility shall have ongoing performance improvement initiatives that address the prevention, reduction and, if possible, elimination of restraint and seclusion. The performance improvement initiatives shall include analysis of both individual and aggregate data, with recommendations for enhanced clinical care, to further reduce the use of restraint and/or seclusion. The analysis and recommendations shall be documented in writing as part of the facility’s performance improvement data.

A plan for preventing, reducing and, if possible, eliminating the use of restraint and seclusion, must be in place for each facility and must include goal statements (including areas for improvement), timelines, measurable indicators and outcomes, procedures for monitoring, and provision for a regular review process. As part of the plan, each facility shall specify the titles of senior administrators who will participate in the Senior Administrative Review and when such a review will be required. The composition of the Administrative Review team and the circumstances triggering a review must meet but may exceed the requirements in 104 CMR 27.12(4)(c).

G. Training: Each facility must have a standardized training protocol that meets the regulatory requirements set forth in 104 CMR 27.12(2). DMH facilities must include in their protocol any training modules approved by the Commissioner or his/her designee. Each facility’s protocol must specify which staff are authorized to perform 15-minute safety checks (as per 104 CMR 27.12(5)(h)4) and 30-minute assessments (as per 104 CMR 27.12(5)(h)7), the training requirements for particular staff, standards for determining trainees’ competency in the training protocol, and a plan for documenting staff training and competencies.

Every staff person who authorizes, administers, orders, applies or monitors any form of restraint or seclusion or assesses for release of a patient in restraint or seclusion must receive training and demonstrate competence in these techniques, in the appropriate application and use of any mechanical

device or type of physical restraint, and in appropriate documentation requirements. Such staff are required to participate and demonstrate competency annually in non-violent strategies and de-escalation training, which includes didactic information and a physical demonstration of skills. The training protocol must be reviewed annually and revised if or when new restraint methods are approved.

The training will include but not be limited to:

(1) Additional training modules that have been developed to meet any facility-specific training needs (e.g., special populations);

(2) The development and implementation of the Individual Crisis Plan. This must include a sensitization module on the impact on patients of being in a facility or program (facility should consider asking a former patient to do this). This module will emphasize the potentially disturbing impact of discussing the possibility of the patient being restrained or secluded as part of developing the Individual Crisis Plan;

(3) The use of sensory interventions and therapies;

(4) Elements required by 104 CMR 27.12(5)(h)4 to perform a 15-minute safety check. These elements include checking and monitoring vital signs (when indicated), comfort, body alignment and circulation, and behavioral status. In addition, training shall include recognition of changes or concerns about the patient's condition or the need for assessment for release such that assessment by a licensed medical clinician (i.e., RN, MD, NP or PA) is required;

(5) Elements required by 104 CMR 27.12(5)(h)7 to perform a 30-minute assessment for release. This check must be performed by a licensed medical clinician and requires monitoring vital signs, comfort, body alignment and circulation, and behavioral status;

(6) The appropriate application and use of approved mechanical restraints, including specialty restraints listed in this policy, and physical restraint;

(7) The experience of restraint and seclusion from the patient's perspective, preferably including a presentation by an individual who has personally experienced restraint or seclusion;

(8) An opportunity for trainees to experience restraint. While strictly voluntary, training staff should emphasize that this restraint exercise is a valuable tool for staff to increase their empathic understanding of the patient's experience of restraint;

(9) Documentation requirements.

V. POLICY IMPLEMENTATION

It is the responsibility of each Chief Operating Officer, Unit or Program Director to implement this policy at DMH-operated facilities, DMH/DPH unit(s), DMH-contracted facilities or DMH-contracted programs respectively.

VI. REVIEW OF THIS POLICY

This policy and its implementation shall be reviewed at least every three years, but immediately upon any change to relevant federal or state law or regulation.

The Commonwealth of Massachusetts
Department of Mental Health

Commissioner's Directive #16

To: Senior Staff, DMH Child and Adolescent Inpatient Unit Directors, IRTP and BIRTP Chief Operating Officers, Director of Human Rights for Children and Adolescents
From: Marylou Sudders
Re: General Guidelines for Implementation of the M.G.L. ch.123 § 23 (Five Fundamental Rights) When Children in Department of Social Services Custody are in DMH Inpatient Units, and IRTPs (including BIRTPs)
Date: December 16, 2002

In 1997, M.G.L. Chapter 123 section 23 was amended to set forth certain statutory rights for all persons regardless of age, who receive services in any program or Facility or part thereof, licensed by or contracting with the Department of Mental Health (DMH). These include the right to: a) reasonable access to a telephone to make and receive confidential telephone calls; b) send and receive sealed, unopened, uncensored mail, subject to inspection for contraband under certain circumstances; and c) receive visitors of the person's own choosing daily and in private. The statute allows for restriction of only telephone and visitation rights in inpatient facilities, where there is a showing of harm, and where less restrictive alternatives have either failed or would be futile to attempt. It also has specific detailed provisions protecting the client's right to receive or refuse to receive visits and telephone calls from his or her attorney, legal advocate, physician, psychologist, clergy member or social worker. By spreading the umbrella of protection over all persons, *regardless of age*, the legislature has acknowledged the independence and autonomy that all mentally ill persons should enjoy as citizens, without discrimination or unreasonable infringement simply because they are psychiatric patients, or clients in community programs. Children unequivocally share with adults the right to a humane psychological and physical environment.

For children in the custody of the Department of Social Services (DSS) who are in inpatient facilities (including IRTPs and BIRTPs), issues of abuse or neglect, or other serious risk factors, may complicate the decision making process regarding visitors or telephone contact. DSS, in its custodial role, may have made a determination that a child's contact with a particular individual or individuals poses a risk of harm. Facilities must give these determinations serious consideration in their decision making around such contact. These Guidelines apply to DMH operated or contracted Child and Adolescent Inpatient Units, and to IRTPs and BIRTPs, and are intended to assist Facility and DSS staff in implementing the Five Fundamental Rights when DSS has custody of the child in question.

1. When a child in DSS custody is admitted to a Facility, the Facility should remind the child's DSS social worker of the application of the Five Fundamental Rights, and should provide him or her with a copy of these guidelines. In addition, these guidelines should be available in DSS offices.
2. In the absence of specific information concerning a risk of harm to an individual child, it should be presumed that each child shall be permitted to exercise the rights provided in the statute without restriction. Facility staff should ask the child's DSS social worker whether DSS has determined that anyone would create such a risk.
3. Facilities may not limit the child's right of access to an attorney, legal advocate, physician, psychologist, clergy member or social worker.

4. Facilities may restrict any rights in order to conform to judicial orders relating to a child. Such orders might include "no contact" orders as conditions of probation, DSS or DYS custody, 209A protective orders, or other orders relative to custody and visitation.
5. Telephone access should be provided in such a way as to permit children to make and receive confidential telephone calls. Unless a child's right to use the telephone is restricted in accordance with the statute and these guidelines, he or she should be able to carry on telephone conversations without being overheard by staff or other children.
6. For good cause, and with specific documentation in the child's records, a child's mail may be opened and inspected in front of the child, without it being read by staff, for the sole purpose of preventing the transmission of contraband.
7. Facilities may limit the exercise of other specific rights, namely, access to telephone and visitors of a child's choosing, only if the exercise of the right creates a substantial risk of serious harm to the child or others, and if less restrictive alternatives to a restriction have failed or would be futile to attempt. For children, the term harm has physical as well as development components, and may include a substantial risk that the exercise of the rights will have a severe, negative effect on the child's development or mental health. Ongoing assessment of this risk should include consideration of the child's age, and present condition, as well as other developmental factors which might influence the child's exercise of judgment, together with information supplied by parents, and other legally authorized representatives, including DSS. Where DSS has determined that telephone contact or visits with a particular individual or individuals creates a substantial risk of serious harm, DSS should communicate its concerns to the Facility, together with the reasons for its concerns. This communication can be made verbally, or in writing, but should be sufficiently detailed to enable the Facility Director to make a decision regarding such contact.
8. In the event the Facility disagrees with DSS's assessment of the risk of harm, or believes that there are less restrictive alternatives to the restrictions suggested by DSS, the Facility should inform DSS so that DSS can take whatever further action it deems appropriate, including consideration of seeking a court order relative to the particular issue. If DSS informs the Facility that it intends to seek a court order, then the Facility should impose the restriction for a reasonable time in order for DSS to bring the matter to court. DSS should provide the Facility with an opportunity to present its position to the court, if the Facility so desires.
9. Any such restrictions should be subject to ongoing review by the Facility and DSS to ascertain whether the restrictions need to remain in place and whether less restrictive alternatives are available and feasible.
10. The Facility should document in the child's record the facts that support imposition of the restriction, as well as its ongoing assessment of the continuing need for the restriction, any available less restrictive alternatives, and, if less restrictive alternatives are not available or feasible, the reasons for such.
11. Nothing in these guidelines precludes a child from filing a human rights complaint, or seeking other remedies if he or she believes his/her human rights have been unduly restricted.