# QUALITY MANAGEMENT

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THE BEHAVIORAL HEALTH QUALITY MANAGEMENT PROGRAM

NOTE: The Massachusetts Behavioral Health Program (MBHP) manages components of the behavioral health quality management program on behalf of Health New England Be Healthy (HNE BH).

A major internal operating principle for MBHP/HNE BH is that “quality is everyone’s job.” All employees receive training annually on principles of quality management and are expected to apply these principles to their day-to-day responsibilities. As such, the Quality Management (QM) Program applies to each department and all operations. The QM Department is one component of this broader QM Program, and a primary role of the QM Department is to provide support and technical assistance in quality management internally to staff, and externally to the provider community and other stakeholders.

The basic tenets of the QM Program include the beliefs that:

- quality improvement should be a part of each employee’s day-to-day work;
- the people closest to a quality problem are the most knowledgeable in terms of finding a solution to the identified problem;
- education, training, and retraining are critical to quality and facilitate improvements in job performance;
- accessible, reliable, and current data are vital to identifying system strengths and opportunities for improvement;
- poor quality is costly in both human and financial terms;
- inefficient or substandard service frequently stems from faulty processes and systems, rather than individual performance; and
- systematic monitoring, evaluation, feedback, and training concerning internal and external processes can resolve quality concerns and improve services.

The behavioral health quality management process is structured to:

- delineate thresholds and benchmarks for key processes;
- clearly delegate leaders and processes that will lead to process improvements;
- implement corrective action plans and procedures for monitoring process improvements; and
- monitor the corrective action to ensure that the process modifications continue to enhance performance.

This philosophy necessitates an ongoing process that spans every aspect of program operations and unites Members, families, Member advocates, providers, and other stakeholders in a continuously repeating cycle of quality planning, action, and evaluation.
The cycle of behavioral health quality improvement includes, but is not limited to:

- Data collected from monitoring mechanisms is carefully examined. These mechanisms include routine reports, health record audits, and ad hoc analyses.
- As data and experience indicate a need for quality improvement, project teams are formed.
- These teams assess the process to be improved and identify root causes of the problem.
- The team proposes solutions with stakeholder input and management review.
- From this input, the team develops a work plan.
- The team collects indicator data and evaluates the results of the interventions.
- Based on this evaluation, the work plan is revised.

Employees and network providers are responsible for maintaining quality in all aspects of service and project management. Therefore, MBHP/HNE BH is committed to providing training to ensure the success of the quality improvement process and to creating a quality culture throughout the provider network.

**Role of Providers in the Behavioral Health Quality Management Program**

MBHP/HNE BH shares information about the Quality Management Program as well as the results of its program evaluation. Participating providers can learn more about the Quality Management Program and evaluation of the program through this manual, *Alerts*, MBHP’s web site ([www.masspartnership.com](http://www.masspartnership.com)) by clicking on “HNE Be Healthy,” HNE Be Healthy’s web site ([www.hne.com](http://www.hne.com)), quality forums, and training programs. This information is updated at least annually. Providers participating in the program must:

- Participate in the quality program through their representation on behavioral health advisory councils, the local credentialing committee, and quality improvement workgroups and committees. Through these committees, participating providers may: review, evaluate, and make recommendations for credentialing and recredentialing decisions;
- Participate in the development or review of clinical practice guidelines that are distributed to providers; provide peer review and feedback on proposed best practice guidelines, clinical quality indicators, and any critical issues regarding policies and procedures;
- Participate in the planning, design, implementation, and review of the Quality Management Program;
- Review quality improvement program initiatives and activities and make recommendations for plans to improve quality of clinical care and service; and
• Review proposals to conduct clinical data evaluations and to develop profile reports that identify best practices and develop initiatives that will result in improved treatment and improved systems of care.

Providers interested in participating in one of these committees should contact MBHP/HNE BH’s Quality Management Department at 1-800-495-0086.

**Provider Involvement in Behavioral Health Quality Review of Network Services**

MBHP/HNE BH conducts a range of quality measurement and improvement initiatives on an ongoing basis for the purpose of ensuring quality of network services and the quality and safety of clinical care. Providers are expected to cooperate with quality review activities and should areas of improvement be identified, develop and implement plans of correction that address the identified areas of improvement.

Examples of quality measurement and improvement initiatives in which MBHP/HNE BH requires provider participation include:

- health record reviews based on health record-keeping standards distributed to providers;
- outcome data collection;
- Member satisfaction surveys conducted on-site by consumer satisfaction interview teams;
- on-site program reviews, including review of provider profiling data; and
- investigation and resolution of critical incidents, complaints, and grievances.

MBHP/HNE BH does not make public provider-identifiable reports based on its quality reviews without the consent of the provider.

**Policy on Data-Informed Service Planning Using Standardized Clinical Assessment Instruments**

**Policy statement on behavioral health standardized assessments**

The quality of behavioral health treatment services is enhanced when providers use standardized assessment instruments, ones that have good psychometric properties, to supplement the clinical judgments of the clinician. For both acute 24-hour services and community-based services, HNE BH regards the use of clinical information gathered through a standardized assessment to be an important resource for care management discharge planning and for treatment planning. Therefore, MBHP/HNE BH requires that all providers use MBHP/HNE BH-approved standardized assessment instrument to inform:

- discharge planning from 24-hour care services; and
- treatment planning for community-based services.
Facilities that provide 24-hour treatment for acute psychiatric disorders or substance use disorders are required to complete a discharge planning assessment for each Member using an MBHP/HNE BH-approved instrument. Community-based service providers are required to administer an MBHP/HNE BH-approved assessment instrument during the Member’s intake evaluation and periodically, at clinically reasonable intervals, in order to inform treatment planning and choice of treatment interventions. Please see the Provider Specifications in the Quality Management chapter for the operational details for this policy statement.

**Goal of the policy on standardized assessments**
To improve the quality of care to Members by ensuring that:

- all Members have the benefit of objective, standardized assessment, with periodic re-assessments;
- the results of the standardized assessments are incorporated into each Member’s treatment planning process; and
- all assessments should be reviewed by the treating clinician to identify clinical changes in subsequent reassessments that could lead the clinician to make service improvements based on changes in the Member’s needs.

**Definitions of key terms**

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<th>Behavioral Health Care</th>
<th>This term includes all treatment and support services related to mental health disorders, mental illnesses, and substance use disorders, as these disorders are referenced in the Diagnostic and Statistical Manual IV.</th>
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<td>Standardized Assessment Instrument</td>
<td>A standardized assessment instrument is one that measures behavioral health needs, and may include life-functioning needs. The instrument can be clinician-administered or self-administered by the Member. The instrument is developed through research on the validity and reliability of the assessment items. Some instruments are broad measures of clinical and life-functioning domains, while others are narrow (for example, an assessment of depression only). The essential feature is that the assessment items are research-validated indicators of the measurement construct.</td>
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<tr>
<td>MBHP/HNE BH-Approved</td>
<td>In order to comply with this standardized assessment policy, providers must use instruments that MBHP/HNE BH has reviewed and approved as instruments that have valid and reliable psychometric properties. Details on HNE Be Healthy-approved instruments are included in the Provider Specifications section.</td>
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<td>Change in Clinical Status</td>
<td>In order to measure a change in a Member’s clinical status, the clinician must administer a standardized instrument at some point in the treatment process (typically, upon intake) and then re-administer the same instrument at a second point in time (typically, prior to a review of the treatment plan). The difference in the Member’s evaluation between the first assessment and subsequent assessment is the measure of “clinical change.” Many standardized instruments characterize this change in the form of a score related to level of disability. While summary scores are useful for documenting change, clinicians are advised to review a Member’s response to individual assessment items in order to learn about the</td>
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personal content of the change, and not just focus on change scores.

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<th>Treatment Outcome</th>
<th>The term “treatment outcome” is equivalent to the term “change in clinical status.” Typically, outcomes are measured by changes in scored measured of severity. As noted above, clinicians should focus not only on numeric scores, but also on the content of assessment items on which the Member has changed between evaluations.</th>
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<td>Data-Informed Service Planning</td>
<td>The numeric and content information (data) gathered from a standardized assessment and reassessment must be incorporated into a Member’s service plan. That is, if the assessment instrument indicates an elevated concern about depression that was not otherwise noted by the clinician’s own assessment, the clinician should explore the question of depression with the Member during the intake or review process. Based on this review of the standardized assessment with the Member, the results of this review should be incorporated into the treatment goals and interventions included in the service plan. If a standardized assessment points to a clinical concern that is not confirmed with the Member, then the clinician must document in the Member’s medical record that a concern was identified, but not substantiated through further discussion with the Member.</td>
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**Behavioral Health Profile Management Services**

The Profile Management Services Program is a quality improvement reporting process that makes quality indicator data available to providers allowing them to benchmark the success of their clinical practices. There are at present two profile management reports that are made available to network providers:

The *Emergency Services Continuity of Care Report* provides information to ESPs about the outcome of emergency evaluations in linking Members to the continuum of care. Data includes the ESP’s rate of referral to inpatient and community-based care. Demographic and clinical indicators are also included in the report.

The *Outpatient Provider Practice Analysis* is a practice management tool that gives programs a synopsis of their current practice patterns as well as the demographic profile and service usage of the MBHP/HNE BH Member served.

MBHP/HNE BH meets with providers at regularly scheduled intervals to assist the provider in identifying opportunities for improvement, develop associated action plans, identify ways in which improvement goals can be met, and review or identify ways to measure the success of the provider’s goals.

Note that all provider practice analysis reports are confidential, and MBHP/HNE BH will not make these reports public without the consent of the provider.
Provider Quality Improvement (QI) Programs and Plans

Network providers are expected to designate a salaried manager who is assigned overall accountability for the provider’s quality management program. This designated manager must report in this capacity to senior management.

Providers are required to write an annual quality management plan. This plan should be reviewed by the provider’s governing body and updated at least annually. It should include:

- an outline of the organization’s quality objectives and related quality management activities;
- a time frame for completion of QI initiatives;
- the name of the manager responsible for the program; and
- measurable quality improvement objectives associated with each QI initiative, as well as the planned periodic monitoring of results.

Each provider agency should, at any given time, be working on at least one quality improvement project that addresses one or more of the quality of care domains identified in MBHP/HNE BH’s quality management program:

- Access
- Evidence-based, best clinical practices
- Treatment outcomes
- Utilization management
- Rehabilitation and recovery practices, and/or
- Services enhancements

Provider agencies are expected to make a copy of their quality management plan available to MBHP/HNE BH upon request. MBHP/HNE BH staff is available to assist network providers in the development of their plan by calling the Quality Management Department at 1-800-495-0086.

Although individual private practitioners are not required to have formal quality management plans, they are expected to demonstrate a commitment to continuously improving the quality of care they provide. This can be done by participation in a variety of activities that include, but are not limited to, the following:

- Participating in continuing education sufficient to meet licensing requirements;
- Complying with periodic reviews of Member treatment records;
- Complying with appointment access standards; and
- Participating in provider performance profiling activities and Member and provider satisfaction survey administration and/or Outcomes Initiative.
Behavioral Health Quality Management Conferences

MBHP/HNE BH sponsors a variety of quality management forums and other conferences. Providers are encouraged to attend these forums. Whenever possible, MBHP/HNE BH makes continuing education credits available to licensed providers for their participation in these trainings and forums.
MEMBER RIGHTS

Massachusetts Behavioral Health Partnership/Health New England Be Healthy (MBHP/HNE BH) Members have the following rights:

- To be treated with respect and with due consideration for their dignity and privacy

- To receive all medically necessary covered services. Providers may not refuse medically necessary treatment, although providers may refer Members to a specialist for treatment.

- To have discussions and receive information, in a manner appropriate to the Member’s condition and ability to understand, regarding appropriate or medically necessary treatment options and alternatives for his or her condition as well as any risks associated with the treatments, regardless of cost or benefit coverage

- To participate in decisions regarding their health care, including the right to refuse treatment to the extent permitted by law

- To receive emergency care 24 hours a day, seven days a week

- To be informed of all benefits, services, rights, and responsibilities Members have under MassHealth

- To receive information about MBHP/HNE BH’s services, provider network, medical necessity guidelines, provider and Member rights and responsibilities, organizational structure, and physician incentive plans

- To receive information in a manner that is easily understood and is made available in alternative formats. Written information will be made available by MBHP/HNE BH to Members in prevalent languages. Oral interpretation services will be made available upon request and free-of-charge.

- To receive behavioral healthcare within the specified timeframes and the right to file an appeal if he or she does not receive care within these timeframes

- To voice complaints or appeals about MBHP/HNE BH staff or services, its network providers, or the care they receive from those providers and MBHP/HNE BH. Members can do this by filing a grievance or an internal appeal with HNE BH if he or she disagrees with certain actions or inactions by MBHP/HNE BH
• To appeal to the MassHealth Board of Hearings and request a fair hearing if the Member files an internal appeal and disagrees with the decision

• To designate an authorized representative

• To receive a provider directory and other educational/informational materials approved by MassHealth

• To select his/her mental health and substance abuse provider and to change this selection

• To ask for a second opinion from another provider if he or she gets behavioral healthcare from MBHP/HNE BH

• To be informed of significant changes to the provider network

• To be informed of the termination of a provider and helped with transitioning care

• To request and receive a copy of their medical records and request that they be amended or corrected as specified under the Health Insurance Portability and Accountability Act

• To have information about his/her diagnoses and treatment as well as treatment records kept confidential, to the extent allowed by law, unless a written consent for such release of information is provided

• To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion

• To protection under federal and state laws related to anti-discrimination and human rights

• To receive information and healthcare services in accordance with the Balanced Budget Act

• To make recommendations about MBHP/HNE BH’s Member rights and responsibilities policies

• To freely exercise his or her rights without this adversely affecting the way he or she is treated by MBHP/HNE BH or MBHP/HNE BH providers
MBHP/HNE BH Members have the following responsibilities:

- A responsibility to supply information (to the extent possible) that MBHP/HNE BH and MBHP/HNE BH providers need in order to provide care
- The responsibility to understand health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible
- The responsibility to follow plans and instructions for agreed-upon care

These rights must be taken into consideration when furnishing services to Members. Network providers are responsible for compliance with the rights above and with federal and Massachusetts’ laws and regulations governing Member rights, including those put forth in the Balanced Budget Act. Providers are prohibited from engaging in any practice with respect to any Member or Uninsured DMH client that constitutes unlawful discrimination on the basis of health status, need for health care, race, color, national origin, or any other basis that violates any state or federal law or regulation, including, but not limited to 45 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90.

Copies of DMH policy memorandum #96-3r of August 22, 1996 on informed consent; DMH regulations on human rights at 104 CMR 27.13; and M.G.L. C 123 section 23, which codifies Chapter 166 of the Acts of 1997, an act relative to certain rights of persons with mental illness have been included in the appendices. MBHP/HNE BH monitors provider compliance with the requirements of laws and regulations and works with providers in their efforts to achieve compliance.

Providers are expected to cooperate with MBHP/HNE BH in its education efforts to improve understanding about Member rights and responsibilities, both those mandated by statute as well as those defined by MBHP/HNE BH and MassHealth.

Additionally, MBHP/HNE BH acknowledges its own responsibilities to comply with applicable federal and state laws including, but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; Titles II and III of the Americans with Disabilities Act; Section 542 of the Public Health Service Act; and Title 45 Part 46 of the Code of Federal Regulations pertaining to research involving human subjects.

Confidentiality of Member Healthcare Information

All MBHP/HNE BH providers are expected to safeguard the confidentiality of personally identifiable health information for both enrolled and disenrolled Members. MBHP/HNE BH providers are expected to adhere to all federal and state laws and regulations governing the privacy of Member information. All MBHP/HNE BH providers are required to be compliant with HIPAA regulations.
In addition, MBHP on behalf of MBHP/HNE BH does not disclose clinical information other than identifying information (such as Member name and eligibility) to providers rendering treatment to the Member unless the Member has signed an authorization for the Release of Information form. Only information related to specific benefit determinations for treatment provided by the requesting provider is disclosed or discussed. In the event of an urgent or emergency request for care from a Member, MBHP/HNE BH will release pertinent clinical information necessary for an appropriate response.

**Restraint and Seclusion**

MBHP/HNE BH supports the principles that guide the use of restraint and seclusion put forward by the Massachusetts Coalition for the Prevention of Medical Errors: “the adoption of an approach that minimizes the use of restraints and seclusion; supports the use of restraint and seclusion only in emergency situations and after less restrictive interventions have been determined to be ineffective; ensures patient/resident and staff safety; and promotes an approach that values risk assessment, early intervention, and education.” Network providers are responsible for compliance with federal and state regulations governing the restraint and seclusion of Members. Copies of these laws are included as appendices:

- DMH regulations concerning restraint and seclusion at 104 CMR 27.00; and
- Centers for Medicare and Medicaid Services rules entitled, “Medicaid Program: use of restraint and seclusion in psychiatric residential treatment facilities providing services to individuals under 21,” at 42 CFS parts 441 and 483

MBHP/HNE BH monitors provider compliance with the requirements of these laws and regulations and works with providers in their efforts to achieve compliance. Additional information on these principles is available from MBHP/HNE BH’s quality coordinator for incidents at 1-413-233-3449.

All providers, as applicable, are required to submit a copy of their restraint and seclusion policy and procedure during the recredentialing process, or as otherwise indicated by MBHP/HNE BH.

**Exchange of Information with Primary Care Providers**

MBHP/HNE BH is committed to supporting the role that primary care providers and other relevant treatment providers have in coordinating all aspects of a Member’s care. To that end, MBHP/HNE BH expects that behavioral health providers will obtain, when at all possible, a release from Members authorizing the exchange of treatment information between primary care providers, behavioral health providers, relevant state agencies, family members, and others as appropriate.

**Authorization for the Release of Information**

*It is recommended that the Release of Information form be presented to the Member at the point of initial intake.* Please be aware of the provision of federal confidentiality requirements
in 42 CFR section 2.22, especially as the requirements relate to the release of substance abuse information.

The Release of Information form recommended by MBHP/HNE BH authorizes, with the Member’s consent, the exchange of healthcare information. It facilitates communication between primary care providers, behavioral health care providers, state agencies, MBHP/HNE BH, family members, and other parties identified by the Member.

Network providers electing not to use the Release of Information form put forward by MBHP/HNE BH should ensure that their own consent forms be compliant with all Massachusetts privacy laws and federal HIPAA regulations.

**Members’ Right to Access Interpreter Services**

Members with limited English-speaking proficiency have the right to access proficient interpreters. Providers seeking such services should contact the Community Relations Department at **1-800-495-0086** (press 1 for the English menu or 2 for the Spanish menu, then press 3 and then 1 to skip prompts).
QUESTIONS AND CONCERNS

Grievances

Members, their guardians, or their authorized representatives have a right to file a grievance with MBHP/HNE BH about any aspect of their participation in MBHP/HNE BH or the services received through the plan. Grievances can be filed with any MBHP/HNE BH staff person and can be made telephonically or in writing. Sources of dissatisfaction can include any aspect of MBHP/HNE BH’s services as well as access of care and the quality of care received from network providers. Complaints and grievances should be directed to:

Quality Coordinator
Quality Management Department
HNE Be Healthy One
Monarch Place
Springfield, MA 02110
(413) 233-3230 phone
(413) 233-2685 fax

Grievances are investigated and resolved by MBHP/HNE BH’s quality coordinator within 30 calendar days of the date that the original grievance was received. The individual is informed in writing of the results of the investigation and is told that the resolution of the grievance by MBHP/HNE BH is final.

Submitting Provider Concerns

MBHP/HNE BH encourages its network providers to relay any concerns they have regarding any aspect or action of MBHP, on behalf of HNE Be Healthy, or its providers. This includes, but is not limited to, quality of care, administrative operations, and access to care. Concerns can be submitted in writing or by telephone to:

Quality Coordinator
Quality Management Department
HNE Be Healthy One
Monarch Place
Springfield, MA 02110
(413) 233-3230 phone
(413) 233-2685 fax

The quality coordinator documents, reviews, and resolves provider concerns within 15 calendar days of receipt. The findings of MBHP/HNE BH’s complaint review process are final. Providers may not appeal to MassHealth for review of the resolution of a concern.
INCIDENT REPORTING

Adverse Incident Reporting

MBHP/HNE BH has expanded upon the Department of Mental Health’s protocol and categories for adverse incident reporting. All 24-hour level of care providers (e.g., inpatient psychiatric units and acute treatment services for substance abuse) must report each occurrence that represents actual or potential serious harm to the well-being of a Member, or to others by the actions of a Member. Reporting requirements for non-24-hour providers (e.g., outpatient facilities and community support programs) are limited to the deaths of MBHP/HNE BH Members. Incidents must be reported to HNE Be Healthy by fax at (413) 233-3808 within 24 hours of their occurrence. Examples of Reportable Adverse Incidents are provided below.

The incident report must be either printed legibly or typed. **Incident Report forms that are illegible because of poor handwriting or fax quality will not be accepted.** MBHP/HNE BH has an electronic form available for your convenience. Please contact MBHP/HNE BH’s clinical quality coordinator for incident reporting at (413) 233-3449 to request the electronic form or if you have questions regarding the incident reporting process. **This e-form must be faxed, not e-mailed, to MBHP/HNE BH.** This form can also be found on the HNE’s website or by clicking [here](#).

Examples of Reportable Adverse Incidents

**Death:** all deaths of any cause of a covered individual

**Absence without Authorization (AWA):** Please file an Incident Report for individuals who are AWA or absent beyond authorized leave who are in the following circumstances:

- Are covered individuals who are committable or are under the age of 18
- Have been admitted or committed to the facility under M.G.L. Chapter 123, Sections 7&8, 10&11, or 12, and who are a danger to self or others
- Are considered “dangerous persons” and have been voluntarily committed or committed under statutes involving the commitment, retention, and emergency restraint of dangerous persons
- Have been admitted under M.G.L. Chapter 123, Sections 15, 16, 17, or 18, which includes competency to stand trial and the hospitalization of mentally ill prisoners

*Note: AWA incidents differ from a discharge that occurs Against Medical Advice (AMA).*

**Sexual Assault:** Any sexual assault or alleged sexual assault where the covered individuals is either the alleged perpetrator or the alleged victim. This involves any assault that is sexual in nature, such as:

- Any touching or fondling that is physically forceful;
- Forced penetration;
• Sexual contact between patients, whether consensual or not, when at least one of the
patients is a covered individual; or
• Sexual contact between staff and covered individuals, whether consensual or not.

**Serious injury/medical emergency requiring transport and admission to an acute care facility:** injury or medical condition requiring medical treatment more intensive than first aid that is provided off the psychiatric unit and requires medical hospitalization

**Violations or alleged violations of DMH restraint and seclusion regulations:** any restraint or seclusion that is administered outside the purveyance of DMH licensing and operational standards for restraints and seclusions 104 CMR, Section 27.12

**Absence without Authorization (Covered individuals who are not committable and are over the age of 18):** any covered individuals who do not meet the criteria in Category I and are determined through their clinical presentation to be AWA, or absent beyond authorized leave. Also, any covered individual who has not returned to the facility by the midnight census, unless otherwise indicated by his or her treatment plan.

* Note: AWA incidents differ from a discharge that is Against Medical Advice (AMA).

**Any physical assault or alleged physical assault to or by covered individuals:** physical aggression to or by covered individuals either directed to or exhibited by another patient that exceeds normative clinical behavior addressed in the treatment plan. This includes hitting, kicking, and/or use of a weapon. This also includes staff mistreatment of covered individuals and any physical aggression that produces tissue damage.

**Serious injury/medical emergency requiring transport to an acute care facility for ambulatory treatment and release:** injury involving a covered individual requiring medical treatment more intensive than first aid that is provided off the psychiatric unit but that does not require admission to a hospital

**Unscheduled event that results in the evacuation of a program:** any event that occurs whereby all the patients on the unit must be evacuated, such as fire, unsafe air quality, flooding, or serious threats against the facility

**Public health hazard:** any introduction of extraordinary elements into the environment that could be considered hazardous to the community, such as food contamination or lice infestation that causes a major disruption to the unit and results in medical treatment or hospitalization of covered individual(s)

**Medication errors:** any medication error whether through omission, duplication, incorrect dosage, order missing, incorrect patient, packaging/labeling, transcription, incorrect drug, incorrect time, or covered individuals “cheeking” medications that result in the need for urgent or emergent medical treatment and/or admission to an acute care facility

**Riot:** any organized or other significant event on the unit that causes disruption to the milieu and that could result in a potentially harmful situation for covered individuals
General Guidelines for Adverse Incident Reporting

All incidents must be reported to MBHP/HNE BH by fax at (413) 233-3808 within 24 hours of their occurrence.

The incident report must be either printed legibly or typed. Reports that are illegible due to either poor handwriting or fax quality will not be accepted. MBHP/HNE BH can make an electronic copy of the incident report form available to you. Please contact the MBHP/HNE BH quality coordinator for incidents at (413) 233-3449 to request the electronic form or to ask questions regarding the incident reporting process. *This form cannot be e-mailed. It must be printed and then faxed to MBHP/HNE BH.*
HEALTH RECORD STANDARDS

Health Records Components and Guidelines

Broadly modeled after standards published by The Joint Commission, the Massachusetts Behavioral Health Partnership/Health New England Be Healthy (MBHP/HNE BH) requires that providers adhere to the following core record-keeping standards for all MBHP/HNE BH-covered services:

Record organization

| Core Standard | A health record is created and maintained for each Member or family unit who receives care, treatment, or services, and is organized in an easily identifiable format that is consistent for all records. |

General Guidelines:

- A Member’s health record should tell a “story” of the Member’s participation in and response to treatment. The health record should have a “beginning” (Intake and Member Orientation to Services; Assessment), a “middle” (Action Planning; Action Implementation; Monitoring and Review of Treatment) and an “ending” (Discharge Plan and Treatment Summary).

Record Organization Criteria:

- Documentation is organized in a consistent manner;
- Chronology is maintained;
- Emergency contact information is easily located;
- Names of medications prescribed by provider are easily located;
- Names of medications prescribed by other providers are easily located;
- Known allergies are easily located; and
- Each page of the health record has at least one unique form of Member identification (such as Member name, insurance number, or social security number).

Member orientation to treatment

| Core Standard | The Member’s immediate needs and concerns are identified, and the Member’s full participation as a partner in the treatment process is solicited. |

General Guidelines:

- Each Member should be given an orientation to the service to be provided, and the treating clinician should encourage the Member’s participation as a partner in the treatment process;
- The Member’s “voice” should be evidenced in the health record documentation;
• The clinician’s approach to treatment should take into consideration the cultural background and language needs of the Member. Interpreters should be utilized as needed and as available. Cultural considerations should be noted in the health record; and
• A Member is a “partner” in the treatment process when the clinician and the Member work collaboratively to identify the Member’s treatment needs, build on the Member’s strengths, and develop treatment strategies that will support the Member in achieving his/her treatment goals.

Orientation to Treatment Criteria:
a. Member/guardian received human rights information;*
b. Member/guardian received after-hours information;*
c. Member/guardian received information about how to file a complaint;*
d. Member/guardian signed privacy notice;
e. Member/guardian signed authorization for use/disclosure of personal health information for primary care clinicians (PCCs); and
f. Member/guardian signed authorization for use/disclosure of personal health information for collateral contact.

*These criteria are not applicable if a Member began treatment more than 12 months prior to the date of the review.

Comprehensive assessment

| Core Standard | Sufficient and necessary information is collected for the purpose of assessing the Member’s needs for treatment and strengths in support of treatment. The assessment information is evaluated and interpreted to determine the Member’s need for care, treatment, or services. |

General Guidelines:
• Good treatment depends upon a comprehensive assessment of the Member’s bio-psycho-social functioning. Assessment information should include how the presenting problems are affecting the Member’s life functioning, and how the strengths of the Member can be incorporated into the treatment process;
• Providers should have an established assessment protocol appropriate to the level of treatment; and
• A “case formulation” is a brief and concise summary of the intake assessment, a description of the Member’s presenting needs and strengths, and a description of the initial service goals.

Comprehensive Assessment Criteria:
a. Psychiatric history
b. Developmental history (for Members ages 0-13)
c. Domestic violence/abuse history
d. School (for school-aged Members)/employment history
e. Relevant medical history
f. Substance abuse assessment (for Members ages 12 and older)
g. Risk assessment
h. Family history of behavioral health issues
i. Cultural/linguistic factors, as applicable
j. Legal issues
k. Mental status exam
l. DSM-IV diagnosis, Axes I – V
m. Case formulation

Treatment plan

| Core Standard | A comprehensive and individualized care plan is built upon the assessment and is developed with the participation of the Member. |

General Guidelines:
- The goal of a treatment plan is to guide the clinician and the Member in the pursuit of treatment goals that are meaningful and important to the Member, as the Member defines his/her needs;
- For each problem or need identified through the assessment process, a treatment plan is formulated and written in non-technical language that is understandable to the Member;
- For Members with multiple needs and complex conditions, the treatment plan should address the two or three most important needs for immediate treatment.
- Members who participate in the development of the treatment plan and should concur with the final plan; and
- A good treatment plan is flexible, useful, and realistic; is inclusive of the Member’s strengths; is consistent with the assessment; addresses medically necessary treatment needs; and sets realistic timeframes for completion of goals.

Treatment Plan Criteria:
  a. Initial treatment plan is completed within the required timeline (applies to 24-hour, acute inpatient services only).
  b. Measurable and behavioral goals/objectives are included.
  c. Treatment goals/objectives have reasonable timelines for achievement.
  d. Services are individualized.
  e. Treatment strategies are appropriate to diagnosis.
  f. Treatment strategies are appropriate to treatment goals.
  g. Cultural/linguistic needs are addressed, as applicable.
  h. Clinician consulted with prescribing physician, as applicable.
  i. Member/guardian participated in treatment plan development.
  j. Plan was revised based on progress or lack of progress.
  k. Discharge criteria are formulated.

Progress notes

| Core Standard | The treatment plan is implemented and progress is appropriately documented. |
General Guidelines:
- Progress notes are sequential narratives that describe the progress of the Member in relation to the treatment plan and include the following elements:
  1. Subject matter discussed in the session, including what occurred between sessions
  2. How the session addressed the treatment goals
  3. Interventions utilized and their effect on the Member
  4. Description of progress or setbacks noted during session
  5. Changes in the signs/symptoms of the diagnosis, as applicable
- The medical justification for the treatment is described; and
- Documentation that the treatment provided in each session addressed a medically necessary treatment need.

Progress Notes--Clinical/Medical Necessity Criteria:
  a. Progress notes document ongoing treatment, congruent with treatment plan.
  b. Progress notes assess symptomatic progress.
  c. Progress notes assess functional progress.
  d. Progress notes assess clinical risk, as applicable.
  e. All paid services are covered benefits.

Progress Notes--Administrative Criteria:
  a. Each progress note is signed with clinician’s name and credentials.
  b. Each progress note is dated and includes the day, month, and year.
  c. Each progress note indicates treatment strategy utilized.
  d. Each progress note indicates duration of session.
  e. Each progress note indicates date of next session.
  f. Each progress note indicates plan for next session, as applicable.
  g. Collateral contacts are made as appropriate.
  h. Cancelled or missed appointments are noted, and there is documentation of the next appointment.
  i. Each treatment session has a corresponding progress note.
  j. All progress notes are legible to two MBHP/HNE BH reviewers.
  k. All paid services are within authorization parameters.
  l. All paid services match documented service provided.

Review and revision of treatment plan

| Core Standard | The monitoring and review of care, treatment, or services facilitates treatment plan revision. |

General Guidelines:
- The health record should provide evidence of the periodic review of the Member’s progress in achieving the treatment goal(s), including, as needed, the reformulation of the goals, the date of goal achievement, and the inclusion of new goals; and
- The health record should provide evidence of the coordination of treatment with other healthcare providers, including the Member’s primary care clinician.
Review and Revision of the Treatment Plan Criteria:
  a. Multi-disciplinary team (MDT) review includes required signatures;
  b. MDT review includes questions, recommendations, and comments;
  c. MDT review action items document resolution;
  d. Treatment plan is current;
  e. Routine laboratory tests are requested as applicable;
  f. Includes documentation that routine laboratory tests have been reviewed as applicable;
  g. Documentation that a standardized assessment instrument is utilized; and
  h. As clinically indicated, standardized assessment and outcome information is integrated into the treatment plan.

Discharge summary

| Core Standard | Discharge from treatment is a planned and documented process. |

General Guidelines:
- A discharge plan should be given to the Member upon discharge and should be written in non-technical language that is understandable to the Member; and
- The treatment summary should be a concise summation of the Member’s primary presenting problems, the treatment interventions rendered, the Member’s response to treatment, and the discharge disposition.

Discharge Summary:
  a. Reason for termination
  b. Axes I-V diagnoses (at time of discharge)
  c. Progress made relative to each goal in the treatment plan
  d. Recommendations for future treatment
  e. Referrals to relevant healthcare providers made, as applicable

Provider Record-Keeping Requirements

The provider is required to ensure that all health records and clinical files, whether paper or electronic, are maintained in accordance with applicable state and federal law.

Procedure for On-Site, Retrospective Health Record Reviews

MBHP/HNE BH conducts routine, on-site retrospective health record reviews for purposes of quality management. Routine reviews are typically scheduled within a two-week notice to providers.

When the MBHP/HNE BH reviewer arrives at the provider’s office, the reviewer presents a list of Member names to the provider on the day of the review, and the provider selects available records from the list. All records reviewed by MBHP/HNE BH must include documentation to the record review staff at the time of the review or not later than 5 p.m. on the date of the review.
via fax to MBHP/HNE BH. No documentation will be accepted after 5 p.m. If a provider maintains health records off-site from where the review is being conducted, the provider should inform the MBHP/HNE BH review team at the beginning of the review and must provide MBHP/HNE BH with any missing off-site health record documentation within three business days of the review.

**Determination of Documentation Deficiencies**

Upon completion of an on-site health records review, the MBHP/HNE BH reviewer will give verbal feedback to the provider regarding the preliminary findings of the review. MBHP/HNE BH will send a written report of these findings to the provider within 30 days of the review. If documentation deficiencies are noted in the report, the provider will be required to submit an acceptable plan of correction to MBHP/HNE BH’s director of Health Records Review. MBHP/HNE BH may conduct follow-up reviews to verify the implementation of the corrective action plan.

**Clinical Criteria for Retrospective Review of Health Records Documentation**

MBHP/HNE BH will conduct periodic site visits to retrospectively review network providers’ compliance with the core health record components as well as review any clinical documentation deficiencies listed below. The documentation review criteria are:

Clinical/Medical Necessity

- The intake assessment meets MBHP/HNE BH health records criteria.
- The health record has a treatment plan, and the treatment plan meets the MBHP/HNE BH health records criteria.
- Progress notes document that services provided are medically necessary.
- The health record documents the periodic review and revision of the treatment plan.
- The health record of a discharged Member has a discharge summary that meets MBHP/HNE BH’s health records criteria.

**Requests for Reconsideration of Documentation Deficiency Determination**

The provider may submit a written request to MBHP/HNE BH for a reconsideration of documentation deficiency determinations within 30 days of a deficiency notification. The provider will be notified of a decision of reconsideration within thirty days.

Providers’ reconsideration requests should be sent to:

**Director of Health Record Review and Audit**

**MBHP/HNE BH**

1000 Washington Street, Suite 310

Boston, MA 02118-5002
Online Availability of MBHP/HNE BH’s Health Records Sample Forms

MBHP/HNE BH providers may access Massachusetts Standardized Documentation Forms at: http://mtmservices.org/MSDP/2009Forms.html. These forms are not mandatory; they are available for use or adaptation by the provider at his or her discretion.
PROVIDER PERFORMANCE SPECIFICATIONS:  
ASSESSMENT-INFORMED SERVICE PLANNING  
USING STANDARDIZED INSTRUMENTS

**Section 1: Selecting the Standardized Assessment Instrument**

<table>
<thead>
<tr>
<th>1.A</th>
<th>Approved Assessment Instruments</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>MBHP/HNE BH has reviewed and approved the following standardized assessment instruments for use in its Clinical Outcomes Measurement Protocol. Some MBHP/HNE BH services require certain instruments; for a description of required instruments by service, refer to Section 1.F.</td>
</tr>
<tr>
<td></td>
<td>- Adolescent Treatment Outcomes Module (ATOM)</td>
</tr>
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<td></td>
<td>- Behavior and Symptom Identification Scale (BASIS-32)</td>
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<tr>
<td></td>
<td>- Behavioral and Emotional Rating Scale (BERS)</td>
</tr>
<tr>
<td></td>
<td>- Brief Psychiatric Rating Scale (BPRS – adult and child)</td>
</tr>
<tr>
<td></td>
<td>- Brief Symptom Inventory (BSI)</td>
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<tr>
<td></td>
<td>- Child-Adolescent Functional Assessment Scale (CAFAS/PECFAS)</td>
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<tr>
<td></td>
<td>- Child and Adolescent Needs and Strengths (CANS) – See Section 1.B</td>
</tr>
<tr>
<td></td>
<td>- Child Behavior Checklist (CBCL)</td>
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<tr>
<td></td>
<td>- Connor’s Rating Scales – Revised (CRS-R)</td>
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<tr>
<td></td>
<td>- Current Evaluation of Risk and Functioning – Revised (CERF-R)</td>
</tr>
<tr>
<td></td>
<td>- Global Appraisal of Individual Needs (GAIN)</td>
</tr>
<tr>
<td></td>
<td>- Methadone Treatment Quality Assurance System (MTQAS)</td>
</tr>
<tr>
<td></td>
<td>- Personal Experience Inventory (PEI and PEI-Adult)</td>
</tr>
<tr>
<td></td>
<td>- Quality of Life Inventory (QOLI)</td>
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<td></td>
<td>- SF8, 12, 36</td>
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<td></td>
<td>- SOCRATES</td>
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<td></td>
<td>- Symptom Checklist-90-Revised (SCL-90-R)</td>
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<tr>
<td></td>
<td>- Treatment Outcome Package (TOP, TOP-SA)</td>
</tr>
<tr>
<td></td>
<td>- Youth Outcome Questionnaire (YOQ)</td>
</tr>
</tbody>
</table>

This list may be supplemented from time-to-time with the addition of instruments with good psychometric properties for outcomes assessment.

<table>
<thead>
<tr>
<th>1.B</th>
<th>Specifications for the Use of the Child and Adolescent Needs and Strengths (CANS) Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>For Members under the age of 21</strong>, the Child and Adolescent Needs and Strengths (CANS) tool is the required instrument as part of an initial behavioral health assessment in the following services and must be updated at least every 90 days when the treatment plan is reviewed:</td>
</tr>
<tr>
<td></td>
<td>- Outpatient Therapy (diagnostic evaluations and individual, family, and group therapy)</td>
</tr>
<tr>
<td></td>
<td>- Intensive Care Coordination (ICC)</td>
</tr>
<tr>
<td></td>
<td>- In-Home Therapy (IHT)</td>
</tr>
</tbody>
</table>

The CANS must also be completed as part of a discharge planning process in the following 24-hour level of care services: |
|     | - Psychiatric inpatient hospitalization |
|     | - Community-Based Acute Treatment (CBAT) |
|     | - Transitional Care Units (TCU) |
For additional information on the CANS, refer to the following resource:
- Children’s Behavioral Health Initiative (CBHI) web site
  ([www.mass.gov/masshealth/childbehavioralhealth](http://www.mass.gov/masshealth/childbehavioralhealth))

### 1.C Instrument Fact Sheets

MBHP/HNE BH has prepared “fact sheets” for many of the approved instruments listed in this protocol. Each fact sheet gives detailed information about each of these instruments and is available by clicking [here](http://www.mass.gov/masshealth/childbehavioralhealth). MBHP/HNE BH only periodically updates these instrument fact sheets. Please be sure to check with the publishers’ web sites for the latest information about the instruments.

### 1.D 24-Hour, Acute Services (Psychiatric or Detoxification)

Providers of 24-hour, acute psychiatric or detoxification services are required to conduct a comprehensive assessment of the Member for discharge planning purposes. This assessment must include the use of an MBHP/HNE BH-approved assessment instrument (see Sections 1.A and 1.E).

The results of the standardized assessment must inform and be incorporated into the discharge plan. It is the responsibility of the 24-hour provider to obtain the necessary authorizations from the Member, as agreed to by the Member, and to make a copy of the discharge plan to outpatient provider from whom the Member will receive after-care services.

Note 1: For Members under age 21, acute service providers must use the CANS as part of the discharge planning process. Additional instruments can be used to supplement the CANS, at the provider’s discretion.

Note 2: The Brief Psychiatric Rating Scale (BPRS) is not required for acute psychiatric facilities for discharge planning purposes. With the exception of Section 1.D, Note 1, above, acute service providers can select from any of the MBHP/HNE BH-approved instruments for discharge planning purposes.

### 1.E Optional – Request an alternative to the MBHP/HNE BH list of approved instruments

If a provider wishes to use a valid, reliable, and standardized assessment instrument that has not been approved by MBHP/HNE BH, the provider can request approval by submitting information about the instrument to MBHP/HNE BH. See the “Contact Us” section, below.
1.F Overview of Required Assessment Instruments by Service

Many MBHP/HNE BH services have requirements or restrictions for assessment instruments to be used. The following grid outlines the various services and required or restricted assessment tools. For services that do not require a specific assessment instrument, providers may choose an assessment instrument to implement from the approved instrument list (Section 1.A).

<table>
<thead>
<tr>
<th>Service</th>
<th>Assessment Tool</th>
<th>Members under age 21</th>
<th>Members 21 and older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Therapy (diagnostic evaluations and individual, family, and group therapy)</td>
<td>CANS</td>
<td>Any instrument</td>
<td></td>
</tr>
<tr>
<td>Intensive Care Coordination (ICC) (formerly FST)</td>
<td>CANS</td>
<td>N/A</td>
<td></td>
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<tr>
<td>In-Home Therapy (IHT)</td>
<td>CANS</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Community-Based Acute Treatment (CBAT)</td>
<td>CANS (discharge)</td>
<td>N/A</td>
<td></td>
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<tr>
<td>Transitional Care Units (TCU)</td>
<td>CANS (discharge)</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Psychiatric inpatient hospitalization</td>
<td>CANS (discharge)</td>
<td>Any Instrument (discharge)</td>
<td></td>
</tr>
<tr>
<td>Emergency Services Provider (ESP) evaluations</td>
<td>BPRS</td>
<td>BPRS</td>
<td></td>
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<tr>
<td>Community Support Program (CSP)</td>
<td>Any instrument</td>
<td>Any instrument</td>
<td></td>
</tr>
<tr>
<td>Acute treatment services for substance abuse (ATS, E-ATS, Level IV detox)</td>
<td>Any instrument (discharge)</td>
<td>Any instrument (discharge)</td>
<td></td>
</tr>
<tr>
<td>Community Support Services (CSS) for Substance Abuse</td>
<td>Any instrument</td>
<td>Any instrument</td>
<td></td>
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<tr>
<td>Structured Outpatient Addiction Program (SOAP)</td>
<td>Any instrument</td>
<td>Any instrument</td>
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<tr>
<td>Psychiatric Day Treatment</td>
<td>Any instrument</td>
<td>Any instrument</td>
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<tr>
<td>Partial hospitalization</td>
<td>Any instrument</td>
<td>Any instrument</td>
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<tr>
<td>Psychopharmacology evaluations</td>
<td>Exempt</td>
<td>Exempt</td>
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<tr>
<td>Psychological/Neuropsychological testing</td>
<td>Exempt</td>
<td>Exempt</td>
<td></td>
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<tr>
<td>Ongoing medication management</td>
<td>Exempt</td>
<td>Exempt</td>
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<tr>
<td>Family consultation</td>
<td>Exempt</td>
<td>Exempt</td>
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<tr>
<td>Case consultation</td>
<td>Exempt</td>
<td>Exempt</td>
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<tr>
<td>Inpatient-outpatient bridge</td>
<td>Exempt</td>
<td>Exempt</td>
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<tr>
<td>ASAP</td>
<td>Exempt</td>
<td>Exempt</td>
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<tr>
<td>Collateral Contact</td>
<td>Exempt</td>
<td>Exempt</td>
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<tr>
<td>Specializing</td>
<td>Exempt</td>
<td>Exempt</td>
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<tr>
<td>IM injections</td>
<td>Exempt</td>
<td>Exempt</td>
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</tbody>
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Section 2: Administering the Standardized Assessment Instrument

2.A Members to be Included in the Standardized Assessment Process

All Members shall be included in the standardized assessment process, as specified in this protocol. MassHealth members are defined as those who are eligible to receive Covered Services under the Office of Medicaid, Office for Behavioral Health, including MBHP/HNE BH Enrollees.

In order to be compliant with the MBHP/HNE BH standardized assessment policy, the provider must select an assessment assessment(s) to be used for each age group(s) served by the provider caseload (children and/or adolescents and/or adults).
### 2.B MBHP/HNE BH Covered Services Exempted from Standardized Assessments

With the exception of the services listed below, all behavioral health services covered by MBHP/HNE BH will be evaluated through this outcomes protocol. The services (with their associated CPT codes) that are exempt from this protocol are:

**Medication Evaluation Services**
- Simple and complex medication visit (90862)
- Medication diagnostic visit (99404)
- 60-minute medication evaluation groups (90857)
- Psychiatric consultation on a medical floor (99251, 99252, 99253, 99254, 99255)

**Mental Health and Substance Abuse Outpatient Services**
- Family consultation (90887)
- Case consultation (90882)
- Inpatient-outpatient bridge (H0032)
- Collateral contact (H0046)
- Psychological testing (96101, 96111, 96116, 96118, 96119, 96120, 99402)
- IM injections (90772)

**Other Services**
- Specialing (T1004)
- Assessment for Safe and Appropriate Placement (ASAP) (H2028)

### 2.C Intake/Baseline Assessments and Periodic Reassessments for Outpatient and Other Non-24-Hour Services

The assessment process shall include the administration of the MBHP/HNE BH-approved assessment instrument by the clinician, or self-administration by the Member, at the time of the Member’s intake for treatment (baseline assessment), with additional administrations (reassessments) given at least every 90 days (required for youth under the age of 21 (see below, this section) and recommended for adults). If there is a specified end to treatment or the time of discharge is known, the standardized assessment should also be administered at discharge.

In the case of a clinician administering the evaluation instrument, the clinician can bill MBHP/HNE BH for the evaluation session within the regular parameters of direct Member contact for that session.

The CANS is required to be updated every 90 days for services outlined in Section 1.B above.

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1 The exemption for medical evaluation services is made on the assumption that Members for whom psychotropic medications are being prescribed by a network psychiatrist are also receiving psychotherapy or other treatment services and that such Members are receiving outcomes evaluations through these other services. Generally, MBHP/HNE BH recommends against Members receiving medication services only, without receiving other psychosocial treatment in addition to the medication treatment.
2.D Special Considerations Regarding Assessments

**Clinical contraindications:** If a Member’s individual practitioner or treatment team decides that the administration of a standardized assessment instrument is not clinically indicated, or the Member refuses to complete the assessment, then the Member can be exempt from the assessment. These instances should be exceptional and must be justified in the Member’s medical record by the clinician.

**Multiple services:** Members ages 21 and older, receiving multiple concurrent services at a single LOC, do not need to have multiple assessments. *If a Member is receiving services from multiple practitioners, it is the responsibility of the practitioners to jointly identify a lead practitioner who would be responsible for a single outcomes assessment protocol and for the communication of outcome results to subordinate clinicians.*

For example, if a Member is receiving outpatient services and day treatment services, the provider of the core ongoing psychotherapeutic service should take the lead in conducting the assessments.

If outpatient psychotherapy is provided by a clinician and medication management is provided by a psychiatrist, the psychotherapist would in most instances be the provider responsible for the outcome measurement. It would be important that the psychotherapist communicate the results of the outcome measurements to the psychiatrist.

*For Members under age 21, the CANS is an integral, requisite part of the behavioral health assessment process. When a Member is treated by more than one provider, each provider is required to perform their own behavioral health assessment, which will include the CANS.*

**Family therapy:** When an entire family is being treated through family therapy sessions, it may or may not be feasible to administer an assessment to every member of the family. Many times, one or more members of the family are concurrently receiving individual therapy.

In such cases, the *routine outcomes assessment completed for the Member of the family who is receiving individual therapy will suffice.* That is, the family members not seen individually do not need to be included in the outcomes assessment, unless the provider otherwise decides to assess each family member or the family as a unit.

If a family is being seen as a unit with no other services being provided to individual family members, then the administration of an assessment instrument for the family is at the discretion of the clinician.

**Group therapy:** Each Member involved in group therapy is expected to have an assessment as part of the Member’s intake assessment and revision of the Member’s treatment plan.
Section 3: Incorporating Result of Standardized Assessments into Treatment Plans

<table>
<thead>
<tr>
<th>3.A</th>
<th>Provide Feedback to the Member About the Intake Assessment and Reassessments (Outcomes)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>The clinical implications of the initial assessment and the “outcome or change scores” (that is, the differences between the Member’s baseline measurement values and the remeasurement values) should be explained to the Member (or Member’s guardian) at the same or next session following each administration. It should be noted in the Member’s record that an assessment was completed, and the results were discussed with the Member.</td>
</tr>
<tr>
<td></td>
<td>This explanation should be made in clinically appropriate, non-technical language that is understandable to the Member. If such an explanation is deemed by a psychiatrist to be clinically contra-indicated, a clinical note to this effect should be made in the Member’s medical record.</td>
</tr>
</tbody>
</table>

Contact Us for Implementation Support

MBHP/HNE BH recognizes that providers may vary in their readiness or ability to implement this initiative and may need support in developing their outcomes measurement protocol. Depending on available resources, MBHP/HNE BH may offer the provider support through telephone consultation, e-mail correspondence, or provider forum meetings.

MBHP/HNE BH Contacts:
- Outcomes Project Manager
  E-mail: MBHPOutcomes@valueoptions.com
  Phone: 617-350-1942
  Fax: 877-335-5452
- [www.masspartnership.com](http://www.masspartnership.com) (select Outcomes Management)
- MBHP/HNE BH’s Community Relations staff: 1-800-495-0086

Helpful references:


CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) TOOL

MBHP/HNE BH requires a uniform behavioral health assessment process that includes a comprehensive needs assessment employing the Massachusetts Child and Adolescent Needs and Strengths (CANS) tool for MassHealth Members under age 21.

CANS, developed by John S. Lyons, PhD, is a document that organizes clinical information collected during a behavioral health assessment in a consistent manner to improve communication among those involved in planning care for a child or adolescent. The CANS is also used as a decision-support tool to guide care planning, and to track changing strengths and needs over time. The CANS is used in child-serving systems in more than 30 states across the country.

There are two forms of the Massachusetts CANS (“CANS Birth through Four” and “CANS Five through Twenty”). In addition, the CANS assessment form includes a determination of whether a child meets the criteria for Serious Emotional Disturbance (SED).

CANS in other EOHHS Agencies

Separate from MassHealth, certain other EOHHS agencies including the departments of Mental Health (DMH), Children and Families (DCF), and Youth Services (DYS) will adopt or have adopted the Massachusetts CANS for use within their programs. Those agencies will provide instructions to their providers.

CANS as an Outcome Instrument in Relation to MBHP/HNE BH’s Outcomes Management Policy

The CANS is an approved standardized assessment instrument for MBHP/HNE BH’s Clinical Outcomes Management Program for Members under 21 years of age. Inpatient providers can use the CANS as part of the discharge planning process in lieu of the Brief Psychiatric Rating Scale (BPRS). A provider still has the option, of course, to use additional standardized assessment instruments for its own clinical or quality improvement purposes.

No billing will be allowable, nor will any reimbursement be provided, for use of the CANS during the 90-day treatment plan updates. Billing will be allowable and reimbursement will be provided only for 90801-HA when the CANS is used as part of the initial assessment for eligible Members under the age of 21 who entered treatment on or after November 30, 2008. However, if the Member leaves treatment but subsequently returns to the provider for a new course of treatment, the provider must perform a new initial assessment using the CANS, may bill a 90801-HA, and will need to use the CANS for treatment plan updates every 90 days.

Consistent with the current MBHP/HNE BH Clinical Outcomes Management Program policy, providers will be required to incorporate the results of the the CANS evaluation into the Member’s treatment plan.
Services that require the use of the CANS tool
The use of the CANS tool is required as part of an initial behavioral health assessment in the following services for Members under the age of 21 and must be updated at least every 90 days when the treatment plan is reviewed:

- Outpatient Therapy (diagnostic evaluations and individual, family, and group therapy)

In addition, the CANS must be completed as part of the discharge planning process in the following 24-hour level of care services:

- Psychiatric inpatient hospitalization;
- Community-Based Acute Treatment (CBAT);
- Intensive Community-Based Acute Treatment (ICBAT); and
- Transitional Care Units (TCU).

Services that do NOT require use of the CANS tool
The CANS tool will not be required in the following circumstances:

- psychopharmacology evaluations;
- psychological/neuropsychological testing;
- Emergency Services Provider (ESP) evaluations;
- Acute Treatment Services (ATS) for Substance Abuse;
- Community Support Services (CSS) for Substance Abuse;
- ongoing medication management;
- psychiatric day treatment;
- partial hospitalization;
- Structured Outpatient Addiction Program (SOAP);
- Community Support Program (CSP); and
- DPH-licensed substance abuse providers (even if they are billing 90801 code)

The CANS requirement applies to behavioral health clinicians with the following credentials
The following types of clinicians are required to pass the online CANS certification examination and use the CANS: psychologists; LICSWs; LMHCs; LMFTs; LCSWs; unlicensed, master’s-level clinicians working under the supervision of a licensed clinician; and master’s-level clinical interns in psychology and social work working under the supervision of a licensed clinician. Currently, MBHP/HNE BH does not allow doctoral student/master’s-level clinical interns to bill for 90801 (please refer to your Provider Manual), nor can they bill for 90801-HA. Doctoral student/master’s-level clinical interns can, however, bill for ongoing therapy when the CANS is updated as part of the treatment plan every 90 days thereafter.

Psychiatrists, psychiatric residents, and psychiatric nurse mental-health clinical specialists who provide outpatient therapy to Members under the age of 21 also must pass the online CANS certification examination and use the CANS. Please note that psychiatrists, psychiatric residents,
and psychiatric nurse mental-health clinical specialists who only provide medication management are NOT required to use the CANS or pass the CANS certification examination.

**CANS when a Member is seeing more than one provider**
When a Member is treated by more than one provider, each provider is required to perform their own behavioral health assessment, which will include the CANS.

**CANS action checklist for network providers**
(ALERT 48) Network providers need to take the following steps to meet their obligations concerning the CANS:

[ ] Ensure that all clinical staff members who are required to use the CANS are CANS-trained and certified. Information on CANS certification and training can be found on the web at https://masscans.ehs.state.ma.us. This web site includes an online training course, an online certification exam, and more. For more information on training, contact the Massachusetts CANS Training Center by calling (508) 856-1016 ext. 61016 or e-mailing Mass.Cans@umassmed.edu.

[ ] Ensure that your organization is enrolled with the Virtual Gateway (VG). This enrollment is necessary to access the web-based CANS application. *Enrollment with the VG for other business applications (such as STARS, EIM/EIS, etc.) does not satisfy this requirement.* For information on how to enroll, email the VG customer service group at VirtualGatewayCBHI@state.ma.us. If technical assistance is needed with the VG, contact the VG Customer Service group at 1-800-421-0938, ext 5. Please note that if a Member denies consent for a provider to enter information into the VG, then providers must use the CANS paper form. For audit purposes, the paper version of the CANS tool must be stored and maintained with the member’s medical record.

Note: For more information about the CBHI application on the VG, refer to “Frequently Asked Questions” posted at the web site of the Children’s Behavioral Health Initiative, www.mass.gov/masshealth/childbehavioralhealth, and go to “Information for Providers” and then to “CANS tools.” You may also refer to MBHP/HNE BH’s web site, www.masspartnership.com, by clicking on “Children’s Behavioral Health Initiative” and then on “Child and Adolescent Needs and Strengths (CANS).”

**CANS paper form**
Links to paper copies of the appropriate version of the Massachusetts CANS (“Birth through Four,” or “Five through Twenty”) are found at the Children’s Behavioral Health Initiative (CBHI) web site www.mass.gov/masshealth/childbehavioralhealth and at www.masspartnership.com.

For audit purposes, the paper version of the CANS tool must be stored and maintained with the Member’s medical record. The paper version of the CANS tool must be used if a Member denies consent for a provider to enter information into the VG.
CLINICAL PRACTICE GUIDELINES

MBHP/HNE BH has adopted three clinical practice guidelines from nationally recognized sources for behavioral health disorders relevant to its population based on review of claims and utilization data. These guidelines, which are not intended to replace clinical judgment, are statements designed to assist contracted practitioners in making decisions about appropriate healthcare for specific clinical circumstances.

Prior to the adoption and dissemination of each guideline, the relevant scientific literature is reviewed by a multidisciplinary team that includes board-certified psychiatrists. MBHP/HNE BH reviews and approves clinical practice guidelines at least every two years and updates them as needed. As part of MBHP/HNE BH’s routine monitoring of adherence to generally accepted standard clinical practice, MBHP/HNE BH will audit annually at least two important criteria contained within two of the three guidelines to assess adherence to the guideline.

MBHP/HNE BH Clinical Practice Guidelines

A. Substance Use Disorders

MBHP/HNE BH has selected a practice guideline that provides clinically sound, evidenced-based options in the treatment of one of MBHP/HNE BH’s most prevalent diagnostic categories: substance use disorders. The NIAAA (National Institute of Alcohol Abuse and Alcoholism) has developed a useful guideline on the treatment of substance use disorders, entitled “Helping Patients Who Drink Too Much.” MBHP/HNE BH encourages you to access the full guideline on the internet and employ it with your clients where clinically appropriate.


B. Eating Disorders

MBHP/HNE BH has adopted the American Psychiatric Association (APA) guideline for the “Treatment of Patients with Eating Disorders.” The guideline consists of three parts - A, B, and C - not all of which will be equally useful for all practitioners. Part A, “Treatment Recommendations,” contains general and specific recommendations. Part B, “Background Information and Review of Available Evidence,” provides an overview of eating disorders, including information on their natural history, course, and epidemiology. It also includes a synthesis of the evidence that underlies the recommendations made in Part A. Part C draws from the previous sections and summarizes areas for which more research data are needed to guide clinical decisions.

For more information on this guideline, please refer to: http://valueoptions.com/providers/Handbook/PDFs/Treatment_Guidelines/Eating_Disorder.pdf
C. Attention-Deficit/Hyperactivity Disorder (ADHD)

The American Academy of Child and Adolescent Psychiatry’s “Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit Hyperactivity Disorder” has been adopted by MBHP/HNE BH. The practice parameter discusses the clinical evaluation for ADHD, comorbid conditions associated with ADHD, research on the etiology of the disorder, and psychopharmacological and psychosocial interventions for ADHD.

For more information on this guideline, refer to:

MBHP/HNE BH would like providers to consider including these guidelines with their scientifically-based reference materials for clinical staff. MBHP/HNE BH asks that providers consider these guidelines whenever providers think that they may promote positive outcomes for clients. If you are unable to access them through the internet, contact MBHP/HNE BH’s Quality Department at 1-800-495-0086, and we will provide you with a paper copy.
MBHP/HNE BH QUALITY MANAGEMENT FORMS

- Clinical Assessment Instrument Selection: Annual Verification Form
Massachusetts Behavioral Health Partnership/Health New England Be Healthy (MBHP/HNE BH)

Clinical Assessment Instrument Selection: Annual Verification Form

<table>
<thead>
<tr>
<th>Contact Name</th>
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<td>Phone</td>
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| Provider Name and Address |

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<tr>
<th>Provider Type</th>
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<tr>
<td>□ Individual/Group Provider</td>
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<tr>
<td>□ Single-Site/Single-LOC Provider</td>
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<tr>
<td>□ Multi-Site/Multi-LOC Provider</td>
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Note to the Provider: If you are a multi-site and/or provide multiple levels of care (LOC), please submit only one form for the organization.

1) Please check-off the instrument(s) the Provider has chosen to implement (check as many that apply):
   - □ Adolescent Treatment Outcomes Module (ATOM)
   - □ Behavioral and Emotional Rating Scale (BERS)
   - □ Behavior and Symptom Identification Scale (BASIS-32)
   - □ Brief Psychiatric Rating Scale (BPRS) - Adult and Child
   - □ Brief Symptom Inventory (BSI)
   - □ Child-Adolescent Functional Assessment Scale (CAFAS/PECFAS)
   - □ Child-Adolescent Needs and Strengths (CANS)
   - □ Connor’s Rating Scales – Revised (CRS-R)
   - □ Consumer Recovery Outcome System (CROS)
   - □ Current Evaluation of Risk and Functioning – Revised (CERF-R)
   - □ Methadone Treatment Quality Assurance System (MTQAS)
   - □ Personal Experience Inventory (PEI)
   - □ Personal Experience Inventory – Adult (PEI-A)
   - □ Quality of Life Inventory (QOLI)
   - □ SF8, 12, 36
   - □ SOCRATES
   - □ Symptom Checklist-90-Revised (SCL-90-R)
   - □ Treatment Outcome Package (TOP, TOP-SA)
   - □ Youth Outcome Questionnaire (YQO)
   - □ Requesting the use of an alternative instrument (adult services only)
   - □ Requesting the use of functional measures (adult services only)

□ I verify that all statements are accurate to the best of my knowledge and understand that the information I have provided is subject to on-site or telephonic review. I also understand that if there are changes to the information I have provided, it is the responsibility of the provider to notify MBHP/HNE BH, by updating the information on this page.

Please submit this completed form by March 1st of each year. Send by fax to (617) 350-1982 or by mail to:
Outcomes Project Manager
MBHP/HNE BH
1000 Washington Street, Suite 310
Boston, MA 02118-5002

If you have any questions regarding this form, please e-mail MBHP at MBHPOutcomes@valueoptions.com.

MBHP/HNE BH-QUALITY MANAGEMENT FORM
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<tbody>
<tr>
<td>A</td>
<td>DMH Human Rights Regulations and use of Restraint and Seclusion</td>
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<tr>
<td>B</td>
<td>Center for Medicare/Medicaid Services and use of Restraint and Seclusion of Individuals under 21</td>
</tr>
<tr>
<td>C</td>
<td>DMH Policy on Informed Consent 96-3R</td>
</tr>
<tr>
<td>D</td>
<td>Massachusetts General Law-Chapter 123: Section 23. Telephone Access Rights; Mail Rights; Visitation Rights; Legal and Civil Rights; Suspension of Rights; and Notice of Rights</td>
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104 CMR 27.00: LICENSING AND OPERATIONAL STANDARDS FOR MENTAL HEALTH FACILITIES

Section

27.01: Legal Authority to Issue
27.02: Scope

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27.04: Licensing; Intensive Residential Treatment Programs

SUBPART B: OPERATIONAL STANDARDS FOR MENTAL HEALTH FACILITIES

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27.06: Voluntary and Conditional Voluntary Admission
27.07: Three Day Involuntary Commitment
27.08: Transfer of Patients
27.09: Discharge
27.10: Treatment
27.11: Periodic Review
27.12: Prevention of Restraint and Seclusion and Requirements When Used
27.13: Human Rights
27.14: Human Rights Officer; Human Rights Committee
27.15: Visit
27.16: Absence Without Authorization
27.17: Records
27.18: Interpreter Services

27.01: Legal Authority to Issue

104 CMR 27.00 is promulgated under the authority of M.G.L. c. 19, §§ 1, 7, 8, 18 and 19 and M.G.L. c. 123.

27.02: Scope

Unless the contrary is specified in a particular section, the provisions of 104 CMR 27.00 apply to all facilities that are licensed, contracted for, or operated by the Department.

SUBPART A: LICENSING

27.03: Licensing; Generally

(1) All private, county or municipal mental health facilities are subject to licensing by the Department pursuant to M.G.L. c. 19, § 19.

(2) Types of Licenses. Licensed mental health facilities shall be issued a single license which may incorporate one or more of the following classes:

(a) Class II. License to provide diagnosis and treatment of adults on voluntary admission status under M.G.L. c. 123, § 10.

(b) Class III. License to provide diagnosis and treatment of adults on conditional voluntary admission status under M.G.L. c. 123, §§ 10 and 11, and on involuntary committed status under M.G.L. c. 123, §§ 7 and 8, and to use restraint and seclusion.

(c) Class IV. License to provide diagnosis and treatment of adults on involuntary committed status under M.G.L. c. 123, § 12, and to use restraint and seclusion.

(d) Class V. License to provide evaluation, diagnosis and treatment of patients committed by order of a criminal court to determine competency to stand trial or criminal responsibility or for treatment under M.G.L. c. 123, §§ 15, 16, 17 and 18, and to use restraint and seclusion.

(e) Class VI. License to provide diagnosis and treatment of minors on voluntary or conditional voluntary admission status under M.G.L. c. 123, §§ 10 and 11, and on involuntarily committed status under M.G.L. c. 123, §§ 7, 8 and 12, and to use restraint and seclusion.
27.03: continued

(f) **Limited Class VI.** License to provide diagnosis and treatment of minors age 16 and 17 on adult units on voluntary or conditional voluntary admission status under M.G.L. c. 123, §§ 10 and 11, and on involuntarily committed status under M.G.L. c. 123, §§ 7, 8 and 12, and to use restraint and seclusion.

(g) **Class VII.** License to provide diagnosis and treatment of adolescents in an Intensive Residential Treatment Program (IRTP) on conditional voluntary or conditional voluntary admission status under M.G.L. c. 123, §§ 10 and 11, and on involuntarily committed status under M.G.L. c. 123, §§ 7 and 8, and to use restraint and seclusion.

(h) **Class VIII.** License to administer electroconvulsive treatment.

(3) Every licensed facility shall maintain complete records for each patient in accordance with the provisions of M.G.L. 23, § 36 and 104 CMR 27.17.

(4) **Duration of License.** Licenses issued under 104 CMR 27.03 shall be valid for a term of two years and may be renewed for like terms, subject to limitation, suspension or revocation for cause. Licenses are not transferable from one licensee to another individual or agency or from one location to another.

(5) **Requirements for License or Renewal.**

(a) Every applicant for a license or for a subsequent renewal of such license shall use the forms prescribed by the Department and shall submit the fee established by the Department. A schedule of licensing fees may be obtained from the Department.

(b) A hospital, clinic or nursing home licensed by the Department of Public Health under M.G.L. c. 111 which admits mentally ill persons only on voluntary admission status pursuant to 104 CMR 27.06, need not be licensed by the Department of Mental Health as Class II. All other hospitals licensed by the Department of Public Health which admit mentally ill persons on any admission status other than, or in addition to, voluntary status shall also be licensed by the Department of Mental Health.

(c) Every facility seeking a license or a renewal of such license shall meet all applicable fire, health, building and safety codes, and shall make available upon request copies of all required licenses, permits, certificates of inspection and/or occupancy necessary for the operation of the facility in the location where it is situated.

(d) Every facility seeking a license or a renewal of such license shall demonstrate compliance with the standards of the American Institute of Architecture, or other nationally recognized standards, for facilities of the type licensed.

(e) Every facility seeking a license shall submit a statement of ownership, a plan showing the extent of the property, location and plans of existing buildings, and any plans and specifications of buildings to be erected. Notice shall be given to the Department by the applicant or licensee of any changes in these matters.

(f) Every facility seeking a license shall submit written plans describing:

1. its plan for delivery and supervision of clinical services. All clinical services, as well as the supervision of such services, shall be performed by personnel qualified by license or experience in the field in which they are performing.

2. its plan for assuring adequate and appropriate staffing to meet the needs of the patient population at all times.

3. its program of orientation and continuing in-service education for all personnel, both professional and non-professional, who provide care and treatment to patients.

(6) **Staffing.**

(a) The director of a facility licensed as Class II, III, IV, V, VI, Limited VI, VIII or any combination thereof, shall hold an advanced degree from an accredited college or university in a discipline appropriate to the care and treatment of the mentally ill. If the director of a facility licensed as Class II, III, IV, V, VI, Limited VI, VIII or any combination thereof is not a fully licensed physician, there shall be a director of psychiatric or medical services for such facility who is a physician fully licensed to practice medicine under Massachusetts law, and who is certified or eligible to be certified by the American Board of Psychiatry and Neurology in psychiatry; provided that in the discretion of the Department, experience and expertise may be considered in lieu of Board certification or eligibility.
27.03: continued

(b) Facilities licensed as Class II, III, IV, V, VI, Limited VI, VIII or any combination thereof, shall have a physician, under full or limited licensure as defined by Massachusetts law, on the premises at all times.

(c) The director or chief of nursing of a facility licensed as Class II, III, IV, V, VI, Limited VI, VIII or any combination thereof, shall hold an advanced degree in psychiatric nursing and shall be licensed to practice professional nursing. If such director or chief of nursing does not hold such a degree, the facility shall provided for a person with such a degree and license to oversee in-service training for its nursing personnel.

(d) The director or chief of nursing of a facility licensed as Class II, III, IV, V, VI, Limited VI, VIII or any combination thereof, shall hold an advanced degree in psychiatric nursing and shall be licensed to practice professional nursing. If such director or chief of nursing does not hold such a degree, the facility shall provided for a person with such a degree and license to oversee in-service training for its nursing personnel.

(e) The nursing personnel of every facility subject to licensure shall be adequately prepared by education, training and experience to provide care and treatment for patients with mental illness. The facility shall maintain such nursing force at levels deemed adequate by the Department.

(7) Additional Requirements for Class VI, Limited VI, and VII Facilities. In addition to complying with all applicable standards in this title, a facility licensed as Class VI, Limited VI, or VII shall comply with the following requirements:

(a) In its application for a license, or for renewal of a license, the facility shall include a detailed description of its physical facilities as well as its plan for providing age appropriate programming and services. This plan and description shall be subject to approval by the Commissioner or designee. The plan shall include but not be limited to psychiatric, medical, nursing, social work and psychological services, family-focused treatment, occupational therapy, physical therapy if any, educational programs, recreational activities and equipment, and outdoor facilities.

(b) A child and adolescent psychiatrist certified or eligible to be certified in child and adolescent psychiatry by the American Board of Psychiatry and Neurology or the American Board of Adolescent Psychiatry shall provide on-site supervision of the care and treatment of patients in Class VI and VII facilities and shall be available for consultation and case supervision as needed for patients in Limited Class VI facilities.

(c) The facility shall have on its staff, or as consultants, a pediatrician and a pediatric neurologist, both of whom shall be fully licensed to practice medicine under Massachusetts law.

(d) If the facility employs behavioral management, it must meet the requirements of 104 CMR 27.10(7)

(8) Additional requirements for Class VIII Facilities. In addition to complying with all applicable standards in this title, a facility licensed as Class VIII shall comply with the following requirements:

(a) The facility shall establish a written plan for the administration of electroconvulsive treatment in compliance with the standards set forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and with current practice guidelines established by the American Psychiatric Association.

(b) Monthly Reports. All facilities administering electroconvulsive treatment (ECT) to inpatients or outpatients shall maintain aggregate data, which shall be available to the Department for inspection upon request.

(9) Additional Requirements for Class III through VII Facilities. In addition to complying with all applicable standards in this title, a facility to be licensed as Class III through VII shall include the following in its application for a license or renewal of a license:

(a) the facility's plan to reduce and, wherever possible, eliminate restraint and seclusion as required by 104 CMR 27.12(1);

(b) a comprehensive statement of the facility's policies and procedures for the utilization and monitoring of restraint and seclusion, including a listing of all types of mechanical restraints used by the facility, a statistical analysis of the facility's actual use of such restraint and
seclusion, and a certification by the facility of its ability and intent to comply with all applicable statutes and regulations, including 104 CMR 27.12, regarding physical space, staff training, staff authorization, record keeping, monitoring and other requirements for the use of restraint and seclusion.

(10) **Accreditation.**
(a) A facility seeking a license as Class II, III, IV, V, VI, Limited VI, VIII, or any combination thereof, or a renewal of such license, shall be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other nationally recognized accreditation agency approved by the Commissioner utilizing the applicable standards as promulgated by said Joint Commission or agency. Facilities that have not yet attained accreditation shall be in substantial compliance with those standards, and must submit a plan for obtaining accreditation within a reasonable period of time.
(b) A facility seeking a license as Class VII, or a renewal of such license shall be accredited as a residential treatment program by JCAHO or other nationally recognized accreditation agency approved by the Commissioner. Facilities that have not yet attained accreditation must be in substantial compliance with the standards for residential treatment programs set forth by said Joint Commission or agency, and must submit a plan for obtaining accreditation within a reasonable period of time.

(11) **Deemed Status.** In addition to the Departmental action on license applications as set forth below, and any additional requirements for Class VII facilities set forth in 104 CMR 27.04, the Department may approve licensure of accredited facilities in accordance with the following requirements for deemed status.
(a) A facility requesting deemed status shall provide to the Department a copy of the facility’s current accreditation letter and the accrediting agency’s explanation of its survey findings.
(b) A facility requesting deemed status shall submit for Department review and approval written plans for compliance with Department regulations governing restraint and seclusion, human rights, and investigation of complaints.
(c) A facility which has been granted deemed status shall notify the Department of the time and place of the summation conferences scheduled at the completion of an accreditation, and shall permit Department observers to attend such conferences.
(d) The Department may at any time require a facility which has been granted deemed status to demonstrate its compliance with applicable law, accreditation standards, Department regulations, or implementation of any recommendations for corrections or deficiencies, by submitting such documentation or reports or permitting such inspection as may be requested by the Department. The Department may require a validation survey of an accredited facility to verify such compliance.
(e) A facility which has been granted deemed status shall immediately notify the Department of any change in its accreditation status.
(f) The Commissioner or designee may revoke the deemed status of an accredited facility if:
1. The facility loses its accreditation;
2. The facility fails to cooperate with the Department’s validation survey or requests for documentation or reports;
3. The facility fails to cooperate with a Department investigation in accordance with 104 CMR 32.00;
4. The facility is out of compliance with applicable accreditation standards and a significant deficiency is determined to exist;
5. The facility is out of conformity with its plans for compliance with Department regulations on restraint and seclusion, human rights, and investigation of complaints.
6. The facility is out of compliance with other applicable Department regulations.
(g) A facility whose deemed status has been revoked may be subject to a licensing review or full survey pursuant to 104 CMR 27.00.
(h) A facility may request an informal administrative review of a decision to deny or revoke deemed status. The facility must request an informal administrative review in writing within 15 days of the date it receives notice of the denial or revocation of its deemed status by the Commissioner or designee. The request shall state the reasons why the facility considers the
denial or revocation of deemed status incorrect. The written request shall be accompanied by any supporting evidence or arguments.

(i) The Commissioner or designee shall notify the facility, in writing, of the results of the informal administrative review within 20 days of receipt of the request for review. Failure of the Commissioner or designee to respond within that time shall be considered confirmation of the denial or revocation of deemed status.

(12) If a facility is not yet accredited by JCAHO or if an accredited facility chooses not to apply for deemed status, it shall be subject to a full survey for licensure by the Department.

(13) **Provisional License.** A provisional license shall be used for facilities not currently in operation or for which compliance cannot fully be determined without an evaluation of the facility in operation. After the granting of a provisional license or the initial provision of services by the facility, the Department shall conduct a timely evaluation of the facility to determine what action regarding licensure should be taken.

(14) **Departmental Action on License Application.** Upon receipt and review of all required documentation, and after any site visit, the Department may take one of the following actions:

(a) Approve the facility for licensure, if no deficiencies are outstanding;

(b) Approve the facility for licensure, subject to demonstrated progress by the program applicant in implementing a plan of correction approved by Department;

(c) Disapprove the facility for licensure until such time as deficiencies are corrected.

(d) Approve the facility for a provisional license subject to such conditions as the Department deems necessary.

(15) **Departmental Inspection.**

(a) Notwithstanding a facility’s deemed status, the Department may conduct random, periodic surveys or inspections of any facility licensed hereunder to determine compliance with accreditation standards or the provisions of 104 CMR. Such random survey need not pertain to any actual or suspected deficiency in compliance with accreditation standards or 104 CMR 27.00. Refusal to permit inspection shall be sufficient cause for revocation of a facility's license.

(b) Without limiting the generality of the foregoing, the Department shall conduct annual inspections of facilities granted deemed status to determine their compliance with Department regulations governing restraint and seclusion, human rights, investigation of complaints, and interpreter services.

(c) Licensed facilities shall immediately notify the Department of any substantial change in its physical plant, staffing or services, and shall submit documentation of such changes as may be requested by the Department.

(d) The scope of the Department’s inspections shall include any aspect of the operation of the facility, and may include, but is not limited to, confidential interviews with patients and staff, and examination and review of all records, including those of current and discharged patients.

(e) The Department shall provide a copy of the inspection report to the facility director.

(16) **Revocation or Limitation of License.** Failure to comply with the requirements for licensure as set forth in 104 CMR 27.00 may constitute sufficient cause for the Department to refuse to grant, suspend, revoke, limit or restrict the applicability of, or refuse to renew one or more classes of licenses pursuant to the procedural requirements and provisions of M.G.L. c. 30A. The Department, under the authority of M.G.L. c. 19, § 19, may take reasonable action, including, but not limited to, temporarily suspending a license prior to a hearing in cases of emergency if it deems that such action would be in the public interest; provided, however, that upon request of an aggrieved party, a hearing pursuant to M.G.L. c. 30A, § 13 shall be held after such action is taken.

(17) In restricting or limiting the applicability of one or more classes of licenses, the Department may issue deficiency orders, reprimands or other appropriate orders to obtain compliance with 104 CMR 27.00: provided that such actions may be subject to the procedural requirements and provisions of M.G.L. c. 30A.
27.03: continued

(18) Waiver.
(a) The requirements of 104 CMR 27.03 through 27.17 shall be strictly enforced, and shall not be subject to waiver, except as specifically authorized by the Commissioner or designee in accordance with the provisions of 104 CMR 27.03(18).
(b) No waiver may be granted by the Commissioner or designee without a determination by the Commissioner or designee that:  
   1. The health, safety, or welfare of neither patients nor staff may be adversely affected by granting the waiver; and that  
   2. In justification of the waiver, a substitute provision or alternative standard has been stated and is found by the Department to result in comparable services to the patients, and to which the facility will be held accountable to the same degree and manner as any provision of 104 CMR 27.00.
(c) Waivers may be granted for the duration of a facility’s license, or for such other period of time as the Department may determine, and may be renewable.
(d) The granting of a waiver for any single facility or period of time shall not require or signify the granting of a waiver for any other facility or period of time.

27.04: Licensing: Intensive Residential Treatment Programs

(1) Adolescent Intensive Residential Treatment Program. An adolescent intensive residential treatment program (IRTP) is a residential mental health program which provides comprehensive treatment and education in a secure setting to mentally ill adolescents and which has the capacity to admit such adolescents on an involuntary basis pursuant to the provisions of M.G.L. c. 123 §§ 3, 7, 8, 10 and 11. IRTPs are not authorized to administer electroconvulsive treatment.

(2) Eligibility. Only individuals who meet the following criteria may be eligible for admission to an IRTP:
   (a) The individual shall be from 13 through 18 years of age. An individual already admitted to an IRTP who becomes 19 years of age may remain there to complete his or her course of treatment; and  
   (b) The individual has been determined to require long-term (i.e., typically, at least three months or longer) treatment in a secure residential setting; and  
   (c) Treatment in a less restrictive setting has been determined to be inappropriate for the individual; and  
   (d) Failure to place the individual in a secure treatment setting would create a likelihood of serious harm by reason of mental illness.

(3) Admission. Individuals who meet the IRTP eligibility criteria may be admitted to and retained in an IRTP only in accordance with the provisions of M.G.L. c. 123, §§ 3, 10 & 11 or 7 and 8, and the regulations promulgated thereunder. For IRTPs operated by or under contract with the Department, individuals may only be admitted upon approval of the Department. Referrals for admission shall be made through an admissions process, as designated by the Department, and shall contain such clinical information and documentation as the Department may require.

(4) Location. If an IRTP is located on the grounds of a state hospital or in the same building as an adult inpatient mental health unit or an adolescent continuing care inpatient unit, it shall have program, kitchen and eating facilities separate from those of the state hospital or inpatient unit.

(5) Staffing. Each IRTP shall be staffed at a level sufficient to meet the clinical needs of the patients, as well as the administrative and ancillary services necessary to the operation of the program, consistent with the requirements of JCAHO or other accreditation agency approved by the Commissioner. Among the clinical staff shall be persons qualified to provide services in appropriate disciplines, including, but not limited to: psychiatric and psychological intervention; individual, group and family therapy; milieu management; medication administration; discharge planning; education; vocational training; and recreation.
   (a) Each IRTP shall have sufficient full-time senior management to provide adequate oversight of program, clinical and psychiatric operations. Senior managers with responsibility for clinical matters shall be mental health professionals, licensed as
independent clinicians in their field of training and expertise. At least one member of senior
management shall be a licensed mental health professional who is, by training or experience,
a specialist in the treatment of adolescents.

(b) Each IRTP shall have a psychiatrist, board certified (or eligible) in child and adolescent
psychiatry, available for consultation and shall have a psychiatrist on site or on call, 24 hours
da day, for psychiatric emergencies, including but not limited to seclusion and restraint.

(c) Each IRTP shall have sufficient qualified nursing staff for the administration of
regularly prescribed medications, as well as for administration of PRN and emergency
medication and conducting examinations pursuant to 104 CMR 27.12.

(d) Each IRTP shall have a sufficient number of independently licensed mental health
professionals such that the primary individual and family therapist for each patient shall be so
licensed.

(e) Provision shall be made to ensure that sufficient back-up personnel are available to
respond within a reasonable time in emergency situations.

(6) General Physical Requirements.

(a) Each program shall provide space that is safe, comfortable, well-lighted, well-ventilated,
adequate in size and of sufficient quality to be utilized in a manner consistent with the overall
philosophy and treatment goals of the program.

(b) Each program shall provide sufficient security features to enable the staff to prevent
physical harm to patients and to staff and to prevent escape from the program, including the
capacity to lock the program to prevent unauthorized access to the community.

SUBPART B: OPERATIONAL STANDARDS FOR MENTAL HEALTH FACILITIES

27.05: General Admission Procedures

(1) For the purpose of involuntary commitment, mental illness is defined as a substantial
disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment,
behavior, capacity to recognize reality or ability to meet the ordinary demands of life, but shall
not include alcoholism or substance abuse which is defined in M.G.L. c. 123, § 35.

(2) For the purposes of voluntary or conditional voluntary admission to mental health facilities
in the Commonwealth, any degree of severity of a mental disorder including alcoholism may
qualify a person for admission to a mental health facility at the discretion of the facility director
or designee when it is determined that such admission is necessary and appropriate.

(3) Admission Examination. Upon admission, each person shall receive a mental status
examination and, within 24 hours of admission, a complete psychiatric and physical examination.
In the case of admissions to an IRTP, such physical examination shall occur within seven
calendar days of admission. As part of the admission examination, staff shall seek to determine
from the patient, the patient's record, the patient's legally authorized representative or, if
appropriate and authorized, from other sources, whether the patient has a history of trauma,
including but not limited to physical or sexual abuse or witnessing violence. At the completion of
each admission examination, the physician shall make an admission diagnosis, and shall enter the
findings of such admission examination in the patient's medical record.

(4) Admission Examination for Persons under the Age of 22.

(a) In addition to the requirements above, the admission examination for persons under the
age of 22 shall include a determination as to whether the individual has special educational
needs.

(b) If the individual has special educational needs, the facility director shall seek written
authorization to provide necessary clinical information to the patient's Local Education
Authority (LEA) in order that an educational program can be jointly developed for such
patient by the LEA and the facility.

(5) Notice to Family or Others.

(a) Admission of Individuals Age 16 or Over. Within 48 hours after admission of any
patient, including a patient age 16 or 17 who has applied for admission himself or herself, the

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director of the facility, or designee, shall notify the patient’s legally authorized representative

27.05: continued

and, unless requested not to do so, the nearest relative regarding the admission of such
patient to the facility. In the alternative, a competent patient over the age of 18 may
designate any two persons to receive such notification. Notice may be given by telephone,
telegram, letter or other appropriate means.

(b) Admission of all other minors. Except in an emergency, or pursuant to court order, no
minor, except a 16 or 17 year old who has applied for admission himself or herself, shall
be admitted to a facility without notice to and consent of the minor’s legally authorized
representative. In an emergency or pursuant to a court order (including application for
admission pursuant to M.G.L. c. 123, § 12 with or without the consent of the legally
authorized representative), the legally authorized representative shall be notified forthwith
upon receipt of the minor at the facility.

(6) Denial of Admission. Applicants for voluntary or conditional voluntary admission to
mental health facilities shall not be denied admission without an explanation of the basis for such
refusal, and alternatives shall be offered or recommended by the admitting physician where
feasible.

(7) Prohibition of Admission of Individuals under the Age of 19 to Adult Inpatient Units:
Exceptions. Except as provided in 104 CMR 27.05(7), no individual under the age of 19
years shall be admitted to an adult unit of a Department facility.

(a) The Department may place an individual age 17 or 18 on such an adult inpatient unit
where a judge of a court of competent jurisdiction has issued an order for the commitment
of the individual to a mental health facility pursuant to the provisions of M.G.L. c. 123,
§§ 15, 16, 17, or 18, or where the individual has been committed to the Department of
Youth Services, and the Commissioner or designee has determined that one or both of the
following factors exist:

1. placement of the individual on an adolescent inpatient unit would create a
likelihood of serious harm to the individual or others; or
2. the individual is in need of stricter security than is available on an adolescent
inpatient unit.

(b) The factors to be considered in the above determinations include, but are not limited
to the following:

1. the nature, circumstances and seriousness of the offense with which the individual
has been charged;
2. the individual’s court and delinquency record;
3. the individual’s maturity;
4. the individual’s history of mental illness;
5. the individual’s social history;
6. the risk of harm presented by the individual’s placement on an adolescent
inpatient unit;
7. the individual’s history of victimizing others;
8. the mental health treatment most suitable for the individual

(c) The statewide specialty Deaf Unit at Westborough State Hospital and the
Commonwealth Research and Evaluation Unit at Erich Lindemann Mental Health Center
may admit individuals under the age of 19 provided that the Units ensure appropriate
separate physical space and programmatic services for them, as approved by the
Commissioner.

(8) Computation of Time. Unless otherwise specified, all computation of days within 104
CMR 27.00 SUBPART B shall be in accordance with the following:

(a) when the time period is less than 7 calendar days, Saturdays, Sundays, and legal
holidays are not counted;

(b) when the time period is 7 calendar days or longer, the time is counted in calendar days,
except when the last day is a Saturday, Sunday, or legal holiday, in which case the final
day counted is the next business day;

(c) the day on which action or event is initiated is not counted.
27.06: Voluntary and Conditional Voluntary Admission

(1) Eligibility for Voluntary or Conditional Voluntary Admission.
   (a) A person may be admitted on a voluntary or conditional voluntary admission status to a facility upon written application, provided that in the opinion of the facility director, or designee, such person is in need of care and treatment and that the admitting facility is suitable for such care and treatment.
   (b) In order to be admitted on voluntary or conditional voluntary admission status, a person must be competent to apply for such admission, and desirous of receiving treatment.
   (c) A person’s application for voluntary or conditional voluntary status shall only be accepted upon a determination by the admitting or treating physician that the person has attained the age of 16 and is competent to apply for such status, or, if application is made on behalf of the person by a guardian, that the guardian has specific authority to do so. An application made on behalf of a minor by the minor’s parent or guardian may be accepted upon a determination by the admitting or treating physician that the person making such application is in fact the minor’s legally authorized representative.
   (d) For purposes of 104 CMR 27.06, competent means:
      1. that a patient admitted on a voluntary status understands that he or she is in a facility for treatment and that he or she may leave the facility at any time.
      2. that a patient admitted on a conditional voluntary status understands that he or she is in a facility for treatment, understands the three-day notice provisions, and understands the facility director's right to file a petition for commitment and thereby retain him or her at the facility.

(2) Prior to admission such person shall be afforded the opportunity for consultation with an attorney, or with a person who is working under the supervision of an attorney, concerning the legal effect of the admission.

(3) Upon admission the patient and his or her legally authorized representative shall receive information concerning the legal and human rights which he or she retains after admission to the facility.

(4) Voluntary admission status shall be totally voluntary, and may be terminated by the patient or facility director at any time without notice.

(5) A patient on conditional voluntary admission status, or any parent or guardian who applied for the admission of such person, may be required to give three days prior written notice to the facility director of his or her intention to leave such facility or to withdraw such person from the facility. Such three day notice may only be retracted by written notice to the facility director. Such three day notice and any retraction thereof shall become part of the patient’s record. The form and content of such three day notice or retraction thereof shall be deemed sufficient so long as it conveys the patient’s intention, without requirement that it be on any particular form of the facility.

(6) Prior to admitting a person on conditional voluntary admission status, the admitting personnel shall inform such person of the three day notice requirements established in M.G.L. c. 123, § 11, and of the facility director's right to file a petition for commitment upon notice that the patient wishes to leave, pursuant to M.G.L. c. 123, § 11.

(7) A person who is 16 or 17, or during the course of hospitalization attains the age of 16, and who has been admitted to a facility as a voluntary or conditional voluntary patient by application of a legally authorized representative shall have the same rights as those persons 16 or over who have applied and been admitted on their own behalf, including the right to leave the facility upon submission of a three day notice of intent to do so, and the right to remain at the facility, upon written application, despite notice by a legally authorized representative of intention to withdraw such patient.

(8) Application for conditional voluntary admission shall be made only upon such form as the Commissioner may prescribe.
27.07: Three Day Involuntary Commitment

(1) No person shall be admitted to a facility upon application for involuntary hospitalization pursuant to M.G.L. c. 123, § 12 unless the person, his or her legal guardian with authority to ad

mit to a facility or, if a minor, his or her legally authorized representative, has been given the opportunity by the facility to apply for admission under M.G.L. c. 123, §§10 and 11. For a patient aged 16 or 17 this opportunity must be given to both the patient and his or her legally authorized representative. The right to convert to voluntary or conditional voluntary admission status may be exercised by a patient, his or her legal guardian with specific authority to admit to a facility, or, if a minor, by his or her legally authorized representative at any time within the three day period. A mental health professional responsible for the patient shall again inform the patient or legally authorized representative, within three days of admission, of the right to change status, and shall record so informing the patient or the legally authorized representative in the patient’s record.

(2) Examination Prior to Admission. Persons for whom application has been made for three day involuntary hospitalization by the appropriate party pursuant to M.G.L. c. 123, § 12, and who have not been examined by a designated physician prior to reception at the admitting facility, shall receive such examination immediately after reception at such facility. For the purposes of this paragraph, “immediately” shall mean within two hours and before the person has been classified as a patient or has been assigned to a bed or ward by the admitting staff. In the event that the designated physician on call at the facility is engaged in an emergency situation elsewhere, he or she shall conduct such an examination as soon as such emergency no longer requires his or her attention.

(3) Upon admission of a person to a facility pursuant to M.G.L. c. 123, § 12(b), the facility shall inform the person and his or her legally authorized representative that it shall, upon request, notify the Committee for Public Counsel Services of the person’s name and location, upon which notice the Committee will appoint an attorney to meet with the person.

(4) Emergency Hearing. The facility shall inform a person admitted pursuant to M.G.L. c. 123, § 12(b) and his or her legally authorized representative of the right to request an emergency court hearing if he or she or his or her legally authorized representative has reason to believe that the admission is the result of an abuse or misuse of the provisions of M.G.L. c. 123, §12(b). The facility shall, upon request, provide the person and his or her legally authorized representative with the form that may be used to request such a hearing and shall take steps to transmit any such completed forms to the court in accordance with the requirements of the court with jurisdiction over the facility.

27.08: Transfer of Patients

(1) For the purposes of 104 CMR 27.08, “emergency” shall mean those medical, surgical and psychiatric crises which in the opinion of the facility director threaten the safety, health or life of the patient or others, and which could not be appropriately treated in the transferring facility.

(2) Permitted Transfers; Exceptions. Any persons admitted to inpatient treatment status may be transferred from any facility to any other facility, provided that except in an emergency:

(a) Patients on voluntary admission status under 104 CMR 27.06 shall not be subject to transfer without their written consent; and

(b) Patients on conditional voluntary admission status under 104 CMR 27.06 may refuse transfer. Such refusal may be considered equivalent to submission of the patient’s three day written notice of their intention to leave or withdraw from the facility.

(3) Absent an emergency, and except for a patient under the age of 16 or under a guardianship with authority to admit to a psychiatric facility, a patient on conditional voluntary admission status may not be transferred against his or her will unless a court of competent jurisdiction enters a commitment order pursuant to M.G.L. c. 123, §§ 7 and 8.
27.08: continued

(4) Absent an emergency, a patient under the age of 16 or under a guardianship with authority to admit to a psychiatric facility, who has been admitted pursuant to his or her legally authorized representative’s authority, may not be transferred over the objection of the legally authorized representative unless a court of competent jurisdiction enters a commitment order pursuant to M.G.L. c. 123, §§ 7 and 8.

(5) In no event shall an order of commitment for observation pursuant to M.G.L. c. 123, § 12 be issued in order to transfer a patient in lieu of compliance with the requirements of M.G.L. c. 123, § 3, or 104 CMR 27.08.

(6) Transfer of a patient committed pursuant to M.G.L. c. 123, § 12 shall not extend the period of such hospitalization.

(7) Transfer Procedures,
   (a) The approval of the director of the receiving facility shall be obtained by the transferring facility.
   (b) The director of the transferring facility shall give six days written notice to the patient to be transferred and to his or her nearest relative, unless the patient knowingly objects, or his or her legally authorized representative; provided, however, that if such transfer must be made immediately because of an emergency, notice shall be given within 24 hours after the transfer pursuant to M.G.L. c. 123, § 3. The notice shall be provided in a form prescribed by the Commissioner.
   (c) A patient, legally authorized representative of a patient under the age of 18, or a duly appointed guardian with authority to admit the ward to a psychiatric facility may, but shall not be required to, waive the six days notice requirement.
   (d) A copy of the Notice of Transfer, along with a copy of the patient’s underlying admission status documentation shall accompany the patient to the receiving facility, and the underlying status shall remain valid upon admission to the receiving facility.

27.09: Discharge

(1) Discharge Procedures,
    (a) A facility shall arrange for necessary post-discharge support and clinical services. Such measures shall be documented in the medical record.
    (b) A facility shall make every effort to avoid discharge to a shelter or the street. The facility shall take steps to identify and offer alternative options to a patient and shall document such measures, including the competent refusal of alternative options by a patient, in the medical record. In the case of such discharge, the facility shall nonetheless arrange for, or, in the case of a competent refusal, identify post-discharge support and clinical services. The facility shall keep a record of all discharges to a shelter or the street in a form approved by the Department and submit such information to the Department on a quarterly basis.
    (c) When a patient in a facility operated by or under contract to the Department is a client of the Department pursuant to 104 CMR 29.00, the service planning process outlined in 104 CMR 29.00 shall be undertaken prior to discharge.
    (d) A facility shall keep a record of all patients discharged therefrom, and shall provide such information to the Department upon request.

(2) Voluntary Admission Status. A patient voluntarily admitted to a facility under 104 CMR 27.06 shall be discharged without a requirement of a three day notice upon his or her request.

(3) Discharge Initiated by Facility Director. The facility director may discharge any patient admitted as a voluntary or conditional voluntary patient at any time he or she deems such discharge in the best interest of such patient; provided, however, that if a legally authorized representative made the application for admission, 14 days notice shall be given to such legally authorized representative prior to such discharge, in accordance with M.G.L. c. 123, § 10(a). With the consent of such legally authorized representative, the superintendent may discharge a patient under the age of 16 years at any time.
27.09: continued

(4) **Conditional Voluntary Admission Status.** A patient admitted to a facility on conditional voluntary admission status under 104 CMR 27.06 shall be discharged by the facility upon his or her request, but he or she shall give three days written notice to the facility director. The facility director may require an examination of such patient to be conducted to determine his or her clinical progress and suitability for discharge, including such factors as legal competency and family, home or community situation. Such persons may be retained at the facility beyond the expiration of the three day notice period if, prior to the expiration of the said three day notice period, the facility director files with the district court a petition for the commitment of such person at the said facility.

(5) **Discharge at Request of Parent or Guardian.** Hospitalization of a person under the age of 16 may be terminated at the request of his or her legally authorized representative in the same manner as any other patient.

(6) **Patients Aged 16 or 17.** A person who is 16 or 17 years old, or who becomes 16 during the course of hospitalization, and who has been admitted to a facility as a voluntary or conditional voluntary patient by application of a legally authorized representative shall have the same rights pertaining to release, withdrawal and discharge as those persons over the age of 16 who have applied and been voluntarily admitted to the facility on their own behalf.

(7) **Involuntary Commitment Status.**
   (a) **Three day commitment.** A person admitted to a facility under M.G.L. c. 123, § 12, may be discharged by the facility director at any time during such period of hospitalization if the facility director determines that such person is not in need of care and treatment in the facility. The three day hospitalization period authorized under M.G.L. c. 123, § 12 shall not be extended, and, at the end of such period, a person so hospitalized shall be discharged by the facility unless, prior to expiration, such person has applied for voluntary admission to the facility, or the facility director has filed a petition for an order of commitment.

   (b) **Prolonged Commitment.** A person committed to a facility by order of a court of competent jurisdiction shall be discharged by the facility at the expiration of the time period established by the order, unless the commitment order is renewed under the procedures established in M.G.L. c. 123, §§ 7 and 8.

   (c) **At any time during the period of hospitalization, the facility director may discharge such person if he or she determines that such person is no longer in need of care and treatment.**

(8) **Forensic Commitment Status.**
   (a) A person committed to facility under M.G.L. c. 123, § 15 shall not be discharged except to the committing court, or upon other court order.

   (b) A person committed to a facility under M.G.L. c. 123, § 16 shall not be discharged unless appropriate notice has been given by the facility director to the court exercising jurisdiction over such person and to the district attorney of the district within which the alleged crime or crimes occurred. If within 30 days of the receipt of such communication the district attorney has not filed a petition for further commitment of such person, the person may be discharged. If such a petition is filed, a hearing shall take place pursuant to M.G.L. c. 123, § 16(c).

   (c) **In the event the facility director intends to remove or modify any court ordered restrictions on such a person’s movements, he or she shall communicate the intention to remove or modify such restriction in writing to the court.** If within 14 days the court does not make written objection thereto, such restrictions may be removed or modified.

   (d) **A person hospitalized at a facility pursuant to M.G.L. c. 123, § 18, shall not be discharged except to prison, a correctional facility, or the court, unless such person's sentence has expired.**
27.10: Treatment

(1) Consent to Treatment.
(a) Upon admission to a facility for care and treatment, a person shall, upon giving informed consent, receive treatment and rehabilitation in accordance with accepted therapeutic practice, including oral, subcutaneous and intramuscular medication when appropriate and when ordered by a physician. Informed consent means the knowing consent, voluntarily given by the patient, or his or her legally authorized representative, who can understand and weigh the risks and benefits of the particular treatment being proposed.
(b) Treatment with antipsychotic medication, Electroconvulsive Treatment (ECT), psychosurgery, involuntary sterilization or abortion, and other highly intrusive or high risk interventions may not be administered or performed without the patient’s specific informed consent. In the case of a patient incapable of giving informed consent, such interventions may not be administered or performed without prior review and approval by a court of competent jurisdiction or the consent of his or her legally authorized representative.
(c) Prior to an adjudication of incompetence, and court approval of a treatment plan, a patient retains the right to accept or refuse treatment as prescribed.
(d) For a patient who is believed to be incompetent to give informed consent to treatment with antipsychotic medication, the right to refuse such medication may be overridden prior to an adjudication of incompetence and court approval of a treatment plan only in rare circumstances to prevent an immediate, substantial and irreversible deterioration of the patient’s mental illness. If treatment is to be continued over the patient's objection, and the patient remains incompetent, then an adjudication of incompetence and court approval of a treatment plan must be sought.
(e) Chemical restraints may be used only in an emergency situation pursuant to 104 CMR 27.12.

(2) Electroconvulsive Treatment for Patients under the Age of 16.
(a) Electroconvulsive treatment shall not be administered to any patient under the age of 16 unless the Commissioner or designee concurs.
(b) The approval of the administration of electroconvulsive treatments to patients under 16 shall be based on such written recommendations and independent consultations as the Commissioner or designee deems appropriate under the circumstances of the individual case.
(c) The Commissioner or designee’s approval, and the basis therefor, shall become a permanent part of the patient’s record.

(3) Routine and Preventive Treatment. A patient shall be informed upon admission and at each periodic review of the routine and preventive treatment that is ordinarily performed at, or arranged by, the facility. Routine and preventive treatment includes standard medical examinations, clinical tests, standard immunizations, and treatment for minor illnesses and injuries. A patient who is capable of giving informed consent regarding routine and preventive treatment has the right to refuse such treatment, except that such refusal may be overridden by the facility director, without special court authorization, when the treatment consists of:
(a) a complete physical examination, and associated routine laboratory tests, required by law to be conducted upon admission and at least annually thereafter.
(b) immunizations or treatment required by law or necessary to prevent the spread of infection or disease.

(5) Written Treatment Plan. As part of the treatment of a patient in a facility, there shall be a written assessment of the needs and strengths of the individual and a written, multi-disciplinary treatment plan, which shall be developed with the maximum possible participation of the patient or the patient's legally authorized representative. The treatment plan, upon acceptance by the patient or his or her legally authorized representative, shall be implemented by the facility staff in good faith within the limits of available resources. There shall be a periodic written assessment of treatment progress, and significant modifications of the treatment plan and the rationale for such modifications shall be recorded by the responsible clinicians.
27.10: continued

(6) Additional Requirements for Patients Eligible for Public School Education.
   (a) Treatment plans for patients who are "children with special needs," as defined in M.G.L.
       c. 71B shall, where appropriate, take into account the plan for providing special education
       services developed in accordance with regulations of the Department of Education.
   (b) Treatment plans for patients who are eligible for public school education but who are
       not "children with special needs" as defined in M.G.L. c. 71B, § 1, shall, if appropriate, and
       in addition to all other requirements for treatment plans, reflect such patient’s educational
       needs.

(7) Behavior management as defined in 104 CMR 27.10 may only be used in facilities licensed
   as Class VI, Limited VI or VII or in units of Department facilities that admit patients under 19.
   Each facility that employs behavior management techniques shall submit a behavior management
   plan, which shall be subject to Department approval. The plan shall outline the facility's
   philosophy, policy and procedures for behavior management whereby behavior management
   interventions are used as an educational process by which staff assist the patients in developing the
   experience and self control necessary to assume responsibilities, make daily living choices, and
   learn to live in reasonable conformity with accepted levels of social behavior. The plan shall
   include a description of acceptable and unacceptable behavior for the patients, as well as the
   sanctions that will result from unacceptable behavior. The plan shall be submitted to the Human
   Rights Officer and, where applicable, to the Human Rights Committee, for review.
   (a) No behavior modification techniques which involve corporal punishment, infliction of
       pain or physical discomfort, or deprivation of food or sleep shall be used for behavior
       management.
   (b) Seclusion and restraint, as defined in these regulations, may not be used for behavior
       management, but may only be used in accordance with 104 CMR 27.12.
   (c) The treatment plan for each patient for whom behavior management will be employed
       shall 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 patient or his or her legally
       authorized representative.
   (d) Each behavior management plan shall describe behavior management interventions that
       may be used. These may include but are not limited to the following:
       1. level/point systems of privileges, including procedures for the patient’s progress in
          the program;
       2. the type and range of restrictions a staff member can authorize for misbehavior of a
          patient;
       3. the use of the practice of separating a patient from a group or facility activity.
   (e) When feasible and appropriate, patients shall participate in the establishment of rules,
       policies and procedures for behavior management.
   (f) Upon admission, the facility shall provide patients and their legally authorized
       representatives with a copy of the facility’s behavior management plan.
   (g) Any behavior management plan which provides that a patient may be separated from the
       group or facility activities shall include, but not be limited to, the following:
       1. guidelines for staff in the utilization of such procedures;
       2. persons responsible for implementing such procedures;
       3. the duration of such procedures, including provisions for approval by the facility
          director or his or her designee of a period longer than 30 minutes;
       4. a requirement that patients shall be observable at all times and that staff shall be in
          close proximity at all times;
       5. a procedure for staff to directly observe the patient every 15 minutes;
       6. 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 patient at least every 15 minutes.
   (h) A time out room shall not be locked.
   (i) Any room or space used for the practice of separation must be physically safe.
27.11: Periodic Review

(1) **Schedule of Periodic Reviews.** Every facility shall conduct a periodic review of each inpatient upon admission, and for patients whose hospitalizations are expected to be at least 90 days, during the first three months, during the second three months, and annually thereafter until discharge, except that for facilities licensed as Class VI, Limited Class VI and VII and for units of Department facilities that admit patients under 19, such periodic reviews shall be conducted quarterly.

(2) **Notice to Patient and Family.** Prior to the periodic review, the facility director or designee shall give reasonable advance written notice to each patient and his or her legally authorized representative and, unless the patient knowingly objects, to the nearest relative, giving the date of such review and requesting their participation in such review.

(3) **Thorough Clinical Examination.** Each periodic review shall include a thorough clinical examination, which shall consist of: a mental status examination; a review of the patient's clinical history, including a review of the treatment plan, of response to treatment, and of medications administered; and an evaluation of general behavior and social interaction by clinical personnel from the various disciplines providing treatment. At least once in every 12 month period, a thorough clinical examination shall also include a physical examination.

(4) **Evaluation of Competency.** For each periodic review, the legal competency of a patient shall be evaluated by the senior reviewing clinician in terms of whether he or she is competent to remain on, or to apply for, conditional voluntary admission status, to render informed consent to customary and usual medical care or extraordinary treatment, including administration of antipsychotic medications, or to manage his or her own funds in accordance with the requirements of 104 CMR 30.01(3).

(a) If a patient is on voluntary or conditional voluntary admission status, and the patient is believed no longer to be competent, and the patient remains in need of continued hospitalization, then the facility director shall take reasonable steps to obtain alternate authority for continued hospitalization either by seeking an order of commitment pursuant to M.G.L. c. 123, §§ 7 and 8, or a guardianship with authority to admit the ward to a psychiatric facility.

(b) If the question of a patient's competency is raised by a periodic review or if the facility director has reason to believe that a patient who has been under the care of the facility, who is not under guardianship or conservatorship, is unable to care for his or her property, he or she shall promptly take reasonable steps to initiate the process for the appointment of a guardian or conservator.

(5) **Consideration of Alternatives to Hospital.** For each periodic review the alternatives to hospitalization should be evaluated, with consideration being given to specific and available resources in the community which the patient could utilize.

(6) **Results of the Periodic Review.**

(a) Upon completion of every periodic review subsequent to admission, the person in charge of conducting the review shall prepare a full and complete record of all information presented at such review, including medical evidence or information, the reasons for a determination that a patient requires continued care and treatment at the facility, and the consideration given to alternatives to continued hospitalization. This written record of each periodic review shall become part of the patient's permanent medical record.

(b) If upon completion of the periodic review, it is determined that the patient is in need of further care and treatment, facility director or designee shall notify the patient and his or her legally authorized representative, or, if there is no such legally authorized representative and the patient does not knowingly object, his or her nearest relative, of that determination, and of the right to leave the facility if he or she was not committed under a court order. If said patient is not committed under a court order and does not choose further treatment as an inpatient, within 14 days of said notification the patient shall be discharged or shall be made the subject of a petition for a court ordered commitment. Following any review under the provisions of 104 CMR 27.11, or at any other time, any patient who is no longer in need of care as an inpatient shall be discharged.

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27.12: Prevention of Restraint and Seclusion and Requirements When Used

(1) **Prevention/Minimal Use of Restraint and Seclusion.** A facility licensed as Class III through VII shall develop and implement a plan to reduce and, wherever possible, eliminate the use of restraint and seclusion. The facility's plan shall include, at a minimum, the following:
   
   a) a posted statement of the facility's commitment to the prevention and minimal use of restraint and seclusion;
   
   b) policies and procedures that support the prevention and minimal use of restraint and seclusion;
   
   c) staff training that focuses on crisis prevention, de-escalation and alternatives to restraint and seclusion;
   
   d) programming and milieu that are consistent with the prevention and minimal use of restraint and seclusion;
   
   e) the development and use of sensory interventions and therapies designed to calm and comfort patients that utilize sight, touch, sound, taste, smell, pressure, weight or physical activity;
   
   f) the development and use of an individual crisis prevention plan for each patient;
   
   g) assessment of the impact of trauma experience and the potential for retraumatization;
   
   h) the regular use of debriefing activities;
   
   i) the process for addressing patient concerns and complaints about the use of restraint or seclusion;
   
   j) the use of data to monitor and improve quality and prevent and minimize the use of restraint and seclusion, such as identifying times or shifts with a high incidence of restraint or seclusion.

(2) **Staff Training.**

   a) A facility shall ensure that all unit staff and other staff who may be involved in restraint and seclusion receive training in the prevention and minimal use of restraint and seclusion during orientation, which shall be no later than one month after hire, and receive annual training thereafter. Training shall include, at a minimum, the following:
   
   1. the harmful emotional and physical effects of restraint and seclusion on patients and staff;
   
   2. the impact of trauma, including sexual and physical abuse and witnessing of violence, on individuals;
   
   3. the impact of restraint or seclusion on individuals with a history of trauma, including the potential for retraumatization;
   
   4. crisis prevention approaches and de-escalation strategies;
   
   5. the use of the individual crisis prevention plan.

   b) In addition to the training in 104 CMR 27.12(2)(a), staff who may be directly involved in authorizing, ordering, administering or applying, monitoring, or assessing for release from restraint or seclusion shall receive additional training, and annual retraining thereafter. No staff shall be permitted to participate in any restraint or seclusion prior to receiving such additional training. Such training shall include, at a minimum, the following:
   
   1. applicable legal and clinical requirements for restraint and seclusion;
   
   2. the safe and appropriate initiation of physical contact and application and monitoring of restraint and seclusion;
   
   3. approaches to facilitate the earliest possible release from restraint or seclusion.

   c) Following initial training and each annual retraining, a facility shall require each staff member to demonstrate competencies in all areas of training. A facility shall maintain documentation of staff training and competencies.

(3) **Individual Crisis Prevention Planning.** A facility shall develop an individual crisis prevention plan for each patient.

   a) **Definition.** An individual crisis prevention plan is an age and developmentally appropriate, patient-specific plan that identifies triggers that may signal or lead to agitation or distress in the patient and strategies to help the patient and staff intervene with de-escalation techniques to reduce such agitation and distress and avoid the use of restraint and seclusion.

   b) **Development of the Individual Crisis Prevention Plan.** As soon as possible after admission, facility staff shall collaborate with each patient and his or her legally authorized representative, if any, and, where appropriate, with other sources, such as family members, caregivers, and the patient's health care proxy, to complete and implement an individual crisis
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prevention plan. If the patient refuses or is unable to participate in the initial development of the plan, staff shall develop a plan using available information and shall make continuing efforts to include the patient's participation in review and revision of the plan. Relevant clinical data, including medical risk factors, physical, learning, or cognitive disability, and the patient's history of trauma shall inform the development of the plan. The plan shall include, at a minimum, the following elements:

1. 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;
2. identification of the particular approaches and strategies that are most helpful to the patient in reducing agitation or distress, such as environmental supports, physical activity, and sensory interventions;
3. in order to minimize trauma or retraumatization if restraint or seclusion is used, identification of the patient's preferences, such as type of intervention and positioning, gender of staff who administer and monitor the restraint or seclusion, and supportive interventions that may have a calming effect on the patient.

(c) Update and Revision of Plan. The plan shall be updated as necessary to reflect changes in such triggers and strategies and shall be reviewed at each treatment plan review.

(d) Access to Plan. A facility shall ensure that all staff on all shifts are aware of and have ready access to the individual crisis prevention plans for the patients in their care. A copy of the individual crisis prevention plan and any revisions thereto shall be placed in the patient record.

(4) Debriefing Activities. A facility shall 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 shall be documented and used in treatment planning, revision of the individual crisis prevention plan, and ongoing facility-wide restraint and seclusion prevention efforts.

(a) Staff Debriefing. As soon as possible following each episode of restraint or seclusion, supervisory staff and staff involved in the episode shall convene a debriefing. The debriefing shall, at a minimum, include the following:

1. identification of what led to the incident;
2. determination of whether the individual crisis prevention plan was used;
3. assessment of alternative interventions that may have avoided the use of restraint or seclusion;
4. determination of whether the patient's physical and psychological needs and right to privacy were appropriately addressed;
5. consideration of counseling or medical evaluation and treatment for the involved patient and staff for any emotional or physical trauma that may have resulted from the incident;
6. consideration of whether other patients and staff who may have witnessed or otherwise been affected by the incident should be involved in debriefing activities or offered counseling;
7. consideration of whether the legally authorized representative, if any, family members, or others should be notified of and/or involved in debriefing activities;
8. consideration of whether additional supervision or training should be provided to staff involved in the incident;
9. determination of whether the incident should be referred for senior administrative review because it meets one or more of the criteria outlined in 104 CMR 27.12(4)(c)1. through 6. or otherwise warrants such review.

(b) Patient Debriefing. Within 24 hours after a patient's release from restraint or seclusion, the patient shall be asked to debrief and provide comment on the episode, including the circumstances leading to the episode, 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 or she may be experiencing from the restraint or seclusion. Whenever possible and appropriate, the staff person providing the patient with the opportunity to comment shall not
have been involved in the episode of restraint or seclusion. As part of the debriefing, the patient shall be provided with a copy of the restraint and seclusion order form required pursuant to 104 CMR 27.12(5)(i)1. with an attached patient debriefing and comment form approved by the Commissioner and shall be offered the opportunity to provide comment in writing. The staff person shall provide the patient with any necessary assistance in completing the patient debriefing and comment form. If the patient does not complete the form, but provides verbal or other response to the episode, the staff person shall document such response on the form. If the patient provides verbal or other response to the episode at any other time, the staff person witnessing the response shall document it in writing. The patient debriefing and comment form or other documentation shall be attached to the restraint and seclusion order form and included in the patient record and copies of the form shall promptly be forwarded to the treatment team and the human rights officer. The patient shall also be notified of the availability of the complaint procedure outlined in 104 CMR 32.00. The human rights officer shall meet with a patient who has expressed a response to an episode of restraint or seclusion that suggests a possible rights violation or other harmful consequence.

(c) Senior Administrative Review. The facility director shall ensure that senior administrative and clinical staff who are empowered to make recommendations and decisions about the need for expert consultation, training, performance improvement activities, change in policy, or other appropriate measures conduct regular reviews of all incidents of restraint and seclusion. In addition, such staff shall conduct a specific review of an episode of restraint or seclusion by the next business day if any of the following apply:

1. A patient or staff member experienced significant emotional or physical injury as a result of the episode.
2. The episode of restraint or seclusion 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. An exception to the restrictions on mechanical restraint of minors has occurred pursuant to 104 CMR 27.12(5)(g)5.
4. The episode appears to be part of a pattern warranting review.
5. The episode is marked by unusual circumstances.
6. The episode resulted in a complaint or reportable incident pursuant to 104 CMR 32.00.
7. the staff involved in the episode requested such a review pursuant to 104 CMR 27.12(4)(a)9.

(5) Requirements for the Use of Restraint and Seclusion.

(a) Definitions. For purposes of 104 CMR 27.12, the following definitions shall apply:

1. Authorized Physician. An authorized physician is any physician who has been authorized by the facility director to order medication restraint, mechanical restraint, physical restraint or seclusion, to examine patients in such restraint or seclusion, and to assess for readiness for release and order release from restraint or seclusion.
2. Authorized Staff Person. An authorized staff person is any member of the licensed clinical staff at a facility who has been authorized by the facility director to initiate or renew mechanical restraint, physical restraint or seclusion pursuant to 104 CMR 27.12(5)(e)2. or (01., and to assess for readiness for release and order release from restraint or seclusion.
3. Restraint. Restraint, for purposes of 104 CMR 27.00, means 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. Restraint does not include the use of restraint in association with acute medical or surgical care, adaptive support in response to the patient's assessed physical needs, or standard practices including limitation of mobility related to medical, dental, diagnostic, or surgical procedures and related post-procedure care.

a. Medication Restraint. Medication restraint occurs when a patient is given medication involuntarily for the purpose of restraining the patient. Medication restraint shall not include:
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i. involuntary administrations of medication when administered in an emergency to prevent immediate, substantial and irreversible deterioration of serious mental illness, provided that the requirements of 104 CMR 27.10(1)(d) are complied with;

ii. for other treatment purposes when administered pursuant to a court approved substituted judgment treatment plan.

b. Mechanical Restraint. Mechanical restraint occurs when a physical device or devices are used to restrain a person by restricting the movement of a patient or the movement or normal function of a portion of his or her body.

c. Physical Restraint. Physical restraint occurs when a manual method is used to restrain a person by restricting a patient's freedom of movement or normal access to his or her body. Physical restraint may only include bodily holding of a patient with no more force than is necessary to limit the patient's movement. Physical restraint shall 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, such as blocking a blow, breaking up a fight, or preventing a fall, a jump, or a run into danger;

4. Seclusion.

a. Seclusion occurs when a patient is involuntarily confined in a room and is prevented from leaving, or reasonably believes that he or she will be prevented from leaving, by means that include, but are not limited to, the following:

i. manually, mechanically, or electrically locked doors, or "one-way doors," that, when closed and unlocked, cannot be opened from the inside;

ii. physical intervention of staff;

iii. coercive measures, such as the threat of restraint, sanctions, or the loss of privileges that the patient would otherwise have, used for the purpose of keeping the patient from leaving the room.

b. Seclusion shall not include voluntary, collaborative separation from a group or activity for the purpose of calming a patient.

(b) Emergency Basis for Medication Restraint, Mechanical Restraint, Physical Restraint or Seclusion. Medication restraint, mechanical restraint, physical restraint or seclusion may be used only in an emergency, such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide. Such emergencies shall only include situations where there is a substantial risk of, or the occurrence of, serious self-destructive behavior, or a substantial risk of, or the occurrence of, serious physical assault. As used in the previous sentence, a substantial risk includes only the serious, imminent threat of bodily harm, where there is the present ability to effect such harm.

1. Restriction on Medication Restraint, Mechanical Restraint, Physical Restraint or Seclusion: Use of Individual Crisis Prevention Plan. Medication restraint, mechanical restraint, physical restraint or seclusion may be used only after the failure of less restrictive alternatives, including strategies identified in the individual crisis prevention plan, or after a determination that such alternatives would be inappropriate or ineffective. under the circumstances, and may be used only for the purpose of preventing the continuation or renewal of such emergency condition. The preferences in the patient's individual crisis prevention plan, such as type of restraint or seclusion and gender of staff, shall be considered in ordering or initiating restraint or seclusion.

2. Duration of Medication Restraint, Mechanical Restraint, Physical Restraint, or Seclusion. Medication restraint, mechanical restraint, physical 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), (f) and (g).

3. PRN Orders Prohibited. No "PRN" or "as required" authorization of medication restraint, mechanical restraint, physical restraint or seclusion may be written.

4. Seclusion Used with Mechanical Restraint Prohibited. No patient shall be placed in seclusion while in mechanical restraints.

5. Other Requirements. When an emergency condition exists justifying the use of medication restraint, mechanical restraint, physical restraint or seclusion, such use must
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conform to all applicable requirements of 104 CMR 27.12.

(c) Physical and Mechanical Restraint or Seclusion - Physical Conditions.
1. Position in Physical or Mechanical Restraint. A patient shall be placed in a position that allows airway access and does not compromise respiration. A face-down position shall not be used, unless:
   a. there is a specified patient preference and no psychological or medical contra-indication to its use; or
   b. there is an overriding psychological or medical justification for its use, which shall be documented.
2. Personal Needs and Comfort. Provision shall be made for appropriate attention to the personal needs of the patient, including access to food and drink and toileting facilities, by staff escort or otherwise, and for the patient's physical and mental comfort.
3. Personal Dignity. Patients in restraints or seclusion shall be fully clothed, limited only by patient safety considerations related to the type of intervention used, and the restraint devices used shall afford patients maximum personal dignity.
4. Physical Environment. The physical environment shall be as conducive as possible to facilitating early release, with attention to calming the patient with sensory interventions where possible and appropriate.
5. Seclusion - Observation. Any room used to confine a patient in seclusion must provide for complete visual observation of the patient so confined.
6. Mechanical Restraint - Locks Prohibited. No locked mechanical restraint devices requiring the use of a key for their release may be used.

(d) Medication Restraint - Order. A patient may be given medication restraint only on the order of an authorized physician who has determined, either while present at the time of (i.e., at any time during the course of) the emergency justifying the use of the restraint or after telephone consultation with a physician, registered nurse or certified physician assistant who is present at the time and site of the emergency and who has personally examined the patient, and using all relevant information available regarding the patient, that such medication restraint is the least restrictive, most appropriate alternative available.
1. Such order along with the reasons for its issuance shall be recorded in writing at the time of its issuance.
2. Such order shall be signed at the time of its issuance by such authorized physician if present at the time of the emergency.
3. Such order, if authorized by telephone, shall be transcribed and signed at the time of its issuance by the physician, registered nurse or physician assistant who is present at the time of the emergency.
4. An authorized physician shall conduct a face-to-face evaluation of the patient as soon as possible but no later than within one hour of the initiation of the restraint if the restraint was authorized by telephone.

(e) Initiation of Mechanical Restraint, Physical Restraint or Seclusion.
1. The order that a patient be placed in mechanical restraint, physical restraint, or seclusion shall be made by an authorized physician who is present when an emergency as defined in 104 CMR 27.12(5)(b) occurs, except as provided in 104 CMR 27.12(5)(e)2.
   a. Such order along with the reasons for its issuance and criteria for release shall be recorded in writing and signed at the time of its issuance by such physician.
   b. Such order shall authorize use of mechanical restraint, physical restraint or seclusion for no more than two hours, subject to the additional restrictions in 104 CMR 27.12(5)(g).
   c. Such order shall terminate whenever a release decision is made pursuant to 104 CMR 27.12(5)(h), and shall be subject to the monitoring, examination and release provisions of 104 CMR 27.12(5)(h).
2. If an authorized physician is not present when an emergency justifying the use of mechanical restraint, physical restraint or seclusion occurs, a patient may be placed in mechanical restraint, physical restraint or seclusion at the initiation of an authorized staff person, subject to the following conditions and limitations:
   a. Such initiation shall be subject to the additional restrictions in 104 CMR 27.12(5)(g).
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b. Such initiation along with the reasons for its issuance shall be recorded in writing and signed at the time of the incident by such authorized staff person.

c. Such initiation shall authorize use of mechanical restraint, physical restraint or seclusion for no more than one hour, shall terminate whenever a release decision is made pursuant to 104 CMR 27.12(5)(h)8., and shall be subject to the monitoring, examination and release provisions of 104 CMR 27.12(5)(h).

d. An authorized physician shall examine the patient as soon as possible but no later than one hour of such initiation of mechanical restraint, physical restraint, or seclusion.

3. At the time of initiation of restraint, an authorized staff person or authorized physician shall observe and make written note of the patient's physical status, including respiratory functioning, skin color and condition, and the presence of undue pressure to any part of the body.

(f) Mechanical Restraint, Physical Restraint or Seclusion - Renewals to Continue Use.

1. Continuation for a Second Hour of Mechanical Restraint, Physical Restraint or Seclusion Initiated by an Authorized Staff Person - Exceptional Circumstances. In exceptional circumstances, where an authorized physician has not examined the patient within the first hour of initiation of restraint or seclusion as required by 104 CMR 27.12(5)(e)2.d., an authorized staff person may issue a single renewal for a second one hour period, subject to the following conditions and limitations:

a. Such renewal shall be subject to the additional restrictions in 104 CMR 27.12(5)(g).

b. Such renewal may only be issued if such authorized staff person determines that such restraint or seclusion is necessary to prevent the continuation or renewal of an emergency condition or conditions as defined in 104 CMR 27.12(5)(b).

c. Such renewal shall authorize use of mechanical restraint, physical restraint or seclusion for no more than one hour, shall terminate whenever a release decision is made pursuant to 104 CMR 27.12(5)(h)8., and shall be subject to the monitoring, examination and release provisions of 104 CMR 27.12(5)(h).

d. An authorized physician shall examine the patient as soon as possible but no later than within one hour of such renewal of mechanical restraint, physical restraint or seclusion, and may order the restraint to continue for no more than two hours from the initiation of the restraint or seclusion by the authorized staff person, subject to the additional restrictions in 104 CMR 27.12(5)(g).

2. Continuation of Mechanical Restraint or Seclusion for Additional Two-Hour Periods. Subsequent orders for renewals of mechanical restraint or seclusion may be made for up to two-hour periods only if an authorized physician has examined the patient and ordered such renewal prior to the expiration of the preceding order, subject to the following conditions and limitations.

a. Such a renewal order shall be subject to the additional restrictions in 104 CMR 27.12(5)(g).

b. Such a renewal order may only be issued if such physician determines that such restraint or seclusion is necessary to prevent the continuation or renewal of an emergency condition or conditions as defined in 104 CMR 27.12(5)(b).

c. Each such order shall be recorded in writing and signed by such physician, but only after examination of the patient in restraint or seclusion by such physician.

d. Each such order shall authorize continued use of mechanical restraint or seclusion for no more than two hours from the time of expiration of the preceding order, shall terminate whenever a release decision is made pursuant to 104 CMR 27.12(5)(h)8., and shall be subject to the monitoring, examination and release provisions of 104 CMR 27.12(5)(h).

(g) Additional Restrictions and Limitations on the Use of Restraint or Seclusion.

1. No episode of physical restraint shall exceed two hours.

2. No order for the restraint or seclusion of a minor under age nine may exceed one hour.

3. No minor under age nine shall be in seclusion or restraint for more than one hour in any 24-hour period.
4. No minor age nine through 17 shall be in seclusion for more than two hours in any 24-hour period.
5. No minor under age 13 may be placed in mechanical restraint, except under the following conditions:
   a. The facility medical director is notified prior to the use of such restraint or immediately after the initiation of the restraint, if an emergency as defined in 104 CMR 27.12(5)(b) occurs. The facility medical director shall inquire about the circumstances warranting the use of such restraint, the efforts made to de-escalate the situation, the alternatives to such restraint considered and tried, any preferences indicated in the individual crisis prevention plan, and whether other measures or resources might be helpful in avoiding the use of mechanical restraint or in facilitating early release.
   b. The facility director shall also be immediately informed of the use of such restraint and shall report it in writing to the Commissioner or designee by the next business day.
   c. All other applicable provisions of 104 CMR 27.12 shall be complied with.
6. Mechanical Restraint or Seclusion Exceeding Six Hours or Multiple Episodes. If an episode of mechanical restraint or seclusion has exceeded five hours and it is expected that a new order will be issued to extend the episode beyond six hours or if there are two or more episodes of any restraint or seclusion for a patient in any 12 hour period, the facility director and facility medical director shall be notified. The facility medical director shall inquire about the circumstances of the episode(s) of restraint or seclusion, the efforts made to facilitate release, and the impediments to such release, and help to identify additional measures or resources that might be beneficial in facilitating release or preventing additional episodes.
7. Mechanical Restraint or Seclusion Exceeding 12 Hours or Total Episodes Exceeding 12 Hours in a 48-Hour Period. If an episode of mechanical restraint or seclusion has exceeded 11 hours and it is expected that a new order will be issued to extend the episode beyond 12 hours, or if episodes of restraint and/or seclusion for a patient have exceeded 12 hours in the aggregate in any 48-hour period, the following shall occur:
   a. The patient shall receive a medical assessment.
   b. The facility director and facility medical director shall be notified. The facility medical director shall inquire about the outcome of the measures identified pursuant to 104 CMR 27.12(5)(g)6., in the case of a continuous episode, and about the circumstances that resulted in the continued or multiple use of restraint or seclusion. The facility medical director shall take steps, including consultation with appropriate parties, to identify and implement strategies to facilitate release as soon as possible and/or eliminate the use of multiple episodes, such as psychopharmacological reevaluation or other consultation, assistance with communication, including interpreter services, and consideration of involving family members or other trusted individuals.
   c. The episode(s) shall be reported to the Commissioner or designee by the next business day.
8. Release Prior to Expiration of Order. If a patient is released from restraint or seclusion prior to the expiration of an order and an emergency as defined in 104 CMR 27.12(5)(b) occurs prior to such order's expiration, but no later than one-half hour after release, the patient may be returned by an authorized staff person to restraint or seclusion without a new order for the time remaining in the order. Such return to restraint or seclusion shall be documented in the record. If the time permitted by the order or one-half hour has elapsed at the time of such emergency, the procedures for ordering or initiating restraint or seclusion pursuant to 104 CMR 27.12(5)(e) shall be followed.

(h) Monitoring and Assessment of Patients in Mechanical Restraint, Physical Restraint or Seclusion; Release.
1. One-on-One Staff Monitoring. Whenever a patient is in physical or mechanical restraint or seclusion, a staff person shall be specifically assigned to monitor such person one-on-one.
2. The staff person conducting such monitoring may be immediately outside a space in
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which a patient is being secluded without mechanical restraint provided that the following conditions are met:

a. The staff person must be in full view of the patient (e.g., the patient may approach the seclusion door and see the staff person through a window in the door if he or she wishes to do so); and

b. The staff person must be able at all times to observe the patient.

3. The staff person shall monitor a patient in mechanical or physical restraint by being situated so that the staff person is able to hear and be heard by the patient and visually observe the patient at all times. It is not necessary for a staff person monitoring a patient in mechanical or physical restraint to be in full view of the patient, although if such visibility has been expressed as a preference by the patient, consideration shall be given to honoring such preference.

4. Staff who monitor a patient in physical or mechanical restraint or seclusion shall continually assist and support the patient, including monitoring physical and psychological status and comfort, body alignment, and circulation, taking vital signs when indicated, and monitoring for readiness for release pursuant to 104 CMR 27.12(5)(h)6. Such monitoring activities shall be documented every 15 minutes.

5. Staff who monitor a patient in restraint or seclusion shall continue appropriate interventions designed to calm the patient throughout the episode of restraint or seclusion and shall ensure that the patient has access to a means of marking the passage of time, either visually or verbally.


a. Staff conducting monitoring shall continually consider whether a patient in mechanical restraint, physical restraint or seclusion appears ready to be released. If the staff person believes that the patient may be ready to be released from such restraint or seclusion either because the criteria for release have been met or an emergency condition or conditions as defined in 104 CMR 27.12(5)(b) no longer exists, he or she shall immediately notify an authorized physician or authorized staff person, who shall promptly assess the patient for readiness to be released.

b. If a patient falls asleep while in mechanical restraint, staff conducting monitoring shall notify an authorized physician or authorized staff person, who shall release the patient from the restraint or seclusion, unless such efforts are reasonably expected to re-agitate the patient.

c. If, at any time during mechanical restraint, physical restraint, or seclusion, a patient is briefly released from such restraint or seclusion to attend to personal needs pursuant to 104 CMR 27.12(5)(c)2. or for other purpose, staff conducting monitoring shall consider the patient's readiness to be permanently released, rather than returned to the restraint or seclusion, and notify an authorized staff person if the patient appears ready to be released.

7. Assessment. An authorized staff person or authorized physician shall assess a patient in mechanical or physical restraint or seclusion for physical and psychological comfort, including vital signs, and readiness to be released at least every 30 minutes and at any other time that it appears that the patient is ready to be released. Such assessments shall be documented in the record.

8. Permanent Release. A patient shall be released from mechanical restraint, physical restraint or seclusion as soon as an authorized physician or authorized staff person determines after examination of the patient or consultation with staff that such mechanical restraint, physical restraint, or seclusion is no longer needed to prevent the continuation or renewal of an emergency condition or conditions as defined in 104 CMR 27.12(5)(b) and, in no event, no later than the expiration of an initial or renewed order for such mechanical restraint or seclusion, unless such order is renewed in accordance with the requirements or 104 CMR 27.12(5)(f). The circumstances considered in making such a determination shall be documented and signed by the authorized physician or authorized staff person making the determination.
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(i) Documentation Requirements.

1. The Restraint and Seclusion Order Form. Each facility subject to these regulations shall ensure that a restraint and seclusion order form is maintained and completed on each occasion when a patient is placed and maintained in restraint or seclusion. The restraint and seclusion order form shall conform to the following requirements:
   a. The restraint and seclusion order form must be in a form approved by the Commissioner.
   b. The restraint and seclusion order form shall be completed in triplicate, one copy of which shall be placed in the patient's record, one copy of which shall be used for the patient's comments pursuant to 104 CMR 27.12(4)(b), and one copy of which shall be used for the review by the Commissioner or designee pursuant to 104 CMR 27.12(5)(i)2.
   c. Any attachments required by 104 CMR 27.12 shall be attached to each copy of the restraint and seclusion order form.

2. Submission to the Commissioner; Review. At the end of each month, a facility shall submit to the Commissioner or designee copies of all restraint and seclusion forms with attachments, if any, required by 104 CMR 27.12 and an aggregate report for each facility unit, on a form approved by the Commissioner, containing statistical data on the episodes of restraint and seclusion for the month. The Commissioner or designee shall review such aggregate reports and review a sample of restraint and seclusion forms, and shall maintain statistical records of all uses of restraint or seclusion, organized by facility and unit.

3. Human Rights Committee/Human Rights Officer Review. At the end of each month, copies of all restraint and seclusion order forms and attachments, if any, sent to the Commissioner or designee pursuant to 104 CMR 27.12(5)(i)2. shall be sent to the human rights committee of the facility, if operated by or under contract to the Department, and otherwise to the human rights officer, which shall review the use of all restraints by the facility or program. The committee or human rights officer shall have the authority to:
   a. review all pertinent data concerning the behavior that necessitated restraint or seclusion;
   b. obtain information about the patient's needs from appropriate staff, relatives and other persons with direct contact or special knowledge of the patient;
   c. 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;
   d. review and refer to the person in charge for action in accordance with 104 CMR 32.00 all complaints that the rights of a patient are being abridged by the use of restraint or seclusion; and
   e. generally monitor the use of restraint and seclusion in the facility.

27.13: Human Rights

(1) No right protected by the Constitutions or laws of the United States and the Commonwealth of Massachusetts shall be abridged solely on the basis of a patient’s admission or commitment to a facility, except insofar as the exercise of such rights have been limited by a court of competent jurisdiction. Furthermore, no person shall be deprived of the right to manage his or her affairs, to contract, to hold professional, occupational or vehicle operator's licenses, to make a will, to marry, to hold or convey property or to vote in local, state, or federal elections solely by reason of his or her admission or commitment to a facility.

(2) In cases where there has been an adjudication that a person is incompetent, or when a conservator or guardian has been appointed for such person, such person’s human rights may be limited only to the extent of the guardian or conservator's adjudicated responsibility. If at any time during a patient’s treatment, the clinical team believes the patient to be incompetent to make treatment or other personal or financial decisions, the director or designee shall notify the patient that a recommendation has been made that there be an adjudication or other determination of the competency of such patient.
27.13: continued

(3) **Right to Treatment.** 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.

(4) **Right to Education.** Patients under the age of 22, under the care and treatment of the Department, shall receive education and training appropriate to their needs in accordance with M.G.L. c. 71B and the regulations promulgated thereunder.

(5) In addition to the foregoing, a patient of a facility:
   (a) shall have reasonable access to a telephone to make and receive confidential telephone calls and to assistance, when desired and necessary to implement this right, provided that such calls do not constitute a criminal act or represent an unreasonable infringement of other persons’ right to make and receive phone calls;
   (b) shall have the right to send and receive sealed, unopened, uncensored mail, provided, however, that the facility director or designee may direct, for good cause and with documentation of specific facts in the patient’s record, that a particular patient’s mail be opened and inspected in front of the patient, 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 patients. Reasonable assistance shall be provided to patients in writing, addressing and posting letters and other documents upon request;
   (c) shall have the right to receive visitors of such patient’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 patients and to avoid serious disruptions in the normal functioning of the facility and shall be sufficiently flexible as to accommodate individual needs and desires of such patients and their visitors;
   (d) shall have the right to a humane psychological and physical environment. Each such patient 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. 104 CMR 27.13 shall not be interpreted as requiring individual sleeping quarters;
   (e) shall have the right to receive, or refuse, visits and telephone calls from his or 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;
   (f) shall, upon admission and upon request at any time thereafter, 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 paralegals from such organizations; provided, further, that the facility shall designate reasonable times for unsolicited visits and for the dissemination of educational materials to patients by such attorneys or paralegals;
   (f) shall have the right to file complaints and to have complaints responded to in accordance with 104 CMR 32.00.

(6) Any rights set forth in 104 CMR 27.13(5)(a) and (c) may be temporarily suspended, but only by the facility director or designee upon concluding that based on the experience of the patient’s exercise of such right, such further exercise of it in the immediate future would present a substantial risk of serious harm to said patient or others and that less restrictive alternatives have either been tried or 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 the patient’s record.

(7) Patients have the right to be free from unreasonable searches of their person or property.

(8) **Right of Habeas Corpus.** Any patient involuntarily committed to any facility who believes or has reason to believe he or she should no longer 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).
27.13: continued

(9) **Rights at Court Hearing.** Whenever a court hearing is held under the provisions of M.G.L. c. 123 for the commitment or further retention of a person in a facility, such person shall have the right to a timely hearing and representation by counsel as provided by law.

(10) **Rights of Aliens.** Aliens shall have the same rights under the provisions of M.G.L. c. 123 as citizens of the United States.

(11) **Human Rights Information to Each Patient on Admission.** A member of the admitting staff shall give each patient, and, if applicable, his or her legally authorized representative, at the time of admission a copy of the rights set forth in 104 CMR 27.13, or other materials explaining his or her rights prepared in accordance with Departmental guidelines.

(12) **Copies of Rights Posted and Available in Facilities.** Each facility shall post a copy of the rights set forth in 104 CMR 27.13 in the admitting room of the facility, in each unit, and in other appropriate and conspicuous places in the facility, and shall make copies available upon request.

27.14: **Human Rights Officer; Human Rights Committee**

(1) **Human Rights Officer.** Each facility shall have a person or person employed by or affiliated with the facility appointed to serve as the human rights officer and to undertake the following responsibilities:
   (a) To participate in training programs for human rights officers offered by the Department;
   (b) To inform, train and assist patients in the exercise of their rights;
   (c) To assist patients in obtaining legal information, advice and representation through appropriate means, including referral to attorneys or legal advocates when appropriate;
   (d) In the case of Department facilities, to serve as staff to the facility’s human rights committee.

   In the case of Department facilities, the Commissioner or designee shall appoint the human rights officer. Otherwise, the facility director shall make such appointment.

(2) **Human Rights Committee.** For each facility operated by, or under contract to the Department, the Commissioner or designee shall establish, inpanel and empower a human rights committee in accordance with the provisions of 104 CMR 27.14. Such a human rights committee may be established jointly with other programs in an Area; provided, however, that the number, geographical separateness or programmatic diversity of the programs is not so great as to limit the effectiveness of the committee in meeting the requirements of 104 CMR 27.14.

(3) Each such human rights committee shall be composed of a minimum of five members, a majority of whom shall be consumers of mental health services, family members of consumers, or advocates; provided, however, that no member shall have any direct or indirect financial or administrative interest in the facility or the Department.

(4) The general responsibility of each such human rights committee shall be to monitor the activities of the facility with regard to the human rights of the patients in the facility. The specific duties of the committee shall include:
   (a) Reviewing and making inquiry into complaints and allegations of patient mistreatment, harm or violation of patient's rights and referral of such complaints for investigation in accordance with the requirements of 104 CMR 32.00;
   (b) Reviewing and monitoring the use of restraint, seclusion and other physical limitations on movement;
   (c) Reviewing and monitoring the methods utilized by the facility to inform patients and staff of the patient's rights, to train patients served by the program in the exercise of their rights, and to provide patients with opportunities to exercise their rights to the fullest extent of their capabilities and interests;
   (d) Making recommendations to the facility to improve the degree to which the human rights of patients served by the facility are understood and enforced;
   (e) Visiting the facility with prior notice or without prior notice provided good cause exits.
27.15: Visit

(5) Each such human rights committee shall meet as often as necessary upon call of the chairpersons, or upon request of any two members, but no less often than quarterly. Minutes of all committee meetings shall be kept and shall be available for inspection by the Department upon request. The committee shall develop operating rules and procedures, as necessary.

(1) A visit is a temporary release of any patient, with the exception of those patients committed pursuant to M.G.L. c. 123, §§ 15, 17 and 18, to the community for a period of not more than 30 days.

(2) A patient committed pursuant to M.G.L. c. 123, § 16 may be released on visit only if not restricted by court order, and upon authorization by the facility director after review by senior clinical staff.

(3) Readmission to Facility. A patient on visit may be readmitted to the facility at any time within 30 days from the day of release without new admission procedures. In the case of persons involuntarily committed, the original commitment order shall remain in effect. Readmission to the facility terminates a visit.

(4) Every facility shall maintain a record of the names of all patients on visit status.

27.16: Absence Without Authorization

(1) Classification as AWA. Any patient admitted or committed to a Department facility pursuant to M.G.L. c. 123, §§ 7 & 8, 10 & 11, 12, 15, 16, 17, or 18, who leaves the facility grounds or an off-grounds program or activity without permission and fails to return within a reasonable time, or any patient who, having left the facility with permission, fails to return at the designated time or within a reasonable time thereafter, shall be classified by the facility director as “absent without authorization.” (AWA).

(2) Classification as AWA: Action to Be Taken.
   (a) Immediate classification: A patient who is admitted or committed pursuant to M.G.L. c. 123, §§ 7 & 8, 10 & 11, or 12 and who is at a high risk of harm to self or others or a patient who is committed pursuant to M.G.L. c. 123, §§ 15, 16, 17, or 18 shall be immediately classified as AWA.
   (b) Classification by midnight census: A patient who does not meet the criteria of 104 CMR 27.16(2)(a) shall be classified as AWA if he or she has not returned within a reasonable time based on clinical judgment or by the midnight census, whichever is earlier.
   (c) The facility shall take prompt and vigorous measures to secure the patient’s return.
   (d) When a patient is classified as AWA, the facility director or designee shall immediately notify the following parties:
      1. local and state police. The police shall be provided with the patient’s description, other information that would assist the police in locating the patient, and information of the patient’s tendencies to be assaultive, homicidal, suicidal or to use weapons;
      2. the district attorney of the county in which the facility is located;
      3. the patient’s next of kin;
      4. the patient’s legally authorized representative;
      5. any person known to be placed at risk because the patient has left the facility;
      6. designated individuals within the Department.
      If such notification is made by telephone, it shall be followed by written notification.

(3) Return from AWA: Action to Be Taken.
   (a) A patient may return or be returned to the facility under the original patient status within six months of being classified as AWA.
   (b) All parties who were notified at the time of a patient’s classification as AWA, shall be notified of the patient’s return to the facility by the facility director or designee.
(4) Discharge of Patients on AWA: Action to Be Taken.
   (a) Six months after being classified as AWA, a patient on AWA who is not committed pursuant to M.G.L. c. 123, §§ 15, 16, 17, or 18 may be discharged from the facility upon authorization by the facility director after review by senior clinical staff. After such six month period, subsequent hospitalization of patients discharged while on AWA status shall require new admission proceedings. However, under specific circumstances, the facility director, in consultation with senior clinical staff, may discharge a patient on AWA status at an earlier date.
   (b) There shall be no such discharge after a six month period for persons committed to a Department facility pursuant to M.G.L. c. 123, §§ 15, 16, 17 or 18.
   
   (c) All parties who were notified at the time of a patient’s classification as AWA, shall be notified of the facility’s decision to discharge the patient pursuant to 104 CMR 27.16(4)(a).

(5) All incidents of AWA shall receive clinical review and such other review as may be determined by the Commissioner.

27.17: Records

(1) "Individual record" shall refer to the medical and psychiatric record of a patient admitted to a facility providing care and treatment, and shall not include any financial, statistical or bookkeeping records of the facility.

(2) Contents of Individual Record. The facility shall maintain a permanent individual record containing all significant clinical information for each person admitted to the facility. Such record shall include:
   
   (a) identification data, including patient's admission status;
   (b) admission information, including admission diagnosis;
   (c) health care proxies and advance directives;
   (d) history and results of physical examination and psychiatric examination or mental status;
   (e) consent forms;
   (f) social service and nurses' notes, and psychological reports;
   (g) reports of clinical laboratory examinations and X-rays, if any;
   (h) reports of diagnostic and therapeutic procedures;
   (i) diagnoses recorded in accordance with the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association;
   (j) progress notes;
   (k) reports of periodic reviews;
   (l) conclusions, including primary and secondary final diagnoses and clinical resume;
   (m) all restraint and seclusion orders, including comment forms;
   (n) commitment orders and records of transfer, including notice of transfer;
   (o) records of all placements;
   (p) reports of treatment for accidents, injuries or severe illnesses while the patient is in the care of the facility;
   (q) requests for and consents to disclosure of information from such individual patient record;
   (r) discharge information; and
   (s) any other information deemed necessary and significant to the care and treatment of the patient.

(3) Maintenance of Records for 30 Years. Each facility providing care and treatment shall maintain individual patient records for at least 30 years after closing of the record due to discharge, death, or last contact.

(4) Microfilmed or Electronic Storage of Records. Facilities may put on microfilm or other form of electronic storage an individual case record after ten years have elapsed from the last contact with such patient. However, such microfilmed records shall be maintained for at least 20 years after being microfilmed. Any form of electronic storage system shall have adequate backup and security provisions to safeguard against data loss, as well as against unauthorized
27.17: continued

access.

(5) **Reporting Patient Data to the Department.** Each facility shall maintain and make available to the Department such statistical and diagnostic data as may be required by the department.

(6) **Confidentiality of and Access to Records.** Except as provided in 104 CMR 27.17, all records relating to any persons admitted to or treated by a facility shall be private and not open to public inspection.

(a) Records of patients shall be open to inspection upon proper judicial order, whether or not such order is made in connection with pending judicial proceedings. For the purposes of 104 CMR 27.17(6), the term “proper judicial order” shall mean an order signed by a justice or special justice of a court of competent jurisdiction as defined from time to time by the General Laws, or a clerk or assistant clerk of such a court acting upon instruction of such a justice. A subpoena shall not be deemed a “proper judicial order.” Wherever possible, a patient’s legally authorized representative, if any, shall be informed of a court order commanding production of the patient’s record.

(b) The Commissioner or designee shall permit the attorney of a patient to inspect the records of said patient upon the request of the patient or attorney. For the purposes of 104 CMR 27.17(6), the Commissioner or designee may require that the request be in writing and may further require appropriate verification of the attorney-client relationship.

(c) A patient and the patient’s legally authorized representative shall be permitted to inspect the patient’s records, absent a determination by the Commissioner or designee, provided that the individual making the determination must be a licensed health care professional, that inspection by the patient is reasonably likely to endanger the life or physical safety of the patient or another person; the record makes reference to another person (other than a health care provider) and inspection is reasonably likely to cause substantial harm to such other person; or inspection by the legally authorized representative is reasonably likely to cause substantial harm to the patient or another person. The facility director may require the legally authorized representative’s consent before permitting a patient under the age of 18 to inspect his or her own records, provided that a patient who is 16 or 17 years old and admitted himself or herself pursuant to G.L. c. 123, §§ 10 & 11, may inspect records of the admittance without such consent. The records of emergency medical or dental treatment of a patient under 18 who consented to such care in accordance with G.L. c. 112, § 12F shall be confidential between the minor and physician or dentist and shall not be released except upon the written consent of the patient under 18 or a proper judicial order. Clinical staff may offer to read or interpret the record when necessary for the understanding of the patient or his or her legally authorized representative. In no circumstance may an individual be denied access to a record solely because he or she declines the offer of clinical staff to read or interpret the record. If access to a record is denied based on the criteria in 104 CMR 27.17(6)(c), the patient or legally authorized representative 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.

(d) Records or parts thereof shall be open to inspection by other third parties, upon the written informed consent of the individual or legally authorized representative, provided that such written informed consent shall meet the requirements for authorization set forth in 45 CFR 164.508.

(e) Records may be disclosed as required by law. In addition to the laws and regulations of the Department, such laws include, but are not limited to:

1. M.G.L. c. 6, §§ 178C through 178O (the Sex Offender Registry Law - Department only);
2. M.G.L. c. 19, § 15 (Department of Elder Affairs - abuse of elderly persons, age 60 or over);
3. M.G.L. c. 19C, § 10 (Disabled Persons Protection Commission – abuse of disabled persons ages 18 to 59);
4. M.G.L. c. 119, § 51A (Department of Social Services – abuse or neglect of children under 18);
5. 42 U.S.C. 10806 (Protection and Advocacy for Mentally Ill Individuals);
6. M.G.L. c. 221, § 34E (Mental Health Legal Advisors Committee).
27.17: continued

(f) The Commissioner or designee may in his or her discretion permit inspection or disclosure of the records of a patient where the Commissioner or designee has made a determination that such inspection or disclosure would be in the best interest of the patient and that such disclosure is permitted by the privacy regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA) at 45 CFR Parts 160 and 164. Prior to authorizing any release of records under 104 CMR 27.17, other than by court order or to the attorney for a patient, the Commissioner or designee shall have made a determination that it is not possible or practicable to obtain the informed written consent of the patient, if competent, or the patient’s legally authorized representative.

(g) Without limiting the discretionary authority of the Commissioner or designee to identify other situations where inspection or disclosure is in the patient's best interest, if it is not possible or practicable to obtain the informed written consent of the patient, if competent, or the patient’s legally authorized representative, such inspection or disclosure may be made in the patient’s best interest in the following cases:

1. from a sending facility to a receiving facility for purposes of transfer pursuant to M.G.L. c. 123, § 3;
2. to a physician or other health care provider who requires such records for the treatment of a medical or psychiatric emergency; provided however that the patient is given notice of the access as soon as possible;
3. to a medical or psychiatric facility currently caring for the patient, when the disclosure is necessary for the safe and appropriate treatment and discharge of the patient;
4. where the patient has provided consent for a particular treatment or service, to those persons involved in such treatment or service;
5. between the Department and a contracted vendor regarding individuals being served by the vendor for purposes related to services provided under the contract;
6. to persons authorized by the Department to monitor the quality of services being provided to the individual;
7. to enable the patient, or someone acting on his or her behalf, to obtain benefits, protective services, or third party payment for services rendered to such patient;
8. to persons conducting an investigation involving the patient pursuant to 104 CMR 32.00;
9. to persons engaged in research if such access is approved by the Department pursuant to 104 CMR 31.00;
10. to the Joint Commission on Accreditation of Healthcare Organizations or other accrediting bodies;
11. reports of communicable and other infectious disease to the Department of Public Health and/or local board of health consistent with 105 CMR 300.000 et seq.;
12. in the case of death, to coroners, medical examiners, or funeral home directors.

(h) Any disclosure pursuant to the exceptions outlined in 104 CMR 27.17(6)(a) through (g) shall be limited to the minimum information necessary to achieve the purpose of the exception.

(i) Notwithstanding the provisions of 104 CMR 27.17(6)(a) through (h), inspection or disclosure of records or information shall not be permitted in the following circumstances:

1. if the record or information was obtained from someone other than a health care provider on a promise of confidentiality, and the requested disclosure would likely reveal the source;
2. on a temporary basis only, during the course of research involving treatment, where the subject of the research agreed to such temporary suspension of access when consenting to participation in the research study;
3. if the subject of the record is in the custody of a correctional institution and the correctional institution has requested that access not be provided for health and safety reasons;
4. if the records are restricted under the Federal Clinical Laboratory Improvement Amendments;
5. if the records are created in anticipation of litigation.
27.18: Interpreter Services

(1) For the purposes of 104 CMR 27.18, the following words shall have the following meanings:
   (a) Competent interpreter services means interpreter services performed by a person who is fluent in English and in the language of a non-English speaker, who is trained and proficient in the skill and ethics of interpreting and who is knowledgeable about the specialized terms and concepts that need to be interpreted for purposes of receiving care or treatment.
   (b) Facility shall mean a Department-operated hospital, community mental health center with inpatient unit, or psychiatric unit within a public health hospital; a Department-licensed psychiatric hospital; or a Department-licensed psychiatric unit within a general hospital.
   (c) Non-English speaker means a person who cannot speak or understand, or has difficulty with speaking or understanding, the English language because the speaker primarily or only uses a spoken language other than English.

(2) Each facility shall in connection with the delivery of inpatient services, if an appropriate bilingual clinician is not available, provide competent interpreter services to every non-English speaker who is a patient.

(3) Based on the volume and diversity of non-English-speaking patients served by the facility, the facility shall use reasonable judgment as to whether to employ, or to contract for, the on-call use of one or more interpreters for particular languages when needed, or to use competent telephonic or televiewing interpreter services; provided that such facility shall only use competent telephonic or televiewing interpreter services in situations where either:
   (a) there is no reasonable way to anticipate the need for employed or contracted interpreters for a particular language; or
   (b) there occurs, in a particular instance, an inability to provide competent services by an employed or contracted interpreter.

(4) Interpreter services shall be available 24 hours a day and seven days a week.

(5) The facility shall not require, suggest, or encourage the use of family members or friends of patients as interpreters and shall not, except in exceptional circumstances, use minor children as interpreters.

(6) The facility shall post signs and provide written notification of the right to and availability of interpreter services to patients in their primary language.

(7) The facility shall develop written policies and procedures that are consistent with 104 CMR 27.18 and that assist staff and patients in accessing interpreter services.

REGULATORY AUTHORITY

104 CMR 27.00: M.G.L. c. 19, §§ 1 and 18; c. 123, § 2.
NON-TEXT PAGE
42 CFR PARTS 441 AND 483
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Center for Medicare and Medicaid Services
42 CFR Parts 441 and 483
[HCFA-2065-IFC]
RIN 0938-AJ96

Medicaid Program; Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Psychiatric Services to Individuals Under Age 21

AGENCY: Center for Medicare and Medicaid Services (CMS), HHS.

ACTION: Interim final rule with comment period.

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SUMMARY:
This interim final rule with comment period establishes a definition of a “psychiatric residential treatment facility” that is not a hospital and that may furnish covered Medicaid inpatient psychiatric services for individuals under age 21. This rule also sets forth a Condition of Participation (CoP) that psychiatric residential treatment facilities that are not hospitals must meet to provide, or to continue to provide, the Medicaid inpatient psychiatric services benefit to individuals under age 21. Specifically, this rule establishes standards for the use of restraint or seclusion that psychiatric residential treatment facilities must have in place to protect the health and safety of residents. This CoP acknowledges a resident's right to be free from restraint or seclusion except in emergency safety situations. We are requiring psychiatric residential treatment facilities to notify a resident (and, in the case of a minor, his or her parent(s) or legal guardian(s)) of the facility's policy regarding the use of restraint or seclusion during an emergency safety situation that occurs while the resident is in the program. We believe these added requirements will protect residents against the inappropriate use of restraint or seclusion.

Effective Date: These regulations are effective on March 23, 2001.

For the reasons set forth in the preamble, 42 CFR chapter IV is amended as follows:
PART 441--SERVICES:
REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

A. Part 441 is amended as set forth below:

1. The authority citation for part 441 continues to read as follows:
   Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 441.151 is revised to read as follows:
   Sec. 441.151 General requirements.
   a) Inpatient psychiatric services for individuals under age 21 must be:
      1) Provided under the direction of a physician;
      2) Provided by--
         (i) A psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations; or
         (ii) A psychiatric facility that is not a hospital and is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the State.
      (3) Provided before the individual reaches age 21, or, if the individual was receiving the services immediately before he or she reached age 21, before the earlier of the following--
         (i) The date the individual no longer requires the services; or
         (ii) The date the individual reaches 22; and
      (4) Certified in writing to be necessary in the setting in which the services will be provided (or are being provided in emergency circumstances) in accordance with Sec. 441.152.
   (b) Inpatient psychiatric services furnished in a psychiatric residential treatment facility as defined in Sec. 483.352 of this chapter, must satisfy all requirements in subpart G of part 483 of this chapter governing the use of restraint and seclusion.
PART 483:
REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

B. Part 483 is amended as set forth below:

1. The authority citation for part 483 continues to read as follows:
   Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. A new subpart G, consisting of Secs. 483.350 through 483.376, is added to part 483 to read as follows:
   Subpart G--Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21

Section:
483.350 Basis and scope.
483.352 Definitions.
483.354 General requirements for psychiatric residential treatment facilities.
483.356 Protection of residents.
483.358 Orders for the use of restraint or seclusion.
483.360 Consultation with treatment team physician.
483.362 Monitoring of the resident in and immediately after restraint.
483.364 Monitoring of the resident in and immediately after seclusion.
483.366 Notification of parent(s) or legal guardian(s).
483.368 Application of time out.
483.370 Postintervention debriefings.
483.372 Medical treatment for injuries resulting from an emergency safety intervention.
483.374 Facility reporting.
483.376 Education and training.

Subpart G--Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21

Sec. 483.350 Basis and scope.
(a) Statutory basis. Sections 1905(a)(16) and (h) of the Act provide that inpatient psychiatric services for individuals under age 21 include only inpatient services that are provided in an institution (or distinct part thereof) that is a psychiatric hospital as defined in section 1861(f) of the Act or in another inpatient setting that the Secretary has specified in regulations. Additionally, the Children's Health Act of 2000 (Pub. L. 106-310) imposes procedural reporting and training requirements regarding the use of restraints and involuntary seclusion in facilities, specifically including facilities that provide inpatient psychiatric services for children under the age of 21 as defined by sections 1905(a)(16) and (h) of the Act.

(b) Scope. This subpart imposes requirements regarding the use of restraint or seclusion in psychiatric residential treatment facilities, that are not hospitals, providing inpatient psychiatric services to individuals under age 21.
Sec. 483.352 Definitions.
For purposes of this subpart, the following definitions apply:

Drug used as a restraint means any drug that--

(1) Is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others;

(2) Has the temporary effect of restricting the resident's freedom of movement; and

(3) Is not a standard treatment for the resident's medical or psychiatric condition.

Emergency safety intervention means the use of restraint or seclusion as an immediate response to an emergency safety situation.

Emergency safety situation means unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention as defined in this section.

Mechanical restraint means any device attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.

Minor means a minor as defined under State law and, for the purpose of this subpart, includes a resident who has been declared legally incompetent by the applicable State court.

Personal restraint means the application of physical force without the use of any device, for the purpose of restricting the free movement of a resident's body.

Psychiatric Residential Treatment Facility means a facility other than a hospital, that provides psychiatric services, as described in subpart D of part 441 of this chapter, to individuals under age 21, in an inpatient setting.

Restraint means a "personal restraint," "mechanical restraint," or "drug used as a restraint" as defined in this section.

Seclusion means the involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving.

Serious injury means any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

Staff means those individuals with responsibility for managing a resident's health or participating in an emergency safety intervention and who are employed by the facility on a full-time, part-time, or contract basis.

Time out means the restriction of a resident for a period of time to a designated area from which the resident is not physically prevented from leaving, for the purpose of providing the resident an opportunity to regain self-control.
Sec. 483.354 General requirements for psychiatric residential treatment facilities.
A psychiatric residential treatment facility must meet the requirements in Sec. 441.151 through Sec. 441.182 of this chapter.

Sec. 483.356 Protection of residents.
(1) Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.

(2) An order for restraint or seclusion must not be written as a standing order or on an as-needed basis.

(3) Restraint or seclusion must not result in harm or injury to the resident and must be used only-

(i) To ensure the safety of the resident or others during an emergency safety situation; and

(ii) Until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired.

(4) Restraint and seclusion must not be used simultaneously.

(b) Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse).

(c) Notification of facility policy. At admission, the facility must--

(1) Inform both the incoming resident and, in the case of a minor, the resident's parent(s) or legal guardian(s) of the facility's policy regarding the use of restraint or seclusion during an emergency safety situation that may occur while the resident is in the program;

(2) Communicate its restraint and seclusion policy in a language that the resident, or his or her parent(s) or legal guardian(s) understands (including American Sign Language, if appropriate) and when necessary, the facility must provide interpreters or translators;

(3) Obtain an acknowledgment, in writing, from the resident, or in the case of a minor, from the parent(s) or legal guardian(s) that he or she has been informed of the facility's policy on the use of restraint or seclusion during an emergency safety situation. Staff must file this acknowledgment in the resident's record; and

(4) Provide a copy of the facility policy to the resident and in the case of a minor, to the resident's parent(s) or legal guardian(s).

(d) Contact information. The facility's policy must provide contact information, including the phone number and mailing address, for the appropriate State Protection and Advocacy organization.
Sec. 483.358 Orders for the use of restraint or seclusion.

(a) Only a board-certified psychiatrist, or a physician licensed to practice medicine with specialized training and experience in the diagnosis and treatment of mental diseases, may order the use of restraint or seclusion.

(b) If the resident's treatment team physician is available, only he or she can order restraint or seclusion. If the resident's treatment team physician is unavailable, the physician covering for the treatment team physician can order restraint or seclusion. The covering physician must meet the same requirements for training and experience described in paragraph (a) of this section.

(c) The physician must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.

(d) If the physician is not available to order the use of restraint or seclusion, the physician's verbal order must be obtained by a registered nurse at the time the emergency safety intervention is initiated by staff and the physicians verbal order must be followed with the physician's signature verifying the verbal order. The ordering physician must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

(e) Each order for restraint or seclusion must:

1. Be limited to no longer than the duration of the emergency safety situation; and
2. Under no circumstances exceed 4 hours for residents ages 18 to 21; 2 hours for residents ages 9 to 17; or 1 hour for residents under age 9.

(f) Within 1 hour of the initiation of the emergency safety intervention, a physician or clinically qualified registered nurse trained in the use of emergency safety interventions must conduct a face-to-face assessment of the physical and psychological well being of the resident, including but not limited to--

1. The resident's physical and psychological status;
2. The resident's behavior;
3. The appropriateness of the intervention measures; and
4. Any complications resulting from the intervention.

(g) Each order for restraint or seclusion must include--

1. The ordering physician's name;
2. The date and time the order was obtained; and
3. The emergency safety intervention ordered, including the length of time for which the physician authorized its use.

(h) Staff must document the intervention in the resident's record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:
(1) Each order for restraint or seclusion as required in paragraph (g) of this section.
(2) The time the emergency safety intervention actually began and ended.
(3) The time and results of the 1-hour assessment required in paragraph (f) of this section.
(4) The emergency safety situation that required the resident to be restrained or put in seclusion.
(5) The name of staff involved in the emergency safety intervention.
(i) The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes.
(j) The physician ordering the restraint or seclusion must sign the order in the resident's record as soon as possible.

Sec. 483.360 Consultation with treatment team physician.
If the physician ordering the use of restraint or seclusion is not the resident's treatment team physician, the ordering physician or registered nurse must--

(a) Consult with the resident's treatment team physician as soon as possible and inform the team physician of the emergency safety situation that required the resident to be restrained or placed in seclusion; and

(b) Document in the resident's record the date and time the team physician was consulted.

Sec. 483.362 Monitoring of the resident in and immediately after restraint.

(a) Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing and monitoring the physical and psychological well-being of the resident and the safe use of restraint throughout the duration of the emergency safety intervention.

(b) If the emergency safety situation continues beyond the time limit of the physician's order for the use of restraint, a registered nurse must immediately contact the ordering physician in order to receive further instructions.

(c) A physician, or a registered nurse trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the restraint is removed.

Sec. 483.364 Monitoring of the resident in and immediately after seclusion.

(a) Clinical staff, trained in the use of emergency safety interventions, must be physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well-being of the resident in seclusion. Video monitoring does not meet this requirement.

(b) A room used for seclusion must--

(1) Allow staff full view of the resident in all areas of the room; and
(2) Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.

(c) If the emergency safety situation continues beyond the time limit of the physician's order for the use of seclusion, a registered nurse must immediately contact the ordering physician in order to receive further instructions.

(d) A physician, or a registered nurse trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the resident is removed from seclusion.

Sec. 483.366 Notification of parent(s) or legal guardian(s).

If the resident is a minor as defined in this subpart:

(a) The facility must notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention.

(b) The facility must document in the resident's record that the parent(s) or legal guardian(s) has been notified of the emergency safety intervention, including the date and time of notification and the name of the staff person providing the notification.

Sec. 483.368 Application of time out.

(a) A resident in time out must never be physically prevented from leaving the time out area.

(b) Time out may take place away from the area of activity or from other residents, such as in the resident's room (exclusionary), or in the area of activity or other residents (inclusionary).

(c) Staff must monitor the resident while he or she is in time out.

Sec. 483.370 Postintervention debriefings.

(a) Within 24 hours after the use of restraint or seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the resident. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident's parent(s) or legal guardian(s). The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint or seclusion.

(b) Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of--

(1) The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention;
(2) Alternative techniques that might have prevented the use of the restraint or seclusion;

(3) The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and

(4) The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.

c) Staff must document in the resident's record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, names of staff that were excused from the debriefing, and any changes to the resident’s treatment plan that result from the debriefings.

Sec. 483.372 Medical treatment for injuries resulting from an emergency safety intervention.

(a) Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an emergency safety intervention.

(b) The psychiatric residential treatment facility must have affiliations or written transfer agreements in effect with one or more hospitals approved for participation under the Medicaid program that reasonably ensure that--

(1) A resident will be transferred from the facility to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care;

(2) Medical and other information needed for care of the resident in light of such a transfer, will be exchanged between the institutions in accordance with State medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and

(3) Services are available to each resident 24 hours a day, 7 days a week.

c) Staff must document in the resident's record, all injuries that occur as a result of an emergency safety intervention, including injuries to staff resulting from that intervention.

d) Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

Sec. 483.374 Facility reporting.

(a) Attestation of facility compliance. Each psychiatric residential treatment facility that provides inpatient psychiatric services to individuals under age 21 must attest, in writing, that the facility is in compliance with HCFA's standards governing the use of restraint and seclusion. This attestation must be signed by the facility director.

(1) A facility with a current provider agreement with the Medicaid agency must provide its attestation to the State Medicaid agency by July 21, 2001.

(2) A facility enrolling as a Medicaid provider must meet this requirement at the time it executes a provider agreement with the Medicaid agency.
(b) Reporting of serious occurrences. The facility must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State-designated Protection and Advocacy system. Serious occurrences that must be reported include a resident's death, a serious injury to a resident as defined in Sec. 483.352 of this part, and a resident's suicide attempt.

(1) Staff must report any serious occurrence involving a resident to both the State Medicaid agency and the State-designated Protection and Advocacy system by no later than close of business the next business day after a serious occurrence. The report must include the name of the resident involved in the serious occurrence, a description of the occurrence, and the name, street address, and telephone number of the facility.

(2) In the case of a minor, the facility must notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence.

(3) Staff must document in the resident's record that the serious occurrence was reported to both the State Medicaid agency and the State-designated Protection and Advocacy system, including the name of the person to whom the incident was reported. A copy of the report must be maintained in the resident's record, as well as in the incident and accident report logs kept by the facility.

Sec. 483.376 Education and training.

(a) The facility must require staff to have ongoing education, training, and demonstrated knowledge of--

(1) Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations;

(2) The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and

(3) The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or in seclusion.

(b) Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required.

(c) Individuals who are qualified by education, training, and experience must provide staff training.

(d) Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.

(e) Staff must be trained and demonstrate competency before participating in an emergency safety intervention.
(f) Staff must demonstrate their competencies as specified in paragraph (a) of this section on a semiannual basis and their competencies as specified in paragraph (b) of this section on an annual basis.

(g) The facility must document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training.

(h) All training programs and materials used by the facility must be available for review by HCFA, the State Medicaid agency, and the State survey agency.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

   Robert A. Berenson, Acting Deputy Administrator, Health Care Financing Administration.

   Donna E. Shalala, Secretary.
I. PURPOSE

To establish a statewide system for assuring informed consent for psychiatric medications, electroconvulsive treatment and/or psychosurgery and related treatment information.

II. SCOPE

This policy applies to any entity, be it an individual, program or facility (or any of their staff) that is operated or funded by the Department of Mental Health and the clients (child, adolescent or adult) who receive treatment from them. This policy also applies to any private program or facility that agrees by contract (or other agreement to comply with this policy.

For clients under the age of 16, it must be understood that each time the policy references “client,” it is the parent or legal guardian of the minor client who must be consulted for the purposes of giving informed consent unless the client has been determined to be an emancipated minor (see IV A5). This does not, however, preclude the necessity of involving the minor client in discussions regarding the implications of any recommended treatment.

III. DEFINITIONS

A. Emancipated Minor: A client under the age of 18 may give consent for medical or dental care if he/she is: married, widowed or divorced; the parent of a child; pregnant or believes herself to be pregnant; a member of the armed forces; living separate and apart from parent or legal guardian and managing his/her own financial affairs.

B. Authorized Prescribing Clinician: For the purposes of this document, includes licensed physicians, licensed physician’s assistants of licensed clinical nurse specialists practicing in the expanded role, who are authorized under Massachusetts law to prescribe certain kinds of treatment.

C. Roger’s Order: The judicial review and approval required to treat individuals with antipsychotic medications, electroconvulsive treatment or psychosurgery who are unable to give informed consent.

D. Treatment: For the purposes of this document, includes use of psychiatric medications, electroconvulsive treatment and/or psychosurgery.

E. Competence: Ability to understand the nature of the illness; the risks, benefits and side effects of the proposed treatments and capable of rationally manipulating the information to arrive at an informed decision.
IV. INTRODUCTION

Although this policy is limited to programs that are operated or funded by DMH, under Massachusetts law, the doctrine of informed consent is applicable to all Authorized Prescribing Clinicians. However, the doctrine of informed consent only extends to clients able to make informed decisions. For those clients incaable of making an informed decision to accept or forego certain for of treatment, the law provides an alternative means to protect their interests, i.e., appointment of a guardian and application of the doctrine of substituted judgment. In anyevent, clients who are not able to consent to or refuse treatment shall neverthe less be informed of the purpose, risks, benefits and side effects of the proposed treatment (as provided under this policy) to the extent possible, consistent with the client’s ability to understand this information.

There are other circumstances where an incompetent client’s right to refuse medication may be overridden to prevent an immediate, substantial and irreversible deterioration of the client’s mental illness. Similarly, chemical restraint may be used in an emergency situation pursuant to applicable Department regulations.

A. Consistent with Massachusetts law, the following principles are established with regard to informed consent:

1. For consent to treatment to be informed, it must be voluntary, (i.e., free of coercion), knowing, and competently given. Individuals are presumed competent to make informed decisions.

2. The Authorized Prescribing Clinician owes to the client the duty to disclose, in a reasonable manner, all significant medical information that the Authorized Prescribing Clinician possesses or reasonably should possess that is material to an informed decision by the client as to whether or not to undergo a proposed treatment.

3. Knowing exercise of the right to accept or forego treatment requires knowledge of the available options and risks attendant on each.

4. Competent adults have the right to forego treatment, or even cure, if it entails what, for them are unacceptable consequences or risks, however unwise their decision may be in the eyes of the medical profession or others.

5. An “emancipated minor” has the same right as an adult to consent to or refuse medical treatment.

6. It is the Department’s policy that parents and other legal guardians (for example, DSS if it has custody) of 16 and 17 year old clients should pay a central role in the development of the client’s treatment plan. The parent(s) or legal guardian(s) should be given the opportunity to be involved in the decision-making and to co-sign the treatment plan unless it is not in the best interests of the 16 or 17 year old client to do so. However, because 16 or 17 years old clients are authorized by law to sign themselvesinto and out of inpatient mental health facilities, it is the Department’s policy to afford these 16 and 17 year old clients the right to consent to and refuse treatment. In order to give informed consent, the 16 or 17 year old client must be capable of understanding the nature of his or her illness and the risks and benefits of the proposed treatment.

In cases where the 16 or 17 year old client refuses treatment, court approval must be obtained before beginning treatment.
Whenever questions arise as to the specific rights of minors, their parent(s) or legal guardian(s), the appropriate DMH legal office should be contacted for clarification.

B. Consistent with acceptable health care practices, facilities and programs covered by this policy shall adhere to standards regarding informed consent established by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and identified in its Accreditation Manual for Hopsitals, Accreditation Manual for Health Care Networks, and Mental Health Manual.

V. AUTHORIZED PRESCRIBING CLINICIAN RESPONSIBILITIES

A. Introduction

Providing information necessary for informed consent is the responsibility of the Authorized Prescribing Clinician. This information shall be provided in the client’s own language, in terms the client can understand. The Authorized Prescribing Clinician will discuss the nature of the illness and the need for medication with the client, describing the type of treatment, its risks and benefits, probability of side effects, alternative treatments, and the prognosis with and without any treatment. Further discussion then shall proceed in response to questions that the client has about specific issues of possible side effects, for example, tardive dyskinesia or certain dystonic reactions from neuroleptic medications. The Authorized Prescribing Clinician assesses the client’s ability to understand and process the information and documents this discussion in the medical record.

B. Obtaining Valid Informed Consent

Informed consent must include the following elements:

1. An assessment of the competency/ability of the client to understand that there may be something wrong, that there is a treatment that might help and that the client has the capacity to recognize and report side effects.

2. A description of the condition being treated;

3. An explanation of the proposed treatment;

4. An explanation of the risks, side effects and benefits of the proposed treatment;

5. A set of materials provided to the client that are written in common, everyday language describing the benefits, risks, and side effects of the prescribed medication;

6. An explanation of alternatives to the proposed treatment, including not having treatment and the risks, benefits and side effects of the alternatives to the proposed treatment;

7. An explanation of the right to freely consent to or refuse the treatment without coercion, retaliation or punishment. Loss of privileges, threat/use of restraints, discharge, guardianship, Roger’s orders or any form of retaliation and/or coercion shall never be used as punishment when a client freely exercises his/her right to refuse/accept treatment. Such interventions may only be utilized in accordance with applicable legal and clinical standards. In cases where a competent client refuses a recommended treatment, alternative, clinically appropriate treatment acceptable to the client, including no treatment, shall be explored and offered where possible.
8. An explanation of the right to withdraw one’s consent to treatment, orally or in writing, at any time.

C. Ongoing Communication and Review
When initiating or making substantial changes in treatment for inpatients or outpatients, the discussion of informed consent shall be documented early in the treatment process and periodically as continuing dialogue about it occurs. For stable outpatients, documentation at annual intervals is sufficient, unless there are changes in the treatment or the client’s mental and/or physical status. For long stay inpatients, informed consent issues will be documented as part of the periodic review process, at three and six month intervals, and then annually unless there are changes in the treatment or in the client’s mental and/or physical status.

Obtaining informed consent is an ongoing process rather than a one-time event. Discussions about informed consent, in particular regarding psychiatric medications, do not stop with the initial consent but continue through the course of treatment as the client experiences the medication and its benefits and side effects and especially when the care of the client is transferred to a new Authorized Prescribing Clinician. If at any point in time a client decides to stop taking the treatment or experiences side effects that were not previously discussed, such discussions shall then take place and be subsequently documented in the medical record as part of the informed consent process.

A continuing assessment of the capability of making informed decisions must also occur, particularly when the Authorized Prescribing Clinician has reason to believe that the client’s ability to understand and process the information has changed.

D. Documentation of Informed Consent
Documentation of informed consent in the medical record shall include:
1. An assessment of the client’s capacity to understand and process the information;
2. An indication that the client has been provided information including risks, benefits and side effects;
3. A notation that the client has assented to, or refused treatment;
4. A signed copy of a consent form, or an indication of the oral consent on the form. These forms shall be duplicate carbonless forms. The client shall be given a signed copy of his or her consent form.
5. A description of any questions and comments offered by the client and the Authorized Prescribing Clinician’s response;
6. An ongoing review of the efficacy of treatment, the side effects of medications; alternative treatments and continuing competency; this review should include appropriate diagnostic tests. Discussion of all of these shall occur on a regular basis and shall be documented in the medical record.

E. Incompetency, Guardianship or an Order for Psychiatric Treatment under Chapter 123 s. 8B
1. If after conversations between an Authorized Prescribing Clinician and a client, the Authorized Prescribing Clinician has reason to believe that a client is not capable of giving
informed consent, this is documented in the medical record describing the specific facts upon which this conclusion is based. The client should be fully and honestly informed of the pursuit of the guardianship, in a manner appropriate to his or her needs. A discussion regarding the process of obtaining guardianship or a court order for treatment in accordance with MGL c. 123 s. 8B shall be initiated with legal counsel. Legal counsel will work with the Authorized Prescribing Clinician to determine whether a petition will be filed, and in which forum, based upon relevant criteria such as the standards set for in DMH Policy #83-50, an assessments of the merits of the case, resources of the legal office, and other considerations. In addition, if the Authorized Prescribing Clinician has reason to believe that a client under guardianship has been restored to competency, s/he should contact legal counsel for advice.

2. If the client has a legal guardian with responsibility for treatment decision, the above procedures for informed consent shall be followed with the guardian. It should be noted that if antipsychotic medications, electroconvulsive treatment or psychosurgery are to be given, information should be shared with the guardian, but only the court can give consent to this treatment.

3. Clients who are not able to consent to or refused treatment shall nevertheless to be informed of the purpose, risks and benefits of the proposed treatment (as provided under this policy) to the extent possible, consistent with the client’s ability to understand this information.

4. It is the parent or legal guardian or a client under the age of 16 who has the authority to make treatment decisions on behalf of the client, unless the client is an Emancipated Minor. Additionally, see Section Iv. A.6 of this policy regarding 16 and 17 year olds.

VI. TREATMENT TEAM RESPONSIBILITIES

A. Treatment Teams in conjunction with the client shall assess the best method to provide ongoing information about treatment.

B. Written materials that supply current and accurate explanations of treatment in common, everyday language shall be made available to clients for review and discussion. A copy of these materials shall be given to the client and client’s guardian if s/he has one, and a copy shall be placed in the medical record. At the client’s request, a copy will be given to the client’s family or significant others designated by the client.

VII. ADMINISTRATIVE RESPONSIBILITIES

A. On inpatient units and in 24-hour resident facilities, a human rights officer shall introduce himself/herself to a client as soon as possible and preferably within 72 hours of admission to inform the client of his/her human rights, including informed consent, and the right to refuse treatment, accept treatment, or request alternative treatments. The human rights officer will also answer any questions or provide additional information if requested to do so.

B. A blank copy of the consent form shall be posted in patient areas of outpatient services and on inpatient units. Information from the most recent edition of the PDR Family Guide to Prescription Drugs, unless at such time another standardized, regularly updated set of fact sheets are adopted by the Department, shall be available at the place of service. These fact sheets shall be translated into languages spoken by the clients, where possible.
C. Settings that prescribe and/or administer medications shall have methods appropriate client
needs to provide ongoing information and education about medication including, but not
limited to medication groups.

D. A separate document on Informed Consent Rights shall be posted in patient areas. This
posting shall reflect the values and principles embodied in this policy and shall convey that
clients have the right to freely consent to or refuse recommended treatment without coercion,
retaliation or punishment unless a court has ordered said treatment or in an emergency
situation.

The posted document shall read as follows:

You are an active partner in your treatment.

You have the right to know the benefits, risks and side effects of the proposed treatment,
alternative treatments and what is likely to occur if you go untreated. This information should be
discussed with you and given to you in the form of a consent form. Information sheets for each
prescribed medication also will be given to you.

You are entitled to an explanation of your right to freely consent to or refuse treatment without
coercion, retaliation, or punishment. Loss of privileges, threat/use of restraints, discharge,
guardianship, Roger’s orders or any form of retaliation and/or coercion shall never be used as
punishment when you freely exercise your right to refuse/accept treatment. Such interventions
may only be utilized in accordance with applicable legal and clinical standards. When you are
competent and refuse a recommended treatment, alternative clinically appropriate treatment
acceptable to you, including no treatment, shall be explored and offered where possible.

You have the right to freely consent to or refuse recommended treatment unless a court has
ordered said treatment. (In emergency situation, medication may be given without your consent.)

If you have not received adequate information about your treatment rights, believe that your
rights are being violated, or that you are being coerced into treatment, you may contact: The
Human Rights Office, Mental Health Legal Advisors Committee or other Mental Health
Protection and Advocacy agency, etc. (include local methods of access
of each).

When an inpatient is under guardianship with a Roger’s order from a Probate Court, the order
should be sent to the treating outpatient psychiatrist upon discharge along with a copy of the
discharge summary. Similarly, when an outpatient under guardianship with a Roger’s order from
a Probate Court is admitted to a hospital, a copy of the order should be sent to the inpatient
treatment facility. The release of client records an information must be consistent with
confidentiality requirements.

VIII. TRAINING AND EVALUATION

A. The process of informed consent is reviewed at least annually as part of each facility’s
quality improvement plan.

B. Annually, all Authorized Prescribing Clinicians credentialed to provide services at each
facility will be trained regarding the requirements of informed consent. Furthermore, all staff
involved in medication delivery, dispensing and education, as well as human rights officers,
will also receive this training annually.
IX. IMPLEMENTATION RESPONSIBILITY

Implementation of this policy, including training and evaluation, shall be the responsibility of the person in charge of each facility or program included under Part II (scope).

X. REVIEW

This policy shall be reviewed annually.

References:

The following statutes, regulations, and policies are applicable to this policy and may be referenced:

MGL c. 111, s. 70E; MGL c. 123, ss. 4, 23, 24 and 25; MGL c. 201; 104 CMR.3.08; 104 CMR 15.06; 104 CMR 3.12; 104 CMR 16.00; DMH Policy #83-50
GENERAL LAWS OF MASSACHUSETTS

PART I - ADMINISTRATION OF THE GOVERNMENT.

TITLE XVII - PUBLIC WELFARE.

CHAPTER 123. MENTAL HEALTH.

Chapter 123: Section 23. Telephone access rights; mail rights; visitation rights; legal and civil rights; suspension of rights; notice of rights.

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.