

Readopt with amendment and renumber Cor 303, effective 3-23-18 (Document #12502), as Cor 501 and Cor 502, cited and to read as follows:

PART CHAPTER Cor 303 500 STANDARDS FOR HEALTH, AND MEDICAL, AND BEHAVIORAL HEALTH CARE IN CORRECTIONS FACILITIES

Cor 501.01 Purpose. The purpose of these rules is to define the circumstances in which, and mechanisms by which, involuntary emergency treatment, seclusion, or restraint can be provided for adult persons under departmental control in correctional settings. These emergency interventions are designed to be effective, safe, and time-limited and utilized only after all less restrictive options have been exhausted.

Cor 501.02 Definitions.

(a) "Administrator" means the non-medical administrator of the secure psychiatric unit or, in the absence of the administrator, the designee in charge of the facility.

(b) "Administrative Review Committee" (ARC) means a committee comprised of administrators from the division of medical and forensic services assigned by the director of medical & forensic services as a risk management and clinical review committee of the treatment rendered persons under departmental control who have committed sexually-related offenses or a sexually violent history. The person whose case is being reviewed shall be afforded the opportunity to participate in the review if they request to participate in advance of the review.

(c) "Advance practice registered nurse (APRN)" means an advanced practice registered nurse licensed by the board of nursing who is certified as a psychiatric behavioral health nurse practitioner by a board-recognized national certifying body.

(d) "Behavioral contract" means a document that addresses current negative behaviors that are preventing a person under departmental control from being successful in a program or treatment. It is an agreement to ensure that the resident is made aware of concerns and how they can work together to resolve barriers to treatment.

(e) "CMS regional office" means the office of the U.S. Department of Health and Human Services, Branch Chief, Survey and Enforcement Branch, Centers for Medicare & Medicaid Services, Room 2275, John F. Kennedy Federal Building, Boston, Massachusetts 02203.

(f) "Completion without full application" means that the sexual offender treatment participant is not consistently demonstrating use of the tools and concepts learned in treatment and is not consistently demonstrating the application of interventions necessary for full completion.

(g) "CORIS" means Correctional Offender Record Information System.

(h) "Cycle of offending" means an individual model which graphically demonstrates early antecedents in a person's sexual offending behavior.

(i) "Department" means the department of corrections.

(j) "Emergency" means the physical or behavioral status of a person under departmental control or patient that, if not treated promptly, will likely result in substantial harm to the individual or patient or others.

(k) "Facility" means New Hampshire state prison for men, New Hampshire correctional facility for women, northern New Hampshire correctional facility, the residential treatment unit and the secure psychiatric unit.

(l) "Female sexual offender treatment services" means treatment for females that have sexually related charges unique to the needs and differing typologies of the female offender.

(m) "Individual" means a person receiving services from a facility.

(n) "Individual treatment plan (ITP)" means a documented plan that describes the patient's condition and procedures that will be needed, detailing the treatment to be provided, expected outcomes, and expected duration of the treatment outlined by the treating clinician and with the patients feedback.

(o) "Informed decision" means a choice made voluntarily by an individual or applicant for services or, where appropriate, such person's legal guardian, or durable power of attorney after all relevant information necessary to making the choice has been provided, when:

(1) The person understands that he or she is free to choose or refuse any available alternative;

(2) The person clearly indicates or expresses his or her choice; and

(3) The choice is free from all coercion.

(p) "Involuntary admission" means admission to the secure psychiatric unit pursuant to RSA 623:1.

(q) "Lack of capacity" means the inability of a person, after efforts have been made to explain the nature, effects, and risks of the proposed treatment and alternatives to the proposed treatment, to engage in a rational decision-making process regarding the proposed treatment as evidenced by his or her inability to weigh the nature, purpose, risks, and benefits of the proposed treatment and any available alternatives and the likely consequences of refusing treatment.

(r) "Licensed provider" means a provider licensed in the state of New Hampshire.

(s) "Maintenance contract" means a document created by residents in the sexual offender treatment programs to maintain safety for sexual offending. This is an agreement that is a work in progress during treatment and residents leave with a contract. This document consists of the person under departmental control's triggers and his or her skills to change thinking patterns and ideas to keep him or her free from accusation.

(t) "Medical emergency" means a physical condition of a patient which, if not treated, will result in an immediate, substantial, and progressive deterioration of a serious physical illness.

(u) "Nursing staff" means a registered or licensed practical nurse or other care provider working under the direct supervision of a registered nurse.

(v) "Personal safety emergency" means a physical status or a behavioral status and an act or pattern of behavior of an individual which, if not treated immediately, will result in serious physical harm to the individual or others.

(w) "Patient" means a person involuntarily admitted to the secure psychiatric unit by order of a probate court pursuant to RSA 623:1, or any other person admitted to the secure psychiatric unit.

(x) "Physician" means a medical doctor licensed in the state of New Hampshire who is employed by, consultant to, or otherwise under contract with the department of corrections.

(y) "Psychiatric emergency" means a condition of a patient, resulting from psychiatric illness, which, if not treated promptly, likely will result in either:

(1) Imminent danger of harm to the patient or others as evidenced by:

a. Symptoms that in the past have immediately preceded acts of harm to self or others; or

b. A recent overt act including, but not limited to, an assault, or self-injurious behavior when the likelihood of preventing such harm would be substantially diminished if treatment is delayed;

(2) Deterioration of the patient's psychiatric status from his or her usual behavioral status as manifested by exacerbation of psychiatric symptoms that potentially endanger self or others, or lead to severe self-neglect, or lead to a failure to function in a less restrictive environment when the likelihood of stabilizing and reversing such deterioration would be substantially diminished if treatment is delayed; or

(3) Continued decompensation of the patient's psychiatric status from his or her usual behavioral status as manifested by persistent psychiatric symptoms that potentially endanger self or others, or lead to severe self-neglect, or lead to a failure to function in a less restrictive environment when there is a reasonable likelihood that such symptoms could be alleviated if treatment could be administered to the patient.

(z) "PUDC" means a person or persons under departmental control.

(aa) "Restraint" means a mechanical device, drug or medication when it:

~~Cor 303.02(b)(1)a.~~ (1) Is used as a restriction to manage an individual's behavior or restrict the individual's freedom of movement; and

~~Cor 303.02(b)(1)b.~~ (2) Is not a standard treatment or dosage for the individual's condition, in order to modify a individual's interaction with others to achieve the highest level of function; or

~~Cor 303.02(b)(2)~~ (3) Any manual method, physical or mechanical device, material, or equipment that immobilizes an individual or reduces the ability of an individual to move his or her arms, legs, head, or other body parts freely but does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of an individual, if necessary, for the purpose of permitting the individual to participate in activities without the risk of physical harm.

(ab) "Seclusion" means the involuntary confinement of an individual who:

(1) With regard to a person who is 18 or older:

a. Is placed alone in a room or area from which the individual is physically prevented, by lock or person, from leaving; and

b. Cannot or will not make an informed decision to agree to such confinement.

(ac) “Steering Committee” means a group of participants that steers the direction of a unit or program. The committee works on projects such as the contract, agenda for monthly unit meeting and is the voice of the unit.

(ad) “Sexual offender treatment services (SOTS)” means treatment specifically established to create accountability and eliminate any further sexual victimization and sexually deviant behaviors.

(ae) “Training” means provision of education to staff, based on the specific needs of the individual population, resulting in demonstrated knowledge and documented competency.

(ad) “Treatment” means medical or psychiatric care, excluding seclusion or restraint, provided by a physician, a person acting under the direction of a physician, or a clinician in accordance with generally accepted clinical and professional standards.

(ae) “Treatment team” means all the disciplines participating in the implementation and oversight of the individual treatment plan.

PART Cor 502 STANDARDS OF CARE

Cor ~~303.04~~ 502.01 Health, and Medical Care in Departmental Facilities.

(a) Medical care shall be provided to persons under departmental control at each departmental facility. Medical care shall include services providing for the person’s physical and behavioral well-being as well as treatment for specific diseases or infirmities.

(b) A physician licensed in New Hampshire by the board of medicine shall be designated the chief medical officer and shall be responsible for medical services and work cooperatively with the psychiatric medical doctor ensuring the provision of comprehensive healthcare. ~~departmental behavioral health services on mutually related matters.~~

(c) Persons under departmental control arriving at a departmental facility shall receive a comprehensive medical examination within 14 days of arrival directed to the discovery of physical and behavioral health illness.

(d) Medical examinations shall include:

- (1) Medical and behavioral health history;
- (2) A physical examination;
- (3) A dental examination;
- (4) Diagnostic lab tests;
- (5) Notation of apparent medical physical illnesses or accessibility issues;
- (6) A determination of the physical ability of each person under departmental control for work; and

(7) Notation of referrals or recommended treatment for specific illnesses or accessibility issues.

(e) Based on the history and examination, a licensed medical provider shall prescribe any necessary treatment including referral or therapy.

(f) All medical services shall be performed by medical staff licensed in the State of New Hampshire under the general supervision of a licensed physician.

(g) The department shall include appropriately licensed medical staff to assure persons under departmental control have full-time access to medical care. Medical care shall include provisions for the transfer of sick or injured persons under departmental control to medical facilities as deemed medically necessary. Medical facilities shall include prison infirmaries and referrals to outside medical specialists, other licensed health care facilities, accredited hospitals and the secure psychiatric unit.

(h) Medication shall be prescribed only by properly licensed physicians, physician assistants or ~~ARNPs~~ APRN providers. Such medications shall only be dispensed under the supervision of licensed pharmacists ~~or by physicians~~.

(i) Medications appropriately prescribed and dispensed as described above shall be administered in one of these methods:

- (1) Self-administered by individuals;
- (2) Self-administered by individuals under direct staff supervision; or
- (3) Administered by medical staff.

(j) Medical records shall contain documentation concerning healthcare related encounters including, but not limited to medical and behavioral health assessment and examinations, healthcare findings, and treatments.

(k) A routine sick call policy shall be established for each facility. Each person under departmental control shall be given an opportunity to request to report to sick call. When routine sick call is unavailable, or the PUDC is unable to personally transmit their medical concerns, ~~Corrections officers and other staff members shall transmit persons under departmental control medical concerns to medical authorities. for the persons under departmental control when the individual person under departmental control is unable to do so personally or when routine sick call is unavailable.~~ No one shall prevent persons under departmental control from seeking medical help. Individuals who, because of their custody or other status, are not able to visit the health services center to seek medical care on the schedule established, shall be visited in their cell or other convenient place by a medical professional who shall conduct an examination or perform any medical procedures as necessary. Documentation of medical concerns expressed and addressed shall be completed in the electronic health record. ~~A record shall be maintained in the persons under departmental control's medical health record in regards to sick call activity documenting the nature of the request and the response to that request.~~

(l) Medical personnel shall have available portable screens or other devices to insure adequate privacy during medical examinations and treatment. The medical services in-patient areas shall have a call system so that patients can summon medical help when they are confined in that facility. Nursing stations shall be so located that nurses can monitor the condition of the patients.

(m) Patients requiring monitoring shall be monitored by a trained individual ~~or staff member~~. Persons under departmental control housed in segregation or any other restricted status that prevents them from visiting sick call at the medical facility shall be visited at least once a day by a member of the medical staff. The chief medical officer shall report to the chief administrator of the facility or designee and the

director of medical and forensic services or designee whenever the physical or behavioral health of a PUDC will be adversely affected by continued segregation ~~it is considered that a person under departmental control's physical or behavioral health will be adversely affected by continued imprisonment~~ or by any condition of confinement.

(n) The department shall ensure that there are written policies which detail the operations and procedures of departmental medical facilities, medical care, medical services and medical treatment, and that they are reviewed at least 2 times each year, kept current, and followed.

Cor 502.02 Emergency Response to a Psychiatric Emergency.

(a) As soon as possible after a suspected psychiatric incident, the treatment staff of the facility and the individual shall develop a crisis plan to:

(1) Identify the individual's preferred response to a psychiatric emergency situation in order to avoid more restrictive interventions;

(2) Identify the individual's history of physical, sexual, or emotional trauma, if any; and

(3) Minimize the possibility of involuntary emergency measures.

(b) Involuntary emergency treatment, seclusion, or restraint in a facility shall not be implemented unless a physician or APRN determines that a personal safety emergency exists.

(c) A physician or APRN shall authorize involuntary emergency treatment, seclusion, or restraint without consent of the individual only following personal examination or observation, except as provided in Cor 502.03 or Cor 502.04.

(d) No involuntary emergency treatment shall be administered pursuant to Cor 502 unless it is to take effect within 24 hours and is expected to alleviate or ameliorate the status or condition which has caused the emergency.

(e) The emergency response that is administered pursuant to Cor 502 shall be an intervention that:

(1) Is expected to be effective;

(2) Considers whether any of the following factors regarding the individual's condition would require special accommodation to ensure necessary communication and the individual's safety:

a. Medical factors;

b. Psychological factors; and

c. Physical factors, including:

1. Blindness or other limitations of sight;

2. Deafness or other limitations of hearing; and

3. Any other physical limitation that would require special accommodation;

(3) Is the least restrictive of the individual's freedom of movement; and

(4) Gives consideration to the individual's preferred response to a psychiatric emergency situation.

(f) Involuntary emergency treatment, seclusion, or restraint ordered following a personal safety emergency shall be authorized for no more than is necessary, but in no case for more than 24 hours.

Cor 502.03 Medical Use of Restraints.

(a) An emergency response shall include use of restraints only to the extent authorized by this section.

(b) Restraints shall:

(1) Not be imposed longer than is necessary to resolve a personal safety emergency regardless of the length of the time identified in the order; and

(2) Not exceed 2 hours unless there is documented authorization by a physician or APRN.

(c) Restraints shall be used only as a last resort when no other intervention in an emergency situation is feasible to protect the immediate safety of the individual or others.

(d) Restraints shall never be used explicitly or implicitly as punishment for the behavior of the individual.

(e) Persons under departmental control in restraints shall be afforded privacy through practices including:

(1) The use of a single room;

(2) Minimizing external stimuli such as noise, nearby movement, and approaches by other persons under departmental control; and

(3) Continuous staff observation to assure the conditions in (2) above are met.

(f) Authorization for the use of restraints shall be as follows:

(1) A physician or APRN may write an order for the use of restraints; or

(2) A physician or APRN may authorize the use of restraints via telephone when the order:

a. Follows deliberate and comprehensive consultation between the physician or APRN and a trained APRN or registered nurse (RN) who has personally evaluated the individual by reviewing:

1. The assessments of the individual that have been performed;

2. The safety issues involved; and

3. The potential antecedents to the restraint(s);

b. Is for a period not to exceed 2 hours; and

c. Is countersigned by the ordering physician or APRN within 24 hours of the time such treatment was ordered.

(g) A physician or APRN may authorize in writing, or verbally, by telephone, the extension of an order of restraint(s) if he or she, or a trained APRN or RN, has personally examined, observed, and assessed the individual for whom the seclusion or restraint is ordered.

(h) Following an examination and assessment as required by (g) above, a physician or APRN may issue an order to extend restraints if the order is for not more than 4 hours. Additional restrictions are:

(1) Such authorization shall expire unless it is renewed by telephone order for an additional 4 hours; and

(2) Any further extensions of restraints or shall require a personal examination or observation by a physician or APRN.

(i) A physician or APRN who authorizes restraints shall, in collaboration with the attending staff, establish release criteria for the termination of the restraints.

(j) If the condition of the individual does not improve to meet the criteria for termination, the physician or APRN may renew the order as specified in (h) above for up to the time limits established in (i) above, provided that no individual shall remain in restraints for more than 24 hours from the time such procedure was initiated unless a physician or APRN personally examines, observes and assesses the individual and renews the order in writing.

(k) Staff shall continually monitor the individual during periods of restraint to ensure that:

(1) In the judgment of the staff, all reasonable measures are in place to ensure that the individual's health and safety is protected during the period of restraint;

(2) The individual receives meals and regular opportunities to move and to utilize the bathroom;

(3) All other basic physiological needs are identified and met; and

(4) The restraint is discontinued as soon as the emergency is resolved, regardless of the length of time identified in the order.

(l) Only during incidents requiring immediate action will restraints be utilized without the authorization of a physician or APRN.

Cor 303.02 502.04 Involuntary Emergency Medical Treatment.

~~(a) "Emergency" means the physical or mental status of a person under departmental control or patient that, if not treated promptly, will likely result in substantial harm to the individual person under departmental control or patient or others.~~

~~(b) "Restraint" means:~~

~~(1) Any drug or medication when it:~~

- ~~(2) a. Conducting routine physical examinations or tests;~~
- ~~b. Protecting the individual from falling out of bed; or~~
- ~~e. Permitting the individual to participate in activities without the risk of physical harm.~~

(e a) The department shall maintain the general health and well-being of persons under departmental control and patients of the secure psychiatric unit. Such person whose medical condition requires, in the opinion of the departmental physician, physician's assistant or APRN ~~advanced registered nurse providers~~, expeditious emergency medical treatment to prevent death, substantial worsening illness or injury, contagion or infection of others, or harm to self or others shall be treated in the least intrusive manner as prescribed by the licensed provider, even over the objection of the person under departmental control or patient, pursuant to RSA 627:6, VII (b).

(e b) In the case of an incompetent person under departmental control or patient, pursuant to RSA 627:6, VII(b), emergency treatment shall be administered when the physician, physician's assistant or ~~ARNP~~ APRN licensed provider reasonably believes that a reasonable person concerned for the welfare of the person under departmental control would consent. Legally responsible persons shall be notified before the proposed treatment, if possible, but in no event later than 24 hours after the administration of such treatment.

(e c) Involuntary emergency treatment, seclusion, or restraint in a facility shall not be implemented unless a licensed provider determines that a personal safety emergency exists. Involuntary emergency medical and psychiatric treatment shall be administered by a licensed provider only upon personal examination or observation prior to the decision to administer such treatment, except in situations where emergency physical or mechanical restraint or seclusion is necessary as described in (k) below.

(e d) Involuntary emergency medical treatment, pursuant to RSA 627:6, VII (b) shall be limited to the extent that:

- (1) The authorization by the departmental licensed provider to impose involuntary treatment issued pursuant to Cor ~~303.02~~ 502.04 shall last for not longer than 72 hours unless the licensed provider issues a new 72 hour authorization;
- (2) No treatment shall be administered pursuant to Cor ~~303.02~~ 502.04 which is not reasonably expected to alleviate or ameliorate the condition which has caused the need for said involuntary treatment; and
- (3) The treatment that is administered shall be a form of treatment that is the least restrictive effective treatment.

(e e) When any emergency treatment is administered pursuant to Cor ~~303.02~~ 502.04 the physician, or ~~advanced practice registered nurse (APRN)~~ administering or directing such treatment shall record in the person under departmental control's health record the specific reasons that such involuntary treatment is necessary and the provider's emergency response shall be an intervention that:

- (1) Is expected to be effective;
- (2) Considers whether any of the following factors regarding the individual's condition would require special accommodation to ensure necessary communication and the individual's safety:
 - a. Medical factors;
 - b. Psychological factors; and
 - c. Physical factors, including:

1. Blindness or other limitations of sight;
 2. Deafness or other limitations of hearing; and
 3. Any other physical limitation that would require special accommodation;
- (3) Is the least restrictive of the individual's freedom of movement; and
- (4) Gives consideration to the individual's preferred response to a psychiatric emergency situation.

(h f) Documentation pursuant to (g) above shall be distributed as follows:

- (1) The original of the physician's, or APRN's note regarding the involuntary treatment shall be retained in the person under departmental control's medical health record; and
- (2) A copy shall be promptly transmitted to the ~~chief medical officer~~ psychiatric medical director or designee to keep him or her informed of persons under departmental control receiving treatment pursuant to Cor ~~303.02~~ 502.04.

(f g) A person under departmental control or legally responsible person may complain against and appeal the administration of involuntary treatment pursuant to Cor ~~303.02~~ 502.04 in accordance with the departmental grievance procedure as outlined in the departmental handbooks. The commissioner shall act on the appeal within 48 hours after securing additional advice and expertise from healthcare professionals.

(j h) Each instance of involuntary emergency treatment shall require an administrative review conducted by the director of medical and forensic services or designee which shall review the treatment and circumstances and make recommendations to the commissioner.

(k i) Departmental employees shall use the minimal amount of force and restraint necessary to prevent serious bodily harm to the persons under departmental control or others.

(f j) All such interventions shall be limited to the extent that:

- (1) Any such intervention shall be imposed for a period no longer than is necessary to resolve a personal safety emergency regardless of the length of the time identified in the order;
- (2) Interventions emergently imposed by licensed nursing staff may not exceed one hour until a physician, or APRN can be consulted to determine if continued authorization of emergency treatment is necessary; and

(3) Authorization for the use of seclusion or restraint shall be pursuant to 502.03 (f). ~~as follows:~~

~~a. Follows deliberate and comprehensive consultation between the physician and a trained advanced practice registered nurse (APRN) or registered nurse (RN) who has personally evaluated the individual by reviewing:~~

- ~~1. The assessments of the individual that have been performed;~~
- ~~2. The safety issues involved; and~~
- ~~3. The potential antecedents to the seclusion or restraint.~~

~~b. Trained nursing staff shall continually monitor the individual during periods of seclusion or restraint to ensure that:~~

- ~~1. In the judgment of the nursing staff, all reasonable measures are in place to ensure that the individual's health and safety is protected during the period of seclusion or restraint;~~
 - ~~2. The individual receives meals and regular opportunities to move and to utilize the bathroom;~~
 - ~~3. All other basic physiological needs are identified and met; and~~
 - ~~4. The seclusion or restraint is discontinued as soon as the emergency is resolved, regardless of the length of time identified in the order; and~~
- ~~e. Include in the authorization order established release criteria for the termination of the seclusion or restraint.~~
- ~~(4) The physician, or APRN shall authorize the use of restraint or seclusion by telephone order for a period not to exceed 4 hours;~~
 - ~~(5) Such authorization shall expire unless it is renewed by telephone order for an additional 4 hours;~~
 - ~~(6) Any further extensions of restraint or seclusion shall require a personal examination or observation by a physician, or APRN;~~
 - ~~(7) Individuals in seclusion or restraint shall be afforded privacy through practices including:
 - ~~a. The use of a room designed for the purpose of seclusion or restraint;~~
 - ~~b. Minimizing external stimuli such as noise, nearby movement, and approaches by other individuals; and~~
 - ~~c. Continuous staff observation to assure the conditions in (2) above are met.~~~~
 - ~~(8) Seclusion or restraint shall never be used explicitly or implicitly as punishment for the behavior of the individual; and~~
 - ~~(9) Restraint or seclusion shall be used only as a last resort when no other intervention in an emergency situation is feasible to protect the immediate safety of the individual or others.~~

Cor 303.03 502.05 Involuntary Non-Emergency Medical Treatment.

Except as provided in Cor 304.02 502.04 and 504.04, medical treatment shall be administered only with the consent of the person under departmental control or the person under departmental control's duly appointed legal guardian. In the event a person under departmental control is legally incapacitated, as defined in RSA 464-A:2, XI, to consent to medical treatment which, in the opinion of the departmental physician, or APRN, would tend to promote the physical or ~~mental~~ behavioral health of the person under departmental control, and the person under departmental control or patient does not have a legal guardian, the director of medical and forensic services shall consult with and refer the matter to the department of justice who shall petition the appropriate court for the appointment of a guardian or guardian ad litem pursuant to RSA 464-A.

Cor 502.06 Emergency Medication and Other Emergency Treatment.

(a) A physician or APRN in a facility shall prescribe medication as a form of emergency treatment, to be administered without the individual's consent, at the time a personal safety emergency is declared. Such authorization shall be countersigned by the ordering physician or APRN within 24 hours of the order for involuntary administration of the medication.

(b) When emergency medication is ordered, the individual shall be offered, whenever feasible, a choice of taking the medication orally or by injection.

(c) Psychosurgery, electroconvulsive therapy, sterilization, or experimental treatment of any kind shall not be used as involuntary emergency treatment.

Cor 502.07 Review and Documentation of Emergency Response.

(a) At the time that any emergency treatment, seclusion, or restraint is administered in a facility pursuant to Cor 502.03, the physician or APRN administering or directing such treatment, or a person acting under his or her direction, shall promptly record the circumstances pertaining to the personal safety emergency.

(b) The person completing a record pursuant to (a) above shall include the following:

(1) The individual's name;

(2) The date and time when the report is completed;

(3) The physician or APRN's name;

(4) A description of the individual's physical or behavioral status and the act or pattern of behavior which constitutes the emergency;

(5) The names of any witnesses other than the individual;

(6) A description of any alternatives attempted or considered prior to declaring a personal safety emergency;

(7) Any treatment limitations;

(8) A description of the specific emergency treatment, seclusion, or restraint ordered; and

(9) The physician or APRN's signature.

(c) As soon as possible following an involuntary emergency treatment, seclusion, or restraint, facility medical or nursing staff, or both shall document the incident in the individual's medical record.

(d) As soon as possible following the resolution of the emergency situation, nursing staff shall:

(1) Address any physical injuries or trauma that might have occurred as a result of the episode;

(2) Hold and document a discussion with the individual to:

a. Review the circumstances that led up to the emergency with the individual involved;

b. Ascertain the individual's willingness or desire to involve their clinician in a debriefing to discuss and clarify their perceptions about the episode and to identify additional alternatives or treatment plan modifications;

c. Hear and document the individual's perspective of the episode;

d. Discuss and clarify any possible misperceptions the individual or staff might have concerning the incident;

e. Identify with the individual any environmental changes or alternative interventions to reduce the potential for additional episodes;

f. Ascertain whether the individual's rights and physical well-being were addressed during the episode and advise the individual of the process to address perceived rights grievances; and

(3) Support the individual's re-entry into their assigned housing.

(e) Within one business day, their clinician shall, after discussion with the individual, modify the treatment plan as needed through a treatment team review including areas noted in (d)(1)-(3) above and seek an informed decision on that plan by the individual.

(f) A review of the clinical appropriateness of the use of seclusion or restraint shall be conducted:

(1) As authorized by the facility's psychiatric medical director;

(2) On the next business day following a personal safety emergency;

(3) To assess compliance with the requirements of Cor 503.02;

(4) To consider and take any action needed to prevent the recurrence of the same or similar personal safety emergencies; and

(5) By the facilities chief of security.

Cor 502.08 Training.

(a) At a minimum, facilities shall provide training at the following intervals to all staff who will be involved in the use of any type of restraint or seclusion:

(1) During initial academy training; and

(2) During annual training.

(b) Staff shall not perform any action relative to restraint or seclusion without having been trained in the use of such methods, in accordance with (d) below.

(c) Training in the use of restraint shall address at least the following:

- (1) Techniques to identify behaviors, events, and environmental factors regarding persons under departmental control and staff that might trigger circumstances that require restraint or seclusion;
 - (2) Use of non-physical interventions;
 - (3) How to identify and choose positive behavioral supports and the least restrictive intervention based on an individualized assessment of the individual's medical or behavioral status or condition;
 - (4) How to ensure that the individual and staff are able to communicate effectively;
 - (5) Safe application and use of all types of restraint or seclusion, including mitigating positional risks that can result in asphyxia or airway obstruction, in accordance with individual needs;
 - (6) How to monitor the physical and psychological well-being of the individual who is restrained or secluded;
 - (7) How to recognize and respond to signs of physical and psychological distress;
 - (8) How to identify clinical changes that indicate that restraint or seclusion is no longer necessary;
 - (9) How to monitor respiratory and circulatory status, skin integrity, and vital signs during restraint; and
 - (10) Training in first aid techniques and certification in cardiopulmonary resuscitation (CPR), including CPR recertification every 2 years.
- (d) Training shall be given by a person who:
- (1) Possesses the requisite qualifications based upon education, training, experience, and certification to teach the assessment of, and response to, an individual's medical or behavioral status or condition;
 - (2) Is certified by a nationally recognized program as an instructor in CPR; and
 - (3) Is trained in crisis prevention utilizing a nationally recognized program or comparable curriculum.

Cor 502.09 Notice of Right to Appeal.

(a) On the business day following administration of emergency treatment seclusion or restraint Under Cor 502, the individual's clinician or another staff member designated by the facility shall provide notice of the individual's right to complain against and appeal the administration of emergency treatment to the individual or his or her guardian.

(b) Appeals on the final decision shall be forwarded, in writing, to the director of medical and forensics. An exception shall be that the appeals may be filed verbally if the individual is unable to convey the appeal in writing.

Cor 502.10 Reporting of Death.

(a) In accordance with Patient Rights 42 CFR 482.13(g)(1)i and the Protection and Advocacy for Mentally Ill Individuals Act (PAIMI Act), 42 U.S.C. § 10801-10851, facility staff shall make a telephone report to the CMS regional office, no later than the close of the next business day and to the state protection and advocacy agency within 7 days following knowledge of an individual's death that:

(1) Occurs while an individual is in restraint or in seclusion at the facility;

(2) Occurs within 24 hours after the individual has been removed from restraint or seclusion;
and

(3) Occurs within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or placement in seclusion contributed directly or indirectly to the individual's death including, at a minimum:

a. Death related to restrictions of movement for prolonged periods of time; and

b. Death related to chest compression, restriction of breathing, or asphyxiation.

(b) Staff shall document in the individual's medical record the date and time the death was reported.

Adopt Cor 503 to read as follows:

PART Cor 503 MEDICAL AND PSYCHIATRIC EMERGENCIES

Cor 503.01 Guardianship.

During the course of the authorized treatment period, secure psychiatric unit staff shall assess the patient's need for the appointment of a guardian and take actions consistent with RSA 464-A and RSA 547-B.

Cor 503.02 Treatment Limitations.

The authorization to provide emergency treatment to the PUDC shall immediately expire if a guardian over the person of the patient with authority to make treatment decisions is appointed during the period of emergency treatment authorized.

Readopt with amendment and renumber Cor 304, effective 3-23-18 (Document #12502), as Cor 504 to read as follows:

PART Cor ~~304~~ 504 STANDARDS FOR TREATMENT AT THE SECURE PSYCHIATRIC UNIT

Cor ~~304.01~~ 504.01 Administration.

~~(a) An administrative director of medical and forensic services~~ The administrator of the secure psychiatric unit (SPU), in collaboration with a board certified or board eligible psychiatrist licensed in New Hampshire, under the administrative supervision of the commissioner or designee, shall be jointly responsible for the provision, supervision, and administration of the medical and psychiatric services of the department and the secure psychiatric unit (SPU);

- (b) A psychiatrist who is a licensed physician in New Hampshire, who shall be board certified or who shall by virtue of education and training be board eligible, shall provide psychiatric services under the supervision of the administrator of the SPU ~~administrative medical and forensic director~~;
- (c) A non-medical administrator shall oversee the implementation of programs and services at the unit;
- (d) There shall be on staff a psychiatrist, licensed and board certified in New Hampshire;
- (e) There shall be on staff an advanced practice registered nurse (APRN); and
- (f) Nursing and security coverage shall be provided 24 hours a day.

Cor 304.02 504.02 Secure Psychiatric Unit Persons Under Departmental Control ~~Inmate~~ and Patient Management.

- (a) SPU patients and ~~persons under departmental control~~ PUDC shall be those who are so classified pursuant to RSA 622:40-48, RSA 171-B:2, RSA 135:17-a, I & II, RSA 135-C:34, RSA 651:8-b, RSA 651:9-a, RSA 651:11-a, RSA 623:1, or RSA 135-E:4& RSA 135-E:11 and are committed or transferred to an environment which provides for the safety and security of the public, the staff, and those committed;
- (b) SPU patients and ~~persons under departmental control~~ PUDC shall be under supervision at all times when not in their rooms;
- (c) SPU patients and ~~persons under departmental control~~ PUDC, when outside the boundaries of the SPU, shall be supervised to ensure the safety and security of the public, the staff, patients and ~~persons under departmental control~~ PUDC;
- (d) Patients and ~~persons under departmental control~~ PUDC whose behavior and mental condition permit shall be fed in a communal dining area;
- (e) If an individual patient or ~~person under departmental control~~ PUDC is disruptive, assaultive, violent, or dangerous within the constraints of the secure psychiatric unit and has demonstrated a propensity to throw his or her food or to use utensils as weapons, he or she shall be denied the utensils and wholesome and nutritious sandwiches or finger food shall be substituted for the regular food;
- (f) SPU patients and ~~persons under departmental control~~ PUDC whose behavior and mental condition permit shall have in their possession in their rooms appropriate allowable property as detailed in the SPU handbook;
- (g) The SPU shall be a 24-hour forensic treatment facility and the ~~persons under departmental control~~ PUDC housed within shall be provided with the services of a psychiatrist, or advanced registered nurse practitioner, an on-call physician, and 24-hour nursing coverage;
- (h) Therapeutic recreational opportunities shall be offered to SPU patients and persons under departmental control if clinically indicated;
- (i) SPU patients and persons under departmental control shall be provided the opportunity for religious counseling by ministers, priests, rabbis, or other religious representatives of organized faiths on a regular basis;
- (j) SPU patients and persons under departmental control shall be provided the opportunity to participate in educational and vocational programs as clinically able;

(k) SPU patients and persons under departmental control shall have the opportunity to work when their level of functioning permits, consistent with security;

(l) SPU patients and persons under departmental control shall be provided access to law library materials and access to regular library materials. Books being transferred into the SPU shall be carefully searched to preclude the introduction of contraband through library materials;

(m) Property taken from a patient or person under departmental control shall be accounted for by the SPU property officer. A receipt will be made for any property removed from the possession of the patient or person under departmental control and the patient or person under departmental control shall be furnished a copy of the receipt;

(n) SPU patients and persons under departmental control shall be provided a weekly opportunity to list items they desire from the canteen. A list shall be provided to patients and persons under departmental control reflecting the items available to them from the canteen. If a patient or person under departmental control has the money to pay for the items listed by that patient or person under departmental control, and subject to a security screening of the items, they shall be picked up by staff and delivered to the patient or person under departmental control;

(o) SPU patients and persons under departmental control using the day rooms shall be afforded use of the collect-only telephones provided in the day room areas;

(p) SPU patients and persons under departmental control shall be afforded the opportunity to consult with their attorneys;

(q) SPU patients and persons under departmental control not under visiting restriction shall be allowed social visits to be conducted during scheduled visiting hours in a supervised visiting area provided in the SPU; and

(r) Patients and persons under departmental control admitted to the SPU shall be photographed and fingerprinted for the purpose of positive identification.

Cor ~~304.03~~ 504.03 Medical Records.

Notwithstanding the provisions of RSA 329:26, RSA 329-B, and RSA 330-A:32, medical and ~~mental~~ behavioral health records concerning current persons under departmental control and patients of the secure psychiatric unit shall be exchanged between other state medical and mental health facilities to facilitate treatment pursuant to RSA 622:47.

Cor ~~304.04~~ 504.04 Commitment.

Any person admitted or transferred to the unit shall be under the care and custody of the commissioner and the administrator of the SPU ~~administrative director of medical and forensic services~~ and shall be subject to the rules and policies of the commissioner until the person is transferred to a receiving facility in the state mental health services system or otherwise discharged.

Cor ~~304.05~~ 504.05 Persons Under Departmental Control and Patients of the SPU Rights.

Persons committed or transferred to the unit who are convicted offenders, persons found not guilty because of insanity, pre-trial detainees, or persons civilly committed, shall retain all their individual rights, subject to those restrictions that are inherent with confinement within a secure forensic setting ~~as defined in the patient handbook.~~

Cor ~~304.06~~ 504.06 Procedures for Commitment to the Secure Psychiatric Unit.

(a) All persons committed or transferred to the unit pursuant to RSA 171-B:2, RSA 135:17-a, RSA 135-C:34, RSA 135-E:4, RSA 135-E:11, RSA 623:1, RSA 651:8-b, RSA 651:9-a, RSA 651:11, or RSA 651:11-a, as lawfully ordered by the court of competent jurisdiction or the commissioner, shall be persons under departmental control or patients of the unit unless otherwise discharged pursuant to New Hampshire law;

(b) A person in the custody of the commissioner who needs hospitalization for a ~~mental~~ behavioral health illness shall be transferred to the unit following a due process hearing pursuant to RSA 623:1. If the person requires immediate transfer, the due process review shall occur within 24 hours following the transfer;

(c) Any person subject to an involuntary admission to the SPU shall be transferred to the unit, per RSA 622:40-48, upon a determination that the person would present a serious likelihood of danger to ~~himself~~ themselves or to others if admitted to or retained at New Hampshire hospital;

(d) Admission to the unit shall be ordered by:

- (1) A probate court pursuant to the relevant sections of RSA 135-C, RSA 171, or RSA 135-E;
- (2) A criminal court order pursuant to the relevant sections of RSA 651; or
- (3) An emergency transfer pursuant to RSA 623;

(e) Except upon an order of court or in an emergency, no admission or transfer to the SPU shall occur without the prior approval of the commissioner or designee and the director of medical and forensic services or their designees. The request for approval shall be made in writing to the commissioner by the sending unit. The commissioner's approval shall be based upon the physician's or ~~ARNP's~~ APRN's certification documenting the dangerousness of the person to self or others. In such instances, if the person to be admitted or transferred objects to the admission or transfer, he or she shall request a review of the decision by the director of medical and forensic services or their designee. The review shall occur prior to the admission or transfer, or within 24 hours following the admission or transfer where immediate admission or transfer has been determined necessary by the physician or APRN to protect the person or others. If the director of medical and forensic services upholds the objection of a person to be transferred, the transfer shall not be made. If the director of medical and forensic services upholds the objection of a person already admitted or transferred, the person shall promptly be transferred back to a receiving facility named by the director of medical and forensic services.

Cor ~~304.07~~ 504.07 Procedures Upon Admission.

(a) Upon admission to the SPU, each person in departmental custody and patient shall receive:

- (1) A psychiatric examination to be completed by the psychiatrist or APRN;
- (2) A preliminary treatment plan, resulting from the completion of the above documents by the psychiatrist or APRN;
- (3) A physical examination to be completed by the physician's assistant or APRN within 24 hours of admission or on the next weekday including diagnostic lab tests such as blood and urine;
- (4) Nursing assessment; and
- (5) Nutritional assessment;

(b) Upon admission to the SPU each person in departmental custody and patient's transfer paperwork shall be assessed to verify the completeness of the legal documents and the validity of the admission;

(c) A preliminary oral examination shall be made during the admission physical. Referral to a dentist shall be made when necessary. On-going oral hygiene shall be scheduled while the PUDC resident is admitted in the SPU. Additional dental services shall be available at the request of the patient or PUDC and accomplished as determined necessary by the dentist.

Cor ~~304.08~~ 504.08 Individual Treatment Plans.

(a) Each patient and person under departmental control admitted to the SPU shall have an individualized treatment plan which shall be formulated by a multi-disciplinary treatment team and authorized by a psychiatrist or APRN;

(b) The preliminary individualized treatment plan shall be completed within 10 days ~~the first~~ ~~working day~~ after admission;

(c) Reviews of the preliminary individualized treatment plan shall be completed ~~10~~ 20 days after admission, 30 days after admission, every other month thereafter, and quarterly after a year;

(d) A comprehensive clinical assessment shall be completed within 10 days of inmate's and patient's admission;

(e) A therapeutic recreational assessment shall be completed within 10 days following admission; and

(f) Any other clinical assessments ordered by the psychiatrist or APRN shall also be completed within the first 10 days of admission.

Cor ~~304.09~~ 504.09 Procedures for Release or Transfer from the Secure Psychiatric Unit.

(a) When a person committed or transferred to the unit no longer requires the security provided by the SPU, the commissioner shall initiate his or her release or transfer, as follows:

(1) A person who was in pre-trial or post-trial confinement when admitted to the unit shall be returned to the sending facility or other appropriate facility; or

(2) The commissioner or his designee shall transfer to the state mental health services system any person admitted or transferred to the unit, pursuant to RSA 622:45, I, upon a determination that the person no longer presents a serious likelihood of danger to himself or others if confined within a receiving facility in the state mental health services system;

(b) A patient of the SPU pursuant to RSA 651:9-a shall be eligible for transfer by the commissioner to the state mental health services system provided:

(1) That in consultation with the patient and or patient's treatment team, a psychiatrist or APRN determines that the person presents a potentially serious likelihood of danger to himself or others as a result of ~~mental~~ behavioral illness but that the person no longer requires the degree of safety and security as provided by the SPU;

(2) That prior approval of the proposed transfer is obtained from the superior court if the transfer is not already allowed in an existing court order; or

(3) The person to be so transferred agrees to the proposed transfer;

(c) If the person does not desire to be transferred, a review shall be held by a designee of the commissioner to ascertain the reasons why the transfer is recommended and the person under departmental control and patient's reasons for objecting ~~thereto~~. The designee shall recommend to the commissioner or designee whether the person should be transferred and the circumstances relative to the ~~thereto based on~~ data presented at the review;

(d) The ~~administrative~~ director of medical and forensic services shall have complete access to the departmental medical and ~~mental~~ behavioral health records of the proposed transferee; and

(e) Pursuant to RSA 622:49, if the director of medical and forensic services intends to grant off-grounds privileges to any person committed to the unit by criminal proceedings and who has subsequently transferred to the state mental health services system, the administrative director of medical and forensic services shall give written notice of such intention to the commissioner. The commissioner shall give written notice of the director of medical and forensic services' intention to the superior court for the county in which the person was committed, to the department of justice, and to the county attorney, if any, who prosecuted the case.

Readopt with amendment and renumber Cor 302.03, effective 3-23-18 (Document #12502), as Cor 505.01, cited and to read as follows:

PART Cor 505 SEXUAL OFFENDER TREATMENT SERVICES

Cor ~~302.03~~ 505.01 Diagnosis, Counseling, and Therapy.

(a) There shall be an outpatient behavioral health unit which shall provide for the ~~person under departmental control~~ PUDC's behavioral health needs as determined by completion of an initial behavioral health interview and a biopsychosocial assessment which results in a ~~mental~~ behavioral health diagnosis. Referrals for such assessments may be via self-referral made by ~~inmates~~ PUDC themselves or by any departmental staff member. These referrals shall be triaged accordingly, and for those cases requiring ongoing behavioral health treatment, a treatment plan shall be developed and filed in the ~~person under departmental control~~ PUDC's medical record.

(b) The behavioral health unit shall be sufficiently staffed to include at a minimum:

(1) A full-time New Hampshire licensed administrative clinician who shall:

- a. Oversee and supervise the testing operations and determine what types of behavioral health interventions are needed;
- b. Conduct staff training, triage referrals to the behavioral health unit, and assist behavioral health staff with individual cases;
- c. Provide individual and group counseling and supervise the provision of such counseling by mental behavioral health clinicians; and
- d. Review the behavioral health needs of the ~~persons under departmental control~~ PUDC and implement new treatment modalities as indicated;

(2) New Hampshire licensed psychiatric providers who shall provide for the psychiatric needs of the ~~persons under departmental control~~ PUDC and the secure psychiatric unit including

prescription of medications, coordination of care between disciplines, and consultation with administration with regard to behavioral health policy development; and

(3) A sufficient number of full-time clinical staff who, at a minimum, shall be qualified under the state personnel system to include, without being limited to, social workers or clinical mental health counselors.

(c) Newly arrived ~~persons under departmental control~~ PUDC shall be processed in a reception cycle during which the ~~person under departmental control~~ PUDC shall be interviewed and assessed under the supervision of the administrative clinician to determine, where possible, whether the ~~person under departmental control~~ PUDC is suffering from mental illness requiring further interventions from the behavioral health delivery system.

(d) Reception cycle operations shall include any or all of the following:

(1) Administration of screening and assessment tools that are necessary to adequately identify behavioral health needs;

(2) An initial behavioral health interview which shall include but not be limited to:

a. Obtaining a behavioral health history;

b. Recommendations for further screenings, assessments and/or tests;

c. Advising each ~~person under departmental control~~ PUDC as to their behavioral health needs, sexual offender treatment needs, and how to access services; and

d. Referrals to medical, psychological, psychiatry, educational, or others staff for counseling, and treatment, and other interventions.

(e) The department shall initiate procedures to transfer a ~~person under departmental control~~ PUDC when in the opinion of the psychiatrist, physician, or psychiatric nurse practitioner the ~~inmate person~~ PUDC is suffering from a psychological or psychiatric impairment or intellectual disability which could be treated or managed better in the secure psychiatric unit or other ~~mental~~ behavioral health or medical facility due to a threat of harm to themselves or others per RSA 623.

(f) The out-patient behavioral health unit shall provide at a minimum the following services:

(1) Documentation and implementation of a treatment plan;

(2) Psychiatric services;

(3) Medication management;

(4) Individual counseling pursuant to RSA 329-B;

(5) Group therapy sessions as appropriate; and

(6) Such other specialized treatment for individuals or groups of ~~persons under departmental control~~ PUDC as needed.

(g) Behavioral health services shall be available to all ~~persons under departmental control~~ PUDC regardless of their custody status.

(1) Individuals who are transferred to the restricted housing settings such as the special housing unit (SHU) shall be screened prior to being placed in a cell. Behavioral health shall conduct a suicide risk assessment and suitability review of the ~~individual~~ PUDC's placement. If behavioral health is not on-site, nursing staff shall conduct the assessment within health services. All staff shall complete appropriate clinical documentation recording the assessment and outcome of the assessment in the ~~individual~~ PUDC's health record. If the individual presents at risk as a result of the assessment, alternative housing arrangements shall be made to secure the individual for their safety;

(2) ~~Individuals~~ PUDC who are prescribed psychotropic medications or are diagnosed with a severe ~~and persistent~~ mental illness (SPMI) that are housed in the SHU shall have clinical appointments scheduled at least every 14 business days that will include at a minimum the following:

a. ~~Mental~~ Status examination as follows:

1. Appearance;
2. Interaction;
3. Speech;
4. Mood/Affect;
5. Thought Process;
6. Thought Content;
7. Suicidality; and
8. Violence.

b. A review of their medications and any reported side-effects for triaging to psychiatric providers;

c. A subjective statement of each ~~individual~~ PUDC's current emotional status;

d. An assessment of diagnosis/es with reflection of psychiatry's perspective, if available in the health record;

e. A treatment plan, or an updated existing treatment plan, will be updated which ~~may~~ shall include referral to a case manager, assignment to group therapy, triage to medical staff, or other individual specific goals based on the clinical appointment; and

f. A monthly report of these clinical appointments to track compliance to the 14-day standard and treatment plan development which shall be reviewed by the Director of Medical and Forensic Services for compliance to the standards.

(3) The department will provide a psycho-social skill development program in restricted housing settings at all facilities. Such programs will be provided in consultation with the bureau of behavioral health. These shall operate in quarterly cycles with at a minimum of 4 offerings a year for ~~individuals~~ PUDC referred in these settings by the behavioral health staff;

(4) The correctional staff assigned to restricted housing settings shall be provided with specific training at a minimum of quarterly on topics related to the treatment and supervision of individuals with behavioral health issues; and

(5) The correctional staff assigned to restricted housing settings will conduct at minimum 30-minute rounds on individuals housed in these settings on psychotropic medications or diagnosed with a severe and persistent mental illness.

(h) There shall be a therapeutic ~~community~~ communities ~~in the form of a residential treatment unit (RTU)~~ as follows for those ~~persons under departmental control~~ PUDC: ~~who because of significant functional impairment due to their documented mental illness are unable to successfully live in the general population:~~

(1) Who because of significant functional impairment due to their documented mental behavioral illness are unable to successfully live in the general population;

(2) Substance use disorders; or

(3) Other behavioral health disorders.

~~(4)~~ (i) The ~~RTU~~ therapeutic communities shall be sufficiently staffed to include at a minimum:

a. (1) A full time administrator who shall:

~~1. a.~~ Oversee the day to day operations of RTU clinicians managing the therapeutic communities to ensure proper procedures are followed regarding admission, treatment, and discharge transition of patients and person under departmental control PUDC;

~~2. b.~~ Manage the process of evaluating and triaging inmates PUDC those referred for RTU therapeutic communities services; and

~~3. c.~~ Supervise the collection of quality improvement data and participate in the development of quality improvement benchmarks;

~~b. (2)~~ Sufficient clinical staff to meet the treatment needs of those receiving treatment in the RTU therapeutic communities in the areas including but not limited to of recreational therapy, psychological services, special education, mental behavioral health therapy, medical care, safety, and but not limited to psychiatric interventions; and

~~(2)~~ (3) Persons under departmental control PUDC admitted to the RTU therapeutic community shall receive a complete evaluation of their psychiatric needs including at a minimum:

a. A complete psychiatric evaluation;

b. A comprehensive clinical assessment; and

c. An assessment of skills required to successfully navigate in their housing unit; ~~and~~

(1) (3) Above mentioned assessments shall result in the development of a master treatment plan that specifically addresses the individual's clinical needs.

(i) (j) There shall be a sexual offender treatment services unit which provides for the treatment needs of ~~individuals~~ PUDC who are incarcerated for sexually-related offenses, and which meets the following requirements:

(1) The sexual offender treatment services unit shall be sufficiently staffed to provide services as follows:

a. A full time administrator who shall:

1. Oversee and supervise the assessment and treatment of services for ~~individuals~~ PUDC identified as in need of these services;
2. Review the sexual offender treatment needs of the ~~individuals~~ PUDC and implement treatment modalities as indicated;
3. Provide individual and group therapy and supervise the provision of such services by other sexual offender treatment therapists; and
4. Conduct staff training and supervision, ~~;~~ ~~and~~

b. A sufficient number of full-time clinical staff who at a minimum shall be qualified under the state personnel system, ~~;~~ ~~and~~

(2) Referrals to sexual offender treatment services shall be made through the initial classification process and on-going as needs are identified by departmental staff. Assessments shall be based on risk and needs assessment and triaged into appropriate treatment services accordingly by ~~trained~~ qualified sexual offender treatment staff;

(3) Individuals convicted of sexual offenses who are willing to participate in sexual offender treatment services shall be provided with an initial screening assessment in order to determine their treatment needs which shall include:

- a. A complete comprehensive clinical assessment;
- b. A risk and needs assessment;
- c. A determination of required services will be provided to the ~~inmate individual~~ PUDC;
 - a. A review of any special accommodations necessary to participate in treatment (e.g. language barriers, intellectual disability or accessibility issues); and
- e. A referral to any other services as indicated, ~~;~~

(4) Individuals shall be placed into the appropriate form of treatment services or on the waiting list for appropriate services; and

(5) The sexual offender treatment services unit shall at a minimum provide the following services:

- a. Specific needs assessment to determine the specific treatment needs of each ~~individual~~ PUDC as it relates to his or her sexual offender treatment;
- b. The development of an individualized treatment plan specific to sexual offender treatment;
- c. Group and individual therapy sessions;
- d. Discharge planning;

b. Coordination with other prison services and external services as indicated by the ~~individual~~ PUDC's specific sexual offender treatment needs; and

f. Treatment reviews of services to ensure public safety and risk mitigation through the establishment of an administrative review committee as follows:

1. The administrative review committee shall review the outcome of sexual offender treatment services. The administrative review committee shall provide oversight to ensure the department is meeting its mission in preventing further victimization from sexually-related crimes;

2. The purpose of the administrative review committee is to ensure that each ~~individual~~ PUDC participating in the department's sexual offender treatment service has satisfactorily completed their treatment goals as specified on their individualized treatment plan and outlined by the clinicians discharge summary proposal. The person whose case is being reviewed shall be afforded the opportunity to participate in the review if they request to participate in advance of the review.

3. The clinician shall present the case, relating the ~~individual~~ PUDC's progress to his or her goals. The clinician shall also provide information on any disciplinary action, and/or behaviors that resulted in being removed from the program, if applicable. Included in the case presentation shall be a description of the ~~individual~~ PUDC's self-management plan for the community to include therapeutic, vocational, educational and housing activities established for transition;

4. The administrative review committee shall review each case and make recommendations for the case. If treatment is not deemed completed, the administrative review committee shall provide recommendations to enhance attainment of treatment goals to the clinician for implementation with the individual;

5. The administrative review committee shall meet at a minimum on a monthly ~~regular~~ basis;

6. The administrative review committee shall be comprised of administrators and/or senior level clinicians from the division of medical and forensic services as assigned by the director of medical and forensic services; and

7. Decisions made by the administrative review committee may be appealed through the department's grievance process pursuant to Cor 313.

Adopt Cor 505.02 to read as follows:

Cor 505.02 Sexual Offender Treatment Services (SOTS).

(a) SOTS shall be staffed by qualified behavioral health professionals who meet the following requirements:

- (1) Educational and license or certification criteria specified by their professional discipline; and
- (2) Criteria established by the New Hampshire state division of personnel.

(b) All sexual offenders who have sexually related charges or whose crime had a sexual element shall be offered an opportunity for screening and assessment for SOTS. PUDC identified during their initial classification as being in need of sexual offender treatment shall receive an additional assessment conducted by SOTS staff at least 2 years prior to their minimum parole date. If a PUDC is incarcerated with less than 2 years to their minimum parole date the individual will be placed on the assessment waiting list according to their minimum parole date and shall be seen as soon as their name comes up.

(c) SOTS staff shall utilize a nationally recognized assessment tool that has been validated for general recidivism use among general male offenders and their criminal history.

(d) SOTS staff shall utilize gender validated instruments as well as conducting a comprehensive psychological profile of female PUDC and their criminal history. SOTS for women shall consist of open-ended treatment length based on individualized treatment plans (ITPs).

(e) Elements of an assessment shall include, but are not limited to, criminogenic history and needs, developmental history, behavioral health involvement, substance abuse issues, strengths, skill deficits, and the PUDC's cycle of offending. To the extent practicable, data from collaterals such as medical providers, family, criminal records, police reports, court documentation, National Crime Information Center, victim statements, internet search and clinical providers will be utilized during the assessment process.

(f) The timing of the assessment shall be dependent on the PUDC's sentence structure including any provisions outlined by the sentencing court for sentence reduction modifications contingent on successful completion of treatment.

(g) In situations where the PUDC enters the prison with less than two years to their minimum as well as an assessment indicating need for intensive treatment, the department shall enroll them as soon as possible to mitigate the impact of keeping the PUDC over their minimum sentence.

(h) Upon completion of the assessment, PUDC will be provided with the results and recommendations of the assessment including the treatment recommendations they are being recommended to participate in. The sexual offender treatment recommendations offered by the department shall be:

- (1) Community- based treatment;
- (2) Prison-based Sexual Offender Treatment Services; or

(3) No treatment.

(i) PUDC declining SOTS services shall be administered a behavioral status examination to determine if any behavioral health needs exist. Any concerns that might impact the PUDC's ability to make decisions due to a behavioral health condition will be referred to behavioral health services to develop a comprehensive treatment plan with the goal to engage the PUDC into the appropriate sexual offender treatment intervention. If a PUDC refuses treatment recommendations they shall sign a waiver of responsibility indicating that they are refusing treatment and shall suffer no punishment for the refusal.

(j) If a PUDC is eligible for sentence reduction by participating in the program, this shall be included in the calculation for his or her minimum release date to allow the PUDC timely access to treatment. The PUDC shall make SOTs aware of the potential for time off their sentence.

(k) Community-based treatment shall be the recommendation for a PUDC upon release to parole or other community-based supervision.

(l) If an assessing clinician is recommending a PUDC for community-based treatment following the assessment, the PUDC shall be referred for additional screening as necessary to complete the assessment and recommendations. Once the assessing clinician determines that a community treatment referral is warranted, this outcome will be reviewed by the administrator of sexual offender treatment services and the deputy director of forensic services for thoroughness and concurrence.

(m) If the recommendation is approved, a treatment plan shall be developed for participation in behavioral health groups to address any treatment needs of the PUDC while waiting for release into community-based treatment services.

(n) The PUDC shall also participate in continuing treatment until released. If at any time during continuing treatment, a clinician identifies a behavioral status change, acquires additional information with regard to the PUDC's engaging in risky sexual behaviors, or is provided additional collateral information which is a cause for concern; a new assessment will be completed using gender validated tools as appropriate.

(o) All PUDC, who post an assessment by a NH DOC clinician receives a recommendation of community-based treatment shall with an SOT clinician establish an appropriate individualized treatment plan. If the PUDC fails a polygraph or shows deception, they shall be placed in Intensive Sexual Offender Treatment (ISOT) to receive more intense treatment.

(p) Prior to admission into SOTS, PUDC shall begin attending recommended behavioral health groups as part of their treatment plan.

(q) The PUDC shall be referred for participation in groups such as:

(1) Cognitive behavior therapy;

(2) Coping skills;

(3) Dealing with trauma;

(4) Socialization;

- (5) Victim empathy;
- (6) Anger management; or
- (7) Drug and alcohol treatment.

(r) All PUDC who enter the SOTS will be administered the Prison Rape Elimination Act (PREA) potential for sexual assault or sexual victimizing screening instrument and housed accordingly.

(s) SOTS therapeutic services shall be offered in accordance with an individualized treatment plan. If the PUDC is identified with any intellectual disabilities or requires medically restricted housing, a modified individualized treatment program shall be established.

(t) PUDC with multiple treatment needs shall have a collaborative treatment plan established inclusive of areas such as substance use, behavioral health, and psychiatric needs.

(u) SOTS staff shall be responsible for determining completion of goals, and providing feedback to PUDC on how to better achieve goals.

(v) Sexual offender treatment shall be documented in the electronic health record using the progress note, group note, treatment plan, and discharge summary. This shall include such documents as:

- (1) The assessment;
- (2) Polygraph or other validated technologies; and
- (3) Disclosure or administrative tools.

(w) Treatment plans shall be completed during the readiness phase and updated at least every six months or when goals are attained or require modifications based on the PUDC's needs. Treatment plans shall also be updated when entering into the next phase of treatment.

(x) Caseloads shall be entered in CORIS for ongoing informational sharing and awareness for re-entry planning. CORIS shall also be used to document movement in SOTS for purposes of case management. Clinicians shall update this information, for instance when someone has transitioned out of SOTs whether it be due to being removed or because they have been issued a discharge summary.

(y) All discharges from sexual offender treatment services shall be documented by the primary clinician within five days of program completion.

(z) When a program participant has met all program goals, they shall be referred to the SOTS Administrative Review Committee (ARC) by their SOTS therapist for case review.

(aa) The ARC shall:

- (1) Meet at a minimum once a month to review cases. The PUDC's completed packet must be received by the ARC for review at least one week prior to the scheduled meeting;
- (2) Ensure that each PUDC participating in the SOTS has reached maximum benefit via completion of their goals as specified on their individualized treatment plan and outlined by the clinicians discharge summary proposal; and

(3) Determine if they are in agreement with whether a program participant has completed the program or needs further treatment or assessment.

a. The recommendations of the ARC shall be sent to the parole board. The original ARC referral form will be placed in the PUDC's electronic health record, client record and a copy sent to the program participant. Participant s will also receive a copy of their discharge summary.

b. If treatment is not deemed completed, the ARC will provide recommendations to enhance attainment of treatment goals to the clinician for implementation with the PUDC.

(ab) The SOTS therapist shall present the case, relating the PUDC's progress to their goals. The therapist shall also provide information on any disciplinary action, or behaviors that resulted in being removed from the program, if applicable. Included in the case presentation shall be a description of the PUDC's self-management plan for the community to include therapeutic, vocational, educational, and housing activities established for transition.

(ac) No PUDC shall be considered to have completed the SOTS if they have not developed a comprehensive plan which shall include a description of their offending cycle, a maintenance contract, and actions to establish community treatment for release.

(ad) Decisions made by the ARC may be appealed through the process outlined in Cor 313.

(ae) PUDC who have previously completed SOTS treatment or community treatment who are returned on a parole violation shall be assessed within 90 days to determine treatment needs. The assessment may result in admission to the SOTS or may specify other treatment needs and recommendations. A treatment plan shall be developed as a result of the new assessment and documented in the electronic health record.

(af) Once treatment goals have been successfully completed and the PUDC has an updated cycle of offending and maintenance contract, the SOTS therapist shall make recommendations for the PUDC's on-going treatment needs in a discharge summary for use upon release to the community and by the parole board for continuity of care and safety planning.

(ag) An individual shall be removed from SOTS for:

- (1) Disciplinary infractions related to sexual behaviors;
- (2) Multiple instances of non-compliance with program expectations;
- (3) Repeatedly not engaging in treatment;
- (4) Criminal behaviors; and
- (5) Multiple instances of disrupting the treatment milieu.

(ah) All potential removals occurring as a result of founded disciplinary or criminal action as determined by security or investigations shall be reviewed as a team with the SOTs administrator, unless emergent removal is required. A meeting shall be offered to the PUDC to outline reasons they are being considered for removal from treatment.

(ai) All removals shall be reviewed by the administrator of sexual offender treatment services in conjunction with the deputy director of forensic services within five calendar days of the removal.

(aj) A plan for re-admittance shall be completed by the PUDC and reviewed by the primary sexual offender clinician if submitted within 30 calendar days of being removed. A letter shall be sent to the PUDC who is removed from treatment, explaining why they were removed and what they need to work on for consideration of remittance.

(ak) SOTS shall utilize ~~four~~ different forms of polygraph or other validated technology for assessments.

(al) The polygraph and other validated technology shall be administered in a controlled setting and in collaboration with SOTS staff. The procedures shall be in accordance with the current standards and practices of the American Polygraph Association, <http://www.polygraph.org/assets/docs/Misc.Docs/10-10-17%20APA%20STANDARDS%20OF%20PRACTICE%20.pdf>, and the current ethical standards and principles for use of physiological measurements and polygraph examinations of the Association for the Treatment of Sexual Abusers (ATSA), https://www.atsa.com/Public/Ethics/ATSA_2017_Code_of_Ethics.pdf.

(am) SOTS shall include but not be limited to:

- (1) An initial screening evaluation for sexual offenders to determine the level of treatment necessary;
- (2) Ongoing assessment and progress reviews;
- (3) Case management and coordination of ancillary services to meet the specific needs of sexual offenders; and
- (4) Gender responsive treatment consistent with the empirical research related to sexual offenders.

(an) The goals of SOTS shall include:

- (1) Decreasing use of cognitive distortions or distorted thinking patterns;
- (2) Establishing and maintaining trusting, supportive, and equitable intimate relationships;
- (3) Increasing autonomy and self-sufficiency;
- (4) Developing a positive self-concept;
- (5) Increasing effective emotional management;
- (6) Reducing self-destructive or self-injurious behaviors;
- (7) Ensuring healthy sexual development, expression, and boundaries;
- (8) Developing open and honest communication;
- (9) Developing the ability to appropriately express thoughts, feelings, and wishes in a healthy manner;

- (10) Becoming more aware of feelings and developing appropriate coping mechanisms;
- (11) Developing an understanding of the cycle of thoughts, feelings, and behaviors that lead to offender relapse;
- (12) Developing interventions to interrupt the cycle of offender relapse;
- (13) Increasing and improving pro-social skills;
- (14) Developing improved self-esteem and healthier relationship skills;
- (15) Developing victim empathy;
- (16) Demonstrating a consistent understanding and application of treatment concepts in the management of an individual's daily life;
- (17) Self-disclosing entire sexual offending history and verifying offense history by passing a polygraph or EyeDetect® or other validated technology;
- (18) Identifying high-risk areas and intervention strategies;
- (19) Developing a comprehensive, workable maintenance contract that addresses appropriate identification of risks, past unhealthy patterns of coping and appropriate interventions for the future; and
- (20) Referring PUDC to appropriate ancillary services as needed to insure a systemic holistic approach to managing their sexual offending behaviors.

(ao) SOTS shall utilize a holistic approach to treating sexual offenders that includes a combination of cognitive behavioral therapy, psycho-educational components, and the treatment of co-morbid conditions. Emphasis is placed on addressing trauma and its impact on emotional, social, psychological and sexual adjustment.

(ap) PUDC in SOTS shall participate in clinical therapeutic groups and psycho-educational treatment aimed at the specific treatment needs addressed in their ITPs. In addition, PUDC shall participate in other behavioral health treatment, substance abuse treatment, as designated in their ITPs. PUDC shall also complete a number of different homework assignments, journaling assignments, and projects during treatment.

(aq) In their core clinical therapeutic groups PUDC shall address key components of their offending and work on issues of accountability, responsibility, identifying and challenging distorted thinking, identifying and coping with feelings and inappropriate or maladaptive coping skills, developing a positive self-concept, increasing effective emotional management and establishing and maintaining trusting, supportive and equitable intimate relationships. PUDC shall identify the patterns of behavior that lead to their offending.

(ar) There shall be joint consultation between classification and sexual offender treatment services taken in the following areas when an individual is identified through classification or clinical assessment as a sexual predator, per the classification system, or as vulnerable to sexual assault:

- (1) Housing assignments;
- (2) Program assignments; and

(3) Disciplinary measures.

(as) Assessments shall focus on, but not limited to:

- (1) Low self-esteem;
- (2) Self-injury or suicide attempts;
- (3) Victimization during childhood and adulthood;
- (4) Employment difficulties;
- (5) Low educational attainment;
- (6) Difficulties in intimate relationships;
- (7) Anti-social peers and attitudes;
- (8) Behavioral health difficulties; and
- (9) Substance abuse.

(at) The initial assessment shall be an overall psychosocial evaluation and sexual risk assessment evaluation to review the PUDC's general social history, the static and dynamic risk factors present, and the PUDC's overall motivation and appropriateness for SOTS.

(au) The evaluating clinician shall complete a record review that includes the pre-sentence investigation (PSI) report, when available; police records, victim statements, criminal history, and any other clinical evaluations as available including but not limited to behavioral health screening and substance abuse assessments as available.

(av) The clinician shall document in the electronic health record and the CORIS treatment recommendations for each PUDC.

(aw) The assessment shall be utilized to develop an appropriate ITP.

(ax) If a sexual offender declines the SOTS assessment, it shall be noted that the PUDC is not interested in treatment and the assessment has not been completed. Their decline for treatment shall be documented in the electronic health record and the CORIS. PUDC shall sign a waiver of responsibility showing that they are declining services at this time.

(ay) If the sexual offender changes their decision and makes a request for assessment, they shall be placed at the end of the assessment waiting list at the time of their request and processed according to that current list with no special consideration to their minimum parole date due to their initial refusal of assessment and treatment.

(az) After evaluation of the PUDC's need, the outcome shall be sent to the PUDC in writing indicating the recommended treatment needs. A reclassification hearing will be conducted and the sexual offender shall be placed on the waiting list (if applicable) or placed immediately into treatment if space permits.

(ba) A polygraph or other validated truth or deception technology shall be utilized in SOTS for the purpose of full disclosure of the PUDC's range of sexual behavior. A polygraph or other truth or deception technology shall also be utilized as a therapeutic tool in specific issues exams when it is determined to be clinically indicated to further a PUDC's treatment progress.

- (1) All participants of SOTS shall undergo a full disclosure polygraph to ascertain their full spectrum of sexual offender.
- (2) If results of the polygraph indicate no deception, the participant continues in treatment with no delays.
- (3) If results of the polygraph are deceptive or inconclusive, the participant will be offered another opportunity within the standards for timelines of polygraph administration to obtain a truthful or no deception result. During the wait for the 2nd polygraph, the clinician will work with the participant to review any inconsistencies and explore their distortions.
- (4) If the second polygraph is inconclusive, the participant will continue in SOTS with the polygraph result highlighted in their summary of completion.
- (5) If the second polygraph exam indicates deception then the participant will be reassessed and their treatment plan adjusted accordingly.
- (6) If the outcome of any polygraph or other validated deception technology is inconclusive or deceptive, a PUDC shall be referred for another polygraph or validated deception technology evaluation.

(bb) Sexual Offender Treatment shall include group therapy, both process oriented and psycho-educational, journaling, workbook completion, homework assignments, and other projects. Participants shall meaningfully participate in community and community meetings.

(bc) The participant will meet with their primary therapist upon entry into the treatment service to review treatment expectation, sign a treatment contract and confidentiality waiver, and review treatment rules.

(bd) An initial treatment plan shall be established with the participant.

(be) Treatment plans will include at a minimum:

- (4) The participant's identifying information;
- (5) Treatment needs;
- (6) Goals and objectives; and
- (7) Identification of any necessary ancillary services to meet the specialized needs of each participant.

(bf) Quarterly progress reviews shall be conducted with the participant and documented on their treatment plans.

(bg) The primary therapist shall complete clinical progress notes for each participant on their caseload. Post treatment encounters shall be documented in the electronic health record.

(bh) After successful completion of all components of treatment, all assignments, achievement of treatment goals and consistent application of treatment concepts, the participant will be sent to the ARC for review for additional treatment recommendations or discharge from the program.

(bi) A participant shall have successfully completed the treatment when the participant has demonstrated the ability to apply, both verbally and behaviorally, the skill sets and treatment concepts instilled through treatment.

(bj) Completion without full application issues will be adequately documented in progress notes or through warnings or behavioral contracts.

(bk) Termination from treatment will be utilized as a last resort after all other possible methods to correct behavior has been exhausted.

(bl) A participant shall be removed from SOTS for:

- (1) Disciplinary infractions related to sexual behavior;
- (2) Multiple instances of non-compliance with program expectations;
- (3) Repeatedly not engaging in treatment;
- (4) Criminal behaviors; or
- (5) Multiple instances of interrupting the treatment milieu.

(bm) The primary therapist shall notify a participant of any concerns regarding quality of work, behavioral issues, non-compliance with treatment rules, and expectations, and any other area in which the participant is failing to progress in treatment or causing a major disruption to the successful treatment of other group members.

(bn) Notification of concern shall occur within seven working days of identification of the concern(s) as it relates to progress in treatment in order to provide the participant the opportunity to improve in the area of concern and to stay in treatment.

(bo) If a participant fails to complete one assignment, or has one absence from any treatment group or meeting the notification shall occur within 7 days.

(bp) If the clinician, after providing written notification, continues to see lack of improvement in the specified areas then the clinician will refer the participant to the treatment team for further consideration such as:

- (1) Development of a behavioral contract;
- (2) Addendum to a behavioral contract;
- (3) Termination from the program; and

(bq) Participants terminated from the program shall be allowed the opportunity to request to re-enter treatment. The former participant will be eligible to request to return to treatment or placement on the waiting list for previously terminated participants, if applicable, once they have been out of treatment. This request will

only place them on the waiting list and shall not guarantee an automatic entry into treatment. Previously terminated participants shall be taken back into treatment as space allows.

(br) An electronic health record shall be utilized to document the treatment of a PUDC participating in SOTS.

(bs) Participant assignments shall be returned to the participant upon successful completion of treatment. No copies shall be maintained in the permanent record unless they document violations of State law or intention to engage in criminal acts requiring investigation.

(bt) SOTS shall not maintain local treatment files.

(bu) No employee shall engage in any activity as an employee of NHDOC, as a private provider or as an employer of a community provider that services the offender population, as that is a conflict of interest. Employees shall disclose and report all potential conflict of interest situations to his or her supervisor immediately.

Appendix

RULE NUMBER	STATUTE IMPLEMENTED
Cor 501	RSA 21-H:13,III(a)
Cor 502.01	RSA 21-H:13,III(a)
Cor 502.02	RSA 21-H:13,III(a)
Cor 502.03	RSA 21-H:13,III(a)
Cor 502.04	RSA 21-H:13,III(a)
Cor 502.05	RSA 21-H:13,III(a)
Cor 502.06	RSA 21-H:13,III(a)
Cor 502.07	RSA 21-H:13,III(a)
Cor 502.08	RSA 21-H:13,III(a)
Cor 502.09	RSA 21-H:13,III(a)
Cor 502.10	RSA 21-H:13,III(a); RSA 611-B:12
Cor 503	RSA 21-H:13,III(a)
Cor 504	RSA 21-H:13,III(a)
Cor 505	RSA 21-H:13,III(a)