



Montana Department of Corrections Policies Manual Table of Contents

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DOC Restricted Policies

Certain policies are restricted. If you have authorization, please click [here](#) to access the web links.



POLICY DIRECTIVE

Policy:	DOC 1.1.2 POLICY AND PROCEDURE MANAGEMENT
Effective Date:	05/01/1996 Page 1 of 3
Revision Date(s):	04/06/2001; 06/14/2001; 09/04/2001; 12/20/2001; 01/06/2006; 04/18/2006; 08/01/2007; 11/28/2011; 10/20/2014; 07/27/2015; 05/21/2024
Signature/Title:	/s/ Brian Gootkin, Director

I. POLICY

The Department of Corrections develops and manages policy and procedure to meet statutory obligations, promote professionalism, and ensure consistency and operational compliance in fulfilling the purpose and mission of the Department.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. DEPARTMENT DIRECTIVES

A. Policy and Procedure Management System

1. The policy and procedure management system governs the development, review, revision, and publication of all Department policies and procedures. The Policy Unit establishes the processes and requirements for the system, including:
 - a. developing policy and procedure to meet the Department director's goals and objectives and fulfill statutory and rule requirements;
 - b. coordinating, tracking, and recording the annual review of designated policies and procedures;
 - c. serving as the primary contact for questions, concerns, and issues regarding policies and procedures;
 - d. assisting employees designated to implement or comply with policies and procedures; and
 - e. responding to requests related to policies and procedures.
2. Policies provide direction and guidance for operations of the Department. Procedures specify how divisions, facilities, and programs implement Department policy.
3. Policies and procedures are organized within sections based on subject:
 - a. Administration
 - b. Secure Facilities
 - c. Probation and Parole
 - d. Rehabilitation and Programs
 - e. Health Services
 - f. Community Programs

B. Policy and Procedure Access and Restrictions

1. For Department employees:
 - a. Policies and procedures, including restricted policies and procedures, are accessible online.
 - b. Employees may not disseminate or share restricted policies or procedures outside of the Department without consent.

2. For individuals outside the Department, policies and procedures are accessible online unless restricted in accordance with 2-6-1003, MCA; a requestor may email opir@mt.gov to request restricted policies and procedures.

C. Policy and Procedure Format

1. Formatting of policies and procedures is consistent with the *DOC Policy/Procedure Format Template* as applicable.

D. Annual Reviews

1. The Policy Unit is responsible for conducting annual reviews of designated policies and procedures.
2. Following annual review, designated policies and procedures may be revised or rescinded.

E. Policy and Procedure Development and Revision Process

1. To request a new policy or procedure or to revise an existing policy or procedure, a supervisor emails a request to corpolicy@mt.gov with:
 - a. identified topics or subjects needing development or revisions;
 - b. justification;
 - c. a minimum of 2 designated Subject Matter Experts (SMEs) to assist the Policy Unit;
 - d. a statement indicating whether rescission is needed; and
 - e. timelines or deadlines for implementation and/or completion.
2. If a request is minor (does not change the substance of a policy or procedure), the Policy Unit implements the revisions and publishes them online with approval from the Operations Bureau Chief or higher.
3. Substantive requests are reviewed by an Executive Team member prior to the Policy Unit initiating the policy and procedure drafting process.
4. The Policy Unit facilitates the drafting process with the identified SMEs, who provide content for the policy or procedure.
5. The Policy Unit sends the draft to the policy review group and the Legal Services Bureau for a 15-business-day review period. Group members can delegate review to their divisions or units and to employees of their choosing. Reviewers should add comments directly to the draft or email them to corpolicy@mt.gov.
 - a. If there is a policy, procedure, or contract in place that specifies a different period for review, that specified period applies.
6. After the policy group review and legal review, the Policy Unit updates and sends the draft to the Executive Team for approval prior to sending the draft for final approval by the appropriate Executive Team Member or designee.
7. After the policy or procedure is approved, the Policy Unit publishes it online consistent with the effective date and distributes it to applicable individuals.
 - a. When a new or revised policy or procedure requires training and/or a later implementation date, the Policy Unit sends it to the appropriate staff to handle the training, implementation, and/or distribution process.
8. Supervisors are responsible for ensuring employees review, understand, and comply with new and revised policies and procedures.
9. For policy or procedure rescission recommendations, the Policy Unit consults with the Executive Team and Legal Services to determine if rescission is feasible. Policy rescissions

are approved by the Director and procedure rescissions are approved by an Executive Team member.

F. Records and Archives

1. The Policy Unit is responsible for maintaining the following in electronic format:
 - a. current policies and procedures;
 - b. archived policies and procedures;
 - c. records of policy and procedure development, review, revision, and approval;
 - d. current and archived glossaries and lists of acronyms; and
 - e. archived notices of rescinded Department policies and procedures.

G. Forms

1. For Department forms created specifically for policies and procedures:
 - a. The Policy Unit is responsible for their maintenance and organization.
 - b. Such forms are not revised by anyone other than staff of the Policy Unit.
 - c. The Policy Unit is responsible for new forms and revisions to forms. For a new form or form revision request, staff must email corpolicy@mt.gov. Approval of a new or revised form follows the same process as policies or procedures unless determined otherwise by a member of the Executive Team.

V. CLOSING

Questions about this policy should be directed to the Department's Policy Unit.

VI. REFERENCES

- A. 2-6-1003, MCA; 2-15-112, MCA; 53-1-203, MCA



POLICY DIRECTIVE

Policy:	DOC 1.1.4 DEPARTMENT AND BOARD OF PARDONS AND PAROLE COORDINATION
Effective Date:	12/21/2004 Page 1 of 2
Revision Date(s):	05/15/2017; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

The Department and the Board of Pardons and Parole (BOPP) are separate entities with administrative ties. The BOPP hires its own personnel and exercises its quasi-judicial and policymaking functions independent from the Department.

However, both the Department and the BOPP ensure that funding and offender populations are independent of parole decisions and do not compromise public safety. Because the two agencies have interdependent roles, it is necessary to have strong formal and informal communication and coordinate strategies to promote efficiency and effectiveness.

II. APPLICABILITY

Probation and Parole and Department and contracted facilities.

III. REQUIREMENTS

A. Department Requirements

1. Assist in development and periodic review of a comprehensive resource manual to guide interdependent agency activities.
2. Identify management information and automation options for ongoing agency operations.
3. Coordinate the collection and sharing of management information.
4. Develop formal processes for coordinating interagency activities.
5. Assist in the establishment of rules and policy that do not conflict with BOPP authority.
6. Provide reasonable access to any offender over whom the BOPP has jurisdiction and ensure that eligible, in-state offenders are available for a hearing before the BOPP.
 - a. Administrators will provide adequate security at all hearings conducted in secure facilities.
7. Furnish the BOPP with relevant reports regarding an offender's suitability for parole.
8. Supervise all persons placed on parole in accordance with the conditions and orders imposed by the BOPP.
9. Allocate office space for BOPP staff.
10. Assist the BOPP in training, budgeting, recordkeeping, reporting, and related administrative and clerical functions.
11. Provide human resource support to assist with human resources functions.
12. Provide a qualified attorney to act as a legal advisor and representative for the BOPP.

13. Disseminate any required notices, rules, or orders adopted, amended, or repealed by the BOPP.
14. Provide an opportunity for the BOPP to respond to and participate in the review process of any mutually dependent policy or order adopted, repealed, or amended by the Department.
15. Provide communications support through the Department Communications Director.

B. Department Meetings

1. The Director's Office will notify the BOPP's Executive Director of the dates, times, and places of all Department meetings that pertain to the interdependent roles and functions of the Department and the BOPP, including, but not limited to management team, legislative, and community corrections management meetings.

C. Semiannual Meetings

1. A Department meeting will occur semiannually with BOPP staff and BOPP members, including auxiliary BOPP members; the Public Safety Division Chief; the Health Services Bureau Chief; Department legal counsel; and select Department staff as determined by the Department Director.
 - a. The Department Director and Warden of the Montana State Prison and Montana Women's Prison will participate at least annually.
 - b. The Director's Office, in coordination with the BOPP Executive Director, will publish agendas and record and publish minutes of the meetings. The Department Director and BOPP Chair must be present simultaneously for at least one meeting per year.

IV. CLOSING

Questions about this policy should be directed to the Department Director.

V. REFERENCES

- A. §§ 2-15-112; 2-15-121; 2-15-124; 2-15-2302; 46-23-215; 46-23-202; 46-23-203; 46-23-1002; 46-23-1021, MCA



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 1.1.6	Subject: PRIORITY INCIDENT REPORTING AND ACTING DIRECTOR
Chapter 1: ADMINISTRATION AND MANAGEMENT	Page 1 of 4 and Attachments
Section 1: General Administration	Effective Date: June 1, 1998
Signature: /s/ Mike Batista, Director	Revised: 07/25/2016

I. POLICY

The Department of Corrections strives to ensure that all incidents that jeopardize or have the potential to jeopardize staff, offenders, visitors, the security of facilities, or the safety of the community at large, are reported in a timely manner. The Department also designates an acting director to ensure that a key administrator is available for consultation during non-working hours, when necessary.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Acting Director – A member of the Leadership Team assigned by the Department Director or Deputy Director when they are not available.

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Automated Notification System – An automated computer alert system with a set of standards and protocols used by Department of Corrections to report incidents that occur within applicable divisions, facilities and programs.

Department Employee – A person employed by the Department of Corrections who has attained permanent status or is eligible to attain permanent status, as provided in *2-18-601, MCA*; volunteers, interns, temporary and short term workers; this term does not include service providers.

MSP Command Post – The location at Montana State Prison to which all Department divisions, facilities, and programs report Priority I incidents.

Office of Investigations – The office that oversees all criminal investigations for the Department.

Service Providers - This term includes contracted persons or other vendors providing service whose assignment is primarily on Department premises, e.g. facility or program office.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

Policy No. DOC 1.1.6	Chapter 1: Administration and Management	Page 2 of 4
Subject: PRIORITY INCIDENT REPORTING AND ACTING DIRECTOR		

1. Department employees and service providers observing or involved in any incident or unusual occurrence will:
 - a. notify the appropriate supervisor; and
 - b. complete an incident report immediately after the incident is under control and prior to the completion of shift.
2. Incidents will be designated as Priority I or Priority II.
3. In determining incident priority, the following will be considered:
 - a. seriousness of the incident by evaluating safety, security, liability, damage to property, and monetary loss;
 - b. need for Department specialized response;
 - c. public impact of the incident; and/or
 - d. media involvement

B. Priority I Incidents

1. Priority I incidents are those incidents that pose the highest risk to the Department and/or the division, facility or program and may include, but are not limited to:
 - a. escape or serious escape attempts;
 - b. use of force incidents resulting in discharge of a firearm and/or injury to employees, service providers, or offenders;
 - c. offender death;
 - d. serious injury, life threatening accident, or illness requiring transportation off facility grounds;
 - e. actual hostage action;
 - f. on-site violent act committed by an employee, on-site service provider, or visitor that may result in criminal charges;
 - g. any incident that results in immediate public or media interest;
 - h. serious assaults either offender on offender or offender on staff resulting in injury;
 - i. confirmed sexual assault by staff or offender;
 - j. medically advised reported or suspected illness from highly contagious diseases;
 - k. significant property damage resulting from natural or man-made, public or offender action;
 - l. discovery of dangerous contraband; and
 - m. equipment, communication system or security system malfunction resulting in disruption to facility or office operation.
2. All Priority I incidents will be reported immediately to the MSP Command Post at the following number: 406-846-6059. The MSP Command Post will enter the report into the automated notification system.
3. Department positions are designated as immediate points of contact for all Priority I incidents reported through procedures established within the automated notification system; the contact lists will be updated as needed with the Powell County Sheriff's Office through the Department Emergency Planning and Preparedness Manager.

C. Priority II Incidents

Policy No. DOC 1.1.6	Chapter 1: Administration and Management	Page 3 of 4
Subject: PRIORITY INCIDENT REPORTING AND ACTING DIRECTOR		

1. Incidents that do not meet the criteria for Priority I are categorized as Priority II and are reported through the established division, facility or program internal chain-of-command process.
2. A designated authority within the chain of command will analyze the incident and may reclassify the incident as a Priority I at which time the designated authority will notify the appropriate Department administrative staff immediately.

D. Reporting Requirements

1. Each facility or program will establish a method to document and track Priority I and II incidents according to the following:
 - a. utilize the standard [Incident Report](#) form for all incidents;
 - b. establish a permanent log indicating the nature of the incident; and
 - c. maintain the incident report in a secure central filing system.
2. It is the responsibility of the supervisor on-duty to notify the appropriate administrator or designated duty officer and the MSP Command Post of all Priority I incidents.
3. Initial written reports for all Priority I incidents will be submitted via the Corrections Incident Management System where available through OMIS/YMS or faxed to the MSP Command Post at 406-846-2953 and the Office of Investigations at 406-846-2951 after verbally reporting the incident to the MSP Command Post. The reports will also be submitted to the Director and Deputy Director. The reporting supervisor is responsible for reviewing all reports for accuracy, completeness, and clarity before signing and will return insufficient reports to the reporting employee with correction instructions and guidance.
4. Once the reporting supervisor has signed the reports, he or she will distribute the copies according to established procedure.
5. In the event of a failure in the automated notification system, the MSP Command Post will notify the Department director, deputy director or acting director. The Department director, deputy director or acting director will notify Department administrators, designated elected officials, and other positions as appropriate.
6. If the MSP Command Post should become unable to send Priority I reports through the system, the Montana Women's Prison Command Post will assume this duty until the MSP Command Post attains operational status.

E. Automated Notification System

1. The Department and MSP Emergency Planning and Preparedness Managers and the MSP Associate Warden of Security are the liaison officers for the automated notification system.
2. Designated notification recipients are responsible for ensuring their contact information and preferences are current. The current [Emergency Notification List](#) is attached to this policy for authorized staff as a restricted access form.

F. Acting Director

Policy No. DOC 1.1.6	Chapter 1: Administration and Management	Page 4 of 4
Subject: PRIORITY INCIDENT REPORTING AND ACTING DIRECTOR		

1. The Department's deputy director serves as the acting director in the director's absence. In the absence of both the director and deputy director an acting director will be designated.

G. Local Facility or Program Duty Officer

1. The administrator may identify staff to serve as a facility or program duty officer. The duties and responsibilities of the duty officer will be established at the local level in accordance with the *Department Emergency Operations Plan*.

V. CLOSING

Questions concerning this policy should be directed to the Department Emergency Planning and Preparedness Manager.

VI. REFERENCES

- A. 2-15-112, MCA; 53-1-203, MCA
- B. *Department Emergency Operations Plan*
- C. *Memorandum of Understanding between Powell County Sheriff's Office and Montana Department of Corrections*

VII. ATTACHMENTS

[Incident Report](#)
[Emergency Notification List](#) (Restricted Access)



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy:	DOC 1.1.7 DEPARTMENT QUALITY ASSURANCE RESPONSIBILITIES
Chapter 1:	ADMINISTRATION AND MANAGEMENT
Section 1:	General Administration
Effective Date:	July 29, 1999 Page 1 of 4
Revised:	January 31, 2022
Signature:	/s/ Brian Gootkin, Director

I. POLICY

The Department of Corrections (Department) performs quality assurance audits and/or reviews of the types and involving the entities identified in IV. C. herein for compliance with applicable laws, rules, contract terms and adherence to best practices. The department also oversees corrective action plans and ensures that deficiencies are corrected and that recommendations are appropriately implemented.

II. APPLICABILITY

All Department divisions, facilities, and programs; facility licensees of the Department, and those providing services to the department's under contract.

III. DEFINITIONS

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Audit – An examination to ensure compliance to one or more requirements, which may include review of documents, interviews with relevant people, and inspection of places or objects.

Audit Tools – Standards-based checklists used to assess compliance by auditees with applicable laws, policies, procedures, and contractual obligations. Some auditing tools and corrective action plan instruments are pre-determined and must be used, e.g., PREA.

Corrective Action Plan – The document that identifies how risk or deficient audit objectives will be corrected, who is responsible for the correction, and the date by which the corrections will be made.

Review – A less formal process than an audit designed to provide guidance and improve quality, and which may address compliance with requirements and adherence to best practices.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. The Department is responsible for:
 - a. maintaining internal controls in accordance with *DOC 1.2.4 Internal Controls*;

- b. ensuring compliance with the Prison Rape Elimination Act of 2003 in accordance with *28 CFR Part 115, Prison Rape Elimination Act of 2003* and *DOC 1.1.17 Prison Rape Elimination Act of 2003 (PREA)*;
- c. ensuring offender programs adhere to evidence-based practices in accordance with *DOC 5.4.1 Offender Programs*;
- d. performing licensing and related audit functions as required by *53-30-504, 53-30-606, MCA* and *ARM 20.9.601 et seq.*;
- e. ensuring contract compliance by conducting audits;
- f. auditing all treatment programs and/or curricula to ensure fidelity using the Department endorsed fidelity tool;
- g. internal Department audits and external contract facility/program audits;
- h. security audits; and
- i. providing audit and quality assurance functions training to designated Department staff in accordance with *DOC 1.1.7.A Quality Assurance Audit Procedure Manual*.

B. Audits Procedures

1. Adhering to the guidelines of [Generally Accepted Governmental Auditing Standards](#) and [International Standards of Professional Practice of Internal Auditing](#), while conducting an audit, assigned audit staff will follow audit procedures set forth in *DOC 1.1.7A Quality Assurance Audit Procedure Manual*.

C. Audit Types

1. Contract Audits:
 - a. contract audits may be conducted on any contract held by the Department. The contract review audit instrument will include standards or requirements outlined in the contract;
 - b. contracts for secure facilities, prerelease centers and treatment facilities are typically reviewed by the Department every three years, with site visits by department employees in intervening years intended to monitor contract requirements and progress toward compliance with audit recommendations; and
 - c. unannounced site visits may be conducted if deemed appropriate by the Department.
2. Internal Department Audits:
 - a. If, while in the course of performing assigned duties, audit staff observe any deficiency or area of concern within the Department, the assigned audit team designated by the Director or Deputy director will provide a [Non-Compliance Report Form](#) to the appropriate bureau chief or administrator, and may include the Deputy Director or Director as appropriate
3. Licensing Reviews:
 - a. the Department will review licensing standards for all juvenile detention facilities in Montana on an annual basis in accordance with *ARM Title 20, Chapter 9, Subchapter 6*;
 - b. licenses of any Montana private or regional correctional facility will be subjected to an annual license review;
 - c. upon completion of a license review, the Department may grant a full or provisional license. A full license is issued when the facility meets all requirements;

- d. the full license expires one year from the date of issuance.
 - e. a provisional license is issued when the facility is found non-compliant in one or more requirements; and
 - f. if the facility demonstrates compliance in the amount of time allotted by the provisional license, the facility will be issued a full license; and
 - g. follow the procedures set forth in 53-30-60- 53-30-611, MCA for provisional, restricted or revoked licenses.
4. PREA Audits:
- a. the Department will conduct PREA audits in accordance with Prison Rape Elimination Act Standards 115.401, 115.402, 115.403, 115.404 and 115.405;
 - b. the auditing year for PREA purposes is from August 20th to August 19th;
 - c. each facility will be audited once every three years by a U.S. Department of Justice (DOJ) certified auditor. Additionally, at least one-third of each facility type operated by the Department, or by a private entity on behalf of the Department, will be audited each year by U.S. DOJ certified auditors; and
 - d. the Department will determine facility compliance with the PREA standards based on a three-year schedule to include a facility self-assessment one year, an internal mock audit from the Department PREA Coordinator the following year, and a federal PREA audit the third year.
5. Offender Program Audits:
- a. approved evidence-based programs and the facility's that house them will be audited following the *Correctional Program Checklist (CPC) Program Evaluation Tool*;
 - b. the Department will maintain a 6-month audit schedule;
 - c. programmatic and scheduling must be finalized no later than one week prior to the on-site;
 - d. following the on-site audit, within 10 weeks, the CPC Audit Group will provide the facility a draft report of the audit results that addresses compliance, non-compliance and recommendations for improvement;
 - e. after receipt of the draft report, the facility will have 30 days to provide a response to the audit report to provide any missing documentation, information, or clarification
 - f. if material is provided in the response that was scored as non-compliant during the on-site audit, the facility will have an opportunity for their scores to reflect compliance; and
 - g. facilities/programs will be subjected to the CPC every two to three years following their initial audit.
6. Security Audits:
- a. secure DOC facilities housing inmates will undergo a security audit at least once every three years; and
 - b. audit criteria for security audits will be based on the American Corrections Association, National Institute of Corrections, Montana Code Annotated, Administrative Rules of Montana, and Department policy and procedure.

D. Compliance with Audits

1. Auditee's staff must comply with requests for interviews, information, records, documentation, and other audit related material requested by an authorized recipient.
2. Employees may not intentionally mislead or conceal information, material, or documentation specifically requested by the audit team.

E. Reviews

1. At a facility/program's request or at the direction of the Director or Deputy Director, The Director or Deputy Director will assign staff to review a division, facility or program to ensure compliance with applicable requirements and adherence to best practices. The review process may be less formal than an audit, but the assigned staff will provide written recommendations to the administrator and, as appropriate, to the Director and Deputy Director.
2. The staff designated by the Director or Deputy Director will ensure corrective actions are implemented within specified timeframes by facilities/programs following a non-compliant finding and may conduct follow-up reviews.

V. CLOSING

Questions concerning this policy should be directed to the Director or Deputy Director.

VI. REFERENCES

- A. *4-4017, ACA Standards Supplement, 2016*
- B. *DOC 1.1.2 Policy Management System; DOC 1.1.17 Prison Rape Elimination Act of 2003 (PREA); DOC 1.2.4 Internal Controls; DOC 5.4.1 Offender Programs; DOC 1.1.7A Quality Assurance Office Audit Procedure Manual*
- C. *Generally Accepted Governmental Auditing Standards, 2011 (GAGAS), commonly known as Yellow Book*
- D. *International Standards for Professional Practice of Internal Auditing*
- E. *53-1-211, MCA 53-30-606, MCA; 53-30-611, MCA*

VII. ATTACHMENTS

- A. [Non-Compliance Report Form](#)

Procedure No. DOC 1.1.7A	Effective Date: 10/20/2014	Revised: 10/19/2016
Signature: /s/ Loraine Wodnik		Position Title: Deputy Director



Quality Assurance Office Audit Procedure Manual

APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted as specified in the contract.

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Quality Assurance Office Mission Statement

The Quality Assurance Office strives to mitigate risk and liability as well as increase performance and economy Department-wide through active monitoring of contracts and licenses, internal controls, and development and maintenance of quality policies and procedures.

I.

Introduction to the Quality Assurance Office

A. Quality Assurance Office General Information

The Quality Assurance Office (QAO) is a division within the Director's Office of the Montana Department of Corrections (Department) and is responsible for monitoring Department-wide internal controls, contract compliance, facility licensure, PREA management, policy and procedural management, and safety and risk management. The QAO designs and implements multiple quality assurance programs and integrates services, policies, and initiatives with all Department-owned and contracted facilities and programs to promote successful, consistent, and quality practices throughout the Department.

The QAO operates under the guidelines of [Generally Accepted Governmental Auditing Standards \(GAGAS\)](#) and [International Standards for Professional Practice of Internal Auditing \(IIA\)](#), however, the QAO does not unconditionally meet all standards at all times.

QAO auditors are independent of the programs or facilities under audit and report solely to the Director's Office, meeting [IIA](#) and [GAGAS](#) requirements for Independent Internal Auditors status.

B. Quality Assurance Office Audit and Testing Function

The QAO is responsible for the development of compliance tools and auditing instruments for Department-owned and contracted facilities and programs as determined necessary by the Department director, deputy director, or by specific request from a Department-owned or contracted facility or program.

The QAO is tasked with auditing Department-owned and contracted facilities and programs and reporting their findings to the Department director, deputy director, and other Department administrators/management as deemed appropriate.

Information regarding the creation of audit tools and licensing instruments may be found in section D below.

The QAO director (QAD), in consultation with the Director's Office or requesting facility or program, will schedule audits based on priority level and time available. It is the responsibility of the QAD to supervise and assign an appropriate number of audit staff needed to conduct each audit.

Facility administrators may request a QAO audit at their program or facility by submitting an Audit Request Memo to the QAD, the letter should include;

- a. a formal intent request including the location and entity to be audited;
- b. general information of the program or facility; and

- c. an estimated time period the requesting facility or program requests the audit take place.

D. Types of Audits and Program Reviews

Performance Audits

Performance audits provide objective analysis to assist management with control and oversight by using audit information to improve program and operations, reduce costs, facilitate decision making parties with responsibility to oversee or initiate corrective action, and increase accountability. [GAGAS](#) defines performance audits as audits that provide findings and conclusions based on an evaluation of sufficient, appropriate evidence against criteria.

A performance audit is the most common type of audit performed by the QAO. There exist multiple types of performance audits which may have interrelated objectives. [GAGAS](#) defines three specific types of performance audits that are implemented by the QAO.

Program Effectiveness

The objectives of these audits are economy and effectiveness of a program. Objectives typically measure the extent to which a program is meeting its goals and address the cost and resources used to reach the objectives.

Internal Controls

These audit objectives relate to an assessment of one or more components of a facility's or program's system of internal control that is designed to provide reasonable assurance of achieving effective and efficient operations, reliable financial and performance reporting, or compliance with applicable laws and regulations. Internal control comprises the plans, policies, methods, and procedures used to meet the facility or program mission, goals, and objectives. Internal control includes the processes and procedures for planning, organizing, directing, and controlling program operations, and managements systems for measuring, reporting and monitoring program performance.

Compliance Audits

The objectives of compliance audits are assessments of compliance with criteria that is established by provisions of laws, contracts, regulations, and other requirements that mandate program or facility action. Compliance audits may be financial, non-financial, or a mixture of both.

Quality Improvement Services

This is a non-audit review performed by, or in consultation with, QAO staff. Program reviews are done at the request of program or facility management and targeted at a single program or process. They do not guarantee compliance or certification and are done as a cursory or complimentary review. As the QAO is an internal entity to the Department they provide assistance and advice to any entity owned or contracted by the Department. However, to maintain sound judgment and audit independence the QAO may use caution in

providing advice or assistance when there is a possibility the QAO may be called upon to perform an audit or review of the facility or program in the future.

E. Development of Audit Tools and License Instruments

The QAO utilizes manufactured compliance tools for programs that have a pre-created instrument. Grant programs and the PREA standard are examples of programs that have predetermined tools.

Montana adult secure facilities, such as the Montana State Prison, Montana Women's Prison, and contracted regional-county and private secure correctional facilities are involved in the creation of the Montana Secure Facility Audit Instrument. The QAD, subject matter experts (SME), and prison administrators will meet at least biennially and approve the content and use of the Montana Secure Facility Audit Instrument. Department-owned and contracted youth secure facilities will follow the same process as that of adult secure facilities.

Probation and Parole Division (PPD) facilities and programs will operate similarly to that of the secure adult program. The QAD, SME's, community or regional administrators, and PPD management will meet at least biennially and approve the content and use of the Montana Probation and Parole Audit Instrument.

Department contracted facilities will be audited to specific requirements such as contracts in place, statutes, best practices and regulations existing in the specific field. Under normal circumstance contracted programs will be provided compliance material in advance of an audit.

II.

Process of Audits

A. Pre-Audit Engagement Memo/Pre-Audit Meeting

After an audit or review is scheduled, the QAD, or audit team lead, will prepare an engagement memo, normally 30 days in advance, for notification purposes to the facility or program administrator, the Department director, or designee, and other appropriate staff. The memo will include:

- a. the purpose of the audit;
- b. the scope that designates the area(s) to be audited;
- c. when appropriate, the audit tool/instrument, including the objectives, to be used;
- d. the scheduled start date and anticipated completion date of the audit; and
- e. any pre-audit requests from the QAO necessary for the upcoming audit to include but not limited to;
 1. organizational charts and job descriptions;
 2. program or facility history relevant to the audit;
 3. program or facility policies and procedures;
 4. financial data; and
 5. prior audit reports.

A pre-audit meeting may take place to further discuss the subjects in the audit memo and to gain a better understanding of the program and/or specific areas of risk.

B. Audit Conferences

Entrance Conference

QAO and the auditee will convene an entrance conference on the first day of the onsite audit, usually immediately following the audit team's onsite arrival. The conference scope may include:

- a. requests for any identified records or documents that are required for the audit;
- b. discussion of the onsite audit process; and
- c. requests for intra-audit conferences by the facility or program administrator. Intra-audit conferences will only be held at the request of the facility or program being audited.

Intra-Audit Conferences

Intra-audit conferences may be held at the end of each day's business by the request of the facility or program administrator. Intra-audit conferences may include the QAO audit team, and any auditee staff deemed appropriate by the administrator, or designee. Intra-audit conferences may include;

- a. informal reporting by the QAO audit team regarding audit findings that are, or may become, less than full compliance;
- b. additional requests for documentation and information from the QAO audit team to the facility; and
- c. an avenue for the facility or program to provide detail or material information regarding areas that may be less than full compliance.

The QAD, or audit team lead, or auditee staff may end an intra-audit conference at any time.

Exit Conference

An exit conference will take place at the conclusion of the onsite audit. The exit conference will include the audit team and auditee staff deemed appropriate by the administrator. Exit conferences will include:

- a. a formal reading of areas found to be below full compliance; and
- b. an opportunity for the facility to respond.

While exit conferences are formal and usually their findings are inclusive, the final audit report may include additional findings or eliminate findings discussed during the exit conference. The facility or program being audited must not consider the exit conference the final audit report. Any finding that will be included in the report must be reported to the auditee so they may respond.

C. Actions of the Audit Team (On-Site)

The audit team will visually observe and interview staff and offenders, examine documentation and records, as well as collect onsite information to determine audit conclusions. Audit members must maintain work-papers that provide reasonable assurance and support of their findings. Typically, the threshold used to gauge sufficient evidence is the reasonable person standard.

It is the responsibility of supervisory audit staff to ensure sufficient evidence is attained to provide for findings that meet the reasonable person standard. The QAO will work together before each audit to determine what the threshold of evidence will be to determine audit level findings. (i.e. full, substantial, or non-compliant)

The audit team will make every effort to limit interference with the daily operations of a facility or program being audited.

Audit team members must be impartial toward the entity of audit and must disclose any issues that may lead to questions of impartiality. Each audit team member will maintain confidentiality of sensitive facility or program material gathered for the audit.

QAO auditors will implement the following process to report and record audit findings during onsite reviews:

- a. Near the end of each business day the audit team will meet as a group and discuss probable audit findings.
- b. An audit team member that reports a finding will inform the team and provide evidence for the finding, as well as the recommendation of finding type (i.e. non-compliant or substantial).
- c. Under normal circumstance, the group must agree with the finding, not agree and eliminate the issue as a possible finding, or request additional information and evidence.
- d. If the audit team agrees the finding merits reporting, it will be documented in the auditor's work-papers as well as listed on the docket for the exit conference.
- e. At no time will an audit team member report a finding to the auditee that was not presented and discussed with the audit team.
- f. Issues that need more evidence, and not concluded while onsite will be reported to the auditee as issues of further investigation during the exit conference.
- g. The auditee must be informed that issues not discussed at the exit conference may be included in the final report and issues discussed in the brief out may be excluded from the report. The auditee will be informed of all findings included in the report so they may respond.

D. Audit Report

After the completion of the onsite audit and acknowledgment between the audit team and auditee regarding findings, the QAD, or audit team lead, will distribute a final Audit Report to the Department director, deputy director, and the facility or program administrator. The Audit Report will include the objectives and scope of the audit as well as include each audit finding with sufficient evidence to support the finding. The report should include the auditee response to the finding as well as a recommendation to correct the finding.

Normal creation of an Audit Report will be under the following procedures:

- a. The audit team leader will draft an Audit Report in the pre-determined format after the conclusion of the onsite visit.
- b. After a draft is produced the document will be circulated to the QAO and all staff included in the audit. Necessary and proper revision will be incorporated and the draft will be presented to the QAD.
- c. The QAD will review the report draft and send suggestions back to the audit team leader for incorporation or further explanation. The audit lead, in consultation with audit staff, will make appropriate modifications and submit the draft back to the QAD. This process will be repeated until deemed completed by the QAD.
- d. After the draft is approved by the QAD, the document will be submitted to a separate and independent member of the Director's Office for further review. If the staff member makes suggestions, the QAD in consultation with the team lead, will incorporate revisions deemed appropriate and resubmit the draft report to the Director's Office staff member.
- e. After the draft report completes all reviews it will be converted to PDF format and considered the final Audit Report.
- f. The report will be submitted to the Department director, deputy director, auditee administrator, and other personnel as deemed appropriate.
- g. Due to the nature of some audits it may be necessary to submit the report to the Department's legal services office before it is finalized and published.

III.

Audit Responsibilities

A. Audited Staff Responsibilities

Auditee staff are encouraged to comply with requests for interviews, information, records, documentation, and other audit related material requested from the audit team.

Department employees may not intentionally mislead or conceal information, material, or documentation specifically requested by the audit team.

B. QAO Audit Staff Responsibilities

QAO staff are responsible for maintaining up-to-date knowledge of facility and program and contracted facility and program operations, as well as auditing standards, correctional best practices, ACA, state and federal laws, and policy and procedure. QAO staff will attend appropriate trainings and will meet the requirements of training and education or have specific knowledge in an audit area.

C. Management Responsibilities

Department or facility or program contract management must provide documentation and information requested by the audit team prior to, during, and after an onsite audit.

Management is encouraged to attend both the entrance conference and the exit conference. Audited management is encouraged to provide audit staff with necessary office space and other necessary peripherals during the onsite audit

IV.

Post Audit

A. Corrective Action Plans and Audit Follow-Up

After the Audit Report is submitted and the auditee is apprised of the findings, the facility or program may be required to submit a corrective action plan that details steps the auditee will take to correct the deficiencies. For some types of audits, such as PREA audits, corrective action plans are a predetermined part of the audit process. Other audit types, such as license audits, include a corrective action plan that contains deficiencies that must be corrected before a license is extended or granted. For other types of audits, the normal corrective process includes the following procedures:

- a. If not included in the Audit Report the auditee will draft a corrective action plan that outlines steps to correct deficiencies. Usually a time frame of 30 days for auditee completion is granted.
- b. If the auditee is a Department-owned program or facility the administrator will be responsible for the corrective action plan.
- c. The QAO may assist the auditee attain compliance during a corrective action process.
- d. At the end of the granted corrective action period, or the completion date as determined by the administrator, the QAD, or audit team lead will meet with the administrator and determine if the steps taken by the program or facility correct the deficient objective.
- e. As determined by the QAD, or audit team lead, follow up audit work may be necessary to determine compliance.
- f. If compliance is not met and the date of completion is past, the QAD, or audit team lead, in consultation with the administrator, will inform the Director's Office of the continued deficiencies. If the purpose of the audit is to approve or extend a license, the license may be delayed, denied, or postponed.
- g. If the auditee is a contracted facility the Department administrator responsible for the program or facility contract is responsible for the corrective action plan and the administrator will facilitate the corrective action process; the QAO may determine follow up compliance as determined appropriate.

An auditee may request the QAO follow-up and/or submit a corrective action plan when not required or a predetermined aspect of the audit process to assure compliance with audit recommendations.

B. Audit Evaluation Survey

After the completion of the Audit Report, or completion of a corrective action plan, the QAO may provide the auditee an Audit Evaluation Survey to identify areas to improve audit/review quality.

V.

DOC Audit Training Standards and Requirements

A. Audit Training for non-QAO staff

Because the validity and effectiveness of an audit is in direct proportion to the knowledge and skill of the auditors, all staff selected as members of the audit team will receive audit related training. Audit team members will participate in and/or observe a minimum of one (1) facility security audit prior to being assigned as an audit team member for an audit.

The QAO, in consultation with the Professional Development Bureau, will provide an introductory training program containing necessary pre-audit knowledge and skills that an entry level auditor must have before they participate in an audit.

All staff requesting to become a certified QAO audit assistant must have approval from their supervisor and have at least one year of DOC experience before they may apply to attend QAO audit training. Staff with advanced educational, technical, or extensive correctional experience that lack one year of Montana correctional experience may be authorized to attain the training by the QAD on a case-by-case basis. The QAO audit assistant training will include:

- a. a comprehensive review of this procedure and DOC Policy 1.1.7 Quality Assurance;
- b. steps and protocols for successfully conducting a systematic review of a facility or program, its operations and equipment;
- c. professional communication with fellow staff members and administrators;
- d. techniques for avoiding confrontation while auditing;
- e. classroom instruction with information needed for an auditor to execute the audit function as well as provide hands on “mock” audit training; and
- f. a sound background to mitigate auditor risk and liabilities.

After staff complete the mandatory audit training and successfully completed a QAO audit they will attain qualified audit assistance status and may assist in any further audit as appropriate.

VI.

Audit-Specific Guidelines

A. Security Audits

1. The security audit instrument will include standards for each of the categories approved by the National Institute of Corrections (NIC), as well as any categories specific to the Department and/or facility being audited.
2. Security standards will be consistent with the mission, vision, and values of the Department and incorporate the following:

- a. agency policies;
 - b. facility procedures;
 - c. accepted practices, procedures and post orders;
 - d. standards, rules, and laws as applicable, i.e. American Correctional Association (ACA), National Commission on Correctional Health Care (NCCHC), state statutes, administrative rules, etc.; and
 - e. best security practices, as identified by recognized professional resources and organizations.
3. Security audit team members will be experienced in the following areas:
 - a. knowledge of security practices and security equipment;
 - b. experience at a supervisory level;
 - c. knowledge of Department policies;
 - d. knowledge of facility equipment, gear, and hardware;
 - e. ability and experience communicating on a professional level with staff; and
 - f. sensitivity to the importance of health, safety and security requirements within a correctional facility.
4. A comprehensive schedule of facility security audits will be developed by the QAD. The schedule will be communicated to the Director, Deputy Director, facility administrators and the QAO. The QAD will maintain the master schedule and will provide advance notice of any schedule changes to these individuals. The audit schedule will include:
 - a. dates and location of each scheduled facility security audit;
 - i. times which the security audit team members are at the facility may vary as auditors will be present to observe procedures such as inmate counts, inmate movement and security processes such as perimeter lighting, perimeter checks, vehicle inspections, etc.;
 - b. the name of the lead auditor for each scheduled audit; and
 - c. the names of the security auditors participating in the facility security audit, if identified in advance.
5. Each facility housing inmates will be audited at least once every three years. Audits may be conducted internally by the facility or at a Department level. Facility audits will be conducted by security audit team members from within the facility. Department level audits will be completed by the QAO and audit team members from outside the facility.
6. With approval from the Director or Deputy Director, if deemed appropriate, unannounced audits of a facility may be scheduled and organized by the QAD.
7. The QAD may schedule and conduct a security system check during the audit of a facility. The purpose of the security system check is to help staff identify areas of risk and vulnerability and to make improvements to any deficiencies noted. The administrator will be notified in advance of a security system check. The security system check will not be conducted in a manner that may expose staff or inmates to risk, harm or injury or jeopardize institutional safety and security.
8. The protocol for conducting a security system check will include:
 - a. identify the system, process, procedure, staff response or equipment being tested;

- b. identify facility staff who should participate in the system check;
- c. identify staff requiring advance notice of the system check;
- d. discuss and implement any safeguards that must be in place prior to conducting the system check;
- e. identify specific instructions or information that will be given to the participants;
- f. determine the duration of the check and when the check will be terminated and by whom; and
- g. schedule for the debriefing following the conclusion of the system check
 - i. Time and schedules permitting, a debriefing should be held following a system check. The QAD, audit team members, staff involved in the check, the training staff at the facility, administrator and other staff designated by the administrator should be present at the debriefing.

B. Contract Reviews

1. Contract review audits may be conducted on any contract held by the Department. The contract review audit instrument will include standards or requirements outlined in the contract.
2. The contract for Crossroads Correctional Center in Shelby, MT will be reviewed annually by the QAO.
3. Contracts for other secure facilities, prerelease centers and treatment facilities will be reviewed by the QAO every three years with site visits by Department employees in the intervening years intended to monitor contract requirements and progress toward compliance with audit recommendations.
4. Unannounced site visits may be conducted to audit specific standards at any time.
5. For planned contract reviews, the QAO will notify the facility administrator of the audit date(s) and request any applicable supporting documentation.

C. Licensing

1. The QAO office reviews licensing standards for all juvenile detention facilities in Montana on an annual basis. The juvenile detention facility audit instrument includes requirements of *Administrative Rules of Montana Title 20, Chapter 9, Subchapter 6 Licensure of Youth Detention Facilities*.
2. Upon completion of a license review, the facility will be granted a full or provisional license. A full license is issued when the facility meets all requirements. The license expires one year from the date of issuance. A provisional license is issued when the facility is found non-compliant in one or more requirements. If the facility demonstrates compliance in the amount of time allotted by the provisional license, the facility will be issued a full license.

VII.

References

[Generally Accepted Governmental Auditing Standards, 2011 \(GAGAS\), commonly known as Yellow Book.](#)

[International Standards for Professional Practice of Internal Auditing \(IIA\).](#)

VIII.

Attachments

- A. DOC Adult Security Standards Audit Tool
- B. DOC Probation and Parole Facility Standards Audit Tool (*In development*)
- C. DOC Youth Security Standard Audit Tool
- D. [PREA Standard Audit Instruments](#)

IX.

Definitions

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Adult Secure Facilities – Department-owned and contract facilities, to include Montana State Prison, Montana Women’s Prison, Crossroads Correctional Facility, Dawson County Correctional Facility, and Cascade County Correctional Facility.

Audit/Licensing Instrument – The QAO internal document designed as a policy and standards-based checklist to assess division, facility or program compliance with Department policies, facility operational procedures, contractual obligations, and statutory requirements

Corrective Action Plan – The document that identifies how risk or deficient audit objectives will be corrected, who is responsible for the correction, and the date by which the corrections will be made.

Internal Control – A process designed to provide reasonable assurance that the objectives of reliable financial reporting, effective and efficient operations, and compliance with laws and regulations are achieved. The process encompasses the control environment, the identification and analysis of risks, control activities, information and communications within and outside the organization, and monitoring of the process over time.

Internal Control Specialist – The Department position of Compliance Manager located in the QAO responsible for Department-wide compliance monitoring and tool creation.

License – A certificate issued by the Department which designates the facility as being suitable for the care and treatment of offenders.

Reasonable Person Standard – A comparative standard that represents what a hypothetical person who exercises average care, skill, and judgment in conduct would consider sufficient evidence to support a finding.

Youth Secure Facilities – Department-owned and contract facilities, to include Riverside Youth Correctional Facility and Pine Hills Youth Correctional Facility as well as county juvenile detention centers.



POLICY DIRECTIVE

Policy:	DOC 1.1.8 MEDIA RELATIONS
Effective Date:	12/01/1996 Page 1 of 4
Revision Date(s):	06/01/2015; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

The Department will maintain positive and informative relationships with the public, the media, and other agencies with related functions. It will provide timely, complete, and accurate information on Department operations, accomplishments, critical incidents, and emergencies in compliance with all statutes that govern confidentiality and public information by balancing the public's right to know with the individual's right to privacy.

II. APPLICABILITY

All divisions, facilities and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The Department will operate in a transparent way that encourages better public understanding of program goals and operational procedures, and will:
 - a. provide prompt, complete responses to correspondence and requests from the media;
 - b. participate in organizations and meetings that assure cooperation with other criminal justice agencies in information gathering, exchange, and standardization, including strategic and contingency planning at federal, state, and local levels;
 - c. provide structured visits to facilities and programs for media, community members, academic professionals, law enforcement agencies, victims and victims' families, and other selected groups and organizations; and
 - d. meet as needed with media staff and editorial boards to address areas of mutual concern about newsworthy event coverage that relates to the Department.
2. The Communications Director and PIO will provide current and factual information in verbal and written form to the public and media unless the information release is limited by the confidentiality, safety, and security needs of the program.

B. Department Spokespersons

1. Designated spokespersons for the Department include the Director, Deputy Director, Communications Director, division administrators, and the PIO.
2. To ensure accuracy of information provided to the public, the Department does not authorize staff or contracted staff to comment to the news media as official Department spokespersons, or to publish or release original printed materials developed by the Department without prior approval from an administrator, the Department Communications Director, or the Director.
3. Department staff wishing to speak to the media as private citizens, not as representatives of the Department, will make such contacts during off-duty hours and make clear to the media they are representing personal views, not the views of the Department.

C. Responsibilities

1. The Department Director is responsible for:
 - a. responding to media inquiries after normal duty hours or referring inquiries to the PIO; and
 - b. contacting the Communications Director and appropriate administrator if an inquiry pertains to an issue that may affect the entire Department or generate significant media coverage.
2. Each facility or program administrator, or designee, is responsible for:
 - a. developing written plans in consultation with the Communications Director that guide contact with the news media to establish and maintain working relationships and to ensure media plans are consistent Department-wide;
 - b. arranging on-site facility and program visits when administrators are provided sufficient notice, when the visit requested is at a reasonable time of day, and as staff availability and time permit; and
 - c. allowing adult offender interviews consistent with security requirements during an on-site visit with willing offenders after the offender and attorney, when applicable, sign the *Interview and Photo Consent* form.
3. The Communications Director is responsible for:
 - a. releasing information to the public and news media about Department operations, policies, procedures, and issues;
 - b. advising and assisting the PIOs as needed;
 - c. reviewing and approving all news releases prior to release; and
 - d. recording radio or television news coverage involving the Department.
4. Responsibilities of the PIO include, but are not limited to:
 - a. providing the public and media information pertaining to the Department;
 - b. promptly reporting any contact from a national or international news representative to the Communications Director;
 - c. promptly contacting the Communications Director if a local reporter's inquiry involves a controversial issue or may impact the Department;
 - d. routinely providing the media with newsworthy coverage about a range of Department operations and activities, the contents of which will be provided to the Communications Director on an as-needed basis or, in the event of emergency, at the earliest possible opportunity; and
 - e. forwarding to the Communications Director, when necessary and available, copies of videotapes and newspaper clippings pertaining to the Department.
5. Department employees are responsible for:
 - a. referring media inquiries to the Department Director, Deputy Director, Communications Director, PIO, or administrator depending on the nature of the inquiry;
 - b. referring media inquiries for staff information to the administrator; and
 - c. consulting with the Department's Legal Services with questions regarding confidentiality or the legitimacy of an inquiry.

D. Media Access to Youth Facilities and Programs

1. In order to access youth facilities and programs, news media representatives must:
 - a. sign the *Youth Confidentiality* form upon admission to the program;
 - b. agree not to identify youth offenders by name; and
 - c. agree not to film or photograph youth offenders in a manner that allows for visual identification.

2. In accordance with confidentiality requirements for youth offenders in correctional facilities, staff may only provide media representatives with information confirming whether a specific offender is in residence.

E. Media Inquiries

1. Designated spokespersons will ensure that media inquiries are promptly and accurately responded to:
 - a. inquiries that require a telephone response will be responded to during the working day in which the inquiry is received, or as soon thereafter as possible;
 - b. written responses will be made within two weeks of receipt of the inquiry; and
 - c. when a response may be significantly delayed, an interim verbal or written response will be provided.
2. In emergencies, the administrator may:
 - a. limit public and media access;
 - b. identify a press spokesperson to periodically brief all media; and
 - c. locate a media briefing center away from tactical operations if an emergency continues for an extended period of time.
3. Information may be released from adult offender records except for information in which the offender or another person has a right to privacy that outweighs the public's right to know as demonstrated in the following circumstances:
 - a. the information threatens the security or safety of a person or institution;
 - b. medical or psychological information;
 - c. the information is made confidential by law (for example, the presentence investigation (PSI) report);
 - d. investigative information; or
 - e. youth offender records maintained within an adult offender record in compliance with this policy.

F. News Releases

1. The Department Director or person authorized as spokesperson must, during an emergency incident command operation, contact the incident commander for approval of content of a news release prior to release.

G. Filmmaker and Writer Access to Programs

1. Filmmakers, writers for non-news magazines, and other related personnel will direct inquiries about access to correctional programs to the Communications Director.
2. The Department Director and program administrator will consult and consider permission for access on a case-by-case basis.
3. Filmmakers and writers will be subject to established requirements for offender confidentiality.

H. Denial of Media Access

1. When the Department Director declares a facility state of emergency or determines that media access could adversely affect the safety or security of a facility, the Department Director, Deputy Director, Communications Director, PIO, or program administrator may deny media access to programs.
2. The appropriate staff will lift the emergency restriction as soon as possible without jeopardizing the safety and security of the program, staff, or offenders.

3. During emergencies, and to the extent possible, regular briefings will be scheduled to ensure the flow of timely information to the media.

V. CLOSING

Questions about this policy should be directed to the Department Communications Director.

VI. REFERENCES

- A. *Art. II, Sec 9 and 10 of the Montana Constitution*
- B. *Title 2, Chapter 3; §§ 2-6-101; 2-6-102; 2-15-112; 41-5-215; 41-5-216; 46-23-504; 46-23-508, MCA*
- C. *4-4019, 4-4020, 4-4021; ACA Standards for Adult Correctional Institutions, 4th Edition*
- D. *3-JTS-1A-25, 3-JTS-1A-26; ACA Standards for Juvenile Correctional Facilities, 2003*
- E. *DOC 1.5.5 Case Records Management; DOC 1.8.1 Victim Services; DOC 3.3.4 Media Access to Offenders*

VII. FORMS

Interview/Photo Consent
Youth Confidentiality



POLICY DIRECTIVE

Policy:	DOC 1.1.9 LEGAL ASSISTANCE FOR STAFF	
Effective Date:	05/01/1998	Page 1 of 3
Revision Date(s):	03/28/2011; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department will provide the Director and employees with legal advice to aid with the performance of Department duties and will provide legal defense for employees who are sued for acts they performed during the course and scope of their duties. This policy establishes processes for obtaining legal assistance and defense and defines the scope of legal assistance provided.

II. APPLICABILITY

All Department divisions, facilities, and programs.

III. REQUIREMENTS

A. Scope of Representation and Indemnification

1. Department attorneys are available to provide general legal advice in all areas of Department-related activities. Attorneys help ensure compliance with federal, state, and local laws, regulations, and court decisions.
2. Department attorneys also defend the Department and its employees when the Department or its employees are sued over actions they took while performing their duties.
3. Department attorneys may recommend to the Department Director that the Department not defend an employee if substantial evidence indicates the employee's conduct was illegal or outside the scope and course of employment.
4. The Department's Chief General Counsel, after consultation with the Department of Administration's Risk Management and Tort Defense Bureau, may refer the defense of Department litigation to the Attorney General's Office, or other state attorneys, or may retain private counsel after the chief has complied with the applicable executive order concerning outside legal services.
5. Employees who are sued may retain private counsel at their own expense.
 - a. Employees who choose to retain private counsel will immediately notify the Department Legal Services and will be responsible for the defense of the lawsuit thereafter.
6. If any court, arbitrator, or other agency orders an employee to pay a monetary award pursuant to a lawsuit concerning actions the employee took while performing the employee's official duties, the Department will pay the award.

B. Requests for General Counsel Assistance

1. A Department employee who needs legal assistance to perform the employee's duties should, under most circumstances, first contact the employee's and discuss the situation with the supervisor.
 - a. If the supervisor and the employee decide they need to contact the Department attorneys, the employee may contact the designated central point-of-contact for Legal Services.

- 1) The best way to contact the Legal Services designated central point-of-contact is by email with a copy to the employee's supervisor.
 - a) The attorney assigned to respond will provide a written email response with copies that can serve to notify others who also need to be aware of the response.
2. In an emergency, such as when a Probation and Parole Officer needs immediate advice about a search and is unable to contact a supervisor in the officer's chain of command, the employee may directly contact an attorney by whatever means is available.

C. Receiving Complaints, Petitions, Summonses, and Subpoenas

1. To prevent default or extra charges for service of lawsuits, an employee who receives a complaint, petition, summons or subpoena outside of routine offender court proceedings must immediately contact Legal Services.
2. When a process server gives a Department employee a complaint, petition, summons, or subpoena, the employee may sign that the employee has received the document but may not sign to accept the documents on behalf of any other employee unless specifically designated to do so.
3. An employee who receives a complaint outside of routine offender court proceedings, etc., by mail with a form titled "Acknowledgment of Service" must immediately forward the complaint and acknowledgment to Legal Services.
 - a. Under no circumstances should the employee ever sign and/or return the acknowledgment.
4. When an employee receives a complaint, petition, summons and/or subpoena concerning a work-related issue outside of routine offender court proceedings, the employee must, as soon as practicable:
 - a. note the date, time, and method by which the employee received the document;
 - b. contact Legal Services to make them aware of the document;
 - c. make a personal copy of the document; and
 - d. forward all the documents to the Legal Services office either at the Montana State Prison or in Helena.

D. Action After Receiving Legal Documents

1. Legal Services will:
 - a. contact the employees named in a lawsuit.
 - b. generally request that the employee named in a lawsuit:
 - 1) put in writing for the attorneys any recollections the employee has about the incidents in the lawsuit;
 - 2) request the employee gather available documents that relate to the lawsuit; and
 - 3) preserve any relevant documents that might otherwise be destroyed.
2. Employees must cooperate fully with the attorneys who defend them.

E. Subpoenas and Summonses to Appear and Testify

1. Employees who receive a summons or subpoena in a work-related case will notify their supervisor and immediately forward a copy of the summons or subpoena to Legal Services.
2. Legal staff will provide instructions to the summoned or subpoenaed employee.
3. Employees will respond to the subpoena in an on-duty status and submit all claims for necessary expenses in accordance with established requirements for travel costs except when the entity or person originating the subpoena prepays such expenses.

4. Employees will forward any witness fees received or state vehicle mileage allowance to the Department's Financial Services office.
5. Employees who are subpoenaed in a civil or criminal case to give testimony or evidence as a personal consultant (non-work related) or expert witness will respond to the subpoena on approved leave and at their own expense.

IV. CLOSING

Questions about this policy should be directed to the Department's Chief General Counsel.

V. REFERENCES

- A. 2-9-305, MCA
- B. *Executive Order 05-93, Outside Legal Services*



POLICY DIRECTIVE

Policy:	DOC 1.1.10 DEPARTMENT FACILITY AND PROGRAM TOURS	
Effective Date:	10/01/1997	Page 1 of 2
Revision Date(s):	03/28/2011; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department may authorize tours of correctional facilities and programs for selected individuals and groups.

II. APPLICABILITY

All facilities or programs under Department jurisdiction or contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Purpose of Tours

1. Administrators may approve facility or program tours to:
 - a. familiarize legislators, judges, law enforcement agents, criminal justice personnel, and other official visitors with the internal operations of a state correctional facility or program;
 - b. offer an opportunity for selected victims of crime and victim advocates to observe the physical security of a correctional facility or program in order to alleviate fears associated with the secure locations of offenders;
 - c. provide the family members of Department employees an opportunity to observe the physical setting in which their relatives work;
 - d. allow the media access to correctional facilities to familiarize them with facility operations and allow them to secure approved photographs and film footage for their files;
 - e. allow selected members of the public and associates of colleges and universities who have an acceptable reason to observe the operations of a correctional facility; and
 - f. allow designated family members the opportunity to view youth facilities during family reintegration meetings.

B. Approval of Tours

1. Requests to tour a correctional facility or program must be directed to the facility or program public information officer or to the administrator in facilities or programs that do not have PIOs.
2. Generally, administrators will not approve tours for the public, students, and others without a specific need or purpose.
3. Administrators and PIOs will consider tour requests on a case-by-case basis. They may solicit input from other Department staff such as the Communications Director, Victim Information Specialist, and community corrections administrators.

C. Facility and Program Requirements

1. Each facility or program must at minimum develop the following:

- a. a standard request form that must be completed in advance of all tours and must include:
 - 1) time and date;
 - 2) rationale for the tour;
 - 3) tour participants;
 - 4) ages of participants;
 - 5) group affiliation; and
 - 6) warnings about potential risk of exposure to offensive or dangerous situations;
 - b. specific timelines for requesting and approving tours;
 - c. requirements that tours are conducted only by officials who are familiar with every area on the tour agenda; and
 - d. provisions that allow the administrator, or designee, to restrict certain areas from tours when safety, security, or other issues are of concern.
2. Each facility and program will establish tour criteria including, but not limited to, the following:
 - a. the number of persons allowed on tour;
 - b. the ages of the participants;
 - c. identification requirements;
 - d. personal property, including money, retained by tour participants;
 - e. entry processes; and
 - f. time frames during which tours normally will be conducted.
 3. Facilities and programs may establish other requirements to address issues that are unique to a particular facility or program.
 4. Designated staff will conduct facility and program tours in compliance with established security procedures and *DOC 3.1.5 Secure Facility Entry and Exit*.
 5. Administrators will ensure that copies of current requirements for facility or program tours are submitted to the Department Communications Director for review.

V. CLOSING

Questions about this policy should be directed to the facility or program public information officer, facility or program administrator, or the Department Communications Director.

VI. REFERENCES

A. *53-1-203 MCA*

B. *DOC 3.1.5 Secure Facility Entry and Exit*



POLICY DIRECTIVE

Policy:	DOC 1.1.11 DEPARTMENT AND TRIBAL GOVERNMENT RELATIONS	
Effective Date:	07/01/2007	Page 1 of 1
Revision Date(s):	05/20/2021; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department recognizes the distinct and unique cultural heritage of American Indians and is committed to maintaining the government-to-government relationship with the recognized tribal governments of Montana by inter-departmental communication, policy and procedure development, and implementing programs for the greater good of tribal members and all Montana citizens.

II. APPLICABILITY

All divisions, facilities, and programs.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The Department will consider impacts on tribal members and tribal governments when developing policies, procedures, and Department programs.
2. The Department will make reasonable efforts to consult with tribal representatives to discuss issues and attempt to resolve tribal concerns when this can be accomplished without jeopardizing Department, public, and offender safety and security.
3. The Department's indigenous liaison will serve as:
 - a. the technical and cultural authority to provide ongoing culturally competent consultation and guidance to Department staff; and
 - b. the primary point of contact between the Department and tribal entities.
4. The Department will provide cultural training to Department staff on the unique nature of individual tribal governments, including knowledge of, and sensitivity to, issues of tribal culture, relations, and legal status.
5. Facility and program administrators will keep the Department's indigenous liaison apprised of issues that involve tribal interests or require tribal and Department participation.

V. CLOSING

Questions about this policy should be directed to the Department's indigenous liaison.

VI. REFERENCES

- A. §§ 18-11-101; 2-15-141; 2-15-142; 2-15-143; 53-30-302, MCA



POLICY DIRECTIVE

Policy:	DOC 1.1.14 SAFETY PROGRAM	
Effective Date:	05/05/2014	Page 1 of 4
Revision Date(s):	03/01/2023; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department maintains a Safety Program to preserve physical, financial, and human resources; to provide a safe environment for staff and offenders; to ensure all staff maintain responsibility for safety; and to comply with applicable state and federal regulations, standards, and statutes.

II. APPLICABILITY

All divisions, facilities, and programs.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The Department will identify, mitigate, investigate, and resolve safety concerns and issues by utilizing the Safety Program to achieve the following objectives:
 - a. establish safety communication responsibilities;
 - b. develop and maintain operational plans in accordance with the requirements of this policy;
 - c. maintain an accident- and injury-free work environment;
 - d. reduce the costs associated with incidents; and
 - e. ensure the performance of proper and safe work processes are a part of daily operations; and
 - f. promote a safety culture to safeguard employees and state resources.
2. The administrator will fulfill the following duties:
 - a. assign a local safety coordinator for each facility or office location to serve as the chair for their division, facility, or program's local safety committee;
 - b. designate staff to comprise the local safety committee;
 - c. meet regularly with the local safety committee and other appropriate staff to develop an assessment of risk for all operations and areas of responsibility;
 - d. closely monitor identified areas of risk and attempt to remedy hazards;
 - e. report deficiencies (that may not be corrected with available resources) to the Department Emergency Preparedness Manager with recommendations for corrective action;
 - f. ensure operations and areas of responsibility are reviewed regularly to include:
 - 1) offender litigation and liability;
 - 2) contracts management;
 - 3) fleet vehicle management;
 - 4) building and facility maintenance (insurance and condition);
 - 5) employee litigation and liability;
 - 6) emergency planning and preparedness; and
 - 7) effectiveness of the local safety committee; and
 - g. ensure fire response plans are maintained outlining response to a fire including:

- 1) provision of security for responding fire crews;
 - 2) preservation of a fire scene until released by the agency responsible for the investigation;
 - 3) notification to the State Fire Marshal when a third-party investigator is required pursuant to an agreement with local authorities; and
 - 4) submission of a final report detailing a fire investigation to the administrator, Department Director, and State Fire Marshal.
3. In coordination with the Department Emergency Preparedness Manager, the Executive Team will discuss, review, and support relevant recommendations and investigations throughout the Department and advise administrators regarding the adoption of risk management plans and, when necessary, administrative or legal action.

B. Department-Wide Safety Program Organization and Responsibilities

1. The Department Emergency Preparedness Manager will fulfill the following responsibilities:
 - a. supervise the Safety Program;
 - b. serve as chair on the Department Safety Committee;
 - c. distribute information to the Department Safety Committee;
 - d. conduct routine inspections of Department facilities and office locations to identify potential safety hazards to mitigate risk;
 - e. report deficiencies identified in inspections not remedied with available resources to facility or program administrators; and
 - f. ensure corrective actions are implemented and report any deficiencies to the Director;
2. The Department Safety Committee will include the Department Emergency Preparedness Manager, local safety coordinators, and additional members appointed by the Executive Team; responsibilities of members include the following:
 - a. establish safety goals;
 - b. ensure prevention programs are in place and adequate;
 - c. meet monthly to discuss identified safety issues, incidents, and trends;
 - d. recommend corrective action for safety incidents, issues, or deficits identified Department-wide; monitor the resolution; and substantiate sustained improvement;
 - e. measure, monitor, and evaluate Department safety performance;
 - f. review pre- and post-occupancy, construction, or renovation plans for safety hazards; and
 - g. consult with the Department of Administration (DOA):
 - 1) Risk Management and Tort Defense Division (RMTD) for support and guidance; and
 - 2) Architecture and Engineering Division regarding fire and safety issues prior to the initiation of major construction or renovation projects.

C. Local Safety Committee Responsibilities

1. The appointed local safety coordinator will supervise the Safety Program within the coordinator's location and serve as a member of the Department Safety Committee.
2. Local safety committees:
 - a. consist of individuals appointed by the division, facility, or program administrator; and
 - b. will ensure accountability and coordination of safety issues for each division, facility, or program.
3. Members are responsible for fulfilling the following duties:
 - a. establishing safety objectives;
 - b. ensuring prevention programs are in place and adequate;
 - c. conducting monthly meetings to discuss safety incidents, issues, or deficits identified including accidents, injuries, and illnesses related to the workplace;
 - d. submitting meeting minutes to the administrator and the Department safety coordinator;

- e. recommending corrective action for safety incidents, issues, or deficits identified, monitoring the resolution, substantiating sustained improvement, and submitting reports of non-compliance with a corrective action plan to the administrator;
 - f. participating in, and requiring staff participation in, safety training and coordinating supplemental training with outside agencies, when necessary;
 - g. recommending additional training for staff to the administrator;
 - h. monitoring workplace for compliance with applicable standards for conditions and safety equipment and reviewing needs and requests for personal protective equipment;
 - i. ensuring drills, inspections, tests, annual reviews, and updates of fire and life safety programs and emergency preparedness plans at the facility or program are scheduled, completed, and recorded in accordance with state and federal guidelines and operational procedures;
 - j. ensuring maintenance of a record-keeping system documenting compliance with applicable standards including, when necessary, certification of the facility's water and sewer systems;
 - k. reviewing inspection reports and drill reports including reports of annual inspections conducted by State Fund, State Fire Marshal, Department of Public Health and Human Services (DPHHS), and other regulatory agencies; and
 - l. reviewing any post-occupancy, construction, or renovation plans for safety hazards.
4. Upon receipt of a *Near-Miss Incident Report* form or an *Employee/Supervisor Accident Report* form from a supervisor, the Incident Analysis Team will perform an investigation using the *Incident/Accident Analysis* form to analyze on-the-job near-miss incidents and accidents.
- a. This investigation will assist in determining what, if any, action needs to be taken to prevent future safety issues and should be conducted within 4 business days of the incident or accident occurrence.

D. Supervisor and Employee Responsibilities

- 1. Department employees are responsible for:
 - a. maintaining awareness of potential fire hazards;
 - b. successfully completing required training; and
 - c. adhering to applicable state and federal safety and health regulations, and Department policies, procedures, and General Safety Rules.
- 2. For near-miss incidents, employees will:
 - a. report the incident to their immediate supervisor using the *Near-Miss Incident Report* form as soon as possible, but within 24 hours of the near-miss incident; and
 - b. assist the supervisor in completing the *Near-Miss Incident Report* form, if possible, before the end of the employee's shift, but not later than 24 hours of the near-miss incident.
- 3. After completion of the *Near-Miss Incident Report* form, the supervisor will forward it to the local safety coordinator.

E. Reporting an Accident or Occupational Disease and Workers' Compensation

- 1. Employees will report all work-related injuries or occupational diseases to their immediate supervisors within 24 hours of their occurrence.
- 2. If medical care is necessary, the supervisor should encourage and assist employees to obtain the required care.
- 3. Employees and their supervisor must complete the *Employee/Supervisor Accident Report* form within twenty-four hours of accident occurrence and, if medical attention is necessary, a *First Report* form.

4. The *First Report* form must be submitted to Human Resources for further processing in accordance with *DOC 1.3.3 Workers' Compensation and Early Return to Work*. The *Employee/Supervisor Accident Report* form must be submitted to the local safety coordinator for review by the Incident Analysis Team.

F. Training

1. Local fire agencies may be asked to provide staff with training in fire and life safety issues.
2. The Department will maintain:
 - a. a life safety program that includes training staff to use resuscitation techniques, first aid equipment and supplies, and to respond to the following:
 - 1) aspiration of vomit;
 - 2) assaults;
 - 3) CPR;
 - 4) heart attacks;
 - 5) intent to commit or actual suicide attempts; and
 - 6) smoke inhalation.
 - b. a fire safety program that includes training staff in the following areas:
 - 1) identification and response to fire hazards;
 - 2) techniques for detection, reporting, suppression, and extinguishing of fires;
 - 3) locations of emergency exits;
 - 4) use of emergency equipment;
 - 5) use and storage of hazardous materials in accordance with *DOC 3.2.12 Control and Use of Hazardous Materials*;
 - 6) internal and external evacuation in accordance with *DOC 3.2.5 Internal Evacuation* and *DOC 3.2.6 External Evacuation*;
 - 7) processes to protect a fire scene until an investigation is completed; and
 - 8) identification and use of proper fire extinguishers and corresponding combustible material categories including:
 - a) Class A: ordinary combustible materials such as wood, cloth, and paper; the material requires the use of extinguishers including water, anti-freeze solution, loaded steam, and foam.
 - b) Class B: flammable liquids such as gasoline, fuel oil, alcohol, or grease; a blanket effect is essential in smothering the fire; material requires the use of extinguishers including foam, loaded steam, carbon dioxide, and dry chemicals.
 - c) Class C: electrical equipment; the use of an electrically nonconductive extinguishing agent is required including carbon dioxide and dry chemicals.

V. CLOSING

Questions about this policy should be directed to the Department Emergency Preparedness Manager.

VI. REFERENCES

- A. §§ 2-15-112; 53-1-203, MCA
- B. *DOC 1.3.3 Workers' Compensation and Early Return to Work*; *DOC 3.2.5 Internal Evacuation*; *DOC 3.2.6 External Evacuation*; *DOC 3.2.12 Control and Use of Hazardous Materials*

VII. FORMS

DOC 1.1.14 (A) General Safety Requirements
DOC 1.1.14 (B) First Report
DOC 1.1.14 (C) Employee/Supervisor Accident Report
DOC 1.1.14 (D) Incident/Accident Analysis
DOC 1.1.14 (E) Near-Miss Incident Report



POLICY DIRECTIVE

Policy:	DOC 1.1.15 SOCIAL MEDIA	
Effective Date:	03/16/2012	Page 1 of 2
Revision Date(s):	06/24/2016; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department utilizes controlled use of social media to improve communication with staff, crime victims, and the public, to increase the Department's transparency, and to expand accessibility of the Department and its services to offenders, staff, and the public.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The Department will use social media to achieve the following goals:
 - a. enhance public safety through rapid and efficient communication to the public upon identification of a threat to safety;
 - b. provide professional development opportunities through staff access to training;
 - c. expand department Human Resource processes including employment opportunities for Department positions and communications with department employees;
 - d. allow for collaboration with community-based service providers to reintegrate offenders more successfully into the community and provide links to services such as housing, hiring, or treatment opportunities; and
 - e. promote inmate training, programs, products, and services.
2. The Department Director will:
 - a. approve, create, and maintain social media utilized by the Department that officially represent the Department;
 - b. approve any modification or expansion of utilized social media sites prior to implementation; and
 - c. moderate comments submitted and not post comments that meet the following criteria:
 - 1) contain obscene language, personal attacks of any kind, or offensive terms that target specific individuals or groups; or
 - 2) unsupported accusations.
3. Users and visitors to social media sites will be notified that the intended purpose of the site is to serve as a mechanism for communication between the Department and members of the public.
4. Wherever possible, content posted by Department staff on social media sites will contain links directing users back to the Department's official website cor.mt.gov for in-depth information, forms, documents, or online services.

B. Department Employee Use of Social Media

1. When accessing Department-authorized social media sites while on-duty, Department employees will use an established personal profile registered with a personal email address and will comply with applicable Department policies and procedures including *DOC 1.3.2 Performance and Conduct*.
2. Employees utilizing social media sites for training purposes will comply with *DOC 1.4.1 Staff Development and Training*.
3. Content contributed to social media by Department employees may not:
 - a. claim to represent the Department or its policies; or
 - b. disclose personal protected information regarding staff, the public, or offenders under Department supervision.

C. Consent for Posting Images on Social Media

1. Department employees will not be photographed or filmed in a manner that allows individual identification without the employee's written consent. On each occasion an employee is filmed or photographed for social media, the employee must sign the *Media Consent Form for Employees*.
2. Offenders will not be photographed or filmed in a manner that allows individual identification without the offender's written consent. On each occasion an offender is filmed or photographed for social media, the offender must sign the *Interview/Photo/Video Publication and Media Consent* form.

V. CLOSING

Questions about this policy should be directed to the Department Communications Director or Human Resources.

VI. REFERENCES

- A. 53-1-203, MCA; 61-12-501, MCA
- B. *DOC 1.3.2 Performance and Conduct; DOC 1.4.1 Staff Development and Training*

VII. FORMS

Interview/Photo/Video Publication and Media Consent
Media Consent Form for Employees



POLICY DIRECTIVE

Policy:	DOC 1.1.16 PUBLIC COMMUNICATION	
Effective Date:	05/18/2012	Page 1 of 3
Revision Date(s):	08/27/2021; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

It is the policy of the Department to promote public trust and enhance accountability and openness through providing the public with access to the Department's records and responding to public requests for services in an expeditious and professional manner.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The Department strives to provide resolution to public communication requests or comments within a 30-day period; however, additional time may be required to complete the following:
 - a. clarify public statements or requests;
 - b. locate and assemble requested information;
 - c. notify persons affected; or
 - d. determine possible exemptions from disclosure.
2. A division administrator is expected to collaborate with subject matter experts or consult within the chain of command when responding to public communication requests or comments that may result in an escalating situation.
3. A division administrator is required to adhere to the following requirements:
 - a. maintain receipt and response records pertaining to public communication; and
 - b. ensure consistency and accuracy of statistical information released, the Department Communications Director must be contacted prior to the release of applicable information.
4. The Department will maintain informative relationships with the news media and will release information to representatives in accordance with *DOC 1.1.8 Media Relations*.
5. If communication subject to the requirements set forth in *DOC 3.3.3 Offender Grievance Program* conflicts with requirements set forth in this policy, the Offender Grievance Program will take precedence.
6. The Department will support and assist in corrections research efforts of other government entities, academic institutions, and foundations by providing data and information to the extent possible. Research efforts must not compromise the security of Department facilities, programs, staff, and offenders.

B. Public Comments

1. Comments submitted by requestors electronically, by mail, or by telephone will be addressed by the Department using standard methods that encourage positive communication, enhance Department responsiveness to public concerns, and increase transparency.
2. Division administrators are responsible for investigating circumstances alleged in submitted comments and responding to comments in ways that do not require inclusion of information related to the following:
 - a. confidential personnel matters;
 - b. the security of an institution; or
 - c. violation of any citizen's right to privacy.

C. Requests for Public Information

1. The Department will adhere to applicable state statutes and administrative rules governing the release of Department records.
2. When release of public information will result in reproduction costs, the responding division administrator will determine the appropriate costs for reproduction and will notify the requestor of costs in advance.
3. Department Legal Services will analyze requests for information and identify exempt and nonexempt material prior to release.
4. If any requested record that is determined to be exempt contains any material that is not exempt, nonexempt material will be separated, copied, and forwarded to the requestor.
5. Requests to receive records may be granted, denied, or granted in part.
 - a. If a request is denied, the Department will issue a written response that includes an explanation for appeal and specific reasons for denial including citations to applicable legal authority.
6. The Department may deny a request for records when it would be unduly burdensome to comply. However, prior to denial, a Department representative will confer with the requestor in an attempt to narrow the request to more manageable proportions.
7. Non-production of records due to the fact that a good faith search by the Department does not produce the requested documents is not a denial of access.

D. Research Activities

1. The Department Communications Director will establish specific criteria for the review of research proposals submitted by outside entities. Those criteria are:
 - a. the Department will consider the results of all Department-related research projects to be within the public domain;
 - b. when proposals are likely to interfere with Department programs, the Department Communications Director may advise the requesting entity to alter elements that may negatively impact programs. in which case approval may be contingent upon minimizing any negative program effects;
 - c. research requests will not be approved if the research data is unavailable to the Department, unless the requesting entity gathers and processes all such data;
 - d. research requests that directly involve increased Department expenditures without benefit to the Department will not be approved;
 - e. Department employees may not receive compensation, remuneration, or payment of any kind beyond their normal salaries for participating or assisting in any research project;
 - f. the Department Director will serve as the final decision-maker regarding Department participation in any research effort; and

- g. if Department participation in a research effort is denied, a letter describing the reasons for denial will be provided to the requestor within 30 days of the decision.

V. CLOSING

Questions about this policy should be directed to the Department Communications Director.

VI. REFERENCES

- A. *Montana Constitution, Article II, Section 9*
- B. *Chapter 2, Title 6, Public Records, MCA*
- C. *DOC 1.1.8 Media Relations; DOC 3.3.3 Offender Grievance Program*



POLICY DIRECTIVE

Policy:	DOC 1.1.17 PRISON RAPE ELIMINATION ACT OF 2003 (PREA)
Effective Date:	09/12/2007 Page 1 of 15
Revision Date(s):	06/22/2021; 10/25/2024
Signature/Title:	/s/ Brian Gootkin, Director

I. POLICY

The Department of Corrections has zero tolerance relating to all forms of sexual abuse and sexual harassment in accordance with the standards set forth in the *Prison Rape Elimination Act of 2003 (PREA)*.

II. APPLICABILITY

All Department divisions, facilities, and programs.

III. DEFINITIONS

Administrative Investigation – Any agency investigation that is not conducted for the purpose of law enforcement or criminal prosecution.

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility, or program operation and management.

Confidential – Information to be shared only by order of a court or with those whose official capacity dictates their absolute need to know.

Criminal Investigation – A formal investigation by a law enforcement agency having jurisdiction (LEAJ) or by a Department of Corrections criminal investigator to discover whether there is probable cause to believe that criminal conduct has occurred.

Criminal Investigator – A Department of Corrections investigator in the Office of Investigations with sworn Peace Officer authority established through a Memorandum of Understanding with the Montana Department of Justice, Division of Criminal Investigations.

Department Employee – A person employed by the Department of Corrections who has attained permanent status or is eligible to attain permanent status, as provided in 2-18-101(20), MCA; a volunteer, an intern, or a temporary or short-term worker. This term does not include service providers.

Garrity Warning – Formal advisement given to an individual during an administrative investigation when potential for criminal charges may exist. Neither the individual's answers nor the fruits of those answers may be used against the individual in a subsequent or concurrent criminal prosecution.

Incarcerated Offender – Any individual detained in a Department-owned, operated, or contracted facility that is sentenced or committed to Department of Corrections supervision.

Intersex – A person whose sexual or reproductive anatomy or chromosomal pattern does not seem to fit typical definitions of male or female. Intersex medical conditions are sometimes referred to as disorders of sex development.

Investigation – A formal fact-finding activity for the specific purpose of addressing complaints or

allegations. Investigations may include, but are not limited to: interviews, surveillance, review of electronic and paper records, correspondence, and other information storage devices.

Investigator – The designated Department employee assigned to conduct an official investigation of a complaint, incident, or report of sexual abuse or sexual harassment of an offender.

Law Enforcement Agency of Jurisdiction (LEAJ) – The government agency, for example, sheriff's office or local police department, operating within their defined area of responsibility.

PREA Coordinator – The Department position responsible for administration and management of the Department-wide PREA program including but not limited to compliance, policy and procedure development, staff training, offender education, and records and statistical tracking.

Qualified Health Care Professional (QHCP): Physicians, physician assistants, nurses, nurse practitioners, dentists, mental health professionals, and others who, by virtue of their education, credentials, training, and experience are permitted by law to evaluate and care for patients, including Department staff and contracted or fee-for-service professionals.

Qualified Mental Health Professional (QHMP) – Psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, psychiatric nurse practitioners, licensed professional counselors, licensed clinical social workers, and others who, by virtue of their education, credentials, training, and experience, are permitted by law to evaluate and care for the mental health needs of patients, including Department staff and contracted or fee-for-service professionals. This definition excludes Mental Health Technicians.

Service Providers – This term includes contracted persons or other vendors providing service whose assignment is primarily on Department premises, for example, facility or program office.

Sexual Abuse of an Offender by Another Offender – Sexual acts, sexual contact or any other intentional touching, either directly, through the clothing or with an object, of or with the genitalia, anus, groin, breast, inner thigh, or the buttocks of another person, excluding contact incidental to a physical altercation, in which the victim does not consent, is coerced by overt or implied threats of violence, or is unable to consent or refuse.

Sexual Abuse of an offender by an Employee or Service Provider – Sexual acts, sexual contact or any other intentional contact, either directly, through the clothing or with an object, of or with the genitalia, anus, groin, breast, inner thigh, or the buttocks, any attempt, threat, or request by an employee or service provider to engage in these activities, any display by an employee or service provider of his or her uncovered genitalia, buttocks, or breast in the presence of an offender, or voyeurism by an employee or service provider, when these acts are unrelated to official duties or where the employee or service provider has the intent to abuse, arouse, or gratify sexual desire.

Sexual Harassment of an Offender by Another Offender – Repeated and unwelcomed sexual advances, requests for sexual favors, or verbal comments, gestures, or actions of a derogatory or offensive sexual nature by one offender directed toward another offender.

Sexual Harassment of an Offender by an Employee or Service Provider – Repeated verbal comments or gestures of a sexual nature to an offender by an employee or service provider, including demeaning references to gender, sexually suggestive or derogatory comments about body or clothing, or obscene language or gestures.

Substantiated – An event was investigated and determined to have occurred, based upon the preponderance of the evidence.

Transgender – A person whose gender identity (i.e., internal sense of feeling male or female) is different from the person's assigned sex at birth.

Unfounded – An event was determined not to have occurred.

Unsubstantiated – Evidence was insufficient to meet the preponderance of the evidence to make a final determination as to whether or not the event occurred.

Volunteer – Any person who has been approved to provide services for Department programs without compensation.

Voyeurism – An invasion of privacy of an offender by an employee or service provider for reasons unrelated to official duties.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. All Department facilities will comply with all applicable standards under *28 CFR Part 115, Prison Rape Elimination Act of 2003*. Documentation of compliance with all standards will be maintained by the facility.
2. Administrators, or designees, will immediately respond to allegations of sexual abuse and sexual harassment, fully investigate reported incidents, pursue disciplinary action, and refer for investigation those who violate the requirements set forth in this policy.
3. The Department director, or designee, will appoint a Department PREA Coordinator responsible for the following:
 - a. coordinating and developing policies and procedures to identify, monitor, and track sexual abuse and sexual harassment;
 - b. conducting audits to ensure compliance with Department policy, applicable state or federal laws, and PREA standards; and
 - c. compiling records and reporting statistical data to the U.S Department of Justice on an annual basis as required by PREA standards.
4. Each administrator, or designee, will assign a PREA compliance manager responsible for the following:
 - a. coordinating facility PREA-related activities with the PREA coordinator;
 - b. ensuring facility compliance with all PREA standards;
 - c. ensuring facility compliance with PREA training requirements; and
 - d. tracking and reporting PREA allegations and statistics to the Department PREA coordinator.

B. Prevention and Intervention

1. Employees must be alert to situations in which sexual abuse or sexual harassment might occur and be capable of identifying indicators of sexual abuse and sexual harassment.
2. Any new contract or contract renewal for the confinement of offenders will include the contract entity's obligation to adopt and comply with the PREA standards and a provision for the Department to monitor the contract to ensure the contractor is complying with the PREA standards.
3. When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the facility and the Department must consider the effect of the design, acquisition, expansion, or modification upon the facility's and Department's ability to protect offenders from sexual abuse.
4. When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the facility and Department must consider how such technology may enhance the facility's and Department's ability to protect offenders from sexual abuse.
5. The Department will not enter into or renew any collective bargaining agreement or other agreement that limits the Department's ability to remove alleged staff sexual abusers

from contact with any offender pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

6. Administrators are required to develop, document, and make best efforts to comply on a regular basis with a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect offenders against abuse. In circumstances where the staffing plan is not complied with, facilities will document and justify all deviations from the plan.
7. The facility will review the staffing plan annually, in consultation with the PREA coordinator, to assess and document whether adjustments are needed.
8. Administrators will require intermediate-level and higher-level staff to conduct random unannounced rounds to identify and deter employee or service provider sexual abuse and sexual harassment. These rounds must be documented in an unannounced rounds log and cover all shifts and all areas of the facility. The facility must prohibit staff from alerting others of the conduct of such rounds.
9. All facilities will identify, assess, and manage offenders with special needs, including those who are potentially vulnerable or dangerous, to provide safe housing, adequate protection, and programmatic resources to meet their needs in accordance with *DOC 4.2.2 Special Needs Offenders*.
10. Transgender and intersex offenders will be given the opportunity to shower separately from other offenders either through physical separation by separate shower stalls, or by time-phasing or scheduling of showers.
11. The Department will not place lesbian, gay, bisexual, intersex, or transgender offenders in dedicated facilities, units, or wings solely on the basis of such identification or status.
12. Victims of sexual abuse and offenders at high risk for sexual victimization will not be placed in segregated housing for protective purposes unless an assessment of all available alternatives has been made and a determination is made that there is no alternative means of separation. If a facility cannot conduct such an assessment immediately, the facility may hold the offender in segregated housing for up to 24 hours while completing the assessment. The facility will clearly document the basis for the facility's concern for the offender's safety and the reason no alternative means of separation could be arranged. The facility will review each offender placed in segregated housing for protective purposes every 30 days.
13. Offenders placed in segregated housing for protective purposes will have access to programs, privileges, education, and work opportunities to the extent possible. If access is restricted the facility will document what opportunities have been limited, the duration of the limitation and the reasons for such limitations.

C. Training

1. Prior to working with offenders, all Department employees with direct and/or incidental contact with offenders, which includes visual, physical, or audio contact, must receive documented PREA training. If an employee is unable to attend comprehensive PREA classroom training prior to contact with offenders, they must receive pre-service training in the form of reviewing the PREA policy and a PREA brochure and signing an acknowledgment form. The employee must then attend the next available classroom training.
2. Comprehensive classroom training and pre-service training will include, but is not limited to:
 - a. review of this policy, *DOC 1.3.12 Staff Association and Conduct with Offenders*, appropriate site-specific procedures, and any other applicable state or federal laws;
 - b. the Department's zero tolerance policy for sexual abuse and sexual harassment;
 - c. how employees and service providers fulfill their responsibilities under the Department's sexual abuse and sexual harassment prevention, detection, reporting, and response

- policies and procedures;
 - d. an offender's right to be free from sexual abuse and sexual harassment;
 - e. offender and employee rights to be free from retaliation for reporting sexual abuse and harassment;
 - f. the dynamics of sexual abuse and harassment in confinement;
 - g. common reactions of sexual abuse and sexual harassment victims;
 - h. how to detect and respond to signs of threatened and actual sexual abuse;
 - i. how to avoid inappropriate relationships with offenders;
 - j. how to communicate effectively and professionally with offenders who might be lesbian, gay, bisexual, transgender, intersex (LGBTI) or gender nonconforming;
 - k. how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities;
 - l. facility procedures on sharing confidential information; and
 - m. gender-specific information tailored to the gender of the offenders at the facility.
3. Each employee will attend refresher training in odd number years to cover the topics in IV.C.2 above. In even numbered years, employees will receive refresher information on current sexual abuse and sexual harassment policies.
 4. All volunteers and service providers who have visual, physical, or audio contact with offenders will be trained at a minimum on the Department's zero tolerance policy concerning sexual abuse and harassment, prevention, detection, and response methods, and how to report such incidents. The level and type of training provided to volunteers and service providers will be based on the services they provide and the level of contact they have with offenders, and could rise to the level of employee training referenced in IV.C.2 above. Volunteers and service providers will sign a training acknowledgment form.
 5. Medical and mental health providers will receive additional, specialized training relevant to their role in detecting and assessing signs of sexual abuse and sexual harassment, preservation of evidence, and responding effectively to victims of sexual abuse and sexual harassment.
 6. Employees who conduct sexual abuse investigations will receive additional training in conducting such investigations in confinement settings, to include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collections, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.
 7. All training will be documented, through signature or electronic verification, showing acknowledgement that the employee, volunteer, or service provider received and understood the training. For comprehensive training, staff will use the *Comprehensive PREA Training Acknowledgment*.

D. Offender Education

1. Within 72 hours of facility intake for adult offenders and during the intake process for residents at juvenile facilities, employees will communicate to offenders, verbally and in writing:
 - a. information about the Department's zero tolerance of sexual abuse and sexual harassment;
 - b. how to report incidents or suspicion of abuse or harassment; and
 - c. this policy, *DOC 1.3.12 Staff Association and Conduct with Offenders*, *DOC 3.3.3 Offender Grievance Program*, and corresponding site-specific procedures.
2. Within 30 days of intake for adult offenders, or within 10 days of intake for residents at juvenile facilities, the facility will provide education to offenders either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding facility procedures for reporting and responding to such incidents.

3. Offenders will receive education upon transfer to a different facility regarding any policies and procedures of the offender's new facility that differ from those of the previous facility.
4. Each facility must take appropriate steps to ensure offenders with disabilities have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect and respond to sexual abuse and sexual harassment. Such steps will include access to interpreters and written materials provided in formats or through methods that ensure effective communication. The facility will provide offender education in formats accessible to all offenders, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to offenders who have limited reading skills.
5. The facility will maintain documentation of offender participation in PREA education sessions and have offenders sign an acknowledgment form.
6. The facility will ensure that PREA information is continuously and readily available or visible to offenders through posters, offender handbooks, or other written formats.

E. Screening for Risk of Victimization or Abusiveness

1. Risk assessment of all offenders using an objective screening instrument for victimization or abusiveness will take place within 72 hours of intake into a facility.
2. Within 30 days of intake the facility will reassess the offender's risk of victimization or abusiveness, taking into consideration any additional relevant information received by the facility since the initial screening.
3. The facility will conduct additional screening assessments when warranted based on any new information, referral, request, or incident of sexual abuse.
4. The screening instrument will consider, at a minimum, the following criteria for risk of sexual victimization:
 - a. whether the offender has a mental, physical, or developmental disability;
 - b. the age of the offender;
 - c. the physical build of the offender;
 - d. whether the offender has previously been incarcerated;
 - e. whether the offender's criminal history is exclusively nonviolent;
 - f. whether the offender has prior convictions for sex offenses against an adult or child;
 - g. whether the offender is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;
 - h. whether the offender has previously experienced sexual victimization; and
 - i. the offender's own perception of vulnerability.
5. The screening will consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse in assessing the offender's risk for being sexually abusive.
6. Offenders will not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked during screening or reassessment.
7. When the risk assessment indicates an offender has experienced prior sexual victimization or previously perpetrated sexual abuse, whether it occurred in the community or in an institutional setting, the facility will ensure the offender is offered a follow-up meeting with a qualified mental health professional within 14 days of the assessment.
8. Information from the risk assessment for victimization or abusiveness will be provided on a need-to-know basis to individuals who make housing, bed, work, education, and program assignments and used with the goal of keeping separate those offenders at high risk of being sexually victimized from those at high risk of being sexually abusive.

9. In deciding whether to assign a transgender or intersex offender to a facility, and in making other housing and programming assignments, the Department will consider on a case-by-case basis the placement's effect on the offender's safety, whether the placement would present management or security problems, and whether such placement would likely endanger the safety of other offenders.
10. The Classification Manager will use the offender classification system outlined in *DOC 4.2.1 Offender Classification System* to conduct an individual assessment with all relevant information, including the offender's own views of their safety and vulnerability when considering placement in a facility.
11. The assessment will occur as soon as possible following notification to the Department that an offender has been committed to a secure facility but no later than 30 days after arrival at a facility.
12. The classification manager will ensure all considered information is documented and maintained in a secure location. Placement will be reviewed at each classification status review.
13. Placement and programming assignments for each transgender or intersex inmate shall be reassessed at least twice each year to review any threats to safety experienced by the inmate. A transgender or intersex inmate's own views with respect to their own safety shall be given serious consideration.

F. Offender Reporting

1. Facilities will provide multiple internal ways for offenders to privately report sexual abuse and sexual harassment, retaliation by other offenders or employees for reporting sexual abuse and sexual harassment, and employee neglect or violation of responsibilities that may have contributed to such incidents.
2. Facilities must provide at least one way for offenders to report abuse or harassment to a public or private entity that is not part of the Department, and that is able to receive and immediately forward any reports from offenders of any sexual abuse or harassment to facility or Department officials, allowing the offender to remain anonymous upon request.
3. Offenders who are victims of or have knowledge of sexual abuse or sexual harassment should immediately report the incident by one of the following methods:
 - a. report the incident to an employee or service provider verbally, in writing, anonymously or through a third party;
 - b. utilize the "locked box" formal grievance procedure in accordance with *DOC 3.3.3 Inmate Grievance Program*;
 - c. contact the external agency listed on PREA posters and brochures that are posted and available throughout the facility; or
 - d. use the inmate phone system following the instructions on the phone to leave a message for a Department employee.
4. Employees and service providers will accept reports verbally, in writing, anonymously, and from third parties and will immediately document any verbal reports.
5. Reports made in bad faith, which includes deliberately malicious reports by offenders or other parties, will result in disciplinary action and/or criminal charges.

G. First Responder Duties

1. Upon learning of an allegation that an offender was sexually abused, the first security staff to respond to the report will:
 - a. separate the alleged victim and alleged perpetrator;

- b. preserve and protect any crime scene until appropriate steps can be taken to collect any evidence, in accordance with *DOC 3.1.28 Crime Scene and Physical Evidence Preservation*;
 - c. if the abuse allegedly occurred within a time period that allows for the collection of physical evidence, typically 72 hours, request that the alleged victim and ensure that the alleged abuser not take any actions that could destroy physical evidence such as washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.
2. If the first employee or service provider to learn of an allegation that an offender was sexually abused is not security staff, the employee or service provider will request that the alleged victim not take any actions that could destroy physical evidence, take reasonable steps to ensure the victim's safety, and immediately notify security staff.
3. Each facility will maintain a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among employee and service provider first responders, medical and mental health practitioners, investigators, and facility leadership.

H. Employee and Service Provider Reporting

1. Department employees and service providers will report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the Department; retaliation against offenders or employees who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.
2. Employees and service providers may privately report sexual abuse or sexual harassment through their chain of command or by notifying the Department PREA coordinator.
3. If the alleged victim is under the age of 18, the administrator, or designee, must report the allegation to:
 - a. the Director or Deputy Director immediately upon receipt of the allegation; and
 - b. the Department of Public Health and Human Services in accordance with *41-3-201, MCA*.
4. If the alleged victim is at least 60 years old or is a person with a developmental disability, the administrator, or designee, must report the allegation to the Department of Public Health and Human Services in accordance with *52-3-811, MCA*.
5. Apart from reporting to designated supervisors or officials, employees and service providers will not reveal any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.
6. Unless otherwise precluded by law, medical and mental health practitioners will report sexual abuse according to facility procedures and will inform offenders of their duty to report, and the limitations of confidentiality, at the initiation of services.
7. Allegations that an offender was sexually abused while at another facility must be reported by the administrator to the administrator of the facility where the abuse occurred as soon as possible but no later than 72 hours after the initial report. For allegations involving a resident of a juvenile facility the administrator will also notify the appropriate investigative agency. Notifications will be documented.
8. Potential criminal conduct will be reported to the LEAJ first, immediately followed by the Office of Investigations. If the Office of Investigations has primary jurisdiction over a facility's criminal investigations, however, that facility will report potential criminal conduct only to the Office of Investigations.
9. Sexual abuse or harassment by an employee, service provider, or offender will be reported in

accordance with *DOC 1.1.6 Priority Incident Reporting and Acting Director*.

10. Reports of sexual abuse or sexual harassment by an employee, service provider, or offender will be forwarded to the Office of Investigations, facility PREA compliance manager and the Department PREA coordinator within one business day.
11. Any employee or service provider who fails to report an allegation, or coerces or threatens another person to submit inaccurate, incomplete, or untruthful information may face dismissal or other disciplinary action.

I. Retaliation Monitoring

1. The Department will not tolerate retaliation against offenders, employees, or other parties for reporting sexual abuse or sexual harassment or cooperating with an investigation. Individuals that retaliate against any offender or witness are subject to disciplinary action.
2. Employees who report sexual abuse or sexual harassment of an offender will not be subjected to retaliation by anyone within or outside of their chain of command in accordance with *DOC 1.3.2 Employee Performance and Conduct*.
3. Facilities will employ multiple protective measures, such as transfers or removals to separate victims from abusers, and emotional support services.
4. The facility will monitor, for at least 90 days, the conduct and treatment of offenders and employees who reported sexual abuse or sexual harassment and offenders who were reported to have suffered sexual abuse or sexual harassment to prevent retaliation. Monitoring will continue beyond 90 days if there is a continuing need.
5. Monitoring will include reviewing any offender disciplinary reports, housing or program changes, or negative performance reviews or reassignments of employees. For offenders, monitoring will also include periodic status checks.
6. If an offender is transferred from one Department facility to another Department facility during their monitoring, the transferring facility will notify the receiving facility of the offender's monitoring status and the receiving facility will continue the monitoring for the remainder of the 90 days, or beyond if there is a continuing need.
7. The facility will act promptly to remedy any detected retaliation.
8. Each facility will designate staff members responsible for retaliation monitoring.
9. The facility's obligation to monitor retaliation may be terminated if the allegation is determined to be unfounded.
10. If any other individual who cooperates with an investigation expresses a fear of retaliation, the Department will take appropriate measures to protect that individual against retaliation.

J. Medical, Mental Health, and Victim Services

1. Medical and mental health services for victims will be consistent with the community level of care.
2. The administrator, or designee, will develop procedures for providing services to offenders alleged to be victims of sexual abuse or sexual harassment within a confinement setting. Services must be made available without financial cost to the victim and must include, at minimum:
 - a. access to medical examination and treatment to include follow up care and referrals;
 - b. mental health crisis intervention and treatment;
 - c. timely access to emergency contraception, STD prophylaxis, and all pregnancy-related tests and services; and
 - d. access to a victim advocate or rape crisis center that can offer emotional support services

throughout the investigative process, or access to a qualified employee or service provider.

3. Department employees and service providers will adhere to the following standards for examination of victims of sexual abuse or sexual harassment:
 - a. if the victim refuses medical or mental health attention, document the refusal on the *Medical Treatment Refusal* form;
 - b. if reported within a time period which allows for collection of physical evidence, typically within 72 hours of the incident, and with the victim's permission, immediately transport the victim to a medical facility equipped with medical personnel certified as Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs), or if none are available, to a medical facility with other qualified medical practitioners, to evaluate and treat sexual assault/rape victims; and
 - c. if reported more than 72 hours after the incident, and with the victim's permission, adhere to the following:
 - 1) refer the victim to appropriate health care providers responsible for treatment and follow up care for sexually transmitted or other communicable diseases who will complete a patient history, conduct an examination to document the extent of physical injury and determine whether referral to another medical facility is required; and
 - 2) upon request from law enforcement, transport the victim to a community medical facility for evidence collection.
4. Qualified mental health professionals will provide crisis intervention and ongoing services for victims of sexual abuse and sexual harassment and for other offenders affected.
5. Facilities will attempt to conduct a mental health evaluation of all known offender-on- offender abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by qualified mental health professionals.
6. Each facility will provide all offenders with access to outside victim advocates for emotional support services related to sexual abuse by giving offenders mailing addresses and telephone numbers of local, state, or national victim advocacy or rape crisis organizations. The facility will enable reasonable communication between offenders and these organizations in as confidential a manner as possible. The facility will inform offenders, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities.

K. Investigative Protocols

1. All reported incidents of sexual abuse and sexual harassment will be investigated promptly, thoroughly, and objectively. Criminal investigations will be conducted by either the LEAJ or by the Department's Office of Investigations in accordance with *DOC 3.1.19 Investigations*.
2. Administrators, or designees, will ensure all staff follow appropriate evidence procedures outlined in *DOC 3.1.28 Crime Scene and Physical Evidence Preservation*.
3. A *Request for Investigation (RFI)* for all allegations of sexual abuse and sexual harassment will be sent to the Office of Investigations to initiate an investigation.
4. The Office of Investigations will forward requests for investigation that do not rise to the level of a criminal investigation to the PREA compliance manager and/or the appropriate administrator, or designee, to open an administrative investigation. For cases involving employees, the Office of Investigations will also notify the Office of Human Resources.
5. All allegations of sexual abuse or sexual harassment that are criminally investigated will also be administratively investigated. The administrative investigation will begin when the Office of Investigations determines that the administrative investigation will not interfere with the criminal investigation.

6. Investigations of offender sexual abuse or sexual harassment will be conducted by Department employees who have received specialized training in conducting sexual abuse and sexual harassment investigations in a confinement setting.
7. Investigators will gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data. Investigators will interview alleged victims, suspected perpetrators, and witnesses and will review prior complaints and reports of sexual abuse involving the suspected perpetrator.
8. When the quality of evidence appears to support criminal prosecution, compelled interviews will only be conducted after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.
9. The credibility of an alleged victim, suspect, or witness will be assessed on an individual basis and will not be determined by the person's status as an inmate or employee.
10. Offenders who allege sexual abuse will not be required to submit to a polygraph examination as a condition for proceeding with the investigation of an allegation.
11. The facility will not rely on offender interpreters for investigations regarding sexual abuse or sexual harassment except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the offender's safety, the performance of first-response duties or the investigation of the offender's allegations.
12. Department employees are guaranteed constitutional and administrative protections; within the boundaries of those protections, employees will cooperate with any authorized investigation or inquiry and will relate fully and truthfully their knowledge of all issues pertaining to the alleged conduct under investigation. Material omissions or the provision of materially false information which the employee knows or suspects to be false will result in the employee being subject to disciplinary action in accordance with *DOC 1.3.2 Employee Performance and Conduct*.
13. Administrative investigators will issue the *Interviewee Administrative Investigation Warning* to employees who are being interviewed as the subject of an investigation or witnesses in an investigation.
14. In cases of sexual abuse involving staff, the *Separation Order Pending Investigation* will be issued to the alleged staff member at the time of the allegation. *The Return to Work – Case Closed* form will be given to the staff member at the end of the investigation when the allegation is unfounded or unsubstantiated.
15. When a staff member reports an allegation involving another staff member, the administrative investigator assigned to the case will give the complainant the *Investigation Notice for Complainant*.
16. Information obtained during either a criminal or an administrative investigation may be jointly shared and utilized; however, a self-incriminating statement may not be utilized in a criminal investigation against an individual that has been provided with a *Garrrity Warning*.
17. Investigators will not use a standard higher than preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated in administrative investigations.
18. Administrators must provide investigators with unrestricted access to Department records including, but not limited to, documents; electronic recordings; and correspondence materials relevant to the investigation.
19. Administrative investigators must conduct fair and objective investigations, exercise professionalism during an investigation, and conduct investigations in such a manner that

information is kept confidential.

20. Administrative investigations will include an effort to determine whether employee actions or failures to act contributed to abuse.
21. All investigations will be documented in a written report that includes a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.
22. Investigative materials including, but not limited to incident reports, statements, and investigative reports will be stored in a criminal or administrative investigative case file. Criminal investigative case files must be submitted to the Investigations Manager. Administrative investigative case files must be submitted to the PREA Compliance Manager and the PREA Coordinator.
23. All administrative and criminal investigation written reports will be retained for as long as the alleged abuser is incarcerated or employed by the Department, plus five years.
24. Conduct that appears to be criminal will be referred by the Office of Investigations for prosecution.
25. The departure of the alleged abuser or victim from the employment or control of the facility or Department will not provide a basis for terminating an investigation.
26. If an outside agency investigates sexual abuse, the facility will cooperate with outside investigators and will endeavor to remain informed about the progress of the investigation.

L. Reporting to Offenders

1. Following an investigation into an offender's allegation of sexual abuse or sexual harassment in a facility, the facility will inform the offender as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.
2. If the investigation is conducted by a LEAJ, the Department will request relevant information from the LEAJ in order to inform the offender.
3. Following an offender's allegation that an employee or service provider has committed sexual abuse against the offender, the facility will inform the offender, unless the allegation is unfounded, whenever:
 - a. The employee or service provider is no longer posted within the offender's unit;
 - b. The employee or service provider is no longer employed at the facility;
 - c. The Department learns that the employee or service provider has been indicted on a charge related to sexual abuse within the facility; or
 - d. The Department learns that the employee or service provider has been convicted on a charge related to sexual abuse within the facility.
4. Following an offender's allegation that they have been sexually abused by another offender, the facility will inform the alleged victim whenever:
 - a. The facility learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or
 - b. The facility learns that the alleged abuser has been convicted on a charge related to sexual abuse within a facility.
5. All such notifications or attempted notifications will be documented.
6. A facility's obligation to report will terminate if the offender is released from the Department's custody.

M. Incident Reviews

1. The facility will conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. Such review will occur within 30 days of the conclusion of the investigation.
2. The review team will include upper-management from the facility, the facility's PREA compliance manager, line supervisors, investigators, qualified medical or mental health professionals, and other employees with direct involvement.
3. The review team will:
 - a. consider whether the allegation or investigation indicates a need to change policy or procedure to better prevent, detect or respond to sexual abuse;
 - b. consider whether the incident or allegation was motivated by race, ethnicity, gender identity, LGBTI status or perceived status, STG affiliation or was motivated or caused by other group dynamics at the facility;
 - c. examine the area where the incident allegedly occurred to assess whether the physical barriers in the area may enable abuse;
 - d. assess the adequacy of staffing levels in that area during different shifts;
 - e. assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and
 - f. prepare a report of its findings and any recommendations for improvement and submit the report to the facility administrator, the Department PREA Coordinator and facility PREA Compliance Manager.
4. The facility will implement the recommendations for improvement or document its reasons for not doing so.

N. Data Collection, Review, Storage, Publication and Destruction

1. There will be a system in place to collect data on incidents of sexual abuse or sexual harassment. Such data will be analyzed to determine possible corrective action or improvement.
2. The Department will collect accurate, uniform data for every allegation of sexual abuse at facilities and programs under its direct control using a standardized instrument and definitions set forth in this policy.
3. The incident-based data collected will include, at a minimum, the data necessary to answer all questions from the most recent version of the *Survey of Sexual Victimization* conducted by the Department of Justice.
4. The Department's Office of Investigations will maintain records of all criminal investigations of sexual abuse and sexual harassment conducted by that office or as provided by the LEAJ. Each facility will maintain records of all administrative investigations of sexual abuse and sexual harassment at that facility. Records will include information on the outcome of any criminal or disciplinary charges.
5. The Department will aggregate the incident-based sexual abuse data at least annually. The Department will maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.
6. Each facility PREA compliance manager will maintain records of all allegations, investigations, and Incident Reviews and report such information to the PREA coordinator. Upon request, the Department will provide all such data from the previous calendar year to the Department of Justice.
7. The Department will make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, available to the public at least annually

through the Department website. All personal identifiers will be removed from this data prior to making it public. The Department will maintain sexual abuse data for at least 10 years after the date of its initial collection.

O. Sanctions

1. Employees will be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. Termination is the presumptive disciplinary sanction for employees who have engaged in sexual abuse.
2. Disciplinary sanctions for violations of Department policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) will be commensurate with the nature and circumstances of the acts committed, the employee's disciplinary history, and the sanctions imposed for comparable offenses by other employees with similar histories.
3. All terminations for violations of Department sexual abuse or sexual harassment policies, or resignations by employees who would have been terminated if not for their resignation, will be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.
4. Service providers or volunteers who engage in sexual abuse will be prohibited from contact with offenders and will be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. The Department will take appropriate remedial measures, and will consider whether to prohibit further contact with offenders, in the case of any other violation of Department sexual abuse or sexual harassment policies by a service provider.
5. Offenders are subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the offender engaged in offender-on-offender sexual abuse or following a criminal finding of guilt for offender-on-offender sexual abuse.
6. Sanctions will be commensurate with the nature and circumstances of the abuse committed, the offender's disciplinary history, and the sanctions imposed for comparable offenses by other offenders with similar histories.
7. The disciplinary process will consider whether an offender's mental disabilities or mental illness contributed to their behavior when determining what type of sanction, if any, should be imposed.
8. If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility will consider whether to require the offender to participate in such interventions as a condition of access to programming or other benefits.
9. The agency may discipline an offender for sexual contact with staff only upon a finding that the staff member did not consent to such contact.
10. For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred will not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.
11. An offender may not engage in sexual acts, make sexual proposals or threats or engage in indecent exposure pursuant to *DOC 3.4.2 Prohibited Acts*, and is subject to disciplinary action for violations. The facility may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

V. CLOSING

Questions about this policy should be directed to the Department's PREA Coordinator.

VI. REFERENCES

- A. 41-3-201, MCA; 45-5-501, MCA; 45-5-502, MCA; 45-5-503, MCA; 52-3-811, MCA
- B. 4-4281-1 through 4-4281-8; 2008 ACA Standards Supplement
- C. 28 CFR Part 115, Prison Rape Elimination Act of 2003
- D. DOC 1.1.16 Priority Incident Reporting and Acting Director; DOC 1.3.2 Performance and Conduct; DOC 1.3.12 Staff Association and Conduct with Offenders; DOC 1.5.5 Case Records Management; DOC 1.8.1 Victim Services; DOC 3.1.19 Investigations; DOC 3.1.28 Crime Scene and Physical Evidence Preservation; DOC 3.3.3 Offender Grievance Program; DOC 4.1.2 Offender Reception and Orientation; DOC 4.2.1 Offender Classification System; DOC 4.2.2 Special Needs Offenders
- E. *Garrity v. State of New Jersey*, 385 U.S. 493 (1967); *Gardner v. Broderick*, 392 U.S. 273 (1968); *Uniformed Sanitation Men Assoc., Inc. v. Commissioner of Sanitation of the City of New York*, 392 U.S. 280 (1968)
- F. P-F-06; National Commission on Correctional Health Services in Prisons, 2018
- G. MH-B-05; National Commission on Correctional Mental Health Services in Correctional Facilities, 2015

VII. FORMS

- A. Medical Treatment Refusal
- B. Comprehensive PREA Training Acknowledgment
- C. Garrity Warning
- D. Interviewee Administrative Investigation Warning
- E. Investigation Notice for Complainant
- F. Return to Work – Case Closed
- G. Separation Order Pending Investigation



POLICY DIRECTIVE

Policy:	DOC 1.1.18 SYSTEMATIC CRITICAL INCIDENT REVIEW (SCIR)
Effective Date:	07/03/2024 Page 1 of 3
Revision Date(s):	
Signature/Title:	/s/ Brian Gootkin, Director

I. POLICY

The Department of Corrections conducts systematic critical incident reviews of serious incidents to develop an understanding of systemic influences and identify systematic improvements.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS: See Glossary

IV. DEPARTMENT DIRECTIVES

A. Case Selection

1. Categories of incidents potentially subject to review are as follows:
 - a. significant use of force with injury to offender or staff
 - b. claims from inmates regarding mistreatment
 - c. suicide
 - d. staff safety (assault/injury/death)
 - e. unexpected death of an inmate
 - f. escape
 - g. sensitive incident-potential liability
 - h. riot/uprising
 - i. high profile contraband cases
 - j. serious disciplinary action
 - k. critical incidents in community
 - l. sexual intercourse without consent
 - m. high frequency issue/complaint/public concern
 - n. equipment failures (embedded within the review itself)
 - o. other cases designated by the Director
2. Facility Administrators and Bureau Chiefs will continue to review all priority incident reports in accordance with *DOC 1.1.6 Priority Incident Reporting and Acting Director*.

B. Systematic Critical Incident Review (SCIR) Team

1. The purpose of the SCIR Team is to select which incidents to review and to ensure reliable information is collected and tracked through the various stages of the review and implementation process.
2. The Department's Executive Team will designate staff to serve on the SCIR Team. The SCIR Team will include designated staff from various facilities, bureaus, and units to ensure Department-wide representation. At minimum, there will be nine SCIR members.
3. A quorum of five SCIR Team members is required for the monthly SCIR Case Selection meeting.

C. Systematic Critical Incident Review Process

1. Incidents entered into the Department's offender management system and those reported to the SCIR Team or the Executive Team will be evaluated monthly by the SCIR Team to determine whether an incident will be reviewed and mapped.
2. The SCIR Team will collectively determine if any incidents should be selected for further review and mapping based on the criteria listed in IV.A.1 above. SCIR Team members are encouraged not to review and map incidents that occurred in their own facility, bureau, or unit. For each selected incident, at least one designated member of the SCIR Team will:
 - a. present it to the Department's Executive Team for final approval prior to beginning the review and mapping process; and
 - b. after final approval, conduct the review and mapping process.
3. The SCIR Team member(s) conducting the review will identify Department personnel and others who may have been involved in the incident to participate in a human factor debriefing. Human factor debriefings are voluntary for all staff. Staff will receive an electronic invitation to participate and will be provided with specific case identifying information.
4. The SCIR Team member conducting the review will notify the Facility Administrator or Bureau Chief that a case has been selected for further review but will not provide the names of the staff member(s) contacted for debriefing. The SCIR Team member may ask a Facility Administrator or Bureau Chief to assist in communicating with line staff for scheduling debriefing or mapping.
5. The SCIR Team member facilitates a meeting for the Facility/Bureau Mapping Team to analyze the human factors data and other systemic influences at several levels. Staff selected for the Mapping Team will include a cross-section of line staff, supervisors at various levels, and support staff (such as maintenance or administrative staff). Depending on the specific incident being reviewed, the SCIR Team may request additional Department staff to participate as ad hoc members with the established Facility/Bureau Mapping Team.
6. Each incident selected for review and mapping will be scored using the System Analysis Tool and software provided by Collaborative Safety.

D. Recommendations

1. The SCIR Team may develop considerations for improvements to present to the Department's Executive Team based on the cases reviewed, which may include enhancements to the following:
 - a. existing workflows
 - b. processes
 - c. policies
 - d. teamwork
 - e. communication
2. The SCIR Team members who completed the review and considerations will meet with the affected Division Chiefs in preparation for the case to be presented to the Department's Executive Team. The Division Chiefs will coordinate how the considerations may be implemented.
3. Considerations are either approved or left in surveillance. Considerations approved by the Department's Executive Team are considered formal recommendations.
 - a. If considerations are approved as recommendations, tracking and implementation are completed as soon as operationally feasible with the Division Chief's input.

- b. If considerations are left in surveillance, they are directed back to the monthly SCIR Team meeting for additional support or dissolution.
4. Approved considerations will be provided to the Communications Bureau Chief so that appropriate information about the review can be disseminated to staff.

E. System Learning Review

1. The purpose of the System Learning Review (SLR) is to provide a tool for facility or bureau level staff to more quickly review work processes or incidents prior to or instead of a full SCIR.
2. The Department's Executive Team will designate staff to be trained to use the SLR tool.
3. All information gathered through an SLR will be entered into the Collaborative Safety software.

V. CLOSING

Questions about this policy should be directed to the SCIR Team.

VI. REFERENCES

- A. 53-1-203, MCA
- B. DOC 1.1.6 *Priority Incident Reporting and Acting Director*



POLICY DIRECTIVE

Policy:	DOC 1.1.19 PUBLIC INFORMATION REQUESTS	
Effective Date:	01/31/2024	Page 1 of 7
Last Revised:	04/24/2026	
Signature:	/s/ Eric Strauss, Director	

I. POLICY

The Department has established this policy to promote consistency and efficiency in responding to public information requests and fees and costs charged for fulfillment. In all record productions, the Department will honor the right to know and the right of individual privacy guaranteed by the Montana Constitution and comply with other pertinent statutes, regulations, privileges, and judicial decisions.

II. APPLICABILITY

All Department divisions, facilities, and programs.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Department and Office of Public Information Requests

1. The Department has entered into a Memorandum of Understanding (MOU) with the Department of Administration, Office of Public Information Requests (OPIR).
2. OPIR was established to support executive branch agencies in responding to public information requests.
3. OPIR and the Department are responsible for reviewing records and removing or redacting any information that may contain confidential or privileged information prior to production to the requester.
4. OPIR counsel shall provide the Department with legal advice and assistance in production of responsive public information; however, the Department retains final authority regarding the response to each request for Department records.
5. The Department is subject to 2-6-1006, MCA. The statute requires agencies to respond to public information requests within specified times. To comply timely with the statute, the Department shall comply with the following procedures.

B. Department Process for Accepting Public Information Requests

1. The Department must establish a designated contact for public information requests. The Department has designated OPIR as its public information request contact.
 - a. The Department will:
 - 1) provide a button or link on the Department home page to the Department's "Request Public Information" web page;
 - 2) post OPIR's contact information and link to OPIR's website on the Department's "Request Public Information" web page; and
 - 3) provide OPIR a primary and alternate contact to work with OPIR in responding to public information requests; these Department employees will be the primary and backup contact for OPIR staff for public information purposes.

2. All requests for Department public information **must** be made to OPIR, either through the DOA website, opir.mt.gov/records-request, by email to [publicrecords\(at\)mt.gov](mailto:publicrecords(at)mt.gov), or by other method specified by OPIR. All requests must be submitted in writing. If a public information request is not submitted to OPIR as required by this section, the Department and OPIR are not required to respond within the timeframes established in 2-6-1006, MCA.
3. A public information request must be made utilizing OPIR's website or request form. The requester must:
 - a. include their name and contact information, including complete mailing address, phone number, and email address (if any); and
 - b. provide all information in required sections of the OPIR website or form.
4. Public information requests are public information, and the requester must identify the requestor and any organization on whose behalf a request is filed. Anonymous record requests will not be accepted, and any person seeking to make an anonymous request will be directed to provide the required information. If the required information is not provided, OPIR will request the required information and will not begin fulfillment of the request until it is provided.
5. If a public information request is sent to a Department employee, the employee will redirect the request to OPIR. The employee shall not fulfill the public information request. If a request is sent to a Department email address, the request will be forwarded to [publicrecords\(at\)mt.gov](mailto:publicrecords(at)mt.gov). Paper requests for public information will be scanned by the Department employee and emailed to OPIR at [publicrecords\(at\)mt.gov](mailto:publicrecords(at)mt.gov).
6. Once OPIR routes the request back, if the info is readily available, the Department may provide access to and copying of public information. The Department staff member will be present during the examination and copying of any public information documents (*see IV.F and IV.G below*).

C. Department Process for Responding to Public Information Requests

1. Section 2-6-1006, MCA separates public information requests into different categories.
 - a. For purposes of this policy, a request for "a single, specific, clearly identifiable, and readily available public record," as provided in 2-6-1006(3)(a)(ii), MCA, is considered a simple request.
 - b. Other requests are considered complex requests.
 - c. "Requests pertaining only to a specified person or property, including requests for applications, vital records, licenses, permits, or registrations," as provided in 2-6-1006(3)(a)(ii), MCA, will be managed according to the Department's established statutes, rules, policies, procedures, and practices for handling requests for those documents.
2. Classifying Requests
 - a. Upon receipt of a properly filed public information request, OPIR will review the request and consult with the Department to determine whether it is a simple public information request, a complex public information request, or a request pertaining only to a specified person or property.
 - 1) The Department and OPIR will make the classification determination within 3 working days.
3. Acknowledging Requests
 - a. Upon receipt of a properly filed public information request, after the classification determination is made but no more than 5 working days from receipt of the request, OPIR will acknowledge receipt of the request to the requester and copy the Department on the acknowledgment.
 - 1) A properly filed public information request is a request made in compliance with IV.B above.

4. Requests Pertaining Only to a Specified Person or Property
 - a. A “request pertaining only to a specified person or property” refers to a request for specific information about a specific person or property that the Department has a duty to maintain in the ordinary course of the Department’s business.
 - 1) To the extent the Department collects applications or vital records or issues licenses, permits, or registrations under a statutory duty or incidental to running a program authorized by statute, requests for these types of records about a specific person (individual or entity) or property should be handled by the Department.
 - 2) The Department is not required to use the processes set forth in this policy but should follow the Department’s established processes for providing such information.
5. Simple Public Information Requests
 - a. Definition. A simple public information request is a request:
 - 1) that does not require any clarification or additional information from the requester;
 - 2) for a single, specific, clearly identifiable, and readily available public record that is easily accessible.
 - b. Upon receipt of a properly filed simple public information request, OPIR will:
 - 1) work with the Department to classify the request;
 - 2) acknowledge the request; and
 - 3) send the response to the requester within 5 working days of acknowledgment of the request and copy the Department on the response.
 - c. The Department will assist OPIR in fulfilling requests by:
 - 1) retrieving records that are in the sole possession or control of the Department; and
 - 2) advising OPIR whether any confidential material needs to be redacted before the records are provided to the requester.
 - d. If the request was submitted through the OPIR website or email, the response will be sent to the requester by email or secure file transfer.
 - 1) The Department and OPIR may agree with a requester to transmit the response by another method; however, the requester must pay the cost, if any, of the alternate method of transmission before the response is sent.
 - e. If the request was submitted on paper, the response will be mailed unless otherwise instructed. Any mailing or copying costs must be paid in advance by the requester.
6. Complex Public Information Requests
 - a. All requests that are not requests pertaining only to a specified person or property or simple public information requests are considered complex public information requests.
 - b. Unless OPIR and the Department determine that responding to a request is not feasible within 90 days, OPIR and the Department will respond to all complex public information requests within 90 days as follows:
 - 1) Upon receipt of a properly filed complex public information request, OPIR will:
 - a) work with the Department to classify the request;
 - b) acknowledge the request;
 - c) conduct a preliminary search of enterprise systems to assist in estimating the time and effort involved in responding to a request;
 - d) ask the Department to perform an initial search of Department systems and other locations where records may be stored to assist in estimating the time and effort involved in responding to a request;
 - e) collaborate with the Department to:
 - (1) develop an estimate of the time it will take to respond to the request and the cost of collecting and preparing the response; and
 - (2) determine whether further clarification of the request is necessary; and
 - f) prepare and send the cost estimate and requested clarification, if any, to the requester.

- 2) Upon receipt of the estimated cost from the Department and clarification from the requester, if any, OPIR will:
 - a) collect the estimated cost from the requester and instruct the Department to begin its search;
 - b) search enterprise systems to gather responsive records;
 - c) review any responsive records to determine whether a record is confidential or otherwise privileged and redact any such materials, noting the reasons why records are redacted; and
 - d) notify the Department when OPIR has completed search, review, and redaction.
 - 3) Upon receipt of the estimated cost and clarification from the requester, if any, the Department will:
 - a) search Department systems and other locations where records may be stored to gather responsive records;
 - b) review any responsive records to determine whether a record is confidential or otherwise privileged and redact any such materials, noting the reasons why records are redacted; and
 - c) notify OPIR when the Department has completed search, review, and redaction.
 - 4) When both OPIR and the Department have completed search, review, and redaction, they will share their results with each other and review all collected materials to make a final determination regarding which records must be provided in response to the request.
 - a) The final determination will be made by the Department, and the Department will provide OPIR a written explanation of the reasons any records must be withheld as provided in 2-6-1009(1), MCA;
 - 5) OPIR will provide the requester the records determined to be responsive, subject to any withholding or redaction the Department has determined are necessary.
 - a) If records are withheld, OPIR will communicate to the requester the Department's written explanation of the reasons records were withheld.
 - 6) OPIR and the Department of Administration will transfer funds collected from the requester for the Department of Corrections portion of the cost of providing records.
- c. If the Department and OPIR determine 90 days is not feasible for a response, the Department will instruct OPIR to send written notice to the requester:
- 1) that the response requires longer than 90 days; and
 - 2) explain the reasons it may take the Department up to 6 months (from the date of the initial acknowledgment) to provide the Department's response. See 2-6-1006(3)(b)(i)(B), MCA.

D. Estimating Costs and Fees Associated with Requests for Public Information

1. The Department charges a fee for fulfilling all public information requests.
 - a. The fee shall include the cost of the time required to collect information and the actual costs directly incident to fulfilling each request. See 2-6-1006(1)(c), MCA.
2. For complex public information requests, OPIR will prepare and send a written cost estimate to the requester.
 - a. The cost estimate will inform the requester that a request may be closed without further response if the estimated costs are not paid within 30 days.
3. The cost of time spent by the Department and OPIR employees will be computed based on each employee's salary and benefits. Time will be billed in quarter (0.25) hour increments.
 - a. Employees are required to record and report all time and expenses associated with fulfilling public information requests to the Department and OPIR.
4. The estimate shall include the cost of:
 - a. staff member's time to search, identify and gather the potential items in a preliminary search;
 - b. preparing the estimated cost and time for response;

- c. gathering information;
 - d. reviewing information; and
 - e. providing information.
5. If a requester does not agree to pay the estimated cost, the Department is not required to provide information.
 6. A requester will not be billed for the Department's time spent conducting the preliminary search or preparing the cost estimate, unless the requester chooses to refine their request as provided in IV.E below.
 7. OPIR shall notify the requester that:
 - a. payment of the estimated costs must be made prior to the documents being gathered; and
 - b. the final cost of production may exceed the initial estimate invoice and may include legal review fees.
 8. If the costs of fulfilling the request exceed the initial estimate paid, an additional estimate must:
 - a. be provided to the requester; and
 - b. inform the requester that continued work on fulfillment of the information request will cease until the additional fees/cost are paid.
 9. Requesters will have 30 days from the date a cost estimate or revised cost estimate is sent to pay the estimated cost or refine their request as provided in IV.E below.
 - a. If a requester does not pay the estimated cost or refine their request within 30 days, the request will be closed without further response.
 10. The Department and OPIR are not required to alter or customize public information to provide it in a form specifically for the needs of the requesting person.
 - a. If the Department agrees to customize a records request response, the cost of the customization may be included in the fees charged by the Department to the requester.
 11. Upon fulfillment of a request, if the Department or OPIR determine the estimated costs collected from the requester exceed the actual cost of fulfillment, a refund will be issued to the requester.
 12. The Department and OPIR shall not show bias or favoritism in requesting fees and costs from requesters.
 - a. Fees and costs are applicable to all public information requests whether made by a citizen, student, the media, a business, or non-profit or for-profit organization.

E. Refinement and Clarification of a Request

1. OPIR or the Department may ask for more information about a request or request clarification if:
 - a. it is not clear what the requester is seeking,
 - b. the requester has not provided all of the required information necessary to submit a request, or
 - c. the Department cannot perform an information search without additional information.
2. OPIR may request clarification or refinement of a request if:
 - a. it is not clear what the requester is seeking; or
 - b. when OPIR or Department employees have reason to believe the search may produce more than 1,000 results.
3. A person requesting public information may decline a request for clarification.
 - a. If the requester refuses to clarify a request, OPIR or the Department will perform the search to the best of its ability based on the information provided.

- 1) The actual cost of conducting the search must be included in the cost estimate provided to the requester.
4. When OPIR or the Department request more information, clarification, or refinement of a request, the Department's response time is suspended until the requester clarifies, refines, or responds to the request for additional information:
 - a. if the requester does not respond within 30 days, the request will be closed without further action; and
 - b. when requesting additional information, clarification, or refinement, OPIR will notify the requester that the request will be closed without further action if the requester does not respond within 30 days.
5. When OPIR receives additional information, clarification, or refinement, it will conduct a search using the additional information or clarification.
 - a. OPIR and the Department will prepare an estimate as provided in IV.D above and notify the requester.
 - b. The requester may clarify or further refine the request as provided above; however, OPIR and the Department may charge an additional fee for each clarification or refinement.
 - 1) OPIR and the Department may require payment of this fee prior to initiating the clarified or refined search.

F. Confidentiality, Privacy, and Legal Review

1. All materials provided in response to public information requests may be subject to review by the Department or OPIR legal counsel.
 - a. Legal review protects individuals' privacy, ensures compliance with confidentiality requirements, and safeguards individual and facility safety.
2. The "right to know" affords persons the right to examine documents of public bodies or agencies of state government, "except in cases in which the demand of individual privacy clearly exceeds the merits of public disclosure."
3. Judicial decisions have established that agencies must review information before it is produced to determine whether the information should be protected under an individual's right of privacy or another applicable confidentiality provision or privilege.
 - a. Such review and analysis typically requires involvement of legal counsel.
4. The Department and OPIR legal counsel will perform legal review of public information prior to release to determine whether they include "confidential information."
5. Under 2-6-1002(1), MCA, "confidential information" means information that is accorded confidential status or is prohibited from disclosure as provided by applicable law. The term includes information that is:
 - a. constitutionally protected from disclosure because an individual privacy interest clearly exceeds the merits of public disclosure;
 - b. related to judicial deliberations in adversarial proceedings;
 - c. necessary to maintain the security and integrity of secure facilities or information systems owned by or serving the state; and
 - d. designated as confidential by statute or through judicial decisions, findings, or orders.

G. Examination of Records

1. When information is readily available for inspection and copying, the Department may make it available for direct public inspection and examination.
 - a. In such cases, the Department shall protect and maintain the integrity of the original records.
 - b. Department employees must supervise the examination and copying of such records.

H. Fee Schedule

GENERAL CHARGES

Per page (photocopying)	\$0.25 per page + cost of postage
Identifying, gathering, reviewing, redacting, and preparing information for release	Employee hourly wages and benefits x actual time (in ¼ hour increments)
Initial search	Actual cost. If the initial request is not fulfilled, the requester is not obligated to pay the initial search cost.
Second and subsequent searches	\$50. If the request was refined after an initial search, there is a \$50/search fee for each subsequent search.

V. CLOSING

Questions about this policy should be directed to the Department's Communications Director.

VI. REFERENCES

- A. *Mont. Const. Art. II, 9; Mont. Const. Art. II, 10*
- B. §§ 2-6-1002; 2-6-1006, 2-6-1009, MCA



POLICY DIRECTIVE

Policy:	DOC 1.1.21 MOBILE DEVICES IN SECURE FACILITIES	
Effective Date:	12/04/2024	Page 1 of 3
Revision Date(s):		
Signature/Title:	Shane Hildenstab, Acting Public Safety Chief	

I. POLICY

This policy ensures accountability, tracking, and control of mobile devices in secure facilities. The Department recognizes the possible need for and convenience of mobile devices for employees and contractors while in a secure facility; however, the Department also recognizes that there are serious security and safety concerns involved.

II. APPLICABILITY

All employees and contractors in secure facilities are subject to this policy.

III. DEPARTMENT DIRECTIVES

A. General

1. A mobile device includes a cellphone, smartphone, smart watch (on a cellular network), or any device on a cellular network that performs similar functions, whether state-issued or for personal use.
2. The use of mobile devices within secure facilities is prohibited except as provided in this policy. Any mobile device that negatively impacts the security of the facility or staff's performance is not allowed.
3. The use of mobile devices is limited to the area of the secure facility for which the individual was approved.
4. Additional restrictions may be placed on the use of the device in certain areas and at certain times. Authorization can be suspended or revoked at management's discretion.
5. Possession and/or use of any mobile device that is not specifically approved in accordance with this policy will be considered contraband and may result in administrative action, criminal charges, or both.
6. All mobile devices authorized to enter a secure facility must be verified by entrance staff when the devices are brought past any entry point.
7. Staff at off-site duty stations such as hospital duty are allowed to use state-issued cell phones. Personal cell phones are allowed with permission of the shift supervisor. No other mobile devices are allowed.
8. Authorizations are effective for the calendar year in which they were approved.

B. Application

1. Any individual who needs access to a mobile device past any entry point must complete and submit the *DOC 1.1.21 (A) Application to Use Mobile Device in a Secure Facility (Application)*. Each mobile device should be on a separate *Application*.

2. Each *Application* will be reviewed on a case-by-case basis. The signed approval of both the supervisor (or designee) and the Warden (or designee) is required.
3. Approval will be categorized by the following categories. A designated color for each category will be determined by all facilities on an annual basis. Only approved mobile devices are allowed to be retained by an individual during their work shift.
 - a. Administration area only
 - b. Inside compound (includes MCE/Industries and inmate-accessible areas)
 - c. Other
4. Applicants must agree to:
 - a. password protect the device;
 - b. never leave the device unattended;
 - c. not use a disposable, “unlocked,” “jail broken,” or “rooted” device;
 - d. not use a device that does not have a screen lock function;
 - e. not use a device the service provider cannot disable;
 - f. not plug the device into Department computers;
 - g. not take pictures or video of any person or any area inside a secure facility or of the outside of the facility without permission;
 - h. immediately report loss or theft to security staff;
 - i. not hold the Department responsible for any physical damage or loss to the device including but not limited to any content or data;
 - j. accept the risks and potential dangers of bringing a mobile device into a secure facility;
 - k. accept that if a device poses a safety risk or is accessed by an inmate, this may result in the loss of the device either temporarily or permanently;
 - l. limit use to ensure that usage does not interfere with the performance of duties;
 - m. not use mobile devices when inmates are present (including programming, visiting, day room, meals), or during inmate movements, count times, tier checks, etc., unless approval has been given by the Warden or designee;
 - n. not listen to music;
 - o. not make audio recordings;
 - p. not watch movies, sporting events, etc.;
 - q. not allow inmates to use or view images or text on the device; and
 - r. the requirements specified in IV. below.

C. Entry and Exit

1. Upon entry into the secure facility:
 - a. Individuals with an unauthorized mobile device who choose to bring it past any entry point must place the device in a secure receptacle designated for daily storage.
 - 1) Each such individual will be assigned a lockable receptacle.
 - 2) During a break and/or meal break, a staff member may use a mobile device in designated areas.
 - 3) Contractors are only permitted to bring mobile devices into secure facilities if they are necessary for them to perform their contract work as approved by the Warden or designee.
 - b. Individuals carrying authorized mobile devices must carry their approval card and present it to area staff.
2. Individuals must always keep the screen lock function enabled in the mobile device settings when inside the facility.
3. Mobile devices must always be secured with the individual.
4. In the event of loss or theft of a mobile device, the individual must immediately notify security and the shift supervisor or designee, if applicable, and the device must be disabled by the owner or provider.

5. When staff members and contractors leave the facility, they must retrieve their mobile device from the receptacle in which it was placed and return the key, if applicable, to the entrance officer.

IV. AUTHORIZATION TO SEARCH

- A. Approved mobile devices may be subject to search at the direction of the Warden and/or the Public Safety Division Chief.
- B. The Department may require an employee to enroll in and sign a mobile device management agreement for any personal mobile device allowed on a secure facility campus.

V. CLOSING

Questions about this policy should be directed to the Warden at the facility.



POLICY DIRECTIVE

Policy:	DOC 1.2.3 ACCOUNTING PROCESSES
Effective Date:	05/01/1996 Page 1 of 2
Revision Date(s):	07/17/1997; 04/18/2006; 12/15/2008; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

The Department will practice accounting processes in compliance with generally accepted accounting principles; Montana Code Annotated; Administrative Rules of Montana; *Montana Operations Manuals, Volume I and II*; and *Department of Corrections Payroll Procedures Manual*.

II. APPLICABILITY

All Department divisions, facilities, and programs.

III. REQUIREMENTS

A. Accounting Principles

1. The Department will adhere to Accounting Principles and State Accounting Policies as outlined in Sections 17-1-101 through 17-6-512 and 17-8-101 through 17-8-311, MCA, and *Volume II, Chapter 200, Montana Operations Manual (MOM)*.

B. Accounting Structure

1. The Department will utilize the accounting structure outlined in Title 17, MCA, and Volume II, Chapter 200, MOM.

C. Receivables, Collectibles, and Deposits

1. Receivables, collectibles, and deposits will be accounted for as outlined in 17-4-101, MCA, through 17-4-111, MCA; 17-6-101, MCA, through 17-6-512, MCA; and *Volume II, Chapters 1100 and 1200, MOM*.

D. Expenditures and Disbursements

1. Expenditures and disbursements will be accounted for as outlined in 17-8-101, MCA, through 17-8-311, MCA; 17-6-101, MCA through 17-6-512, MCA; and *Volume II, Chapters 1500 and 1600, MOM*.

E. Encumbrances

1. Encumbrances will be accounted for as outlined in 17-7-302, MCA, and 17-7-303, MCA, and *Volume II, Chapter 1300, MOM*.

F. Property Accounting

1. Property accounting will be accounted for as outlined in Sections 2.5.701 through 2.5.801, Administrative Rules of Montana (ARM), and *Volume II, Chapter 1700, MOM*.

G. Investment Accounting

1. Investment accounting will be accounted for as outlined in 17-6-101, MCA through 17-6-512, MCA, and *Volume II, Chapter 1800, MOM*.

H. Employee Travel

1. Employee travel will be accounted for as outlined in 2-18-501, MCA, through 2-18-512, MCA; ARM 2.4.101 through ARM 2.4.202; and *Volume I, Chapter 300, MOM*.
2. Travel expenses will be reimbursed through payroll.
3. Employee travel using State Motor Pool and personal vehicles will be done in compliance with ARM 2.4.112 through ARM 2.4.116 and *Volume I, Chapter 500, MOM*.

I. Payroll

1. Payroll will be accounted for as outlined in 2-18-401, MCA, through 2-18-412, MCA.

J. Long-Term Debt

1. Long-term debt will be accounted for as outlined in *Volume II, Chapter 2200, MOM*.

K. Records Retention

1. Accounting document retention will be accounted for as outlined in *Volume I, Chapter 1-800, MOM*.

IV. CLOSING

Questions about this policy should be directed to Financial Services.

V. REFERENCES

- A. 2-18-401, MCA, through 2-18-412, MCA; 2-18-501, MCA, through 2-18-512, MCA; Title 17, MCA
- B. ARM 2.4.101 through ARM 2.4.202; ARM 2.5.701 through ARM 2.5.801
- C. *Volume I, Chapters 300, 500, 1-0800; Volume II, Chapter 200, 1100 and 1200, 1300, 1500 and 1600, 1700, 1800, 2200; Montana Operations Manual*
- D. *Department of Corrections Payroll Procedures Manual*



POLICY DIRECTIVE

Policy:	DOC 1.2.4 INTERNAL CONTROLS
Effective Date:	12/15/2008 Page 1 of 2
Revision Date(s):	08/14/2020; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

The Department maintains internal control functions that provide management data concerning the adequacy and effectiveness of the Department's internal controls and the quality of operating performance compared to established standards and management expectations.

II. APPLICABILITY

All divisions, facilities, and programs of the Department.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Internal Control Program

1. The internal control program requires written plans and practices to determine whether the Department's network of risk management and control adequately ensures that:
 - a. the Department complies with the *Montana Operations Manual (MOM) 399, Internal Control Guidebook*;
 - b. risks are appropriately identified and addressed through internal control assessments;
 - c. significant financial, managerial, and operating information is accurate, reliable, and timely;
 - d. employee actions comply with policies, procedures, standards, regulations and applicable laws;
 - e. resources are acquired economically, used efficiently, and protected effectively; and
 - f. Department goals, plans, and objectives are clearly defined and identified.
2. The internal control officer will ensure that written documentation of the Department's internal control system of reporting is on file and available for review by agency administrators and auditors.
3. The internal control testing team will assist in the testing effort and report all findings to the internal control officer.
4. The internal control program staff will demonstrate independence and objectivity by:
 - a. providing report findings directly to the Department's management team on an annual basis;
 - b. reporting any conflicts of interest to the internal control officer to provide reasonable assurance of impartial and unbiased assessments; and
 - c. ensuring accountability by removing a staff member from the affected area of review if the staff member's independence or objectivity may be compromised in the performance of duties.

B. Internal Control Evaluation and Monitoring Plan

1. The Evidence-Based Practices Compliance Unit maintains an annual *Internal Control Evaluation and Monitoring Plan* for the Department based upon the following factors:

- a. risk assessments of critical systems;
 - b. reviews of internal, financial, and administrative systems and plans;
 - c. past internal audit experience; and
 - d. review of the risks inherent with the implementation of new processes.
2. The *Internal Control Evaluation and Monitoring Plan* will include:
 - a. an annual risk assessment that uses a flexible testing plan that identifies potential risks;
 - b. a draft report to include, at minimum, objectives, scope conclusions, recommendations, notes of quality performance, and expectations and opportunities for improvement;
 - c. a review of the draft report with the Internal Control Committee at the completion of testing; and
 - d. a corrective action plan that outlines how the internal risks will be corrected.
3. The Internal Control Officer will ensure:
 - a. written documentation of the Department's internal control systems is on file and accessible by agency personnel and auditors;
 - b. the Department's quantitatively and qualitatively material internal control systems are evaluated at least annually or more often as conditions warrant;
 - c. the results of audits and recommendations to improve agency internal controls are promptly evaluated by the Evidence-Based Practices Compliance Unit Supervisor and Internal Control Committee and that appropriate measures are implemented on a timely basis; and
 - d. all action determined by the Department as necessary to correct or otherwise resolve matters will be addressed by the Department.

V. CLOSING

Questions about this policy should be directed to the Evidence-Based Practices Compliance Unit.

VI. REFERENCES

A. *Montana Operations Manual (MOM) 399, Internal Control Guidebook*

VII. FORMS

Overall Internal Control Process and Evaluation Document



POLICY DIRECTIVE

Policy:	DOC 1.2.6 INMATE FINANCIAL TRANSACTIONS	
Effective Date:	05/01/1996	Page 1 of 3
Revision Date(s):	01/11/2012; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department will account for all inmate funds in compliance with generally accepted accounting principles, establish adult inmate non-interest-bearing accounts, and discourage theft and the inappropriate use of cash that may present safety and security concerns within Department and contracted facilities and programs.

II. APPLICABILITY

The secure facilities and programs that include Montana State Prison, Montana Women's Prison, Montana Correctional Enterprises, Riverside, and Pine Hills Youth Correctional Facilities, and contracted facilities, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Financial Disclosure

1. Designated facility staff will require an inmate to complete and sign the *Offender Financial Disclosure* form authorizing Department access to all of the inmate's financial records.
2. Staff will forward the original, completed financial disclosure form to the inmate file and provide copies of the form to Department Investigations and the facility or program accounting unit.
3. If the monies identified on the *Offender Financial Disclosure* form are deposited in the inmate trust account, Financial Services will freeze the funds until notified by the Investigations Bureau that the funds may be disbursed or until an order directing payment of the monies is received from a court.
4. If an inmate refuses to complete and sign the *Offender Financial Disclosure*, facility staff will notify the Investigations Bureau.
 - a. A designated staff member will serve the inmate with a disciplinary infraction report for failure to follow a direct order and refer the inmate to the appropriate Hearings Officer for disciplinary action in accordance with *DOC 3.4.1 Inmate Disciplinary System*.
5. If the Investigations Bureau has probable cause to believe that the inmate has committed an offense outlined in 53-1-108, MCA or 45-7-302, MCA, it should refer the case to the applicable county attorney for possible criminal prosecution.

B. Deposits

1. When an inmate is admitted to a facility, admissions or reception staff will:
 - a. take all monies in the inmate's possession;
 - b. place the money in an envelope;
 - c. ensure it is sealed, dated, and signed by two employees; and
 - d. process the transaction in accordance with the facility or program guidelines.

2. Admissions staff will secure the envelopes with inmate funds in a locked area and take the envelopes to the facility business office as soon as possible but in all cases by the end of the business day in which the monies were received.
3. The business office will deposit all inmate funds no later than the end of the next business day.
4. The facility business office will establish an inmate account in compliance with facility guidelines.
5. Youth facility staff have the option to place youth inmate money in an interest-bearing account if recommended by a caseworker and approved by the facility administrator.
 - a. Principal and interest will be held in trust for the youth in accordance with *3-JTS-IB-20, ACA Standards for Juvenile Correctional Facilities, 2003*.

C. Transactions/Purchases

1. A designated supervisor will approve all inmate account transactions, and the facility business office will enter the transaction on the inmate's account.

D. Deductions

1. The facility accounting unit will make deductions from an inmate's account in accordance with a court order prior to crediting the inmate's trust account.
 - a. However, deductions from an inmate's account must not result in a balance of less than the indigent benchmark.
2. Child Support Orders
 - a. Designated facility staff will maintain child support orders in the inmate's file and ensure the following receive a copy of any child support order:
 - 1) Financial Services;
 - 2) Records; and
 - 3) Montana Correctional Enterprises.
 - b. The Prison Industry Enhancement Certification Programs (PIECP) will ensure that deductions for family support are withheld for the payment of child support orders.
 - 1) The PIECP program will document the amount of income withheld for the payment of child support and provide that information to Financial Services on a monthly basis.
 - 2) If the child support deduction by the PIECP program is not sufficient to satisfy a child support order, Financial Services will deduct from inmate income any further funds necessary to comply with the child support order.
 - c. When an inmate is subject to more than one child support order and there are insufficient funds to satisfy all orders, Financial Services will divide the available funds by the number of child support orders to determine the amount of child support to deduct for each child support order.
3. Financial Services will deduct the appropriate funds from the inmate's account in accordance with the order or directive and this policy.
 - a. If orders or directives are unclear, Financial Services will consult with the Department's Legal Services for clarification.

E. Significant Inmate Financial Transactions

1. When a Department employee becomes aware that an incarcerated inmate has received or is entitled to receive a significant amount of money from any source, the employee will immediately notify the facility administrator and the accounting unit of the facility in which the inmate is housed.

2. The facility administrator, or designee, will prepare a report within 2 business days identifying the monetary obligations.

F. Transfer of Inmate Account Information to Facilities Not Utilizing the Department's Inmate Trust and Commissary System (CACTAS)

1. If an inmate is transferred from one correctional facility to another, inmate account information will be transferred to the accounting unit of the receiving facility within 10 business days. The information will include:
 - a. the inmate's current inmate trust account balance; and
 - b. any obligations owed by the inmate, including:
 - 1) a description of each obligation;
 - 2) the total amount of each obligation;
 - 3) the amount of each obligation that has been paid by the inmate;
 - 4) the remaining balance owed by the inmate for each obligation; and
 - 5) the name and address of the payee, frequency of payment, and other pertinent information necessary for the receiving facility to continue to make payments on behalf of the inmate.
2. If an inmate is released from a correctional facility and placed on supervision in the community, the releasing facility will transmit the information immediately above to the supervising authority.
3. If an inmate is transferred from community supervision to a correctional facility, the supervising authority will transfer the information identified immediately above to the accounting unit of the receiving correctional facility.
4. The receiving facility or supervising authority will ensure that the inmate continues to make the necessary payments to satisfy the inmate's outstanding financial obligations.

G. Statement of Funds

1. Inmate funds will be accounted for in compliance with facility or program requirements. Inmates' account systems will be reconciled at least on a monthly basis.

H. Closing Accounts

1. When an inmate is released from a facility or program, the balance of all monies from that account will be returned to the inmate in compliance with facility or program guidelines.

V. CLOSING

Questions about this policy should be directed to the inmate's facility administrator.

VI. REFERENCES

- A. §§ 45-7-302; 46-18-241; 53-1-107; 53-1-108; 53-1-109, MCA
- B. Policy Number 399, Internal Control Guidebook, Montana Operations Manual (MOM)
- C. 4-4044; ACA Standards for Adult Correctional Facilities, 4th Edition
- D. 3-JTS-1B-18, 3-JTS-1B-19, 3-JTS-1B-20, 3-JTS-1B-21; Standards for Juvenile Correctional Facilities, 2003
- E. DOC 3.4.1 Inmate Disciplinary System; DOC 4.1.4 Indigent Status

VII. FORM

Offender Financial Disclosure



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 1.2.7	Subject: INVENTORIES AND PUBLIC RECORDS MANAGEMENT	
Chapter 1: ADMINISTRATION AND MANAGEMENT	Page 1 of 2	
Section 2: Fiscal Management	Effective Date: May 1, 1996	
Signature: /s/ Loraine Wodnik, Deputy Director	Revised: 11/01/2016	

I. POLICY

The Department of Corrections will conduct inventories, manage capital assets and maintain public records as required by Montana Statutes, Administrative Rules of Montana, and Montana Operations Manual.

II. APPLICABILITY

All Department divisions, facilities, and programs.

III. DEFINITIONS

Capital Assets – Assets of a relatively permanent nature with a useful life of more than one year whose identity does not change with use.

Public Information – Information prepared, owned, used, or retained by any public agency relating to the transaction of official business, regardless of form, except for confidential information that must be protected against public disclosure under applicable law.

Public Record – Public information that is fixed in any medium and is retrievable in usable form for future reference and designated for retention by the state records committee, judicial branch, legislative branch, or local government records committee.

IV. DEPARTMENT DIRECTIVES

A. Inventories

1. The Department will conduct inventories and manage capital assets in accordance with *Montana Operations Manual Policy 335 Capital Assets*.
2. The Business Management Services Division Administrator is the Department's property coordinator.

B. Records Management

1. The Department will maintain public records in accordance with *Title 2, Chapter 6, MCA*.
2. The Business Management Services Division Administrator is the Department's appointed public records manager and is responsible for the functions provided for in 2-6-1103, *MCA*.
3. The public records manager will coordinate with other division administrators to ensure efficient and effective management of public records and public information.

Policy No. DOC 1.2.7	Chapter 1: ADMINISTRATION AND MANAGEMENT	Page 2 of 2
Subject: INVENTORIES AND PUBLIC RECORDS MANAGEMENT		

V. CLOSING

Questions concerning this policy should be directed to the Business Management Services Division Administrator.

VI. REFERENCES

- A. *Title 2, Chapter 6; Montana Code Annotated*
- B. *Montana Operations Manual Policy 335 Capital Assets*

VII. ATTACHMENTS

None



POLICY DIRECTIVE

Policy:	DOC 1.2.8 PROCUREMENT	
Effective Date:	05/01/1996	Page 1 of 2
Revision Date(s):	03/27/2018; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department will administer the procurement of goods and services in accordance with the Montana Procurement Act and *Montana Operations Manual*, ensuring the fair and equitable treatment of all parties involved in the procurement process.

II. APPLICABILITY

All divisions, facilities, and programs.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Purchasing Requirements

1. Division Chiefs will ensure operational processes adhere to the Montana Department of Administration's State Financial Services Division (SFSD) RFP Process.
2. The Department's documentation of purchases will comply with applicable state statutes, the Purchasing Authority Agreement between the Department of Administration and the Department of Corrections, and the *Purchasing Manual*.
3. The Department has several methods for purchasing supplies and services based on the total contract value of the item or service desired.
 - a. A description of each method is located in the *Purchasing Manual* and the *Purchasing Cardholder Standard Operations Procedure Guide*.
4. Procurement documents will clearly indicate the evaluation methodology that will be used to determine the contract award. Evaluations may include:
 - a. physical testing of products;
 - b. review of manufacturer's literature;
 - c. mathematical calculations using vendor pricing and identified usage data; or
 - d. any other form of evaluation that serves the Department's best interests and is specifically identified in the procurement document.
5. Special purchase authorization may be granted through an agreement between the Department of Administration and the Department of Corrections.
6. If a contractor may use state-owned property or resources, the Department will state in the procurement document that such property or resource is available for the contractor's use.

B. Request for Proposal (RFP) Evaluation Committees

1. An evaluation committee will provide a fair and unbiased evaluation of all RFP offers in accordance with the criteria established in the RFP document and will recommend contract award to the most responsible and responsive offeror.

2. To ensure there is no perception that the evaluation committee was formed to favor a particular offeror, the evaluation committee will be formed prior to the date set for receipt of proposals.
3. The evaluation committee may include individuals with knowledge or expertise of the goods or services requested in the RFP.
 - a. If necessary, the evaluation committee may consult with other staff or experts regarding technical or specialized aspects of the RFP.
4. Only evaluation committee members may deliberate and participate in the evaluation process to recommend a contract award.
5. Evaluation committee members are required to sign a *Non-Conflict of Interest* statement prior to serving on an evaluation committee.
 - a. Individuals who have a known or perceived possible conflict of interest with any potential offeror should not serve on the evaluation committee.
6. Responsibilities of evaluation committee members include the following:
 - a. maintaining knowledge of RFP requirements prior to the evaluation process;
 - b. adherence to evaluation criteria set forth in the RFP;
 - c. maintaining a professional manner at all times;
 - d. remaining objective, impartial, unbiased, and fair in all aspects of the evaluation process;
 - e. attending all evaluation committee meetings and vendor presentations;
 - f. referring all vendor and public inquiries related to the submission and/or evaluation of proposals to the purchasing agent or procurement officer responsible for the RFP;
 - g. immediately contacting the assigned purchasing agent or procurement officer if any real or perceived conflict of interest develops during the evaluation process;
 - h. refraining from direct contact with an offeror during the RFP evaluation process unless absolutely required by job duties or functions; and
 - i. recommending contract award.

C. Controlled Purchases

1. The SFSD retains control of specific purchases known as controlled items. Controlled items may be obtained through SFSD in the following ways:
 - a. requisition time schedule;
 - b. exclusive or non-exclusive term contracts;
 - c. Montana Acquisition and Contracting System (eMACS);
 - d. printing;
 - e. vehicles; or
 - f. cooperative purchasing.
2. Purchases of cell service, computer hardware and software, telecommunications systems, and photocopiers require specific approval and/or assistance by designated individuals or programs.
3. Supplies and services purchased outside standard procedures due to unique requirements or unusual circumstances are provided an exception and may require additional justification and documentation as provided in ARM 2.5.301 and 18-4-132, MCA.

V. CLOSING

Questions about this policy should be directed to Finance Services, the Department Purchasing Agent, or the facility procurement officer.

VI. REFERENCES

- A. *Title 18, Chapter 4, MCA; 53-1-203, MCA; ARM 2.5.101 through 2.5.801*
- B. *Purchasing Authority Delegation Agreement between the Departments of Administration and Corrections*
- C. *Montana Operations Manual, Chapter 1-0700*



POLICY DIRECTIVE

Policy:	DOC 1.2.9 CONTRACTS
Effective Date:	05/01/1996 Page 1 of 4
Revision Date(s):	12/15/2011; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

The Department will administer all contracts in compliance with Montana Code Annotated, Administrative Rules of Montana, the Department of Administration *Risk Management Policies and Procedures Manual and Procurement Delegation Agreement*, and the Department of Corrections *Contracting and Purchasing Procedures Manual*.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Procurement and Contracts will:
 - a. administer the routing and approval process of all contracts for services with a total contract value over \$5,000 and all MOUs, Letters of Agreement, inter-agency agreements, and inter-governmental agreements regardless of dollar amount;
 - b. maintain a centralized database of all Department contracts identified herein; and
 - c. facilitate an effective contract management process intended to minimize risk and liability and maximize efficiency.
2. Contract Definition:
 - a. A written or verbal agreement between a Department of Corrections facility/program/division and any other governmental, public, or private entity for the procurement of goods or services of any type.
 - b. The term includes:
 - 1) all written or verbal agreements;
 - 2) leases;
 - 3) Memorandums of Understanding (MOU);
 - 4) letters of agreement;
 - 5) mutual aid agreements between the Department and other state or local government entities that define the safety and security roles of all parties in the event of an incident requiring assistance from the other governmental entities; and
 - 6) subsequent amendments of said documents, regardless of whether there is any Department financial obligation.
 - c. The term does not include:
 - 1) hardware/software maintenance agreements;
 - 2) Service Level Agreements (SLA) with the Department of Administration;
 - 3) service agreements for office machines or telephone systems;
 - 4) software licensing agreements;
 - 5) revenue generating agreements; or
 - 6) purchase orders issued in accordance with the procurement delegation agreement.

B. New Contracts

1. Each facility/program/division (F/P/D) that requires a contract for services with a total contract value over \$5,000 must submit a *Contract Justification* to Procurement and Contracts well in advance of the requested contract start date.
2. Procurement and Contracts will:
 - a. work with the requesting party to draft a document that will comply with all applicable state laws and rules to meet the F/P/D needs;
 - b. assign each contract a number unique to the F/P/D;
 - c. maintain the original contract and provide a copy to the F/P/D and the contract holder;
 - d. route each contract request to the appropriate unit (for example, Budget, Accounting, Information Technology, etc.) for approval;
 - e. submit the final contract to the designated Department attorney for legal review, approval, and attorney signature; and
 - f. acquire appropriate signatures on the final, approved contract.

C. Revenue Generating Contracts

1. Each F/P/D that requires a Revenue Generating Contract, regardless of the amount, will:
 - a. draft a document that complies with all applicable laws and rules, meets the F/P/D needs, and includes a description of the service or product to be provided;
 - b. assign a revenue contract number unique to the F/P/D;
 - c. route the original contract for legal review, approval, and attorney signature, if needed;
 - d. acquire appropriate signatures on the final approved contract; and
 - e. maintain the original contract and provide a copy to Procurement and Contracts.

D. Amendments

1. All requests for contract amendments, including renewals and extensions, will be submitted to Procurement and Contracts for processing and must include a *Contract Justification* and/or *Annual Evaluation of Contractor Performance*.
2. All requests for amendments should be submitted to Procurement and Contracts well in advance of the requested or required effective date of the amendment.

E. Purchases

1. Procurement and Contracts will administer all Department purchases of goods and services, respectively, pursuant to this policy and *DOC 1.2.8 Procurement*.

F. Delegation of Contracting Authority

1. Procurement and Contracts may, on a case-by-case basis, delegate specific contracting authority to the F/P/D for contracts with a total contract value over \$5,000.
2. The F/P/D may request additional delegated contract authority.
3. The F/P/D will submit a written request to Procurement and Contracts for each contract, or type of contract, for which it seeks delegation.
4. The approval of Procurement and Contracts must be in writing and may require additional approval by another state agency.

G. Delegation

1. The F/P/D may directly enter into contracts (except those specifically excluded herein) with a total contract value of less than \$5,000 at the discretion of the facility administrator.

- a. These contracts must follow Department format and comply with Title 18, MCA, and ARM 2.5.101 through 2.5.801, and do not require review or approval from Procurement and Contracts.
- b. The F/P/D must maintain a contract log, contract copies on-site, and provide Procurement and Contracts with a signed copy of each contract within 30 days of the contract start date.

H. Contract Liaison

1. Generally, the administrator (or contract signatory) is ultimately responsible for managing contracts from the beginning to the end of the contract cycle.
2. The designated contract liaison:
 - a. serves as the primary contact person for all communications between the Department and the contractor; and
 - b. typically, provides the principal contract management and monitoring function, unless the administrator and contract liaison otherwise agree.
 - 1) oversees day-to-day operations and provision of services by the contractor;
 - 2) determines necessary contract changes and notifies Procurement and Contracts of requested changes;
 - 3) negotiates contract terms, scope of service, and compensation;
 - 4) reviews invoiced services (per contract) and approves for payment, as appropriate;
 - 5) monitors contracts to ensure contractor compliance with contract terms;
 - 6) evaluates contractor performance (annually) or more often, as necessary;
 - 7) submits *Contract Justification* for new contracts or renewal of existing contracts;
 - 8) submits quarterly contract reports; and
 - 9) submits annual contractor performance evaluation reports.

I. Monitoring Contracted Services

1. A critical part of the contract monitoring process is the selection of an appropriate individual.
 - a. The administrator should select a contract liaison and/or contract monitor based on the individual's knowledge, skills, and abilities to effectively carry out the responsibilities of the position.
2. Responsibilities of the Contract Monitor:
 - a. be intimately familiar with and fully understand the contract language, including the specific contract obligations, and determine the performance indicators by which performance will be monitored;
 - b. determine the methods to be used to measure and track contractor performance and levels of performance acceptable to the F/P/D;
 - c. assess the risks related to the project before contracting for services to determine the extent of monitoring appropriate to the contract;
 - d. ensure the contractor has a clear understanding of how the contract will be managed and monitored;
 - e. provide the contractor with guidance and technical assistance, as needed, to promote effective contract performance;
 - f. monitor the contractor's activities through a variety of means to ensure quality service delivery;
 - g. resolve issues or problems that arise during the contract;
 - h. identify potential contract inefficiencies and risks that, if eliminated, would result in a cost savings to the Department;
 - i. review invoices and verify that the Department is being billed in accordance with the contract terms and that the billed services were provided;
 - j. notify the contractor of discrepancies in billing and contract compliance issues;
 - k. share contractor performance information with appropriate Department staff;

- l. document all contract monitoring activities to validate consistent and effective contract management; and
- m. submit an *Annual Evaluation of Contractor Performance* to Procurement and Contracts, annually, and prior to renewal of an existing contract.

J. Evaluation of Contractor Performance

1. Administrators shall ensure that the performance of all contracted service providers is evaluated prior to entering into contract negotiations and prior to requesting renewal of a contract, but not less than annually.
2. The *Annual Evaluation of Contractor Performance* shall be documented using the forms designated by Procurement and Contracts.
3. Contracts will not be renewed with contractors with an overall evaluation rating of less than "satisfactory," as determined by an assessment of the evaluation of the ratings provided on the *Annual Evaluation of Contractor Performance*.
4. Documentation of contractor performance shall be kept by the contract liaison or monitor in a designated contract file and shall include, at minimum:
 - a. a copy of the contract, as amended;
 - b. invoices;
 - c. memos to contractor;
 - d. a log of discussions with contractor;
 - e. actions taken by the contractor;
 - f. reports; and
 - g. other documents necessary to support contract monitoring activities.

K. Quarterly Contract Reporting

1. Contract liaisons shall submit quarterly contract reports to Procurement and Contracts using the authorized reporting form.
2. Reports shall be submitted by the time and date identified by Procurement and Contracts.
3. Quarterly contract reports are not required for the contract types specifically excluded in the "Contract" definition.

L. Contract Compliance

1. The Director and each Warden and Division Chief are responsible for ensuring Department compliance with contracting requirements.

V. CLOSING

Questions about this policy should be directed to Financial Services.

VI. REFERENCES

- A. 2-15-112, MCA; 3-1-203, MCA; 53-30-132, MCA; 53-30-133, MCA; Title 18, Title 28, MCA
- B. ARM Title 2, Chapter 5
- C. DOC 1.2.8 Procurement
- D. Procurement Delegation Agreement, Department of Administration

VII. FORMS

Annual Evaluation of Contractor Performance
Contract Justification



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 1.2.10	Subject: COMMISSARY/CANTEEN
Chapter 1: ADMINISTRATION AND MANAGEMENT	Page 1 of 1
Section 2: Fiscal Management	Effective Date: May 1, 1996
Signature: /s/ Mike Ferriter, Director	Revised: 04/18/06

I. POLICY

The Department of Corrections must authorize the establishment of commissary/canteen operations in Department and contracted facilities.

II. APPLICABILITY

Department and contracted facilities with canteen operations.

III. DEFINITIONS

Commissary/Canteen – An on-site outlet where offenders may purchase an assortment of personal need items and snack foods that have been approved by facility management.

IV. DEPARTMENT DIRECTIVES

A. Commissary/Canteen Operations

1. Commissary/canteen operations will be conducted by Department or contracted facilities in compliance with generally accepted accounting principles, Department policy and facility operational procedures, and the Purchasing Authority Agreement between the Department of Corrections and the Department of Administration.
2. Department and contracted facility commissary/canteen will be consistent and uniform with respect to the individual needs of each facility.

V. CLOSING

Questions concerning this policy should be directed to the facility or program administrator.

VI. REFERENCES

- A. [53-1-203](#), MCA (2009) *Powers and Duties of Department of Corrections*
- B. *Purchasing Authority Agreement C-94-06*

VII. ATTACHMENTS

None.



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy:	DOC 1.2.12 INMATE WELFARE ACCOUNTS
Chapter 1:	ADMINISTRATION AND MANAGEMENT
Section 2:	Fiscal Management
Effective Date:	May 1, 1996 Page 1 of 4 and Attachments
Last Revised:	August 29, 2023
Next Review:	August 29, 2024
Signature:	/s/ Brian Gootkin, Director

I. POLICY

The Department of Corrections will establish, maintain, and manage an inmate welfare account to enhance programs and services that directly impact inmates in secure facilities; funds may be allocated as release assistance to appropriate inmates. Accounts and revenues will be managed in compliance with generally accepted accounting principles and a system of checks and balances.

II. APPLICABILITY

All secure care facilities, Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Canteen Revenues – Net profits generated from the sale of canteen items at Department and contracted facilities.

Chief Financial Officer – The Chief Financial Officer (CFO) of the Department of Corrections.

Contraband – Any item possessed by an offender or found within the facility that is illegal by law, prohibited by policy or procedure, or unauthorized by those legally charged with the administration and operation of the facility.

Inmate Representatives – Inmates approved by the facility administrator to represent the offender population.

Indigent Status – The status applied to an offender whose previous month's and current financial activity indicates that he or she has insufficient funds to purchase hygiene or legal supplies from the facility canteen.

Miscellaneous Revenues – Revenue generated from food sales and cash proceeds from the sale of confiscated contraband.

Offender Organization – An organization recognized and approved by the facility administration as outlined in *DOC Policy 5.5.2, Offender Organizations*.

Policy No. DOC 1.2.12	Chapter 1: Administration and Management	Page 2 of 4
Subject: INMATE WELFARE ACCOUNTS		

IV. DEPARTMENT DIRECTIVES

A. Inmate Welfare Funds and Accounting

1. There is an inmate welfare (IWF) account in the state special revenue fund. IWF funds are utilized for the needs of inmates within secure facilities and may assist the release of inmates into the community.
2. The following monies will be deposited in the IWF:
 - a. donations by individuals, organizations, or community groups, excluding inmate donations and donations from inmate families;
 - b. public money held for the needs of inmates that has not been allocated elsewhere; and
 - c. revenues generated from the following:
 - 1) commissions from inmate telephone usage;
 - 2) food sales and cash proceeds from the sale of appropriate confiscated contraband pursuant to *53-1-105, MCA*; and
 - 3) sale of canteen items at Department and contracted facilities.
3. Each facility administrator, or designee, must submit the Inmate Welfare Estimated Budget Worksheet by May 31st of each calendar year to the Chief Financial Officer to outline prospective IWF revenues and expenditures; the budget should be developed with the input of inmate representatives.
4. Facility administrators, or designees, must meet with inmate representatives monthly to discuss IWF monies and to document expenditures and deposits of IWF monies. The Department's Financial Services Bureau will provide receipts for IWF monies deposited.
5. A Department budget analyst will provide a monthly report to facility administrators and recognized inmate representatives detailing income and expenditures.

B. General Requirements for the use of IWF Funds

1. IWF Funds are utilized for the needs of inmates and inmate's families including, but not limited to the following expenses:
 - a. purchase of facility-based services, supplies or equipment, fixtures for visiting rooms, inmate TV programming, or other inmate activities approved by a facility administrator, or designee, including educational or library materials that benefit multiple inmates;
 - b. pay for inmate representatives in the amount of one (1) dollar per day, up to five (5) days a week; and
 - c. pay for inmate assignments in accordance with *DOC Policy 5.1.1 Inmate Assignments*.
2. IWF funds may not be used to provide services, supplies, or equipment that the Department or facility is obligated to provide for the health, welfare, security of inmates, or the general operation of a prison.
4. Inmate organizations must submit a request for monies to the facility administrator who,

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Subject: INMATE WELFARE ACCOUNTS		

prior to approving the use of money from the facility budget or submitting a request for use of IWF funds outside of the facility budget, must complete a Request for IWF Funding.

5. The facility administrator, or designee, may approve funding requests for less than \$2,499 that are included in the approved facility budget. The facility administrator, or designee, must present requests for expenditures exceeding \$2,499, and any requests not included in the facility budget to the CFO or designee with the completed Request for IWF Funding. The CFO will review the purchase request for allowability within IWF policy, and availability of funds. The CFO or designee will approve or deny the request.

C. Use of IWF funds for Release Assistance or Travel Assistance

1. An inmate may be provided financial assistance from the IWF based on the inmate's release plan, projected financial needs, and financial status. Release assistance funds may not exceed \$500 and must be provided directly to an appropriate housing owner, treatment provider, or other verified service provider.
2. Decisions regarding release assistance will be determined in accordance with *DOC 1.2.12(A) IWF Fund Release Assistance Operations Procedure Guide* and based upon IWF monies available. Release assistance may be used for the following needs of inmates:
 - a. housing costs, i.e. initial rent payment, deposit, or temporary lodging;
 - b. aftercare treatment with approved providers; and
 - c. continuation of prescription medication.
3. Inmates may request transportation costs upon discharge and release by filling out the IWF Request for Release Transportation. Funding received through other release assistance will not be considered when determining qualification. An inmate must request these funds through an IPPO or case manager.
4. Inmates applying for release assistance must complete and submit the Inmate Release Assistance form to the appropriate case manager, supervising probation and parole officer, or member of the unit team, as applicable, at least 45 days prior to release and comply with all other provisions provide in *DOC 1.2.12(A) IWF Release Assistance Operations Procedure Guide*. In exceptional incidences, and approved on a case-by-case basis, inmates may request the use of release assistance after the inmate is released, but before the 31st day after the inmate's actual release.
5. To be eligible for release assistance inmates must meet the following general requirements:
 - a. maintained inmate status in a facility that contributes to the IWF for a minimum of 8 consecutive months;
 - b. completed, or in the process of completing, programming ordered by the court or the Board of Pardons and Parole (BOPP);
 - c. completed, or in the process of completing, a high school equivalency certificate or received a high school diploma unless determined exempt by the facility administrator, or designee;

Policy No. DOC 1.2.12	Chapter 1: Administration and Management	Page 4 of 4
Subject: INMATE WELFARE ACCOUNTS		

- d. inmate must be assigned to an inmate assignment unless determined exempt by the facility administrator, or designee;
 - e. maintained a minimum of six (6) months conduct without a major rule infraction unless determined exempt by the facility administrator, or designee;
 - f. inmate must not have received release assistance within the last five (5) years; and
 - g. inmate may not have transferred more than \$500 out of inmate's account for unapproved allocations within the previous 12 months.
6. Requests may be made to the IWF to pay for travel expenses for funeral or sick bed visits. Costs associated with travel expenses for funeral or sick bed visits up to \$400 are allowed in accordance with *DOC Policy 3.1.30, Offender Escorted Leave*;

V. CLOSING

Questions concerning this policy should be directed to the facility administrator, or designee.

VI. REFERENCES

- A. 17-7-502, MCA; 53-1-105, MCA; 53-1-109, MCA; 53-1-203, MCA; 53-30-101, MCA
- B. 4-4031, 4-4044, *ACA Standards for Adult Correctional Institutions*, 4th Edition
- C. *DOC Policies 3.1.17 Searches and Contraband Control; 3.1.30 Offender Escorted Leave; 4.1.4 Indigent Status; 5.5.2 Offender Organizations*
- D. *DOC 1.2.12(A) Global Fund Release Assistance Operations Procedure Guide*

VII. ATTACHMENTS

- A. Request for IWF Funding
- B. Inmate Welfare Estimated Budget Worksheet



State of Montana
DEPARTMENT OF CORRECTIONS
INMATE WELFARE ESTIMATED BUDGET WORKSHEET
FACILITY: _____
FISCAL YEAR: _____

Personal Services

	COST
Salaries/Hourly Wages	\$ -
Employee Benefits	\$ -

Other Services

	COST
Professional Services	\$ -
Printing	\$ -
(Enter new item)	\$ -
(Enter new item)	\$ -

Supplies & Materials

	COST
Athletic/Recreational	\$ -
Clothing	\$ -
Educational	\$ -
Food	\$ -
Books/Reference Materials	\$ -
Minor Equipment	\$ -
(Enter new item)	\$ -
(Enter new item)	\$ -

Communications

	COST
Mail	\$ -
Telephone	\$ -
(Enter new item)	\$ -
(Enter new item)	\$ -

Travel

	COST
Lodging	\$ -
Meals	\$ -
Separation Allowance	\$ -
(Enter new item)	\$ -
(Enter new item)	\$ -

Rent

	COST
Non Office Equipment	\$ -
(Enter new item)	\$ -

Other Expenses

	COST
Dues	\$ -
Subscriptions	\$ -
Separation Allowance	\$ -
Licenses	\$ -
(Enter new item)	\$ -
(Enter new item)	\$ -

Equipment

Equipment	\$ -
(Enter new item)	\$ -

Total Budget Requested:

\$ -

Sufficient Funding Available:

YES: _____ NO: _____

Verified by:

DOC Budget Analyst

Date:

Approved by :

CFO or

Date:

Submitted by:

Facility

Date:

Inmate Representative

Inmate Representative



State of Montana
DEPARTMENT OF CORRECTIONS
REQUEST FOR IWF FUNDING

Item/Service Requested: _____

Facility: _____

Justification (why is this allowable under IWF):

Amount Requested \$	_____	Annual	\$	_____
		Monthly	\$	_____
		One Time	\$	_____
		Total	\$	_____

*Is this expense included in the approved annual IWF budget for your facility?

☐ Yes – only the Facility Administrator Signature is required below

*Signature indicates that Facility Administrator has verified compliance with the approved Facility Budget

☐ No – approval from the Inmate Representative and CFO is required

Facility Administrator _____ Date _____

IWF Representative _____ Date _____

MSP Only: Lowside Representative _____ Date _____

Highside Representative _____ Date _____

CFO _____ Date _____

*Requests for IWF funds exceeding \$2,499 or outside the original budget approved must be forwarded to the CFO for approval.

Procedure No. DOC 1.2.12A	Effective Date: 10/28/2013	Revised: 08/19/2016
Signature: /s/ Pat Schlauch		Position Title: Administrator, BMS



GLOBAL FUND RELEASE ASSISTANCE OPERATIONS PROCEDURE GUIDE

APPLICABILITY

All adult secure facilities Department-owned and contracted, as specified in the contract.

GLOBAL FUND OPERATIONS PROCEDURE GUIDE

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I. Introduction to Inmate Welfare Account's Global Fund

A. Inmate Welfare Account

The Department of Corrections (Department) will establish, maintain, and manage inmate welfare accounts to enhance programs and services that directly affect inmates in secure facilities; funds may be allocated as release assistance to appropriate inmates. Accounts and revenues will be managed in compliance with generally accepted accounting principles and a system of checks and balances.

The following monies will be deposited in the IWF:

- a. donations by individuals, organizations, or community groups, excluding inmate donations and donations from inmate families;
- b. public money held for the needs of inmates that has not been allocated elsewhere; and
- c. revenues generated from the following:
 - 1) inmate collect calls and calling card sales;
 - 2) food sales and cash proceeds from the sale of appropriate confiscated contraband pursuant to 53-1-105, MCA; and
 - 3) the sale of canteen items at Department and contracted facilities.

B. Inmate Welfare Account's Global Fund

The Global Fund is comprised of pooled annual contributions of inmate welfare accounts from each secure facility based on inmate population and funds available; funds will be used to provide release assistance to eligible inmates upon discharge, parole, or furlough and may be used as financial assistance to facilities for implementation of projects that benefit inmates directly.

Inmates may review Global Fund contributions through the annual budget process and inmate representatives may be provided monthly financial reports.

C. Release Assistance at a Glance

After extended periods of incarceration many inmates reaching the end of their confinement struggle to afford housing upon release, continue to pay for needed medication, or to cover the costs of treatment programs required as a condition of parole by the Board of Pardons and Parole (BOPP). As a result of these financial difficulties large proportions of inmates released from incarceration return to confinement within three years. In an effort to mitigate these restraints, and achieve the mission of the Department, the Department administers release assistance funds to eligible inmates from the IWF.

Inmates that meet the criteria below are eligible to receive release assistance up to \$500 out of the Global Fund of the Inmate Welfare Account. Release assistance will only be paid from the Department and directly to the approved vender. The vendor must fill out a W-9 tax form and/or have a proper and appropriate Tax Identification Number (TIN). Release assistance funds may be used for:

- a. rent or housing costs, under the guidelines provided below;
- b. continuation of medication and/or medical supplies; and

- c. treatment and/or programming.

The use of global funds for rent or housing costs will only be provided to bona fide landlords. To be considered a landlord the person or entity must rent a room or a housing unit that may be available to any person as deemed appropriate under generally accepted rental practices. The renting of a room or space in an immediate family member's home is not considered a legitimate landlord/tenant agreement and the use of global funds will not be permitted without the express written approval from the facility warden or administrator. The use of regionally appropriate Probation and Parole officers may be required to determine landlord and rental status.

E. Release Transportation Costs

Inmates may request transportation costs upon discharge and release by filling out the [Global Fund Request for Release Transportation](#). Funding received through other release assistance will not be considered when determining qualification. An inmate must request these funds through an IPPO or case manager.

II. Global Fund Release Assistance Process

A. Responsibility of the Case Manager

The case manager will receive the request for release assistance from the Global Fund by the inmate at least 45 days in advance of the inmate's discharge or release; exceptions may be granted for short notice releases granted by the BOPP, to include parole, furloughs, and ISP. In exceptional incidences, and approved on a case-by-case basis, inmates may request the use of release assistance after the inmate is released, but before the 31st day after the inmate's actual release from custody.

The case manager will initiate the preliminary screen for inmate eligibility for release assistance, [Inmate Release Assistance](#) form. The screen for eligibility includes the following seven (7) mandatory screening criteria.

1. Has the inmate remained incarcerated at a secure facility for at least 12 months prior to the issuance of release assistance?

If the inmate has not been incarcerated at MSP, MWP, Crossroads Correctional Center, Dawson County Regional Prison, or Cascade County Regional Prison for 12 continuous and consecutive months they are not eligible for release assistance.

2. Did the inmate previously receive release assistance within the past five (5) years?

If the inmate received release assistance at any time within the previous five years of the date the current release assistance would be allocated, the inmate is not eligible to receive release assistance.

3. Has the inmate completed or in the process of completing all programming required by the DOC, the sentencing court, or the BOPP?

If the inmate is on the waiting list, but not currently enrolled in programming, this will qualify as compliant and will not deter eligibility for release assistance.

4. Does the inmate have any major conduct violations within the previous six (6) months of the issue date for release assistance?

A major rule infraction within the preceding six months of receiving release assistance will disqualify an inmate from eligibility.

The case manager or IPPO may consider the nature of the infraction and the disciplinary history of the inmate to grant objections to this requirement.

The inmate may request a review of the case manager decision to the facility administrator, or designee, by checking the box provided on the [Inmate Release Assistance](#).

The administrator, or designee, will respond to the review request normally within 10 business days. The decision is final and exhausts the review process.

5. Does the inmate have, or has the inmate had a job assignment for a majority of their incarceration?

Inmates are required to work and contribute to receive release assistance. Inmates may be exempt from this requirement due to an Americans with Disabilities Act (ADA) accommodation, or for other approved reasons on a case-by-case basis.

The inmate may request a review of the case manager decision to the facility administrator, or designee, by checking the box provided on the [Inmate Release Assistance](#).

The administrator, or designee, will respond to the review request normally within 10 business days. The decision is final and exhausts the review process.

6. Does the inmate have a high school equivalency certificate, in the process of completing a high school equivalency program, enrolled and waiting for a high school equivalency program, or has a high school diploma?

Inmates are required to be at least enrolled and waiting to receive a high school equivalency certificate unless previously ruled exempt by the facility administrator, or designee, to qualify for release assistance.

If not exempt and the inmate does not qualify under the requirement the inmate may attempt to become exempt by petitioning the facility administrator, or designee; this is not reviewable through the inmate release assistance application process.

7. Has the inmate transferred \$500 or more out of the inmate's account within the 12 previous months of the release assistance date?

This is to exclude funds used to purchase items at the facility including, but not limited to, canteen, phone cards, and hobby items.

This money excludes funds used to cover restitution and court ordered fines and fees.

Inmate accounts may be required to review the inmate account during the initial investigation to determine inmate eligibility for release assistance.

The IPPO may complete this process in place of the case manager when appropriate or needed.

If the initial screen for inmate release assistance is approved the case manager will begin working with the inmate and the inmate's parole plan to identify amount(s) needed and the vendor(s) that will receive release assistance.

The case manager will then forward the release assistance application to the IPPO for continuation in the process.

B. Responsibility of Institutional Probation and Parole Officer (IPPO)

The IPPO will work with the eligible inmate to identify vendors to receive the release assistance if the case manager did not complete this process.

It is the responsibility of the IPPO to approve all identified vendors.

If release assistance is for housing, the IPPO will contact local probation and parole officers located in the area and region of the proposed housing location; local officers will check the residence and determine if it is suitable for habitation by the inmate upon release and if the residence meets the requirements for appropriate use of Release Assistance. If the location is not approved the IPPO and the inmate will determine a different suitable location and the probation and parole officer will again investigate the location in order to determine the locations appropriateness for habitation and rehabilitation.

If release assistance is used to continue medication or medical supplies, the IPPO will work with medical staff to determine medication needs, vendors, and cost.

The IPPO will use the parole plan and the release conditions by the BOPP to determine appropriate treatment and program vendors if release assistance is used for treatment or programming as directed by the BOPP; or when the inmate desires to pursue treatment services independently.

After the vendor(s) have been identified and approved the IPPO will forward the application for inmate release assistance to the applicable budget analyst usually within 10 days of the release date. The IPPO will route copies of the form to all applicable divisions noted at the bottom of the Application for Release Assistance form.

C. Responsibility of the Budget Analyst

The budget analyst will forward all necessary paper work to the accounting bureau so a warrant(s) may be issued and sent to the approved vendor(s).

The budget analyst will record all approved request and reconcile monthly with the State Accounting Budget Human Resource System (SABHRS). The budget analyst will provide each facility a copy of the SABHRS release assistance report monthly.

The budget analyst will record each use of funds and report the usage of funds at each PIB meeting along with all other necessary documents to facility administrators. The budget analyst will also provide facility administrators IWF fiscal data for use in the annual budget process.

D. Responsibility of the Accounting Bureau

A representative of the accounting bureau may be requested to review inmate account history to verify if the inmate initially qualifies for release assistance.

After the accounting bureau receives the release assistance paper work from the budget analyst, they will begin the process of issuing the warrant(s)

The accounting bureau will send the warrant(s) directly to the approved vendor(s) and notify the case manager, IPPO, and budget analyst when the warrant(s) are mailed out.

III. Duties of the Facility Administrator, or Designee

A. Review Process

The facility administrator, or designee, will have final authority to approve inmate release assistance in situations that the inmate requests a review of the case manager or IPPO's decision to deny release assistance because of misconduct violations or inmate work inadequacies.

The facility administrator, or designee, may not review a denial of release assistance because the length of incarceration was less than 12 consecutive months, payment of release assistance was provided within the previous five (5) years, or because an inmate transferred more than \$500 out of the inmate account for unapproved allocations during the previous 12-month period.

IV. References

- A. 17-7-502, MCA; 53-1-105, MCA; 53-1-109, MCA; 53-1-203, MCA; 53-30-101, MCA
- B. DOC Policy 1.2.12 Inmate Welfare Account

V. Definitions

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Adult Secure Facilities – Department and contract facilities to include Montana State Prison, Montana Women's Prison, Crossroads Correctional Facility, Dawson County Correctional Facility, and Cascade County Correctional Facility.

Canteen Revenues – Net profits generated from the sale of canteen items at Department and contracted facilities.

Contraband – Any item possessed by an offender or found within the facility that is illegal by law, prohibited by policy or procedure, or unauthorized by those legally charged with the administration and operation of the facility.

Facility Fund – Funds within an inmate welfare account, reviewed by inmates and utilized for the needs of inmates and inmate's families within a Department-owned or contracted facility.

Global Funds – Pooled annual contributions of inmate welfare accounts from each secure facility based on inmate population and funds available; funds will be used to provide release assistance to eligible inmates upon discharge, parole, or furlough and may be used as financial assistance to facilities for implementation of projects that benefit inmates directly and are reviewed by inmate representatives.

Inmate Representatives – Inmates approved by the facility administrator to represent the offender population.

Miscellaneous Revenues - Revenue generated from food sales and cash proceeds from the sale of confiscated contraband.

Prison Issues Board – Administrators and staff from Department and contracted facilities and prisons who meet to discuss and coordinate the policy and operational functions of the facilities.

Telephone Revenues - Proceeds generated from offender collect calls and calling card sales.

VI. Attachments

- A. [Global Fund Request for Release Transportation](#)
- B. [Request for IWF Funding](#)
- C. [Inmate Welfare Estimated Budget Worksheet](#)
- D. [Inmate Release Assistance](#)



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 1.2.13	Subject: NON-TREASURY CASH ACCOUNTS
Chapter 1: ADMINISTRATION AND MANAGEMENT	Page 1 of 2
Section 2: Fiscal Management	Effective Date: May 1, 1996
Signature: /s/ Mike Batista, Director	Revised: 02/11/2015

I. POLICY

The Department of Corrections will maintain Non-treasury Cash Accounts in compliance with the Montana Operations Manual.

II. APPLICABILITY

All divisions, facilities, and programs Department owned and contracted as specified in contract.

III. DEFINITIONS

Cash Change Account – An account consisting of monies withdrawn from a treasury account used to provide coin and currency needed to conduct cashiering or similar operations. This account is never used to make purchases.

Custodian Cash Account – An account consisting of monies held in local checking or savings accounts by an agency as an agent for individuals or organizations, and where the monies are held for the benefit of the individual or organization and are not to be used for the support of the agency.

Imprest Cash Account – An account consisting of monies withdrawn from a treasury account used for relatively small purchases requiring the use of cash as a means of payment.

Non-treasury Cash Accounts – Monies held outside the state treasury. These accounts exist to give state agencies readily available cash to conduct day-to-day business.

Revolving Cash Account – An account consisting of monies withdrawn from a treasury account to establish a local checking account to make disbursements where timing needs cannot be met by the state warrant system.

IV. DEPARTMENT DIRECTIVES

A. Non-treasury Cash Accounts

1. The Department will establish, utilize, and account for Non-treasury Cash Accounts, including Cash Change Accounts, Imprest Cash Accounts, Revolving Cash Accounts, and Custodian Cash Accounts, as outlined in [Montana Operations Manual-Category 300, Policy 326](#).

B. Non-treasury Cash Account Deposits

1. Any program or facility utilizing a Non-treasury Cash Account will deposit receipts as outlined in *Montana Code Annotated Sections 17-6-101 through 17-6-105*, and [Montana Operations Manual-Category 300, Policy 325 and 326](#).

Policy No. DOC 1.2.13	Chapter 1: Administration and Management	Page 2 of 2
Subject: NON-TREASURY CASH ACCOUNTS		

V. CLOSING

Questions concerning this policy should be directed to the Business Management Services Division.

VI. REFERENCES

- A. *Montana Operations Manual-Category 300, Policy 325*
- B. *Montana Operations Manual-Category 300, Policy 326*
- C. *Montana Code Annotated 17-6-101 through 17-6-105*

VII. ATTACHMENTS

None.



POLICY DIRECTIVE

Policy:	DOC 1.2.14 EMPLOYEE TRAVEL
Effective Date:	06/01/1998 Page 1 of 1
Revision Date(s):	05/03/2011; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

The Department will adopt the guidelines established in the *Montana Operations Manual (MOM)*, Volume 1, Chapter 0300, Employee Travel.

II. APPLICABILITY

All Department divisions, facilities, and programs.

III. REQUIREMENTS

A. General Requirements

1. Employees who are authorized to travel will review the travel section in the *MOM* upon hire and at such times as changes are promulgated by the Department of Administration.
2. The Department will notify all facilities of changes in employee travel requirements and will modify this policy as needed.
3. Employees must submit travel expense vouchers for reimbursement of travel expenses.
 - a. Vouchers may be completed electronically or manually.
4. It is the responsibility of the employee to retain a copy of each expense voucher and any attached receipts for the employee's own records.

IV. CLOSING

Questions about this policy should be directed to Financial Services.

V. REFERENCES

- A. 2-15-112, MCA; 53-1-203, MCA
- B. *MOM*, Volume 1, Chapter 0300, Employee Travel



POLICY DIRECTIVE

Policy:	DOC 1.2.15 DISCHARGE OR PAROLE GATE MONEY	
Effective Date:	10/31/2013	Page 1 of 1
Revision Date(s):	08/19/2016; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department will provide inmates discharging or paroling from a secure facility the remaining balance on the inmate's account and may provide gate money to assist inmates, who meet the general requirements below, with expenses upon facility departure.

II. APPLICABILITY

All secure facilities Department-owned and contracted, as specified in the contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Inmates with less than a \$100 balance on the inmate's account when discharged or paroled may be eligible for gate money in an amount up to \$100, which can be requested by submitting the *Application for Gate Money*.
 - a. The combination of gate money and the inmate's existing account may not exceed \$100 total.
 - 1) This allocation, and any additional assistance, may be provided to all discharging or paroling inmates unless ineligible in accordance with the provisions of this policy.
2. Inmates discharging or paroling from a secure facility are not eligible for gate money if the inmate:
 - a. period of incarceration was for less than 12 consecutive months;
 - b. discharges one felony sentence to another;
 - c. is released to Immigration and Customs Enforcement (ICE) or is not a citizen of the United States;
 - d. previously received gate money within the last 5 years;
 - e. is released because the court vacated the sentence; or
 - f. is discharged or delivered to federal or other state jurisdiction.
 - 1) Inmates discharged or delivered to the federal system or another state jurisdiction will be given \$5 in accordance with 53-30-111, MCA.
3. Facilities will provide a single set of suitable clothing at discharge or parole in accordance with 53-30-111, MCA.

V. CLOSING

Questions about this policy should be directed to the facility administrator.

VI. REFERENCES

- A. 53-30-111; MCA

VII. FORM

Application for Gate Money



POLICY DIRECTIVE

Policy:	DOC 1.2.17 DEPARTMENT GRANTS AND ASSISTANCE MANAGEMENT	
Effective Date:	04/01/1997	Page 1 of 3
Revision Date(s):	03/01/2016; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department manages pre-award and post-award activities associated with federal, state, and private assistance including grants, cooperative agreements, and technical assistance and facilitates grants management as a collaborative effort between the Department facility or program receiving the award and Department grant staff.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The Department will actively pursue non-general fund resources to promote activities or projects consistent with the Department's mission.
2. The Department Director and division administrators will stay informed regarding potential funding opportunities for topics or projects.

B. Pre-Award Process

1. Internal funding needs are identified by Department employees or when a grant posting suitable to the Department's goals is announced.
2. A grant project team will be identified by the Grants Contracts Coordinator (GCC).
3. A project lead is identified and will be the primary contact between grant and program staff.
4. The GCC will present RFP requirements to the project team and set project deliverable due dates.
5. The GCC, Grants Manager (GM), and project lead will delegate tasks regarding the grant project.
6. The project team is responsible for determining project scope and providing programmatic details and statistics to the GCC and GM.
7. All grant project information including, but not limited to, project details, statistics, letters of support, and position descriptions must be sent to the GCC at least 7 working days prior to the grant application due date.
8. The budget narrative must be completed by the GM and submitted to the GCC at least 3 working days prior to the grant application due date.
9. Prior to the application deadline:
 - a. application edits and modifications must be finalized by the GCC; and
 - b. the application must be submitted to the awarding agency.

C. Post-Award Process

1. Upon the Department's receipt of the grant award, the GM will forward the Grant Award Notification (GAN) to Financial Services.
2. The Department Director will sign post-award materials. The GM must submit post-award materials to the grantor within 21 days of GAN.
3. The project lead and division administrator assume primary responsibility of the project and must establish regular meetings, as required by the grant.
4. The GM will:
 - a. continually assess compliance with grant conditions and determine whether corrective action or grant adjustments are needed;
 - b. collect program progress reporting information from the project leader and submit reports, at pre-determined intervals, to the awarding agency; and
 - c. meet with the project team to complete grant close-out and submit any required reports to the awarding agency.

D. Grants and Assistance Management

1. The Program Manager will:
 - a. define program needs unmet through current available funding resources;
 - b. submit proposals, including the program description, to the GCC using the *Grants and Assistance Research Request* form;
 - c. review the RFP requirements of current federal assistance opportunities with the GCC and work with the GCC to determine the best RFP posting for project goals;
 - d. work with the GCC to develop project-specific details for all RFP required deliverables and mandatory requirements for compilation of the grant application;
 - e. monitor all items listed in the grant award, including but not limited to goals, objectives, performance measures, implementation, budget management, and policies;
 - f. coordinate with the GM and GCC to determine the accuracy of expenditures and propose grant adjustment requests relating to the project scope and budget;
 - g. submit corrective action plans to the GM for identified compliance issues; and
 - h. complete the final grant closeout, in coordination with the GM and GCC.
2. The Grants Contracts Coordinator (GCC) will:
 - a. develop and maintain a network of potential public and private funding sources;
 - b. review proposals submitted by division administrators;
 - c. research funding opportunities that correspond with verified Department needs;
 - d. notify the Director, Executive Team, and appropriate administrator of funding opportunities;
 - e. provide advisement and guidance to the management team regarding prioritizing proposals including the most appropriate submission in there are conflicting project proposals for the same funding;
 - f. assist with the pre-award and post-award processes including participation in work groups, clarifying proposal scope, and contributing to compiling application contents;
 - g. develop goal and objective measures for specific projects;
 - h. ensure application compliance with RFP requirements;
 - i. submit applications on behalf of the Department; and
 - j. collaborate with the GM to provide quarterly program and fiscal status reports to the program managers of grant-funded projects and increase public awareness of grant activities.

3. The Grants Manager (GM) will:
 - a. assist with the pre-award process by reviewing abstract proposals, participating in work groups, and developing the application's budget proposal;
 - b. complete post-award activities including accepting the award, providing key staff with an orientation, implementing the grant project, establishing internal controls, reporting performance data as required, and closing out the grant;
 - c. submit award documentation to budget analysts for submission of a budget change document (BCD) to the Office of Budget and Program Planning;
 - d. monitor all expenditures of federal funds and follow applicable cash management policies and procedures;
 - e. collect data on match contributions, such as number of hours contributed to grants, organizational coding, and other information;
 - f. provide ongoing technical assistance related to project management;
 - g. prepare and submit quarterly program and financial status reports to awarding agencies for each grant-funded program;
 - h. identify issues of concern and suggest corrective action;
 - i. prepare and submit grant adjustments and budget modifications to awarding agencies as appropriate;
 - j. prepare and submit the Department's Indirect Cost Rate (IDCR) proposal to its federal cognizant agency, US Department of Justice, which is used in all applicable federal assistance applications;
 - k. maintain a current listing of federal assistance awarded to the Department and publish it on the Department website quarterly; and
 - l. maintain complete electronic files for all Department federal assistance.

V. CLOSING

Questions about this policy should be directed to the Department's Contracts Management Bureau Chief.

VI. REFERENCES

A. 53-1-203, MCA

VII. FORMS

Grants and Assistance Research Request
Quarterly Grant Compliance



POLICY DIRECTIVE

Policy:	DOC 1.2.18 FLEET VEHICLE OPERATION AND MANAGEMENT	
Effective Date:	12/01/1997	Page 1 of 8
Revision Date(s):	12/04/2015; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department owns and leases motor vehicles for the purpose of conducting Department business. The Department requires all employees to comply with administrative rules, statutes, and policies governing the use and management of motor vehicles.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Authorized Vehicle Use

1. The Department of Administration Risk Management and Tort Defense Division (RMTD) must approve, in advance and in writing, any exception to authorized drivers, passengers, and/or vehicle use as defined in this policy.
2. Authorized **drivers** of Department-owned or leased vehicles include:
 - a. Department employees conducting business on behalf of the state;
 - b. authorized passengers relieving drivers due to illness, fatigue, or other physical or mental incapacity;
 - c. aides for disabled employees subject to the prior written approval of the Department Director; and
 - d. independent contractors or temporary employment agency employees contracting with the state when a state employee is not available and subject to the prior written approval of the Department Director.
3. Authorized **passengers** of Department-owned or leased vehicles include:
 - a. Department employees, independent contractors, guests, or clients while conducting business on behalf of the state;
 - b. aides to employees with a disability with prior written approval of the Department Director;
 - c. persons rendering or in need of assistance during a medical or other life-threatening emergency;
 - d. offenders in transport currently under the care or supervision of the Department; and
 - e. nursing infants if the parent is an authorized driver or passenger as provided in the *Montana Operations Manual (MOM)*.
4. Authorized daily vehicle operation includes:
 - a. parking a vehicle overnight at the home of a Department employee in order to begin travel the next day;
 - b. obtaining food, necessities, and lodging while in travel status;
 - c. responding to medical or other life-threatening emergencies; and

- d. conducting after-hours personal business, recreation, or leisure within a 30-mile radius of the Department employee's lodging when required to stay overnight at a location other than the established work location.
5. Requirements regarding use of personal vehicles to travel on behalf of the state include:
 - a. Employees who require a vehicle must use a Department-owned or leased vehicle unless circumstances justify the use of a personal vehicle, prior written approval is obtained from a supervisor, and the *Personal Vehicle Use Authorization* form is completed.
 - b. Employees are not required to use personal vehicles and, in accordance with RMTD insurance agreements, are encouraged to use Department-owned or leased vehicles.
 - c. If Department-owned or leased vehicles are not available, reimbursement for personal vehicle use will be at the highest current rate determined by 2-18-503, MCA.
 - d. If a Department-owned or leased vehicle is available for use and/or the employee requests to conduct personal business while in travel status, reimbursement will be at the lowest current rate determined by 2-18-503, MCA.
 - e. When requesting or approving personal vehicle use, the following criteria apply:
 - 1) employees assigned a permanent vehicle for commuting will not be approved to use a personal vehicle;
 - 2) requests will be considered based on vehicle availability and/or the employees' desire to conduct personal business while on travel status; and
 - 3) employees requesting to use a personal vehicle regularly must obtain annual written approval from the Chief Financial Officer and the Department Director.
6. Administrators requiring offender use of state vehicles as drivers must develop written processes authorizing such use and receive prior written approval of the RMTD as required per ARM 2.6.203.

B. Prohibited Vehicle Use

1. The following are prohibited while using a Department-owned or leased vehicle:
 - a. transporting unauthorized passengers;
 - b. when employee is not in travel status, personal business use, for example, shopping, medical appointments, lunch, and recreation;
 - c. attending wakes, funerals, or bereavement services, unless the deceased was a Department employee killed in the line of duty;
 - d. attending retirement functions;
 - e. operating a vehicle within 8 hours of consuming or while under the influence of alcohol, illegal drugs, or prescription drugs that affect the person's ability to operate a vehicle safely;
 - f. carrying or consuming an alcoholic beverage;
 - g. smoking, in compliance with 50-40-104, MCA, Montana Clean Indoor Act; and
 - h. using smokeless tobacco.

C. Disciplinary Actions

1. Supervisors are responsible for monitoring employee vehicle use and taking appropriate disciplinary action for noted violations.
 - a. Employees who violate this policy, statute, or administrative rules are subject to disciplinary action up to and including discharge as provided in 2-17-421, MCA.
 - b. All Department employees, responsible for the periodic operation of a Department-owned or lease vehicle, or an employee who uses the employee's own vehicle for Department services, must sign the *Vehicle Use Agreement*. By signing this form, the employee agrees to abide by all conditions set forth within.

D. Agreements and Requirements

1. In order to operate a vehicle on behalf of the state, and to ensure employees meet driver requirements specified in statute and administrative rules, employees who are new or who transfer from another state agency must complete the *Vehicle Use Agreement* upon employee orientation and submit the agreement to Human Resources (HR).
2. In compliance with 61-5-103, MCA, Department employees possessing out of state driver's licenses must transfer or renew their driver's license in Montana within 60 consecutive days of residency.
3. HR will report driving record checks that reveal the accumulation of conviction points over 11 total points, as provided in 61-11-203, MCA, and may notify the employee's supervisor.
4. The Department will conduct random motor vehicle driving record checks on a random 8% quarterly basis for all Department employees.
5. Employees must use seat belts at all times and lock the vehicle when left parked.
6. While operating a Department-owned or leased vehicle, employees are strongly encouraged not to use cell phones or other mobile electronic devices while driving if the device is not already prohibited by local ordinance.
7. Employees using a Department of Transportation (MDT) State Motor Pool leased vehicle must be familiar with the MDT lease packet and all applicable rules and procedures governing vehicle use.

E. Vehicle Accident and Driver Reporting

1. Employees who have an accident while conducting state business resulting in injury or death of any person or property damage shall immediately give notice of the accident to the appropriate law enforcement entity in accordance with 61-7-108, MCA.
2. An employee who is involved in a vehicle accident or becomes aware of damage or vandalism to a Department-owned or leased vehicle must:
 - a. complete and submit the *Report of Incident* to the Fleet Management Unit (FMU) within 24 hours; and
 - b. notify the State Motor Pool if driving a leased vehicle reserved through State Motor Pool.
3. An employee involved in an accident in a Department-owned or leased vehicle that results in a claim or a citation will be required to attend a Distractive or Defensive Driving Course and will be subject to a current check of their motor vehicle driving record.
4. In accordance with ARM 2.6.205 and 61-11-203, MCA, employees authorized to operate a motor vehicle on state business who accumulate conviction points in a 36-month period must comply with the following:
 - a. if 5 or more conviction points are accumulated while driving a state vehicle or a personal vehicle for state business, the employee must report points to a supervisor within 10 days of conviction or forfeiture of bond;
 - b. if 12 or more conviction points are accumulated while driving any motor vehicle for any purpose, the employee must report points to a supervisor within 10 days of conviction or forfeiture of bond and may not operate a motor vehicle for state business until a certified safe driver course approved by the RMTD is completed and written approval to drive from RMTD and the Department Director is received;
 - c. if 15 or more conviction points are accumulated, the employee must complete training and reporting requirements listed above and may not operate a motor vehicle for state business until total points accumulated within a 36-month period are less than 12;

- d. if 18 or more conviction points are accumulated, the employee must complete the training and reporting requirements listed above and may not operate a motor vehicle for state business until 2 years have passed without accumulating conviction points; and
- e. if the employee fails to report convictions points within the structure detailed above, the employee is subject to disciplinary action up to and including termination.

F. Permanent Vehicle Assignments

1. An employee may request a permanent vehicle assignment by completing and submitting the *Request for Vehicle Assignment* to the employee's supervisor.
2. The administrator and Department Director may approve permanent vehicle assignments consistent with the Department's mission, division, or facility operational needs, and other Department and state policies.
 - a. Per 2-17-425, MCA, *Request for Vehicle Assignment* approvals must be submitted to the FMU who will forward the signed copy to the Governor's office.
3. Employees approved for a permanent vehicle assignment and employees sharing or benefiting from an employee assigned a permanent vehicle for commuting must submit a *State Vehicle Commuting* form to FMU to ensure compliance with federal requirements outlined in 26 CFR § 1.61-21(f)(3) and *IRS Publication 15-B (2009) Commuting Rule*.
4. An employee who is approved a permanent vehicle assignment to commute to and from a residence must meet one of the following:
 - a. the employee is a Department psychiatrist assigned to the Montana State Prison;
 - b. 24-hour vehicle use is specifically authorized by law as an elected or appointed official and vehicle use is part of a compensation package; or
 - c. the vehicle used is in effect the employee's worksite and the employee is assigned one of the following positions:
 - 1) field-based Probation and Parole officer;
 - 2) investigator assigned to Investigations; or
 - d. the employee's residence is less than 30 miles from the employee's worksite, job duties include on-call responsibilities for quick response to an emergency threatening life or property, employees in the position have responded to more than one emergency call in the past 6 months, and the exception is approved by the Department Director.
5. If an exception is provided, emergency response records must be submitted to the FMU to forward to the Department Director for review biannually.
6. A vehicle is in effect an employee's worksite when at least one of the following apply as necessary to the employee's job requirements and performance of duties:
 - a. use of a vehicle with safety and emergency response equipment (for example, police radio, bullet-resistant vest, weapon, first-aid kit, search kit, or security partition);
 - b. use of a vehicle during alternative work schedule hours to conduct work functions in a variety of geographic locations and the employee is not required to report to a specific location for assignments or work shifts; or
 - c. use of a vehicle to meet with, interview, or detain offenders; secure evidence such as contraband seized in performing position duties; conduct offender searches; or investigate Interstate placement, parole, or conditional release plans.

G. Minimum Mileage Requirements

1. Department-owned and leased vehicles should be driven at least 10,000 miles annually.
 - a. For vehicles driven less than 10,000 miles in a fiscal year, a *Low Mileage Vehicle Exemption* form must be submitted to the FMU immediately following the conclusion of the fiscal year.
 - b. If a vehicle is driven less than 5,000 miles, written justification not containing any exemption listed in IV.H.2 below must be included.

2. The Department Director may exempt vehicles from the minimum mileage requirement if 3 or more of the following conditions are met:
 - a. the vehicle is used daily for tasks (for example, security checks, home visits, pickup, delivery);
 - b. the facility cannot access the State Motor Pool or agency vehicles;
 - c. liability or safety concerns render using a personal vehicle inappropriate;
 - d. storage of specialized equipment in the vehicle is required;
 - e. the vehicle is necessary for emergency response;
 - f. the vehicle is used to transport offenders;
 - g. an employee is not willing to use a personal vehicle for state business;
 - h. more cost-effective than reimbursement for use of a personal vehicle; or
 - i. the vehicle is used primarily for one of the following:
 - 1) travel on non-maintained roads;
 - 2) on facility property for maintenance, construction, or groundskeeping; or
 - 3) moving and distributing large items or a large quantity of items.
3. The FMU will forward *Low Mileage Vehicle Exemption* forms to the Department Director annually.
 - a. Vehicles found not to be exempt will be disposed of through the State Surplus Property Program.

H. Vehicle Purchases and Transfers

1. To determine the impact of a new or used vehicle purchase with regard to overall fleet mileage requirements, all requests for motor vehicle purchases must be submitted to the FMU, regardless of delegated purchasing authority.
 - a. The FMU will determine if the vehicle is exempt or non-exempt from mileage requirements and forward the request to the State Procurement Services Division or return it to the requesting agency as applicable.
 - b. New vehicles are purchased annually in conjunction with the State of Montana *Requisition Time Schedule*.
2. In accordance with 2-17-416, MCA, new vehicles purchased after January 1, 2008, must meet or exceed the CAFE standard unless an exemption is provided by the Department Director and the vehicle meets any of the following conditions:
 - a. used primarily in off-road use or for moving and distributing large items or a large quantity of items;
 - b. used for maintenance, construction, or groundskeeping;
 - c. has a manufacturer-stated seating capacity of more than six persons; or
 - d. utilizes alternative fuels.
3. Administrators requesting to retain or acquire an SUV or large utility vehicle (for leased vehicles, a class 04 or class 11 vehicle) must complete and submit an *SUV and Large Vehicle Justification* form to the FMU.
 - a. The FMU will forward the form to the Department Director to approve or deny the request.
4. The FMU must be notified prior to any transfer of a Department-owned or leased vehicle from one facility to another or from one party to another.

I. Maintenance and Repairs

1. The FMU will send designated responsible parties a *Vehicle Condition Report* annually to complete and return to the appropriate fleet staff by May 1 to evaluate the current condition of each Department-owned vehicle.
 - a. Fleet staff located at Montana State Prison (MSP) and Montana Correctional Enterprises (MCE) are responsible for collection and review of reports pertaining to vehicles under respective division responsibility.

2. Vehicle operators must ensure that Department-owned or leased vehicles are clean, mechanically maintained at all times, and not operated with any defect or problem that would prevent safe operation.
3. The administrator will assign an individual to ensure non-exempt vehicles have a functional odometer or employ an alternative method for tracking mileage and maintenance.
4. The Department utilizes maintenance intervals consistent with manufacturer's recommendations and has management information systems in place to ensure maintenance is completed as required.
5. Preventive maintenance (PM) is performed on vehicles as a part of a scheduled maintenance program performed at regular intervals based upon manufacturer's recommended standards and vehicle driving conditions.
6. Department-owned or leased vehicle repairs, maintenance, and vehicle-related purchases that are not part of a PM schedule or emergency must be pre-approved by submitting a *Department-Owned Vehicle Repair* form to the FMU or individuals designated at MSP or MCE to maintain the fleet, as applicable, in accordance with the following:
 - a. if estimated cost is over \$300 and not performed by Motor Vehicle Maintenance (MVM), the form must be submitted to the FMU;
 - b. if estimated cost is over \$1,000 and performed by MVM:
 - 1) on an MSP or MCE vehicle, the form must be submitted to the corresponding fleet staff; or
 - 2) on a vehicle not under the supervision of MSP or MCE, the form must be submitted to the FMU.
7. Emergency repair is permissible if:
 - a. a Department-owned vehicle breaks down after normal business hours,
 - b. immediate vehicle use is necessary,
 - c. a reasonable alternative is not available; and
 - d. the FMU, MSP, or MCE fleet staff, as applicable, is notified of the repair costs the next business day.
8. The assigned driver or responsible party should contact the dealer and check the vehicle owner's manual before scheduling repairs that may be covered under warranty.
 - a. Warranty repairs must be performed by an authorized dealer.
 - b. Warranty repair information must be submitted to the FMU for entry in the AgileAssets database.
9. Vehicle maintenance and repairs:
 - a. conducted by MVM must be entered on a monthly basis into the AgileAssets database by the FMU or a staff member at MSP or MCE licensed as an authorized user of AgileAssets; or
 - b. not conducted by MVM and not obtained by using a WEX card will be entered into the AgileAssets database by the FMU.

J. Vehicle Disposal

1. Department-owned vehicles may not be transferred, sold, traded, or otherwise disposed of without written authorization of the Department of Administration, General Services Division, Surplus Property Program in accordance with ARM 2.11.201.
2. Department vehicles will be disposed of and processed as surplus through the Surplus Property Program according to the following:
 - a. individuals designated at MSP or MCE to maintain the fleet will manage the disposal of vehicles under respective division responsibility that are wrecked, in need of costly repairs, or stored for parts and will notify the FMU upon removal from operation; and

- b. remaining divisions, facilities, and programs will submit a written request for disposal to the FMU.

K. Insurance Coverage

1. The Department will consider age, use, and retail value of vehicles when determining liability or comprehensive/collision coverage.
2. Employees who are approved to use a personal vehicle for Department business must use personal insurance coverage and are responsible for deductibles and co-insurance payments.
3. The Department will participate in the RMTD Automobile Insurance Premium Discount Program by completing all requirements and documentation required and ensuring that 5% of Department employees complete defensive driving, or other equivalent training, sponsored or approved by RMTD on an annual basis.

L. Fueling Cards

1. Employees authorized to operate a state vehicle must read the *MOM Fuel Card Policy 1-0790.00* and sign the *Fuel Card Use Employee Agreement* form acknowledging responsibility for fuel card use.
2. A Wright Express (WEX) fuel card will be assigned to each vehicle to be used by drivers when fueling a **Department-owned vehicle**.
 - a. All Department vehicles will be assigned a PIN that must be used when fueling the vehicle.
3. **State Motor Pool vehicles** will be fueled using a WEX fuel card requiring that the driver enter a MDT-assigned PIN issued to the vehicle and not a specific PIN issued to the employee.
 - a. Employees using WEX fuel cards must follow the MDT *General Lease Operator Requirements* when fueling vehicles or purchasing other vehicle-related items.
4. In compliance with *MOM Fuel Card Policy 1-0790.00*, the Department will maintain internal controls on fuel card use that include:
 - a. a limited number of transactions during a time period (for example, day, month, week);
 - b. a limited dollar amount per transaction;
 - c. a limit on merchant category codes; and
 - d. a required odometer reading at the point of sale (for example, gas station).
5. Fuel cards assigned to Department-owned vehicles may only be used for purchases of petroleum products, new tires, tire and tube repair, automated car washes, maintenance items, and labor for services.
 - a. Vehicles must be fueled using the least expensive grade from self-service pumps.
 - b. Fuel card receipts for items other than fuel must be submitted monthly to the FMU with the *State-Owned Vehicle Monthly Report*.
6. Department employees must report lost or stolen fuel cards to the FMU.
7. Designated responsible parties will ensure that cards assigned to a vehicle that is transferred, sold, or surplus, will be cancelled immediately.

M. Bulk Fuel Tank Use

1. The Department will use state term contracts in compliance with the *MOM Bulk Fuel Policy 1547* to purchase fuel for bulk tanks.
 - a. If term contracts are not available, the Department will purchase fuel in accordance with 18-4-304 and 18-4-305, MCA.
2. The Department will maintain physical and internal controls on bulk tank use including:

- a. installation of a bulk tank fuel dispensing meter and fuel card device;
- b. gates or fencing around bulk tanks to limit access;
- c. reconciling vehicle log books and/or monthly reports against bulk tank transaction logs or WEX monthly transaction statements; and
- d. comparison of the bulk tank fuel gauge against the monthly transaction log or statement.

N. Fuel Transaction Review

1. Fuel transactions will be reviewed monthly and on a random basis to determine appropriateness of transactions in comparison to employee work hours and locations, duties, and normal expenses.
 - a. Criteria may include date and time of transaction, number of transactions per vehicle and/or employee, merchant and/or location information, and odometer readings.

O. Vehicle Use Reporting

1. In accordance with 2-17-422, MCA, the Department will:
 - a. maintain operating history records for motor vehicles under control of the Department including the purchase price of the vehicle and the items of expense incurred in the operation of the vehicle; and
 - b. prepare a complete summary of the operating cost and history record of all state-owned vehicles for each fiscal year.
2. To maintain adequate records, equipment purchased for a vehicle must be:
 - a. reported to the FMU; or
 - b. entered in the AgileAssets database.

V. CLOSING

Questions about this policy should be directed to Financial Services or Human Resources.

VI. REFERENCES

- A. 26 CFR, 1.61-21(f)(3) Internal Revenue Service Regulation
- B. Title 2, Chapter 17, Part 4, MCA; §§ 2-18-503; 18-4-304; 18-4-305; Title 19; 50-40-104; 61-7-108; 61-11-203, MCA
- C. ARM 2.6.201-214; ARM 2.11.201
- D. Volume 1, Chapter 1-0500; Montana Operations Manual; Volume 111, 3-01-1; Montana Operations Manual; 1-0500, MOM; 1-0790.00, MOM; 1-0795.00, MOM

VII. FORMS

- DOC 1.2.18 (A) Department-Owned Vehicle Repair*
- DOC 1.2.18 (B) Fuel Card Use Employee Agreement*
- DOC 1.2.18 (C) Low Mileage Vehicle Exemption*
- DOC 1.2.18 (D) Report of Incident*
- DOC 1.2.18 (E) Request for Vehicle Assignment*
- DOC 1.2.18 (F) Personal Vehicle Use Authorization*
- DOC 1.2.18 (G) State-Owned Vehicle Monthly Report*
- DOC 1.2.18 (H) Vehicle Use Agreement*
- DOC 1.2.18 (I) State Vehicle Commuting*
- DOC 1.2.18 (J) SUV and Large Utility Vehicle Justification*
- DOC 1.2.18 (K) Vehicle Condition Report*



POLICY DIRECTIVE

Policy:	DOC 1.2.19 FRAUDULENT ACTS REPORTING	
Effective Date:	02/02/2000	Page 1 of 2
Revision Date(s):	04/12/2012; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

Department employees and contractors must immediately report any suspected or actual fraudulent acts involving state resources or programs.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Responsibilities

1. Department supervisors are responsible for detecting and preventing fraudulent acts including misappropriation of resources and other improper activity.
2. All Department employees must report suspected or actual fraudulent incidents that may involve other employees, consultants, vendors, contractors, or any other party engaged in Department business. Failure to report may result in disciplinary action or criminal charges.
3. The Department Training Unit is responsible to provide refresher training on fraudulent acts based on a review of annual investigative activity and the results of annual training needs assessments.

B. Fraud

1. The following is a partial list of acts that may serve as examples of conduct and behaviors that constitute fraud:
 - a. forgery or alteration of any Department document or account;
 - b. forgery or alteration of a check, bank draft, or any other financial transactions;
 - c. misappropriation of funds, supplies, or other assets;
 - d. impropriety in the handling or reporting of money or financial transactions;
 - e. disclosing confidential information to unauthorized parties;
 - f. accepting or seeking anything of material value from contractors, vendors, or persons providing Department services or materials (with the exception of gifts valued at less than \$50.00);
 - g. unauthorized destruction, removal, or inappropriate use of records, furniture, fixtures, or equipment; and
 - h. any similar or related impropriety.
2. Employees are directed to:
 - a. review *DOC 1.3.2 Performance and Conduct* and *DOC 3.1.28 Crime Scene and Physical Evidence Preservation* for additional information on standards of conduct; and
 - b. address moral, ethical, or behavior concerns with the appropriate supervisor.

C. Theft

1. The following is a partial list of acts that constitute theft according to state law. A person commits theft if the person purposely or knowingly:
 - a. obtains by threat or deception control over an owner's property;
 - b. obtains control over stolen property knowing the property to have been stolen by another;
 - c. exerts unauthorized control over any part of the Family and Social Services public assistance provided under Title 52 and 53;
 - d. obtains or exerts or helps another obtain or exert unauthorized control over any part of any benefits provided under Worker's Compensation laws Title 39, Chapter 71;
 - e. commits insurance fraud; or
 - f. obtains or exerts unauthorized control over property of the person's employer or over property entrusted to that person.

D. Reporting

1. Anyone who suspects or has knowledge of dishonest or fraudulent acts may use one of the following to report the activity:
 - a. report to the Investigations Bureau;
 - b. submit a completed *Fraudulent Acts Report* form to the Investigations Bureau; or
 - c. call the Legislative Audit Division Fraud Hotline at 1-800-222-4446.
2. An employee who submits a Fraudulent Acts Report may inform a supervisor or may choose to report only to the Investigations Bureau or the Legislative Audit Division Fraud Hotline.
3. Employees will not attempt to personally investigate, interview, or interrogate any person that the employee may suspect of a fraudulent act.

E. Confidentiality

1. The Investigations Bureau will treat all fraudulent acts reports confidentially within the scope of investigative processes.
2. The Investigations Bureau will not disclose or discuss any investigation with anyone, except those who have a legitimate need to know, to avoid damage to the reputations of persons suspected but subsequently found innocent of wrongful conduct and to protect the Department from potential civil liability.

F. Investigations

1. In accordance with *DOC 3.1.19 Investigations*, the Investigations Bureau will:
 - a. investigate suspected fraudulent acts;
 - b. refer investigations to prosecuting authorities;
 - c. inform the Department's Human Resource Bureau and affected division or facility administrators of the status of any investigative referrals as they relate to ongoing administrative investigations and disciplinary action; and
 - d. in accordance with state law, immediately notify both the state Attorney General and Legislative Auditor in writing if information discovered during the course of an investigation substantiates actual or suspected theft involving state monies or property.

V. CLOSING

Questions about this policy should be directed to the Department's Investigations Bureau.

VI. REFERENCES

- A. 5-13-309, MCA; 45-6-301, MCA
- B. DOC 1.3.2 Employee Performance and Conduct Guidelines; DOC 3.1.19 Investigations; DOC 3.1.28 Crime Scene and Physical Evidence Preservation

VII. FORMS

Fraudulent Acts Report



POLICY DIRECTIVE

Policy:	DOC 1.3.2 EMPLOYEE PERFORMANCE AND CONDUCT	
Effective Date:	01/26/1996	Page 1 of 3
Revision Date(s):	03/01/2021; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department protects the rights of employees, enforces high standards of professional conduct, and provides guidelines of performance and conduct for Department employees.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. On-the-Job Performance

1. Employees are responsible for performing duties as specifically assigned either orally or in writing, and as guided by the *Code of Ethics* and Department policies.
2. Employees and service providers with access to protected health information must read and sign the HIPAA Confidentiality Agreement.

B. Off-the-Job Conduct

1. Employees will maintain ethical standards that:
 - a. contribute to public safety and trust, and
 - b. do not reflect negatively on the reputation of corrections professionals.
2. Employees and service providers are expected to:
 - a. comply with all laws; and
 - b. inform the Department of any criminal charges that:
 - 1) may affect Department or personal credibility; or
 - 2) affect a person's ability to perform in the person's assigned capacity.
3. Employees and service providers who have been arrested for any criminal offense other than minor traffic offenses (except D.U.I.) must notify their supervisor and provide information on their status through final disposition.
4. If an employee is incarcerated or detained and unable to report for work, the employee must contact the immediate supervisor to request a leave of absence for each scheduled shift.
 - a. Failure to request a leave of absence will be considered absence without approval and may result in disciplinary action up to and including dismissal.
5. The supervisor will conduct an inquiry upon notification of an employee's involvement in criminal conduct including gathering facts and consulting Human Resources.

C. Gun Control Act

1. Employees authorized because of their positions to carry or be issued firearms who are subject to any disqualifying cause under the federal Lautenberg Act of 1996 must notify their

supervisors and continue to provide information on their status through final disposition of any such disqualifier.

2. The Department is prohibited from providing firearms or ammunition to any individual who fits any of the following criteria:
 - a. is convicted of a felony offense;
 - b. is a fugitive from justice (for example, fleeing from custody or prosecution);
 - c. is an unlawful user of or addicted to a controlled substance;
 - d. is adjudicated as a mental defective or committed to a mental institution;
 - e. is an illegal alien;
 - f. has received a dishonorable discharge from the military;
 - g. has denounced U.S. citizenship;
 - h. is subject to a restraining order; or
 - i. has been convicted of a misdemeanor crime of domestic violence.

D. Unacceptable Performance and Conduct

1. Performance and conduct behavior unacceptable for Department employees includes, but is not limited to, the following:
 - a. violation of law;
 - b. violation of policy, directives, or other employer regulations;
 - c. neglect or failure to carry out assigned duties and responsibilities;
 - d. assaulting, injuring, abusing, intimidating, threatening, endangering, or withholding reasonable necessities from an offender;
 - e. committing theft, damage, or unauthorized use or possession of state property or property of any offender;
 - f. assaulting, endangering, stalking, or maliciously intimidating or harassing another person;
 - g. falsifying any department record;
 - h. unauthorized dissemination of confidential information;
 - i. abuse of sick leave or excessive tardiness;
 - j. unauthorized use of state time, equipment, or facilities for private business or personal use;
 - k. failure to remain alert and vigilant while on the job;
 - l. failure to follow applicable dress codes;
 - m. employee negligence resulting in damage or loss of state property;
 - n. using, possessing, controlling, or transferring tobacco in unauthorized areas;
 - o. loaning, duplicating, or other use of keys that breach the security of the workplace;
 - p. failure to maintain a courteous, productive and otherwise acceptable working relationship with fellow workers and the general public;
 - q. use of any illegal drugs;
 - r. use of any prescription medications not prescribed by a medical professional;
 - s. use or misuse of any prescribed or over-the-counter substance that may impact the effective performance of duties and responsibilities not reported in advance to the appropriate supervisor;
 - t. unauthorized use, possession, control, or transfer of contraband in violation of specific division or facility policies and/or procedures;
 - u. sabotaging, impeding, interfering, or failing to cooperate with any authorized Department or law enforcement investigation;
 - v. failure to timely report policy violations or job-related illegal or unethical behavior to the appropriate authority;
 - w. failure to timely self-report an arrest, conviction, or professional disciplinary action against a professional license required by the position; and
 - x. failure to self-report potential conflicts of interest to the appropriate administrator prior to acting in possible violation of this policy.

E. Standards of Conduct

1. The Department abides by all applicable laws, regulations, and policies related to state employee Standards of Conduct, including those linked below.
 - a. *State Ethics Policy*;
 - b. *Employee's Guide to Standards of Conduct in Montana State Government*; and
 - c. *Political Activity of Public Officers and Employees*.

F. Disclosure Requirements

1. You may not solicit or accept employment or engage in negotiations or meetings to consider employment with a person whom you regulate in your official duties without first giving written notice to your supervisor or Department Director.
2. If you are a member of a quasi-judicial board or commission or a board, commission or committee with rulemaking authority, and have a conflict created by a personal or private interest that gives rise to the appearance of impropriety, you must disclose the interest creating the conflict prior to participating in official actions.
3. Prior to acting in a manner that may affect your public duty, including the award of a permit, contract, or license, you must disclose the nature of the private interest that creates the conflict.
 - a. This disclosure must be in writing to the Commissioner of Political Practices (Commissioner) and must list the amount of private interest, the purpose and duration of your services, any compensation you have received, and other relevant information.
 - b. If you perform the act involved, you must publicly declare and record the nature of the conflict including all elements required previously for the Commissioner.

G. Code of Ethics and HIPAA Confidentiality Agreement

1. Supervisors will ensure that all employees read and sign the *Code of Ethics* and return the form to Human Resources.
2. Employees and service providers with access to protected health information will read and sign the *HIPAA Confidentiality Agreement* and return the form to Human Resources.

V. CLOSING

Two main principles apply to your conduct in your job: public trust and public duty. By keeping these in mind as you do your job on a day-to-day basis, you will be able to carry out your duties for the benefit of the people of the state and avoid taking actions that would cause you to depart from your public duty and violate the public's trust. Provisions of this policy not required by statute will be followed unless they conflict with negotiated labor contracts, which will take precedence to the extent applicable. Questions about this policy should be directed to Human Resources.

VI. REFERENCES

- A. 2-2-101 through 2-2-304, MCA; 45-7-307, MCA
- B. Title 18 U.S.C. Chapter 44, Gun Control Act of 1968
- C. *Montana Operations Manual, Ethics Policy*
- D. *Ethics - Standards of Conduct for State Employees; Department of Administration*
- E. 4-4069; ACA Standards Supplement, 2008
- F. 3-JTS-1C-23, ACA Standards for Juvenile Correctional Facilities, 2003
- G. 3-3068, ACA Standards for Adult Probation & Parole Field Services, 3rd Edition
- H. DOC 1.3.12 Staff Association and Conduct with Offenders; DOC 1.1.17 Prison Rape Elimination Act (PREA); DOC 3.1.17 Searches and Contraband Control; DOC 3.1.19 Investigations

VII. FORMS

Code of Ethics
HIPAA Confidentiality Agreement



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 1.3.3	Subject: WORKERS' COMPENSATION/EARLY RETURN TO WORK
Chapter 1: ADMINISTRATION AND MANAGEMENT	Page 1 of 4 and Attachments
Section 3: Human Resources	Effective Date: April 1, 1996
Signature: /s/ Mike Batista, Director	Revised: 03/01/2016

I. POLICY

The Montana Department of Corrections maintains workers' compensation insurance through the Montana State Fund to ensure that in the event of workplace injuries or occupational illnesses, Department workers will receive reasonable care costs and wage-loss payments in accordance with the State of Montana's medical fee schedule and applicable statutes and rules to establish wage-loss payments and medical care cost benefits. The Department is committed to assisting injured employees return to work as soon as medically appropriate.

II. APPLICABILITY

All Department divisions, facilities, and programs.

III. DEFINITIONS

Accident – As defined in *Mont. Code Ann. § 39-71-119(2)(a-d) (2014)*, an accident is (a) an unexpected traumatic incident or unusual strain; (b) identifiable by time and place of occurrence; (c) identifiable by member or part of the body affected; and (d) caused by a specific event on a single day or during a single work shift.

Injury – As defined in *Mont. Code Ann. § 39-71-119(1)(a-c)(2) (2014)*, (a) internal or external physical harm to the body that is established by objective medical findings; (b) damage to prosthetic devices or appliances, except for damage to eyeglasses, contact lenses, dentures, or hearing aids; or (c) death. (2) An injury is caused by an accident.

Occupational Disease – Harm, damage, or death arising out of or contracted in the course and scope of employment caused by events occurring on more than a single day or work shift.

Recordable Injuries – Injuries which go beyond minor injuries requiring only first aid treatment, and may involve medical treatment, loss of consciousness, restriction of work or motion, or transfer to another job.

State Fund – The workers' compensation policy holder for state government.

Transitional Duty – Modified, temporary work assigned by a state agency to an injured worker that allows the injured worker to return to the work place prior to the time when he or she is able to perform all normal job functions; fosters fast, more complete recovery.

Transitional Duty Team – A team of individuals consisting of the injured employee, their immediate supervisor, the division, program or facility Human Resource Generalist, and as needed or requested a member of the Department of Administration's Health Care and Benefits Division, Workers Compensation Management Bureau to administer its Return to Work Program.

Transitional Duty Team Coordinator – The Department's Human Resource Generalist

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Subject: WORKERS' COMPENSATION/EARLY RETURN TO WORK		

appointed by management to participate in every Early Return to Work team meeting regarding an injured employee.

IV. DEPARTMENT DIRECTIVES

A. Department Responsibilities

1. The Department will:
 - a. immediately address any employee-related injuries or occupational diseases;
 - b. investigate conditions, and implement environmental and/or procedural changes as necessary to reduce the number of occupational injuries and workers' compensation costs; and
 - c. ensure that injured employees resume work as soon as possible and are provided transitional modified duty assignments until a release to full duty is advised or until it has been determined the employee cannot perform the essential duties of the position with or without appropriate accommodations.
2. Office of Human Resources (OHR) staff members will finalize the [First Report](#) form for recordable injuries, establish tracking, and submit the form to State Fund within two days of the accident.

B. Reporting an Injury or Occupational Disease

1. Employees will report all work-related injuries or occupational diseases to their immediate supervisor as soon as practical.
2. If medical care is necessary, the supervisor should encourage and assist the employee to obtain the required care.
3. The employee and supervisor will complete the [First Report](#) form prior to the end of the assigned shift unless precluded by reasonable circumstances. However, all injuries must be reported no later than twenty-four (24) hours after occurrence.
4. The First Report form will be forwarded to OHR for reporting to State Fund.
5. The supervisor will analyze the accident, utilizing the [Accident Investigation Report](#), within five business days to determine what, if any, action will be taken to prevent future safety issues. The Accident Investigation Report will be submitted to OHR and the local safety committee for review.

C. Compensation for Lost Time

1. State Fund will provide wage loss benefits (temporary total disability) only when the wage loss exceeds four days or 32 hours. Employees may request use of other available leave or leave without pay for the lost time prior to receipt of State Fund benefits. Should an injury cause an employee to be off work beyond 21 days, they may be eligible to apply for retroactive benefits lost during this initial 32-hour period, unless sick leave benefits were used to provide compensation during this time.
2. Sick leave and temporary total disability benefits from the workers' compensation insurance carrier may not be paid concurrently unless provided within a collective bargaining agreement.

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3. Leave, other than sick leave, may be used concurrently with State Fund wage loss benefits, i.e., annual and compensatory time.
4. OHR will work closely with the state's Workers' Compensation Management Bureau, State Fund, and Department employees to address concerns and questions about employee workers' compensation rights, payments, and other issues of coordinated employee benefits.

D. Requesting Leave of Absence

1. Employees must request a leave of absence due to a work-related injury or occupational disease covered by workers' compensation. Failure to request leave may result in disciplinary action.
2. Supervisors who question the need for employee leave requests as a result of a workers' compensation injury may consult with the OHR to seek medical certification.
3. A member of the Transitional Duty Team will maintain weekly communications with employees on workers' compensation leave, either in person or by phone. These communications will allow employees to update the team on their progress and request assistance, where necessary.
4. An employee will submit a completed and signed medical status from their medical provider to the OHR after each medical appointment.

E. Worker's Compensation Leave of Absence and FMLA.

1. Leaves of absence taken in connection with a workers' compensation injury or illness will run concurrently with any FMLA leave entitlement for all eligible employees. Once FMLA leave expires, employees will need to be in a pay status for 40 hours a pay period or be responsible for self-paying the state share in order to maintain health benefit eligibility.

F. Transitional Work

1. The Department is committed to implementing the state's Early Return to Work Program which involves working closely with injured workers and their health care providers to return injured employees to work as soon as medically appropriate.
2. The Transitional Duty Team will identify and coordinate transitional or light-duty work assignments when possible depending on a particular position and the employee's circumstances, including work limitations.
3. Employee's pay during a transitional work assignment will be maintained at its current rate.
4. The Transitional Duty Team will review current work ability and progress toward the time of injury duties at least once a month.
5. An employee who returns to work in a transitional work status will have his or her job retained for a reasonable amount of time, which will be determined based on Department needs, union contract, and medical prognosis for full-time release, or until a medical

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decision establishes that the employee will not be able to perform the essential duties of the employee's job.

6. Transitional duty positions are not considered permanent.
7. Employees must provide a signed medical status form indicating there are no restrictions before returning to regular duty.

G. Reemployment to Time-of-Injury Position

1. Employees will be returned to the time-of-injury positions according to Department needs.
2. During an employee's absence, his or her position may be temporarily filled.
3. Employees who return to work for a brief period (30 calendar days or less) and suffer a reoccurrence of injuries will be considered on cumulative leave from the date of the original injury.
4. Injured employees who have been terminated and then released to regular duty by attending physicians will be given preference over other applicants for the same or another comparable vacant position for a period of two years from the date of injury.

H. Retirement

1. Employees covered by a Montana Public Employees Retiree Administration (MPERA) or Teachers Retirement Administration (TRA) retirement system who are absent from work because of a compensated job-related injury may elect to qualify the absence for retirement credit.

V. CLOSING

Provisions of this policy not required by statute will be followed unless the provisions conflict with negotiated labor contracts, which will take precedence to the extent applicable.

Questions concerning this policy should be directed to the Office of Human Resources.

VI. REFERENCES

- A. 19-3-504, MCA; 19-20-411, MCA; 39-71-119, MCA
- B. 24.29.101 through 24.29.213; *Administrative Rules of Montana*
- C. *Work Comp Benefits Summary (Department of Labor & Industry)*

VII. ATTACHMENTS

[First Report](#)

[Accident Investigation Report](#)

[Early Return to Work Funding Request](#)



POLICY DIRECTIVE

Policy:	DOC 1.3.8 EMPLOYEE TIME MANAGEMENT	
Effective Date:	03/01/1997	Page 1 of 2
Revision Date(s):	03/01/2021; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department follows uniform requirements for administering leave, overtime compensation, and nonexempt compensatory time, and complies with the Fair Labor Standards Act (FLSA), Montana's Wage and Hour Laws, applicable *Montana Operations Manual (MOM)* standards, the Montana Code Annotated, and administrative rules.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Timekeeping Requirements

1. All employees are required to record time worked on the MINE system after the last shift of the pay period.
 - a. Employees without access to the MINE system will record time on a time sheet issued by the payroll office.
2. Supervisors are responsible for the following:
 - a. submitting time records based on the supervisor's knowledge of hours worked; if an employee fails to submit a time record, the employee is responsible for notifying the agency of necessary corrections after submission;
 - b. verifying an employee's hours worked prior to approving time records; and
 - c. approving or denying requests for leave in writing; email responses are acceptable.
3. Department employees who wish to apply for any type of leave must request it from their immediate supervisor in advance, according to the practice established by the supervisor.

B. Overtime and Nonexempt Compensatory Time

1. Supervisors must consider the following prior to approving overtime and compensatory time:
 - a. the employee's exempt or nonexempt classification under the FLSA;
 - b. the first 40 hours of paid time in any workweek between 12:01 a.m. Saturday and midnight Friday are regular hours; and
 - c. a supervisor may, according to the *MOM Overtime and Nonexempt Compensatory Time Policy*, adjust an employee's work schedule or require an employee to take time off without pay to maintain a 40-hour week.
2. Due to unfunded liability, employees are limited to 60 hours of accrued nonexempt compensatory time.
 - a. If an employee will exceed accrual limits in a payroll period, overtime is paid unless the supervisor and employee have agreed upon larger accrual limits in a written and signed agreement submitted to Financial Services.

- 1) The agreement must include the following:
 - a) justification for accrual beyond 60 hours;
 - b) the maximum limit of accrual approved is 120 hours;
 - c) the balance will be reduced to or below 60 hours within the current biennium; and
 - d) language allowing the Department to pay out the accrued balance or modify the agreement at any time.
3. In advance, employees will request and obtain approval for any hours worked outside the regularly scheduled shift.
4. Prior to an employee's transfer or promotion to an FLSA-exempt position, all non-exempt compensatory time will be paid out at the employee's current rate of pay.
5. A supervisor will administer FLSA-exempt and non-exempt compensatory time in accordance with the *MOM Overtime and Nonexempt Compensatory Time Policy*.

V. CLOSING

Provisions of this policy not required by statute will be followed unless the provisions conflict with negotiated labor contracts, which will take precedence to the extent applicable.

Questions about this policy should be directed to Human Resources.

VI. REFERENCES

- A. *The Fair Labor Standards Act of 1938, Title 29 U.S.C, Chapter 8, Sections 201-219, as amended*
- B. *Montana Operations Manual (MOM)*
- C. *Department of Administration, State Human Resource Division Guides: Paid Military Leave in Montana Guide and Family and Medical Leave Act Guide*
- D. *FMLA, USSERRA, MTSERRA and the State of Montana Military Leave Guide FMLA Federal Regulations Part 825*



POLICY DIRECTIVE

Policy:	DOC 1.3.12 STAFF ASSOCIATION AND CONDUCT WITH OFFENDERS	
Effective Date:	06/01/1998	Page 1 of 3
Revision Date(s):	12/30/2020; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department requires employees to limit their association with offenders, offender's immediate family members, and close associates of offenders to a professional relationship. The Department further maintains zero tolerance for misconduct by its employees toward or with any individual in the custody or under the supervision of the Department.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Administrator Responsibilities
 - a. Department employees and service providers review and comply with the provisions of this policy.
 - b. Offenders under the custody or supervision of the administrator's respective division, facility, or program review and understand the processes for reporting alleged staff misconduct toward offenders.
 - c. Staff misconduct is reported and pursued with the assistance of Human Resources.
 - d. Written processes are established and maintained that provide effective policy communication and guidance for the following:
 - 1) confidential reporting processes regarding alleged staff misconduct toward offenders and availability of these processes to Department employees, service providers, offenders, visitors, offenders' immediate families, and offenders' close associates;
 - 2) ensuring offenders have the opportunity to promptly file a complaint anonymously, through third parties, verbally, or in writing using the facility's formal grievance process, if applicable; and
 - 3) investigation and response to misconduct allegations is a high priority and conducted as provided in law and all applicable policies.
2. After consultation with Human Resources and Legal Services, and upon approval of the Department Director or designee, an administrator may approve limited exceptions to this policy on a case-by-case basis to allow limited contacts between employees, offenders, offender's immediate family members, and close associates of offenders.
 - a. Administrators must include documentation of the circumstances supporting the exception and a written plan outlining the permissible contact.
3. Department employees and service providers who violate this policy are subject to disciplinary action, up to and including termination of their employment.

4. Department employees entrusted with confidential records will adhere to *DOC 1.5.5 Offender Records Management, Access, and Release* and report breaches of confidentiality appropriately.
5. Department employees and service providers will not retaliate against the complainant, the victim, the accused, the witnesses, or the informants involved in the filing and investigation of misconduct allegations.

B. Required Conduct

1. Department employees and service providers must:
 - a. maintain a professional relationship with offenders at all times;
 - b. provide offender services without regard to race, color, age, gender, physical or mental disability, marital status, creed, sex, political beliefs, genetic information, veteran's status, culture, social origin or condition or ancestry, national origin, religious preference, sexual orientation, or any other protected class.
 - c. not display favoritism toward, or discrimination against, any offender or group of offenders;
 - d. limit relationships with offenders, offender's immediate family members, and close associates to officially authorized activities; and
 - e. avoid conflicts of interest or situations, such as engaging in personal or business relationships, that may compromise professional integrity or security or cause embarrassment to the Department of Corrections and the State of Montana.

C. Prohibited Conduct

1. Employees who assault, injure, intimidate, threaten, endanger, or withhold reasonable necessities from an offender, or violate any civil right of an offender are subject to felony and misdemeanor criminal penalties as well as disciplinary action, up to and including termination from employment.
2. Department employees and service providers who commit staff sexual misconduct are subject to felony and misdemeanor criminal penalties as well as disciplinary action up to and including termination from employment.
3. Department employees and service providers will not engage in inappropriate behaviors with offenders, offender's immediate family members, or close associates.
 - a. Inappropriate behavior includes, but is not limited to, the following:
 - 1) using profane, indecent, or discriminatory language or references;
 - 2) giving or receiving gifts, favors, or services that exceed Department requirements;
 - 3) engaging in any type of business or fiduciary relationship including trading, selling, or buying from an offender (excluding purchases in accordance with *DOC 5.5.4 Hobby Programs for Adult Facilities*); and
 - 4) interaction that is unnecessary, not a part of the employee's duties, and related to a personal relationship or purpose rather than a legitimate correctional purpose including, but not limited to:
 - a) engaging in horseplay;
 - b) socializing;
 - c) sharing personal information (for example, family member names, ages, schools, etc.);
 - d) contacting offender's immediate family members for matters unrelated to the employee's official duties;
 - e) exchanging written correspondence; or
 - f) developing a relationship with an offender that is anything other than a professional relationship.

D. Department Employee and Service Provider Reporting Requirements

1. Department employees must immediately disclose any of the following events to a supervisor (in consultation with HR, the supervisor will instruct the employee on the appropriate course of action):
 - a. intentional or repeated attempts to contact the employee by an offender, an offender's immediate family members, or close associates;
 - b. the employee engaged in prohibited conduct described in III.C above; or
 - c. an employee's immediate family member or a close associate has been committed to the custody or supervision of the Department and/or is assigned to the facility or program in which the employee is employed using the *Staff Association Disclosure* form.
2. Department employees and service providers who receive information regarding, or have personal knowledge of, sexual misconduct and/or misconduct that causes bodily injury or reasonable apprehension of bodily injury to an offender must immediately report the misconduct to the applicable administrator and HR.
3. Department staff, contract employees, and volunteers who know or have reasonable cause to suspect that a youth offender has been abused or neglected must immediately report the matter to the administrator, or designee, and to the Department of Public Health and Human Services as required by 41-3-201, MCA.

V. CLOSING

Provisions of this policy not required by statute will be followed unless they conflict with negotiated labor contracts which will take precedence to the extent applicable.

Questions about this policy should be directed to Human Resources.

VI. REFERENCES

- A. §§ 45-5-204, 45-5-501, 45-5-502, 45-5-503, 45-7-203, 45-7-307; MCA
- B. 4-4069, 4-4281; *ACA Standards for Adult Correctional Institutions, 4th Edition*
- C. 3-JTS-1C-23, 3-JTS-3D-06; *ACA Standards for Juvenile Correctional Facilities, 2003*
- D. 4-4084, 4-4084-1, 4-4281-6, 7; *2008 ACA Standards Supplement*
- E. DOC 1.1.17 *Prison Rape Elimination Act (PREA)*; DOC 1.5.5 *Case Records Management*; DOC 3.1.19 *Investigations*; DOC 5.5.4 *Hobby Programs for Adult Facilities*
- F. *Department of Corrections Code of Ethics*

VII. FORM

Staff Association Disclosure



POLICY DIRECTIVE

Policy:	DOC 1.3.15 AMERICANS WITH DISABILITIES ACT (ADA)	
Effective Date:	07/01/2008	Page 1 of 3
Revision Date(s):	03/11/2015; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department will make reasonable accommodations to the known physical or mental limitations of an otherwise qualified individual, employee, or member of the public with a disability unless to do so would result in an undue financial or administrative burden, constitute a direct threat, endanger the health or safety of any person, or fundamentally alter the inherent nature of the Department's business.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The Department, as an employer, will provide equal opportunity in hiring and all other aspects of employment and reasonable workplace accommodations to qualified applicants and employees with disabilities.
2. The Department and contracted facilities or programs will provide visitors access to all public areas, services, and programs.

B. Responsibility

1. The Americans with Disabilities Act (ADA) coordinator will assist facility and program administrators' compliance with the ADA and Montana Human Rights Act (MHRA).
2. The ADA coordinator will be assigned from Human Resources to work with employees and the public.
3. The ADA coordinator will have training in the Americans with Disabilities Act, Title I, affecting employment; and Title II, which requires equal access to state programs and facilities by individuals with disabilities.
4. The ADA coordinator, in coordination with the facility or program administrator, may designate a staff member at each facility or program to assist with the implementation of this policy.
5. All Department employees must recognize and take seriously all requests for disability accommodation and any complaints or grievances involving disability discrimination or accessibility.

C. Requests for Reasonable Accommodations

1. An employee or member of the general public may request information or an accommodation by contacting the ADA coordinator verbally or in writing.

2. A request for accommodation is the first step in an interactive process between the individual and the ADA coordinator to clarify the individual's request and to identify any appropriate reasonable accommodation.
3. When the disability is not obvious, the ADA coordinator may request reasonable documentation of the disability. Reasonable documentation is information necessary to establish that an individual has a qualified disability. The individual may be asked to sign a release of information allowing the medical caregiver to respond to the Department. If the individual refuses to provide reasonable documentation, the individual's request cannot be processed, and a disability determination cannot be assessed.
4. Upon receipt of the necessary documentation establishing that the individual has a qualified disability, the individual and the ADA coordinator determine what accommodations would be most effective and reasonable.
 - a. The Department will make the final determination of the reasonableness of an accommodation.

D. Complaints of Disability Discrimination

1. When an employee, visitor, or other recipient of services provided by the Department believes they have been subject to disability discrimination, they must report the allegation to Human Resources for prompt investigation and any appropriate actions.
2. Employees, visitors, or the general public will follow the complaint procedure outlined in the *Discrimination Complaint* form.
3. Requests, complaints, or grievances involving a disability issue should include specific facts such as person or persons involved, structure or barrier involved, the date, time, and place of the occurrence, what was done or said, and the names of any witnesses present.

E. Response to Requests and Complaints

1. Employees and designated personnel at contracted facilities and programs will immediately inform the appropriate ADA coordinator of any request, complaint, or grievance involving a disability-related accommodation or discrimination.
2. Human Resources will promptly investigate and resolve all employee and public related ADA requests, complaints, and grievances.
3. A request may be denied if the accommodation would result in undue financial or administrative burdens, constitute a direct threat, endanger the health or safety of any person, or fundamentally alter the inherent nature of the Department's business.
 - a. After considering all resources, if a request is denied for these reasons, there must be a written statement outlining the reasons for the denial.

F. Recordkeeping Requirements

1. The ADA coordinator will retain all documentation, including the *Discrimination Complaint* form, when necessary, pertaining to the request, grievance, or complaint and the ensuing investigation in a separate investigative file.
 - a. If an employee is involved, this information will not become part of their personnel file.
2. The Department will:
 - a. maintain the confidentiality of all medical information, unless otherwise provided by law; and
 - b. only disclose information about the request internally on a need-to-know basis to personnel involved in making or assisting in the implementation of the reasonable accommodation or resolution of the grievance or complaint.

3. The ADA coordinator will maintain statistical data regarding complaints, grievances, or requests made pursuant to this policy and will prepare an annual report on ADA activities to the Human Resources Chief and Department Director that includes successes, challenges, and recommendations.

V. CLOSING

Provisions of this policy not required by statute will be followed unless they conflict with negotiated labor contracts which will take precedence to the extent applicable.

Questions about this policy should be directed to Human Resources.

Copies of this policy may be posted on employee and public bulletin boards.

VI. REFERENCES

- A. *Americans with Disabilities Act of 1990 enacted July 26, 1990, codified at 42 USC 12010, as amended*
- B. *Montana Operations Manual, EEO, Nondiscrimination, and Harassment Prevention Policy*
- C. §§ 49-3-201; 49-3-205; 49-3-209; 49-4-101; 49-4-202, MCA
- D. ARM 2.21.4005
- E. 4-4054, 4-4142; *ACA Standards for Adult Correctional Institutions, 4th Edition*
- F. 4-4429-1; *ACA Standards Supplement, 2008*

VII. FORM

Discrimination Complaint



POLICY DIRECTIVE

Policy:	DOC 1.3.16 VOLUNTEER SERVICES
Effective Date:	11/01/1996 Page 1 of 3
Revision Date(s):	01/07/2015; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

The Department allows volunteers to provide important ancillary services in its facilities and programs for the benefit of staff and offenders. This policy does not apply to persons designated to serve on boards or advisory councils.

II. APPLICABILITY

Department-owned facilities and programs, and contracted facilities and programs as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Volunteer Programs

1. Volunteer programs encourage increased personal contact for offenders, access to community resources, and increased public awareness.
2. Volunteers assist in meeting the needs of staff and offenders by providing a direct service and a valuable contact between correctional programs and the public.
3. Volunteers will not perform duties that are normally performed by paid staff.
4. Recruitment efforts for volunteers typically occur by making contact with potential candidates in the following areas:
 - a. the public or community at large;
 - b. the media;
 - c. civic organizations;
 - d. local educational programs or facilities;
 - e. public agencies; and
 - f. local businesses.
5. Students may volunteer without compensation as part of a recognized academic program in accordance with *DOC 1.3.17 Student Interns*.

B. Volunteer Coordinators

1. Each facility or program that uses volunteers will appoint a qualified and trained employee to serve as the volunteer coordinator.
2. The coordinator will arrange for the appropriate training and supervision of all volunteer activities and, where applicable, oversee the recruitment and screening of volunteers in coordination with Human Resources (HR).
3. When a volunteer is selected, the coordinator will contact HR to coordinate Workers' Compensation coverage and reporting.

C. Eligibility Criteria

1. Applicants for volunteer positions must meet eligibility and screening criteria prior to approval that include, but are not limited to, the following:
 - a. must be 18 years of age or older, or be approved by the administrator;
 - b. must complete and return a volunteer application form specific to each division, facility, or program; and
 - c. must complete and sign an authorization to allow the Department to conduct background and criminal records checks on all applicants.
2. Relatives or victims of offenders may not provide volunteer services unless approved by the administrator.
3. Department employees must obtain a direct supervisor's written permission before the employee is assigned or trained for volunteer positions.
4. Volunteers may not be placed on an offender's visiting list at a facility where volunteer services are offered.
5. Volunteers may not correspond with offenders unless pre-approved by the administrator.
 - a. If approved, an established process will be developed by designated security and program staff.
6. Individuals previously under the care, custody, or supervision of the Department may be accepted as volunteers on a case-by-case basis, subject to the approval of the administrator.
7. Individuals may only act in the capacity of a professional service volunteer when certified or licensed to do so and only with the written approval of the administrator.

D. Training and Supervision

1. Volunteers must be trained on all rules and requirements applicable to the volunteer's effective functions and receive orientation and refresher training specific to the area, program, or facility where providing services.
2. Volunteers with direct and/or incidental contact with offenders must receive documented PREA training during volunteer orientation in accordance with *DOC 1.1.17 Prison Rape Elimination Act (PREA)*.
3. Each facility or program will address the orientation and supervision of volunteers assigned to work with special needs offenders, such as mentally impaired or developmentally disabled offenders.
4. Volunteers must agree to abide by all rules, obligations, and written responsibilities by signing the *Volunteer Service Agreement*.
5. Short-term and guest volunteers may receive an abbreviated orientation of applicable facility or program policies and procedures; however, the volunteer expectations must be clearly stated in writing.
6. Each administrator will ensure volunteers are provided supervision appropriate to the volunteer's work settings.
7. Under no circumstances will volunteers transport offenders in the volunteer's personal vehicle.
8. The administrator may authorize pre-approved volunteers in good standing with the facility to provide transportation to adult offenders upon release from a secure facility.

E. Usage of State Property

1. Volunteers may use state property (including motor vehicles with written permission of the administrator and on a case-by-case basis) in the performance of volunteer activities.
 - a. If an accident occurs while the volunteer is operating state equipment, state insurance coverage is provided for the state and the volunteer against claims made by others who may have been injured or whose property may have been damaged.
 - b. The Department will not assume liability for medical expenses for an injury to a volunteer.

F. Incidental Expenses

1. Volunteers receive no salary but may be reimbursed for incidental expenses such as transportation, lodging, meals, and other volunteer-related costs when necessary and approved for the performance of the volunteer activity.
 - a. The authorizing document for reimbursement shall be the *Volunteer Service Agreement*.
 - 1) The State of Montana Travel Expense Voucher will be used for reimbursement. The current state rules for travel and mileage reimbursement are authorized.
 - b. Department lodging may be provided in lieu of reimbursement when the volunteer assignment requires overnight lodging.
 - 1) Department housing will not, however, be used to barter volunteer services.

G. Recognition

1. Programs or facilities utilizing volunteers are encouraged to provide special recognition for participants who exhibit extraordinary commitment or performance.
 - a. Recognition can be achieved through recommendations for federal, state, or local awards or letters of appreciation, institutional recognition events, etc.

H. Termination

1. The administrator may suspend or terminate an individual volunteer or volunteer program at any time with or without cause.

V. CLOSING

Provisions of this policy not required by statute will be followed unless the provisions conflict with negotiated labor contracts, which will take precedence to the extent applicable.

Questions about this policy should be directed to Human Resources.

VI. REFERENCES

- A. 2-15-112, MCA
- B. 4-4115; ACA Standards Supplement, 2008
- C. DOC 1.1.3 Organization and Responsibility; DOC 1.1.17 Prison Rape Elimination Act (PREA); DO 1.3.17 Student Interns; DOC 3.1.5 Secure Facility Entry and Exit
- D. State of Montana, Department of Administration, Volunteer Program Guide

VII. FORMS

Volunteer Service Agreement



POLICY DIRECTIVE

Policy:	DOC 1.3.17 STUDENT INTERNS	
Effective Date:	11/08/2007	Page 1 of 2
Revision Date(s):	05/07/2020; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department maintains processes for recruitment and selection of student interns that provide fair and equitable access to Department work experience opportunities.

II. APPLICABILITY

All Department of Correction divisions, facilities, and programs.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Student internships consist of a supervised and structured practical experience to enhance the interns' understanding of the Department and establish future network partnerships.
2. The Department may provide student internships on a compensated basis with a competitive hiring process or non-compensated basis without a competitive hiring process.
 - a. If an internship position changes from non-compensated to compensated, the incumbent intern must participate in a competitive selection process.

B. Recruitment

1. Any candidate who wishes to apply for a student internship must complete the appropriate section of the *Intern Application and Proposal*.
2. Interns must meet minimum qualifications for a position and are responsible for obtaining any necessary certification.
3. The hiring authority must complete a reference and criminal background check on selected applicants.
4. At the beginning of a student internship, the supervisor and intern will complete the *Intern Application and Proposal* to confirm whether the internship will be compensated or non-compensated.
 - a. Non-compensated intern duties and responsibilities must be carefully outlined so there is no misunderstanding over whether the service performed is compensable under the Fair Labor Standards Act or includes bona fide work.
5. Interns will receive orientation to the Department and the assigned division, facility, or program.
6. At the end of the internship, the supervisor will provide the intern with a written evaluation outlining strengths and recommendations for future improvement related to the goals and objectives identified at the beginning of the internship.
 - a. The supervisor may forward a copy of the evaluation to Human Resources.
7. Upon request from the supervisor, Human Resources may conduct an exit interview with the intern.

C. Compensated Interns

1. Divisions, facilities, or programs wanting to recruit a **compensated** intern must have an FTE available or get approval from Financial Services, which will submit a Budget Change Document (BCD) to the Governor's Budget Office with a completed FTE detail sheet:
 - a. The hiring authority must submit the following to the Department budget office:
 - 1) a signed letter from the Department Director stating why the Department needs the paid position; and
 - 2) an Authorization to Recruit form.
 - b. The Department budget office will submit the request to the Governor's budget office requesting a position be created for the intern.
2. Paid interns will be recruited externally in accordance with the *Montana Operations Manual*.
3. Compensation will be based on the nature of the internship, the duties, and the individual's qualifications. The supervisor will establish the rate after consulting with Human Resources to ensure consistency.
4. All paid interns must fill out the new hire employment paperwork on their first day of work.

D. Non-Compensated Interns

1. A **non-compensated** internship position must meet the following criteria:
 - a. the position experience, though operational, is similar to that which would be obtained in a post-secondary institution of higher learning;
 - b. experience is for the benefit of the student;
 - c. intern does not displace an employee and is under supervision of a Department employee;
 - d. the Department derives no immediate advantage from the activities of the intern;
 - e. intern is not entitled to a job at the conclusion of the internship; and
 - f. supervisor and intern understand that the position is non-compensated.
2. The hiring authority must ensure that interns under their supervision have continuous Workers' Compensation coverage during the internship.

V. CLOSING

Provisions of this policy not required by statute will be followed unless the provisions conflict with negotiated labor contracts, which will take precedence to the extent applicable.

Questions about this policy should be directed to Human Resources.

VI. REFERENCES

- A. 2-18-101, MCA
- B. 29 USC Chapter 8: Fair Labor Standards Act

VII. FORM

Intern Application and Proposal



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 1.3.19	Subject: DRUG–FREE WORKPLACE
Chapter 1: ADMINISTRATION AND MANAGEMENT	Page 1 of 4
Section 3: Human Resources	Effective Date: July 1, 1996
Signature: /s/ Mike Batista, Director	Revised: 07/27/2015

I. POLICY

The Department of Corrections is committed to maintaining an alcohol and drug-free workplace environment. The Department prohibits employees from reporting to work who demonstrate a physical or mental impairment as a result of the use of alcohol or other drugs. The Department also prohibits the use of alcohol or other drugs while employees are on call.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Dangerous Drug – The meaning as defined in *50-32-101, MCA*.

On Call – An employee is designated as on call when officially notified by employer of an expectation that the employee will remain available outside regular duty hours for a specified window of time to be called back to duty, and is required at minimum to:

- a. carry a cell phone, radio or provide other reliable means of contact which will ensure their prompt availability in the case of a call back to the workplace or to other duty assignment;
- b. remain within a range of their regular duty station such that they will be able to present themselves at their duty station in less than 1 hour of notice to respond; and/or
- c. refrain from the consumption of alcohol and other substances, prescribed or un-prescribed, that may interfere with alertness or the performance of their normal duties.

Prescription Medication – A drug or medicine prescribed by a certified medical practitioner whether the medication was prescribed to the person having possession of the medication, or to another person.

IV. DEPARTMENT DIRECTIVES

A. General

1. The Department recognizes that alcohol and drug use in the workplace pose a significant threat to the Department's mission and goals.
2. The Department encourages employees to voluntarily seek help with alcohol and drug use problems.

B. Prohibited Behavior

Policy No. DOC 1.3.19	Chapter 1: Administration and Management	Page 2 of 4
Subject: DRUG-FREE WORKPLACE		

1. The Department prohibits employees from using, possessing, selling, trading, and/or offering for sale alcohol, dangerous drugs or intoxicants in the workplace.
2. Prescription and over-the-counter drugs are not prohibited when taken in standard dosage and/or according to a physician's prescription as long as they do not impair the employee's ability to perform their job. Any employee taking prescribed or over-the-counter medications will be responsible for consulting the prescribing physician and/or pharmacist to ascertain whether the medication may interfere with safe performance of his/her job. If the use of a medication could compromise the safety of the employee, fellow employees or the public, it is the employee's responsibility to use appropriate personnel procedures (e.g., call in sick, use leave, request change of duty, notify supervisor, etc.) to avoid unsafe workplace practices. Failure of an employee to inform his/her supervisor of medication use constitutes the employee's waiver of medication usage as a mitigating or defense factor in a disciplinary proceeding.
3. The Department prohibits employees from using illegal or unauthorized prescription drugs or intentionally misusing and/or abusing prescription medications in the workplace. Appropriate disciplinary action will be taken if job performance deterioration and/or accidents occur due to prescription medication misuse or abuse.

C. Notification of Convictions

1. Any employee who is convicted of a criminal drug violation must notify the immediate supervisor in writing within five calendar days of the conviction. The Department will take appropriate action within 30 days of notification.
2. Federal contracting agencies will be notified when appropriate.

D. Consequences

1. If an employee violates the provisions of this policy, he or she will be subject to progressive disciplinary action up to and including discharge.
2. The employee may be offered an opportunity to participate in a rehabilitation program at the employee's expense. In such cases, the employee may be required to sign and abide by the terms set forth in a Last Chance Agreement as a condition of continued employment.

E. Assistance

1. The Department recognizes that alcohol and drug abuse and addiction are treatable illnesses, and that early intervention and support improve the success of rehabilitation. To support employees, the Department:
 - a. encourages employees to seek help if they are concerned that they or their family members may have an alcohol and/or drug problem;
 - b. encourages employees to use the services of qualified professionals in the community to assess the seriousness of suspected alcohol or drug problems and identify appropriate sources of help;
 - c. offers all employees and their family members assistance with alcohol and drug problems through the Employee Assistance Program; and

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Subject: DRUG-FREE WORKPLACE		

- d. allows the use of accrued paid leave while seeking treatment for alcohol and other drug problems.
2. Treatment for alcohol and drug abuse and addiction may be covered by the employee benefit plan; however, the ultimate financial responsibility for recommended treatment resides with the employee.

F. Confidentiality

1. All information pertaining to employee alcohol and drug use or misuse in the workplace is confidential communication. Access to this information is limited to those who have a legitimate need to know and will only be disseminated in conformity with relevant laws and Department policy.

G. Shared Responsibility

1. A safe and productive drug-free workplace is achieved through cooperation and shared responsibility between employees and Department managers.
2. Employees are encouraged to:
 - a. show concern for a safe working environment;
 - b. support co-workers in seeking help;
 - c. use the Employee Assistance Program; and
 - d. report unsafe behavior to supervisors.
3. Supervisors are responsible for:
 - a. informing employees of the drug-free workplace policy;
 - b. observing employee performance;
 - c. investigating reports of unsafe practices;
 - d. documenting negative changes and problems in performance;
 - e. counseling employees on expected performance improvement;
 - f. referring employees to the Employee Assistance Program; and
 - g. clearly stating consequences of policy violations.

H. Communication

1. To ensure that new employees are aware of the Department's drug-free workplace policy, supervisors will provide an electronic or paper copy of the policy at the time of hire.
2. All employees will have access to the current policy and subsequent revisions when updated policies are published on the Department's Intranet and Internet website.

V. CLOSING

Provisions of this policy not required by statute will be followed unless the provisions conflict with negotiated labor contracts, which will take precedence to the extent possible.

Questions concerning this policy should be directed to Human Resources.

VI. REFERENCES

Policy No. DOC 1.3.19	Chapter 1: Administration and Management	Page 4 of 4
Subject: DRUG-FREE WORKPLACE		

A. 50-32-101, MCA; 53-1-203, MCA

B. Drug-free Workplace Act of 1988 (Publ. L. 100-690, Title V, Subtitle D)

VII. ATTACHMENT

None



POLICY DIRECTIVE

Policy:	DOC 1.3.29 ON-CALL STATUS FOR EXEMPT AND NONEXEMPT EMPLOYEES	
Effective Date:	10/05/1992	Page 1 of 2
Revision Date(s):	01/07/2015; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department compensates employees required to remain available outside normal duty hours in a manner consistent with the degree of restriction imposed on the employee's free time and applicable statute and policies.

II. APPLICABILITY

All department divisions, facilities, and programs, except Division Chiefs or Wardens, Montana State Prison physicians, and positions that provide an enhanced salary for on-call responsibilities based on the nature of the position.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Accruing On-Call Leave

1. Employees shall not be assigned to on-call service unless such service is deemed critical and essential to the mission of the Department.
2. When an employee is assigned to on-call service, the Department shall provide a radio or mobile device for the employee's use.
3. On-call leave is accrued by the method described below:
 - a. on a scheduled workday, an employee in on-call status shall be credited with 1 hour of on-call leave for each day of on-call service, regardless of whether time was worked;
 - b. on an employee's regular day(s) off, an employee in on-call status shall be credited with 2 hours of on-call leave for each day of on-call service, regardless of whether time was worked;
 - c. on a legal holiday as provided in 1-1-216, MCA, an employee in on-call status shall be credited with 2 hours of on-call leave for each day, regardless of whether time was worked;
 - d. time accrued for on-call status is not considered hours worked for purposes of overtime accrual; and
 - e. on-call leave accrual may not exceed 120 hours; on-call leave submitted once the maximum allowance is reached may not be approved by supervisors until the balance is below 120.
4. Additional provisions for on-call leave granted to **nonexempt** employees:
 - a. when an employee reports to work due to a call-out, compensation at the overtime rate of pay, or by FLSA compensatory time, shall be administered for hours worked over 40 hours in the work week;
 - b. compensation begins at the clocked time the employee signs in on the premises;
 - c. hours worked may be offset within the workweek, and overtime pay shall not be paid until total hours worked exceed 40 within the workweek; and
 - d. minimum compensation for call-out shall be 1 hour.

5. Additional provisions for on-call leave granted to **exempt** employees:
 - a. an exempt employee must be assigned call-out responsibilities for a minimum of 8 hours to be eligible for compensatory time; lesser periods of time may be compensated when agency needs justify a lesser period of time and with the approval of an administrator or authorization of a supervisor;
 - b. time actually worked through call-out to work shall be compensated by hour-for-hour compensatory time for hours worked exceeding 40 hours within the workweek;
 - c. call-out service begins upon reporting to the employer's premises for service; and
 - d. minimum compensation for call-out shall be 1 hour.

B. Administration of On-Call Leave

1. On-call leave shall be submitted bi-weekly through the established payroll reporting process. Payroll Code "OCLCE" shall be used to accrue on-call leave hours and "OCLCT" shall be used when taking on-call leave.
2. Employees must request to use on-call leave using the process established by their supervisor.
 - a. Approval or denial of on-call leave is based on agency and employee interests.
 - b. Management reserves the right to deny the request based on agency need.
3. The Department encourages employees to make timely requests to use and to manage their accrued on-call leave closely.
4. On-call leave must be used before separating from the agency, as it may not be paid out in a lump sum upon resignation.

V. CLOSING

Provisions of this policy shall be followed unless they conflict with negotiated labor contracts, which shall take precedence to the extent applicable.

Questions about this policy may be directed to Human Resources.

VI. REFERENCES

- A. 1-1-216, MCA



POLICY DIRECTIVE

Policy:	DOC 1.3.35 BLOOD-BORNE PATHOGENS EXPOSURE CONTROL PLAN	
Effective Date:	04/01/1997	Page 1 of 2
Revision Date(s):	12/09/2014; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department complies with the blood-borne pathogens guidelines outlined in ARM 24.30.102 and 29 CFR 1910.1030 to eliminate or minimize employee occupational exposure to human blood or other infectious bodily fluids.

II. APPLICABILITY

All facilities, divisions, and programs Department-owned and contracted, as specified in the contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Responsibility

1. Department administrators are responsible for providing all necessary supplies (for example, personal protective equipment, soap, approved disinfectant cleaner, and Hepatitis B vaccinations) and assuring facilities have an *Exposure Control Plan* in compliance with ARM 24.30.102. Department supervisors are responsible for ensuring their employees comply with the provisions of this policy.

B. Facility Exposure Control Plans

1. Universal precautions will be observed by all employees in order to prevent contact with blood or other potentially infectious materials. All blood or other potentially infectious materials will be considered infectious regardless of the perceived status of the source individual.
2. Exposure control plans must be developed based on the individual and unique needs of each Department facility. Plans must contain and address the following:
 - a. Staff Exposure Determination – identify employee positions that may, based on their duties, have exposure to air-borne, blood-borne, and body fluid pathogens or other potentially infectious material. Examples of positions include:
 - 1) medical services, nursing, and dental care
 - 2) direct offender supervision
 - 3) housekeeping, laundry, facility maintenance, and repair
 - 4) first aid and CPR
 - 5) food service and industry training
 - b. Hepatitis B Vaccine – include provision for administering vaccine, tracking and recordkeeping, and post-exposure incident evaluation and follow up.
 - c. Engineering and Work Practice Controls – eliminate or minimize exposure of employees working at the Department.
 - d. Housekeeping – include decontamination of employees and work areas and equipment, disposal of contaminated sharps and regulated waste, and laundry procedures.
 - e. Personal Protective Equipment – include equipment provided, employee use, and disposal or replacement.
 - f. Employee Orientation and Training – include new employees and ongoing updates and training of current employees.

C. Hepatitis B Immunization

1. The Hepatitis B vaccination will be made available, without charge, to all employees determined to be at occupational risk.
 - a. Immunization of employees is not required but is encouraged, particularly for high risk occupational groups.
 - 1) Exceptions to receipt of the vaccination include:
 - a) the employee has previously received the complete Hepatitis B vaccination series;
or
 - b) the vaccine is contraindicated for medical reasons.

D. Hepatitis B Vaccination Administration

1. Each employee identified as at occupational risk will be provided a copy of the *Hepatitis B Vaccine Disclosure* form that provides information on the vaccine, side effects, indications for receiving the vaccine, contraindications, and other hepatitis diseases.
2. Each employee will also be provided an *Acceptance or Declination Statement* and must elect to either receive or waive the vaccine as indicated on the disclosure form.
 - a. The signed and dated form will be retained in the employee's medical file maintained by Human Resources.
3. Employees who elect to receive the vaccination will obtain the 3-part vaccination series as provided in the *Facility Exposure Control Plan*.
 - a. Employees are responsible for assuring they complete the vaccinations series, following the schedule provided at the initial inoculation.
4. If an employee initially declines the Hepatitis B vaccination, but at a later date decides to accept the vaccination, the vaccination will then be made available.
5. If a routine booster dose of Hepatitis B vaccine is recommended by the U.S. Public Health Service at a future date, such booster doses will be made available at no cost to the employee.
6. The Hepatitis B vaccine will be offered to all Department employees who, during the course of their employment and regular job duties, may come into contact with human blood or potentially infectious bodily fluids.

E. Post-Exposure Evaluation and Follow Up

1. An employee who incurs an exposure incident must immediately report the incident to their supervisor.
 - a. All employee exposure incidents will be reported, investigated, and documented as described in the facility exposure control plan.

V. CLOSING

Provisions of this policy not required by statute will be followed unless they conflict with negotiated labor contracts, which will take precedence to the extent applicable.

Questions about this policy should be directed to Human Resources or the administrator.

VI. REFERENCES

- A. 29 CFR 1910.1030; *Occupational Safety and Health Regulation, Blood Borne Pathogens*
- B. ARM 24.30.102; *Occupational Safety and Health Code for Public Sector Employment*

VII. FORMS

Hepatitis B Vaccine Disclosure
Acceptance or Declination Statement



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 1.3.36	Subject: CRITICAL INCIDENT STRESS MANAGEMENT (CISM)
Chapter 1: ADMINISTRATION AND MANAGEMENT	Page 1 of 4
Section 3: Human Resources	Effective Date: July 1, 1998
Signature: /s/ Mike Batista, Director	Revised: 03/01/2016

I. POLICY

The Department of Corrections provides timely assistance to employees and other individuals exposed to critical job-related incidents or stressful events that may require intervention, assessment, and follow up care.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

CISM Leave – A period of time during which an employee is removed from the worksite due to exposure to a critical incident.

CISM Debriefing – A structured small-group crisis intervention discussion conducted within 14 days of a critical incident for participants to process and discuss reactions to the incident and obtain emotional support.

CISM Defusing – A facilitated communication with both the employee and their immediate supervisor in the first 12 hours to initially identify critical incident stress needs.

CISM Team – A group of individuals which will include someone from the Office of Human Resources (OHR) and may include a mental health provider facilitator, and/or facilitator(s) trained to provide peer support, defusing, and debriefing.

CISM Team Leader – The Department employee responsible for coordinating and directing the CISM team, training team readiness and competence, developing specific debriefing plans, locating debriefing areas, and submitting debriefing reports to the administrator.

Critical Incident – The on-the-job situation or event that precipitates an individual's crisis or critical incident stress reaction.

Critical Incident Stress – The mental, physical, emotional, or behavioral reactions to a critical incident.

Critical Incident Stress Management (CISM) – A comprehensive, integrated, and systematic crisis intervention approach used to manage and alleviate an individual(s) stress reactions after experiencing critical incidents.

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Subject: CRITICAL INCIDENT STRESS MANAGEMENT (CISM)		

Department Employee – A person employed by the Department of Corrections who has attained permanent status or is eligible to attain permanent status, as provided in 2-18-601, MCA; volunteers, interns, temporary and short term workers; this term does not include service providers.

Incident Commander (IC) – The individual with overall authority and responsibility for conducting incident activities and managing operations at the incident site.

Mental Health Professional – A licensed clinical social worker, licensed psychologist, or other licensed professional counselor trained in the critical incident trauma-debriefing model who has an understanding of, and experience with, correctional employees.

Peer Support – A Department employee trained to provide peer support in the form of one-to-one discussions, defusing, debriefing, and assisting a mental health professional conducting an assessment.

Service Providers - This term includes contracted persons or other vendors providing service whose assignment is primarily on Department premises, e.g. facility or program office.

IV. DEPARTMENT DIRECTIVES

A. General

1. Critical incidents may include any incident leading to serious injury, death or trauma. It is the responsibility of the IC and the individual employee to determine if CISM is warranted.
2. Administrators of divisions, facilities, or programs with direct offender contact will implement and maintain operational procedures directing how to activate a CISM team and designate a CISM team leader whose responsibilities include:
 - a. provide advice and counsel to the IC and assist with CISM;
 - b. provide a written report to the administrator with the date, time, and names of those who attended the CISM debriefing sessions;
 - c. maintain a current telephone list of Department employees from each facility trained in CISM;
 - d. maintain a list of individual(s) trained in peer support;
 - e. designate an area for briefing families;
 - f. designate an alternate CISM team leader if primary team leader is unavailable;
 - g. assist in CISM team selection;
 - h. ensure new CISM team members attend a professional CISM training course;
 - i. coordinate and plan periodic training opportunities for CISM team members;
 - j. ensure the training documentation is forwarded to the Department's Professional Development Bureau for entry into the training database; and
 - k. in the event of an emergency will:
 - 1) establish contact with the command center for briefing;
 - 2) implement the emergency procedures for a critical incident; and
 - 3) arrange for logistical support for families of affected individual(s).
3. CISM team members or Department mental health professional are available to assess individual(s) involved in incidents. Employees may also utilize mental health

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professionals within the state's health care system.

4. Services available to individual(s) who have been subject to an incident may include, but are not limited to, the following:
 - a. CISM leave:
 - 1) administrative leave – paid leave for up to 40 hours, where the employee is relieved of all duties;
 - 2) temporary telework – assignment of meaningful work which can be done on a temporary basis, not to exceed 40 hours, from the employee's home; or
 - 3) temporary reassignment – reassignment to another worksite within the Department, which may be either within or outside the facility, division or program, not to exceed 40 hours, unless approved by the administrator in consultation with the Office of Human Resources;
 - b. CISM defusing;
 - c. CISM debriefing;
 - d. counseling through the state health care system;
 - e. hostage rehabilitation; and
 - f. assistance with benefit and insurance issues.

B. CISM Team Responsibilities

1. In the event of a critical incident, the responsibilities of the CISM team include:
 - a. ensure that all participants are identified;
 - b. determine the level of services to be activated; and
 - c. if necessary:
 - 1) activate a Department CISM team in accordance with *DOC Policy 3.2.1A RD, Emergency Operations Plan, Volume IV, Recovery* or access a local CISM team through cooperative agreements;
 - 2) identify CISM debriefing sites;
 - 3) assign peer supporter(s) to support affected individual(s);
 - 4) offer voluntary CISM defusing/debriefing to affected individual(s).
2. The team member from OHR is responsible for referring the individual(s) to a provider within the state's health care system.
3. The responsibilities of each team member include, but are not limited to:
 - a. attend an initial professional CISM training course;
 - b. attend periodic trainings;
 - c. maintain confidentiality regarding information from peer support and CISM defusing/debriefing sessions; and
 - d. disclose information:
 - 1) relevant in an investigation;
 - 2) necessary to ensure individual(s) safety and continuing mental health care; and
 - 3) mandated by law to be reported.

V. CLOSING

Questions concerning this policy should be directed to the Office of Human Resources.

Policy No. DOC 1.3.36	Chapter 1: Administration and Management	Page 4 of 4
Subject: CRITICAL INCIDENT STRESS MANAGEMENT (CISM)		

VI. REFERENCES

- A. 4-4225-1; *ACA Standards Supplement*, 2008
- B. *DOC Policy 3.2.1(A) RD, Emergency Operations Plan (EOP)*
- C. *Critical Incident Stress Management (CISM): Group Crisis Intervention Manual*,
International Critical Incident Stress Foundation (ICISF)

VII. ATTACHMENTS

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 1.3.41	Subject: EMPLOYEE DRESS, UNIFORM AND HYGIENE
Chapter 1: ADMINISTRATION AND MANAGEMENT	Page 1 of 2
Section 3: Human Resources	Effective Date: May 1, 1997
Signature: /s/ Mike Batista, Director	Revised: 02/23/2015

I. POLICY

The Department of Corrections will ensure that all employees wear appropriate clothing and maintain a neat and clean appearance appropriate to their specific duties.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility, or program operation and management.

Facility/Program - Refers to any division, prison, secure care correctional facility, correctional or training program, or community-based program under Department jurisdiction or contract. This term includes the facility building or residence, including property and land owned or leased and operated by the Department.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. In the interest of presenting a professional image to the public and serving as a positive role model for offenders, all employees will observe good habits of grooming and personal hygiene.
2. Supervisors are responsible for enforcing appropriate standards of personal appearance and cleanliness of employees in their work areas.
3. Administrators may establish additional standards or may require uniforms and facility badges as needed for the unique health, safety, modeling, and public image requirements of the work area.

B. Clothing and Uniforms

1. Clothing and uniforms must be clean, in good repair, fit well, and appropriate for the assigned work area.
2. Applicable facilities will establish procedures on the use and care of state-issued uniforms.

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Subject: EMPLOYEE DRESS, UNIFORM AND HYGIENE		

3. When an employee resigns, is terminated, or retires, his or her supervisor will assure return of all state-issued uniforms and accessories, as well as state-issued identification cards.
4. Questions that arise about what constitutes appropriate attire or hygiene may be directed to the immediate supervisor.

C. Facility Badges

1. Adult and youth secure facilities and community corrections programs may issue facility badges to employees.
2. Facilities that elect to issue badges must establish procedures that address:
 - a. when, how, and to whom badges are issued;
 - b. the procurement costs for each facility badge;
 - c. person responsible for maintaining and accounting for badges whether issued to a current employee, awarded to a former employee, or placed in storage; and
 - d. return and inventory of Department equipment/badges upon termination of employment.

D. Permanently Awarded Badges

1. Facilities may permanently award a facility badge affixed to a plaque so that it can no longer be used as a functional badge to individuals who terminate employment, are in good standing with the facility, and have a minimum of ten years of service.
2. Facilities must establish consistent criteria that define whether an employee is in good standing.
3. Eligible employees may apply for a permanently awarded badge by submitting a written request to the administrator.
4. If an employee has ten years of “good standing” service at different Department facilities, the administrator and the employee will determine which facility badge is awarded. If there is disagreement on this matter, the administrator will make the final decision.
5. Exceptions for permanently awarding facility badges may be allowed at the discretion of the administrator.

V. CLOSING

Provisions of this policy not required by statute will be followed unless the provisions conflict with negotiated labor contracts, which will take precedence to the extent applicable.

Questions concerning this policy should be directed to the Office of Human Resources.

VI. REFERENCES

A. 53-1-203, MCA

VII. ATTACHMENTS

None



POLICY DIRECTIVE

Policy:	DOC 1.3.42 FRAGRANCE-FREE WORKPLACE	
Effective Date:	11/17/2010	Page 1 of 1
Revision Date(s):	06/01/2015; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department recognizes that employees and visitors to our workplace may have sensitivity to or allergic reactions to various fragrant products and therefore encourages employees to refrain from wearing or using scented products while on duty.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. REQUIREMENTS

A. Limited Use of Fragrant Products

1. Fragrant personal products (perfumes, colognes, lotions, powders, and other scented products) are to be worn sparingly by employees.
2. If a scent offends or disturbs an employee, customer, or vendor, management will order the employee to cease using the scent.
3. Other fragrance products (scented air diffusers, potpourri, scented candles, sprays, deodorizers, and other similar items) are prohibited.

B. Reasonable Accommodation

1. Employees should contact Human Resources if a reasonable accommodation is required for bona fide health reasons regarding their reaction to scented products used by coworkers or to scent(s) emitted as a result of business processes.

IV. CLOSING

Provisions of this policy not required by statute will be followed unless they conflict with negotiated labor contracts, which will take precedence to the extent applicable.

Questions about this policy should be directed to Human Resources.



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy:	DOC 1.3.45 PERFORMANCE EVALUATIONS
Chapter 1:	ADMINISTRATION AND MANAGEMENT
Section 3:	HUMAN RESOURCES
Effective Date:	June 1, 1998 Page 1 of 3
Revised:	December 30, 2020
Signature:	/s/ Reginald D. Michael

I. POLICY

Department of Corrections (Department) supervisors will conduct employee performance evaluations for their direct reports on a regular basis to assist with managing work performance.

II. APPLICABILITY

All Department divisions, facilities, and programs.

III. DEFINITIONS

Annual Evaluation – The yearly work performance review and rating of an employee

Human Resources Information System (HRIS) – A software or online solution that is used for data entry, data tracking and the data information requirements of an organization's human resources (HR) management, payroll and bookkeeping operations.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. The Department will establish and maintain a performance management system in compliance with the Montana Operations Manual (MOM) Performance Management and Evaluation policy.
 - a. The performance management and evaluations system will address employee performance as it relates to the overall success of the Department's mission, goals, and objectives, as well as adherence to expected standards of conduct such as those identified in *DOC Policy 1.3.2 Performance and Conduct*; and
 - b. performance evaluations will use employee performance goals and measures to further employee development whenever possible.
2. Evaluation meetings must be conducted in person for all employees at least annually.
 - a. In-person evaluation meetings should be conducted in a private location where minimal interruptions are anticipated; and
 - b. annual evaluation meetings are the mandatory minimum requirement. It is recommended that one-on-one performance management meetings are conducted on a regular basis throughout the year.
2. Supervisors will evaluate employee performance utilizing materials approved by the Human Resources Bureau (HR).

Policy No. DOC 1.3.45	Chapter 1: Administration and Management	Page 2 of 3
Subject: PERFORMANCE MANAGEMENT AND EVALUATION		

3. HR, or the applicable Human Resources Information System (HRIS) automated application, will provide the Department notice of pending performance evaluation activities.
 - a. Prior to the due date of an evaluation meeting, the supervisor must schedule an in-person meeting date and time with the employee.
4. Supervisors will ensure employees acknowledge that they have received an evaluation. This acknowledgment must be made by signing a document for the employee's personnel file, or by an electronic acknowledgement via an HRIS automated application.
5. If an employee refuses to acknowledge participation in the evaluation, a supervisory witness may attest the employee was present and participated in performance evaluation. Regardless of a refusal to acknowledge, the employee must be provided access to the evaluation.
6. Performance management training will be provided for all supervisors who conduct performance evaluations.

B. Agency Review

1. Supervisors will be held accountable by their immediate supervisor for compliance with this policy.
2. Supervisors are encouraged to share with their immediate supervisor information about employee evaluations as needed.

C. Evaluation Rebuttal

1. If an employee disagrees with supervisory actions during the performance evaluation process, the employee will be provided an opportunity to submit a response to his/her supervisor or HR to be included with the evaluation.

D. Evaluation Grievance

1. The employee may grieve adverse employment actions taken as a result of the performance evaluation in accordance with *ARM 2.21.4001 et seq.*

E. Records

1. The performance evaluation and rebuttal comments, if any, will be retained in the employee's personnel file or in applicable HRIS electronic records.

IV. CLOSING

Provisions of this policy not required by statute will be followed unless the provisions conflict with negotiated labor contracts, which will take precedence to the extent applicable. Questions concerning this policy should be directed to the Human Resource Bureau.

VI. REFERENCES

- A. *DOC Policy 1.3.2 Performance and Conduct*

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B. ARM 2.21.4001 et seq

VII. ATTACHMENTS

None



POLICY DIRECTIVE

Policy:	DOC 1.3.46 EMPLOYEE REST AND MEAL BREAKS	
Effective Date:	12/28/2006	Page 1 of 2
Revision Date(s):	03/01/2021; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department provides employees with meal and rest breaks that comply with state policy and state and federal labor laws. Employee breaks will be based on facility staffing patterns, operational needs, and security requirements.

II. APPLICABILITY

All divisions, facilities, and programs.

III. REQUIREMENTS

A. General Provisions

1. The following requirements apply to rest periods:
 - a. Rest periods of short duration, running from 5 minutes to about 20 minutes, are common.
 - 1) They promote the efficiency of the employee and are customarily paid for as working time.
 - 2) They must be counted as hours worked.
 - 3) Compensable time of rest periods may not be offset against other working time such as compensable waiting time or on-call time.
 - b. Rest periods are not an entitlement and must not interfere with the accomplishment of assigned duties.
 - c. The Department allows one fifteen-minute break per four hours worked when the break does not interfere with the accomplishment of assigned duties.
 - 1) When an employee is on shift, one break may be taken during the first half of the work period, and one break may be taken during the second half of the work period.
 - d. Breaks may not be used to start shifts late or leave early.
 - e. Administrators may require employees who work in facilities or programs that house offenders to remain on the facility grounds during breaks.
2. The following requirements apply to meal periods:
 - a. Administrators may allow employees to take paid or unpaid meal periods.
 - 1) If the mealtime is unpaid, the employee must be completely relieved from duty for the purposes of regular meals.
 - b. Employees are entitled to one meal break per work period of 6 or more hours in a day or shift.
 - c. Meal periods may not be used to start work late or to leave work early.
 - d. It is not necessary that an employee be permitted to leave the premises if the employee is completely freed from duties during the meal period.

B. Secure Facility Breaks

1. The Department recognizes that secure facilities have unique environments with operational needs.
2. Facility administrators will:

- a. establish requirements to address employee meal period compensation;
 - b. ensure requirements comply with the provisions of this policy; and
 - c. review requirements for adherence to federal and state labor laws.
3. Applicable staff are eligible for a 30-minute paid meal period regardless of established work schedules (for example 8, 10, or 12 hour shifts during which employees must remain on-site at the facility).

C. Alternative Meal Break Periods

1. Employees may take alternative meal breaks up to 1.5 hours in length with approval from their immediate supervisor.

IV. CLOSING

Provisions of this policy not required by statute will be followed unless the provisions conflict with negotiated labor contracts, which will take precedence to the extent possible.

Questions about this policy should be directed to Human Resources.



POLICY DIRECTIVE

Policy:	DOC 1.3.52 FAMILY WORKPLACE RELATIONSHIPS	
Effective Date:	09/08/2011	Page 1 of 2
Revision Date(s):	05/10/2016; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department strives to identify and manage family member relationships between supervisors and subordinates through self-identification and active division administrator involvement to mitigate the perception of preferential treatment and maintain professionalism.

II. APPLICABILITY

All Department divisions, facilities, and programs.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Provisions

1. This policy does not prohibit personal relationships between Department employees, or Department and contractor employees and does not presume family member relationships adversely affect the ability of employees to work together.
2. This policy does recognize the potential for the perception of adverse effects to exist and attempts to ensure such perception does not become reality.
3. A supervisor will not allow family member relationships to affect workplace behavior or job responsibilities.
4. If an individual supervises a family member, the individual must report the existence of the relationship to the division administrator as soon as practical.
5. Supervisors will not participate in a selection process in which a family member is an applicant.
6. Department employees will not participate in the bid award process in which a family member is an employee of a contractor.
7. An employee who believes the employee has been adversely affected by preferential treatment due to a family member relationship will report concerns to the administrator.

B. Resolution

1. Supervisor, subordinate and contractor family member relationships involving new or existing employees will be documented using the *Family Member Relationship Disclosure*.
 - a. The form will be completed by the affected and disclosing individuals and the administrator, stored by Human Resources, and accessible to those in the chain of command on a need-to-know basis.
2. A mitigation plan to maintain a professional working environment will be developed by the administrator and attached to the *Family Member Relationship Disclosure*.

C. Exceptions

1. In circumstances where acting or temporary assignments exceeding 30 days occur, a written alternate reporting structure will be established by an administrator.

V. CLOSING

Questions about this policy should be directed to Human Resources.

VI. REFERENCES

- A. *DOC 1.3.2 Performance and Conduct*

VII. FORM

Family Member Relationship Disclosure



POLICY DIRECTIVE

Policy:	DOC 1.3.54 PUBLIC SAFETY OFFICER DEATH	
Effective Date:	05/10/2016	Page 1 of 2
Revision Date(s):	12/30/2020; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department will provide assistance and support to the immediate survivors of a Department public safety officer who dies in the line of duty, as well as demonstrating fidelity to all public safety officers for off-duty deaths, retired officer's death, or line-of-duty death of an officer from a different jurisdiction.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Death of a Department Public Safety Officer

1. The family support officer:
 - a. will notify the union representative of the officer's death; and
 - b. will be responsible for obtaining:
 - 1) all the officer's personal belongings at the Department and returning them to the family; and
 - 2) all Department-issued equipment for return to the Department.
2. For line-of-duty deaths, the family support officer:
 - a. initially will assist as needed with the officer's family in the planning of memorial services, including offering assistance to the family in meeting their transportation or lodging needs for additional family who may be attending memorial services; and
 - b. will keep the family informed on all new developments relating to press releases, trial proceedings, and investigative findings and will notify, remind, and accompany the family members to all court proceedings relating to the officer's death or serious injury including probation and parole hearings if applicable.
3. The benefits coordinator is responsible for assisting the officer's survivors in obtaining benefits in a timely manner.

B. Mourning Band Protocol

1. The black mourning band:
 - a. should be worn straight across the center of the badge;
 - 1) for star badges, the mourning band should be worn from 11 to 5, as if looking at the face of a clock;
 - b. width should not exceed ½ inch; and
 - c. may not cover a badge number.
2. Upon the line-of-duty death of a Department public safety officer, the mourning band should be worn as indicated:

- a. Officers at the same facility or location should wear the mourning band from the time of death until 2400 hours 30 days following the death or at the discretion of the administrator.
 - b. Officers at other facilities or locations should wear the mourning band from the time of death until 2400 hours on the day of the memorial service.
3. For off-duty death of a Department public safety officer, including retirees, the mourning band should be worn while attending the memorial service and removed at the conclusion of the memorial service.
4. On the day of any memorial service the Department observes honoring officers who have died in the line of duty, the mourning band should be worn from 0000 to 2400 hours.

C. Memorial Service Attendance

1. The Department Director or facility administrator may approve any number of current employees to attend a memorial service for an on-duty death of a Department public safety officer during paid time while balancing the need for security and continued operations.
2. Employees who are not approved to use paid time may ask to attend the memorial service using annual leave or comp time by following the standard request process.

D. Line-of-Duty Death of a Public Safety Officer from Another Jurisdiction

1. Upon the line-of-duty death of a public safety officer from another jurisdiction, the mourning band should be worn from the date of death and removed at the conclusion of the day of burial.
2. At the discretion of the Department Director or the facility administrator, up to two Department public safety officers may be designated to represent the Department on paid time to attend the memorial service of a line-of-duty death of a public safety officer from another jurisdiction.

V. CLOSING

Provisions of this policy not required by statute will be followed unless the provisions conflict with negotiated labor contracts, which will take precedence to the extent possible.

Questions about this policy should be directed to Human Resources.

VI. REFERENCES

- A. 44-4-401, MCA



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 1.3.55	Subject: CRIMINAL CONVICTION IN EMPLOYMENT
Chapter 1: ADMINISTRATION AND MANAGEMENT	Page 1 of 5 and Attachment
Section 3: Human Resources	Effective Date: 01/03/2017
Signature: /s/ Brian Gootkin	Revised: June 16, 2021

I. POLICY

The Department of Corrections conducts criminal background checks as a condition of employment. Evidence of a conviction may not automatically disqualify an applicant or an employee from continued employment. If an individual has a criminal history, the Department will consider the following factors before extending an offer of employment or continuing employment: the nature and gravity of the offense; the time since the completion of the sentence; and the nature of the job held or sought along with the relatedness of the conviction.

II. APPLICABILITY

All divisions, facilities and programs Department-owned.

III. DEFINITIONS

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Brady Act & Lautenberg Amendment – Any person who has been convicted of a misdemeanor crime of domestic violence or is the subject of a court order of protection for “an intimate partner or child of such intimate partner” cannot lawfully possess a firearm or ammunition. *See* 18 U.S.C. § 922(g)(8) & (9).

Criminal Conduct – A charge or conviction of a violation of city, county, state, or federal law, including all felonies and serious misdemeanors, including but not limited to: assault; sexual assault; traffic violations, e.g., hit and run, driving under the influence (DUI), reckless driving; or other violations by staff that could result in the imposition of a jail sentence and/or suspension or revocation of the violator's driver license.

Department Employee – A person employed by the Department of Corrections who has attained permanent status or is eligible to attain permanent status, as provided in § 2-18-101(20), MCA; a volunteer, an intern, or a temporary or short-term worker. This term does not include service providers.

Facility/Program – Refers to any division, prison, secure care correctional facility, correctional or training program, or community-based program under Department jurisdiction or contract. This term includes the facility building or residence, including property and land owned or leased and operated by the Department.

POST Certified – Refers to any public safety officer, as defined under § 44-4-401(2), MCA, certified by the Montana Public Safety Officer Standards and Training Council.

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Service Providers – This term includes contracted persons or other vendors providing service whose assignment is primarily on Department premises, e.g., facility or program office.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. The Department is committed to protecting the safety of all employees and other individuals in our workplace, as well as state assets.
2. The Department will comply with all federal anti-discrimination laws in all employee selection processes.
3. The Department recognizes the important role obtaining meaningful employment plays in the successful reintegration of offenders into the community.
4. Consideration of criminal background information will be based on relevancy to the specific position held or sought.
5. The Department's correctional officers and probation and parole officers, as well as their respective chains of command, are subject to POST certification requirements and the Brady Act & Lautenberg Amendment. Candidates who have been convicted of any felony or a misdemeanor crime of domestic violence or were issued a court order of protection are not qualified for POST certified positions.
6. For positions which may have contact with offenders, the Department will not hire, enlist the services of, or continue employment of an employee or service provider who:
 - a. has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution;
 - b. has been convicted of engaging in or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force or coercion, or if the victim did not consent or was unable to consent or refuse;
 - c. has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (b) of this subsection; or
 - d. has contact with youth and is listed on the DPHHS child abuse registry.
7. Employees have a continuing affirmative duty to disclose any of the misconduct listed in Section IV.A.6 of this policy.
8. Prior to hiring, promoting, or enlisting the services of any individual who may have contact with offenders, the Department will consider any incident where the individual engaged in sexual harassment.
9. Upon hire, transfer, promotion, and every five years thereafter, Human Resources will ensure that criminal background checks are conducted on employees and service providers who may have contact with offenders and ensure a DPHHS child abuse registry search for employees or service providers who may have contact with youth.

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10. All employees who may have contact with offenders must complete the [Policy Acknowledgement and Disclosure Form in written applications or interviews](#) for hiring and promotion and annually. The form will be submitted to Human Resources.
11. Employees must self-report criminal charges and convictions within five days of either the charge or conviction to their immediate supervisor and Human Resources.
12. If an administrator or supervisor has reason to believe a current employee may have been involved in criminal conduct, he or she will notify Human Resources immediately.
13. The Department will abide by the Fair Credit Reporting Act, Montana human rights statutes, and all applicable laws to ensure individuals are not discriminated against.

B. Criminal Background Checks in Hiring

1. Criminal background checks will be conducted on finalists for vacant positions, as identified in the vacancy announcement, and on all individuals assigned to work at the Department by service providers.
2. If the criminal background check indicates there are no convictions, Human Resources will inform the hiring manager that the candidate is eligible for employment.
3. If the criminal background check indicates any convictions, Human Resources will notify the administrator and hiring manager and will follow Section IV.D. of this policy.

C. Convictions During Employment

1. Criminal background checks are conducted every five years on existing employees and service providers in accordance with the *Prison Rape Elimination Act of 2003*.
2. The Department may further review an employee's criminal background during their employment at any time for due cause.
3. If the criminal background check indicates any conviction, Human Resources will then determine whether the conviction was previously disclosed either during the employee's initial hiring process or subsequently to their immediate supervisor, or whether the conviction presents new information not previously known by the Department. If the conviction represents new information, Human Resources will notify the administrator and follow Section IV.D. of this policy.
4. In all cases, the Department will take appropriate action based on the information discovered relative to the position the employee currently holds.

D. Evaluation of Criminal Record History

1. If a pre-employment criminal background check reveals any conviction which the individual disclosed in the recruitment process, Human Resources will consider the factors for each conviction, including any additional information that the individual provides before the offer of employment is confirmed or withdrawn. In consultation with Human Resources and the Department's legal counsel, the administrator supervising the

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position and the hiring manager will determine a course of action. The existence of a conviction does not automatically disqualify an individual from employment.

2. If an unreported conviction for an employee or applicant is discovered in a criminal background check, and unless the individual proves that the report is in error, the offer of employment may be withdrawn, or, if employed, the employee may be subject to formal discipline up to and including termination from employment. DOC will consider the factors for each conviction, including any additional information that the individual provides. In consultation with Human Resources and the Department's legal counsel, the administrator supervising the position and the hiring manager will determine a course of action.
3. Factors to be considered when reviewing convictions are:
 - a. nature and gravity of the offense;
 - b. nature of the job held; and
 - c. time since completion. This factor may not be considered if the employee is POST certified or may have contact with offenders
4. Any decision to reject an applicant or formally discipline an employee up to and including termination with reported, unreported, or new convictions is solely at the discretion of the Department.

E. Confidentiality

1. All information pertaining to an employee's or applicant's criminal conviction history is confidential communication. Access to this information is limited to those who have a legitimate need to know and will only be disseminated in conformity with relevant laws and Department policy. Records gathered as a result of a criminal background check will be kept by Human Resources. These records will include:
 - a. authorization Form;
 - b. information collected from the check;
 - c. analysis and decision regarding any convictions;
 - d. correspondence related to criminal background check.
2. The records will be securely maintained in accordance with state retention policy.
3. The Department will provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom the employee has applied to work.

V. CLOSING

Provisions of this policy not required by statute will be followed unless the provisions conflict with negotiated labor contracts, which will take precedence to the extent possible.

Questions concerning this policy should be directed to Human Resources.

VI. REFERENCES

A. 53-1-203, MCA; 44-4-401 MCA

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B. 28 CFR Part 115, Prison Rape Elimination Act of 2003

C. DOC Policy 1.1.17 Prison Rape Elimination Act of 2003 (PREA)

VI. ATTACHMENTS

[Policy Acknowledgement and Disclosure Form](#)



POLICY DIRECTIVE

Policy:	DOC 1.4.1 STAFF DEVELOPMENT AND TRAINING
Effective Date:	12/01/1996 Page 1 of 4
Revision Date(s):	03/28/2007; 03/26/2008; 06/15/2009; 11/28/2011; 05/05/2014; 05/06/2015; 08/28/2024
Signature/Title:	/s/ Brian Gootkin, Director

I. POLICY

The Department of Corrections will provide job training and professional development to ensure all employees have the skills necessary to perform their jobs competently and professionally, consistent with the Department's mission, values, and expectations.

II. APPLICABILITY

All Department divisions, facilities, and programs.

III. DEFINITIONS – See Glossary

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. Training in the Department is decentralized. Instructors are existing staff across the agency from numerous bureaus and facilities. The Department is responsible for ensuring training meets the requirements of statute, accreditation, certification, policy, and the annual training plan.
2. Employees will receive training relevant to the employees' work and consistent with the needs of respective job classifications and any applicable collective bargaining agreements.
3. Basic training must be completed by employees in the Correctional Officer, Probation and Parole Officer, or Investigator series within one year of hire in accordance with POST. The Department may request an extension for this requirement from POST.
4. A position-specific Field Training and Evaluation Program must be offered to employees identified in the Correctional Officer and Probation and Parole Officer series.

B. Responsibilities

1. The Department is responsible for the following:
 - a. maintaining minimum training requirements to meet accreditation or professional standards;
 - b. providing necessary space and equipment for all Department-required training;
 - c. providing sufficient budgetary resources for mandatory training;
 - d. offering Department training to contracted staff, when feasible;
 - e. approving the annual training plan at the Executive level; and
 - f. approving all Field Training and Evaluation Programs at the Division Chief level.
2. The Public Safety Training Manager or designee is responsible for:
 - a. developing and updating the annual training plan by December 1 each calendar year and presenting it directly to the Executive Team for approval;
 - b. conducting an annual training survey by March 1 and sharing the information with staff;

- c. actively reviewing Department policy and procedure to identify training needs;
 - d. announcing all training for POST-certified positions;
 - e. authorizing orders for training equipment;
 - f. conducting quality assurance activities to ensure training standards and objectives are being met;
 - g. authorizing, if needed, the use of training offered by community agencies, organizations, volunteers, businesses, industries, or other parties for POST-certified positions;
 - h. recommending and implementing training strategies with Department instructors;
 - i. processing employee training requests;
 - j. scheduling and/or announcing mandatory and specialty training;
 - k. reviewing progress towards meeting training goals, identifying training that does not meet standards, and developing solutions;
 - l. reviewing and updating the Instructor Training Guide and Student Training Guide as needed; and
 - m. signing all POST applications, certifications, and forms as a designee of the Public Safety Division Chief.
3. Department staff who are instructors are responsible for:
- a. following the process to become approved instructors and conducting training as outlined in the Instructor Training Guide;
 - b. maintaining POST certification (if their position is POST-certified) to ensure trainees can receive POST credits if applicable;
 - c. assisting the Public Safety Training Manager with meeting training goals, identifying training that does not meet training standards, and developing solutions; and
 - d. documenting all in-service and/or table-top training through submission of a training roster.
4. Supervisors are responsible for:
- a. encouraging employees to pursue professional development training and ongoing education for career development;
 - b. monitoring employees' training requirements and certifications;
 - c. approving or denying employee training requests in a timely manner; and
 - d. ensuring employees are current on training directives and requirements. Supervisors may require staff to attend specific training as a result of coaching, formal discipline, and/or annual performance evaluations.
5. Employees are responsible for:
- a. monitoring training requirements and the annual training plan to meet Department-required training, mandates, recertifications, and accreditation requirements;
 - b. monitoring training announcements and completing training request forms;
 - c. registering in a timely fashion and reserving appropriate accommodations to attend approved training;
 - d. notifying their supervisor and cortraining@mt.gov if they cannot attend any approved training;
 - e. completing and submitting POST training credit forms for training conducted outside of the Department, independent study reports, and/or associated documentation to ensure credit is received for completed training;
 - f. meeting training standards and representing the Department in a professional manner while attending training; and
 - g. reviewing their individual training records for accuracy.

C. Training Plan

1. The Department's annual training plan, approved by the Department Director, will at minimum include:
- a. a list of required and planned trainings;

- b. training course descriptions;
- c. changes in POST-required courses for Correctional Officer, Probation and Parole Officer, or Investigator series staff; and
- d. changes in national training standards (for example, ACA Adult Correctional Institutions, National Commission on Correctional Health Care, ACA Probation and Parole Field Services, and Performance Based Standards).

D. Training Standards

1. Employees and instructors must adhere to standards and requirements for completion of any course and for their professional behavior when in training as outlined in the Instructor Training Guide and the Student Training Guide.
2. Any course may be audited by Department Training staff serving in a quality assurance role to ensure course content aligns with the lesson plan and that instructors and employees are meeting standards.
3. Some training requires staff to meet physical standards or demonstrate physical proficiency. Staff may request reasonable accommodations to participate in training.

E. Professional Development

1. In addition to required training, staff may, with supervisor approval, seek out professional development training through a variety of sources including but not limited to LinkedIn Learning on Talent, continuing education, and professional conferences.
2. In order to receive training credit for continuing education or conferences, additional documentation must be provided in accordance with the Student Training Guide.

F. Training Records

1. The Department will establish an individual training record for each employee and maintain records in a designated system.
2. Instructors and employees will submit the required reports and documentation regarding completed training in accordance with the Instructor Training Guide.

G. Access to Training Records

1. The Training Records Manager will:
 - a. limit access to training records to individuals with a job-related purpose for viewing or using the records;
 - b. request the employee's informed voluntary consent or require a valid legal order before granting access to training records by any other individual; and
 - c. require requests for training record access to be in person, by email, written request, or telephone.

H. Reporting

1. The Training Records Manager is responsible for developing reports based on information entered into designated training management system(s).

V. CLOSING

Questions about this policy should be directed to the Public Safety Support Services Bureau Chief.

VI. REFERENCES

- A. 46-23-1002, MCA; 46-23-1003, MCA; 46-23-1004, MCA; 46-23-1028; 53-1-203, MCA

- B. *ARM 2.21.6606*
- C. *DOC 3.1.8 Use of Force and Restraints; DOC 3.1.31 Firearms; DOC 3.2.1 Emergency Management*
- D. *Montana Secretary of State Records and Information Management RM 3: Records Retention Schedule*
- E. *Montana Operations Manual*
- F. *ACA Standards for Adult Correctional Institutions*
- G. *ACA Standards for Juvenile Correctional Facilities*
- H. *ACA Performance-Based Standards for Adult Probation and Parole Field Services*
- I. *Performance Based Standards*
- J. *National Commission on Correctional Health Care; Standards for Health Services in Adult and Juvenile Detention and Confinement Facilities*



POLICY DIRECTIVE

Policy:	DOC 1.5.1 ADULT OFFENDER GOOD TIME ALLOWANCE	
Effective Date:	04/13/1995	Page 1 of 3
Revision Date(s):	01/25/2012; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department will grant an appropriate good time allowance for offenders who committed offenses prior to January 31, 1997, pursuant to 53-30-105, MCA (repealed). The good time allowance provides a credit on the offender's sentence. It is also the policy of the Department to revoke previously granted good time credits in accordance with *DOC 3.4.1 Offender Disciplinary System*.

II. APPLICABILITY

All adult divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Eligibility

1. An offender is eligible for a good time allowance if the offender committed an offense prior to January 31, 1997, and a court sentenced the offender to prison, the Department, or DPHHS.
2. The good time allowance is available for eligible offenders during the time the offender serves a prison sentence or a DOC commitment in an adult correctional institution or on parole.
3. The good time allowance is available to eligible offenders for time the offender serves in jail before sentencing if a magistrate or judge set bond and the offender did not post it.
4. The Department may not award an eligible offender more than one day of good time credit for each day the offender serves.

B. Offenders Not Eligible for Good Time Credits

1. An offender who participates in the Treasure State Correctional Training Center or a boot camp program may not earn good time credits while participating in the Treasure State or boot camp program.
2. An offender who is found guilty but mentally ill is only eligible for good time credits when the offender serves the sentence imposed in an adult correctional institution or on parole.
3. An eligible offender does not earn good time credits while serving probationary time on a deferred or suspended sentence.
4. If an eligible offender escapes from custody or absconds from parole supervision, the offender does not earn good time credit during the time the offender is on escape or absconder status.

C. Computation of Good Time Credits

1. The Department will credit an eligible offender with appropriate good time credits from the date the court sentences the offender if the offender begins serving the sentence immediately; otherwise, the offender begins to earn appropriate good time credits from the date the offender begins to serve the sentence.
2. The Department will credit an eligible offender with appropriate good time on jail time ordered by the court.
 - a. For the purposes of good time credit for pre-sentence jail time, an offender who was incarcerated in a county jail before April 12, 1995, was a close custody offender.
 - 1) The Department will award good time credits commensurate with close custody status (10 days a month).
3. The Department will award any good time credits that a court orders the Department to give an offender unless the court rescinds or amends the order.

D. Forfeiture of Good Time Credits

1. After a disciplinary hearing for an eligible offender, a facility administrator, disciplinary hearings officer, regional administrator, or Probation and Parole hearings officer may recommend to the Department Director that the offender forfeit any or all previously earned good time credits.
2. The Department will conduct a due process disciplinary hearing when the offender is returned to Department custody after an eligible offender escapes or absconds parole supervision to determine if the offender will retain or forfeit good time earned prior to the time the offender escaped or absconded.
3. The Department Director must approve the forfeiture of good time credits.

E. Restoration of Good Time Credits

1. A facility administrator or the Rehabilitative and Enterprise Division Chief may recommend that the Department Director restore any or all good time credits the offender previously forfeited, if the offender maintains good behavior.
2. The Department Director must approve the restoration of good time credits.
3. For the restoration of good time credits:
 - a. The offender must:
 - 1) submit a written request to the unit manager or supervising officer; and
 - 2) the offender must check with the facility records manager to ascertain the amount forfeited.
 - b. The unit manager or supervising officer will complete the *Application for Restoration of Forfeited Good Time*, which must include the recommended amount of good time credits for restoration and make a recommendation to:
 - 1) the Warden of MSP or MWP; or
 - 2) the Rehabilitative and Enterprise Division Chief (if the offender is in a community corrections program or on parole).
 - c. The Warden or Rehabilitative and Enterprise Division Chief will forward the *Application for Restoration of Forfeited Good Time*, with a recommendation, to the Department Director.
 - d. The Department Director will:
 - 1) determine whether to restore an offender's forfeited good time credits; and
 - 2) forward the approval or disapproval to the records manager at MSP or MWP, whichever is applicable.

V. CLOSING

Questions about this policy should be referred to the Department Director, facility administrator, facility records manager, Rehabilitative and Enterprise Division Chief, or the Department's Legal Services.

VI. REFERENCES

A. §§ 2-15-112; 53-1-203, MCA

VII. FORM

Application for Restoration of Forfeited Good Time



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 1.5.4	Subject: TRANSFER OF OFFENDER RECORDS
Chapter 1: ADMINISTRATION AND MANAGEMENT	Page 1 of 1
Section 5: Case Records Management	Effective Date: Oct. 1, 1996
Signature: /s/ Mike Ferriter, Director	Revised: 03/28/07; 02/01/11

I. POLICY

The Department of Corrections facilities and programs will establish procedures to ensure that current offender records are promptly compiled and sent to the receiving location when offenders transfer from one facility to another.

II. APPLICABILITY

Department and contracted secure care facilities and programs.

III. DEFINITIONS

Facility – Refers to any division, prison, secure care correctional facility, correctional or training program, or community-based program under Department jurisdiction or contract. This term includes the facility building or residence, including property and land owned or leased and operated by the Department.

IV. DEPARTMENT DIRECTIVES

A. Facility Requirements

1. Designated facility staff will ensure that:
 - a. updated offender program files are sent simultaneously on the offender's transport or, at the latest, within 72 hours of an offender's transfer to another facility; and
 - b. program files include all pertinent legal documents, case management, educational, rehabilitation, and medical records.
2. Facility records staff will compile and maintain offender records according to an established file management protocol.

V. CLOSING

Questions concerning this policy should be directed to the facility administrator.

VI. REFERENCES

- A. 4-4096; *ACA Standards for Adult Correctional Institutions, 4th Edition*
- B. 3-JTS-1E-03; *ACA Standards for Juvenile Correctional Facilities, 2003*
- C. DOC Policies 1.5.5, *Case Records Management*; 3.1.12, *Offender Escort and Transport*

VII. ATTACHMENTS

None.



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 1.5.5	Subject: OFFENDER RECORDS MANAGEMENT, ACCESS, AND RELEASE	
Chapter 1: ADMINISTRATION AND MANAGEMENT	Page 1 of 5 and Attachments	
Section 5: Case Records Management	Effective Date: Dec. 1, 1996	
Signature: /s/ Loraine Wodnik, Interim Director	Revised: 06/23/2017	

I. POLICY

The Department of Corrections will manage offender public and private records in compliance with all state and federal laws.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Age Out – When a youth reaches the age of 18, also known as the age of majority or legal adult, a youth may no longer be under the custody and supervision of the Youth Services Division (YSD); this term may refer to offenders up to the age of 25 in accordance with the provisions provided for in 41-5-208, MCA.

Facility/Program – Refers to any division, prison, secure care correctional facility, correctional or training program, or community-based program under Department jurisdiction or contract. This term includes the facility building or residence, including property and land owned or leased and operated by the Department.

Need to Know – The staff member requesting information must have that information in order to properly and adequately perform his or her job related duties and responsibilities.

Offender Case Files – The primary records for adult and youth offenders that may include, but are not limited to, certified documents that authorize the Department to maintain legal custody and/or supervise the offender, reports, classification, treatment programs, and grievances; utilized to provide basic physical, biographical, or historical information about an offender, and to aid placements, custody, classification, treatment, and supervision.

Public Record for Adult Offenders - Information including, but not limited to: name, date of birth, race, gender, eligibility for parole, execution of warrant or sentence, term expiration, court documents unless expressly sealed by court order, FBI number, fine(s) imposed, jail credit time, supervising facility or program, participation or non-participation in a court-ordered program, court docket number, and offense in accordance with 2-6-101, MCA.

Public Record for Juvenile Offenders – Except as provided in 41-5-215, MCA, youth court records on file with the clerk of court, including reports of preliminary inquiries, petitions, motions, other

Policy No. DOC 1.5.5	Chapter 1: Administration and Management	Page 2 of 5
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filed pleadings, court findings, verdicts, orders, and decrees are public information until the record is sealed in accordance with 41-5-216, MCA.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. Offender Management Information System (OMIS) and Youth Management System (YMS) are considered an official record of the Department. Where a paper record exists it may also be considered an official record.
2. Employees must take reasonable precautions to verify the accuracy and reliability of data they enter into official record.
3. The division administrator, or designee, will implement and maintain operational procedures in compliance with this policy, when applicable, that meet the following requirements:
 - a. establish an offender case file for each offender at the time of sentencing or at the time the offender is transferred to Department custody or supervision;
 - b. offender records reflect the adult or youth offender number;
 - c. staff will enter data into OMIS and/or YMS and place incoming material in the file within an appropriate amount of time after receipt; and
 - d. active files and offender case files are accounted for regularly and reconciled against the official count in a facility.
4. The Department's Office of Investigations staff will identify confidential files resulting from offender criminal investigations. Access to these files will be limited to employees with a need to know as determined by the Office of Investigations or Legal Services Bureau.
5. The Department will provide copies of offender records consistent with this policy and may collect a fee to offset the cost of materials, staff time, and postage. Offenders will be charged \$0.25 per page for copies of their records. Additional fees may be charged for the administrative assistant time necessary for records requests if the record copying will be extensively time consuming. Any additional fees will be communicated to the requestor prior to processing the request.

B. Adult Records Release Restrictions

1. Information may be released from adult offender records except for information in which the offender or another person has a right to privacy that outweighs the public's right to know as demonstrated in the following circumstances:
 - a. the information threatens the security or safety of a person or institution;
 - b. medical or psychological information;
 - c. the information is made confidential by law;
 - d. investigative information; or
 - e. youth offender records maintained within an adult offender record in compliance with this policy.

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2. Offender file material will not be removed from Department property or produced for any authority except in the following circumstances:
 - a. a Department employee in the performance of the employee's official duties;
 - b. with written application and the approval of the Department director, division administrator, or designees;
 - c. with a court order to produce the material or when officially requested by an attorney in conjunction with a civil case;
 - d. content is public information;
 - e. authorized representatives of law enforcement require information for conducting official activity;
 - f. a release form is signed by the offender and maintained authorizing release to his or her attorney or other persons authorized by statute;
 - g. medical records except when provided by *DOC Policy 4.5.38 Offender Health Record Access, Release, and Retention*; or
 - h. when records release is necessary for the Department to defend itself from an offender in a lawsuit against the Department or an employee.

C. Records Access

1. An offender may review non-confidential records in accordance with the following:
 - a. designated staff will evaluate all records provided to an offender prior to viewing to ensure that release of information will not threaten the safety and security of the institution or violate this policy;
 - b. the offender must complete a written request for access and both the offender and supervising staff member must sign and date the request;
 - c. the offender may request permission to grant authorization for review of his or her records to an attorney or other persons authorized by statute;
 - d. an offender consenting to release of information from his or her file will be required to sign the [Authorization for Release of Information](#) form prior to release; and
 - e. prior to approving records requests from secure facility offenders, staff must verify that offender has sufficient funds in his or her account to cover the cost associated with provision of copies, when applicable.
2. Basic public information on all adult offenders supervised by the Department is accessible through an online service called Correctional Offender Network Website (CONWeb). The content and management of CONWeb is guided by *DOC 1.5.5A Correctional Offender Network Website (CONWeb) Standard Operating Procedure*.
3. Media and public inquiries for specific offender information must be submitted in writing; inquiries will be referred to the facility public information officer (PIO) stationed where the offender is housed or to the Department's communications director and responded to according to the following:
 - a. the designated PIO or communications director will explain release restrictions and provide the inquiring party with information authorized for release;
 - b. offenders will be provided the opportunity to execute a release form authorizing staff to release specific information, when applicable;
 - c. the inquiring party will be advised when an offender does not consent to an information release; and

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- d. for audit purposes, the facility PIO or communications director will maintain a record of all requests to include: date of request, name of requestor, and disposition.
4. The Department maintains records from non-Department agencies and will release the records in compliance with the applicable regulations of the non-Department agency to bona fide representatives of law enforcement agencies or produce the records in compliance with the order of a court of competent jurisdiction.

D. Youth Offender Records

1. Juvenile records including, but not limited to, medical, psychological, youth assessment materials, predisposition studies, supervision records of probationers, and any report, charge, or allegation that is not adjudicated may only be released to the following:
 - a. the youth court;
 - b. representatives of any agency providing supervision with legal custody of a youth;
 - c. any person, by order of the court;
 - d. any court and its probation and other professional staff or the attorney for a committed party who had been a party to proceedings in the youth court when considering the sentence to be imposed upon the offender;
 - e. the county attorney;
 - f. the youth subject of the report or record, after emancipation or reaching the age of majority;
 - g. a member of a county interdisciplinary child information team formed under 52-2-211, *MCA*;
 - h. members of a local interagency staffing group provided for in 52-2-203, *MCA*; and
 - i. persons allowed access to records under 45-5-624, *MCA*.
2. The YSD administrator, or designee, will seal youth records when a youth becomes 18 years of age unless the following occurs:
 - a. the youth did not complete sex offender treatment ordered by the court in a judgment or disposition, at which time the record will never be sealed; or
 - b. the youth court judgment requires a transfer applicable under 41-5-208, *MCA* on or before the youth's 18th birthday and the record will be sealed at the conclusion of jurisdiction.
3. Youth court records of any youth under Department jurisdiction who is subsequently convicted of an offense in district court pursuant to 41-5-206, *MCA* will be sealed when the youth becomes 18 years of age.
4. Youth records that will or may become sealed will be transferred according to the following:
 - a. YSD staff will designate youth records with blue color-coded packaging prior to transfer;
 - b. Department divisions that receive the transferred youth records will maintain the records separately and not intermingle the records with any adult record generated or maintained by the Department;
 - c. Department divisions that receive blue coded youth records must return all original records to YSD upon the date the records are to be sealed and all non-original records must be destroyed; and

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- d. youth records from youth court probation that belong to the Office of Court Administrator will be returned by YSD to the Office of Court Administrator.
5. Information not included in sealed records that will remain available includes the following:
 - a. medical records;
 - b. fingerprints;
 - c. DNA records;
 - d. photographs;
 - e. youth traffic records; and
 - f. education records.
6. Records that are sealed may be accessed with a court order; if a record is reopened with a court order, the requestor must destroy the record when the need for the record is concluded.
7. All youth records must be dissociated with YMS when the youth offender ages out of YSD supervision.
8. Youth records may be destroyed with the consent of the youth court judge or county attorney after ten years from the date of sealing pursuant to 41-5-216, MCA.

V. CLOSING

Questions concerning this policy should be directed to the Department's Legal Services Bureau.

VI. REFERENCES

- A. 2-6-101; 41-5-206; 41-5-208; 41-5-215; 41-5-216; 41-5-220; 41-5-221; 42-3-203; 45-5-624; 46-18-113; 52-2-203; 52-2-211, MCA
- B. [Article II, § 9 & 10](#), Mont. Const.;
- C. 4-4095, 4-4098, 4-4099, ACA Standards for Adult Correctional Institutions, 4th Edition
- D. DOC Policy 4.5.38, Offender Health Record Access, Release and Retention
- E. DOC 1.5.5A Correctional Offender Network Website (CONWeb) Standard Operating Procedure

VII. ATTACHMENTS

[Authorization for the Release of Information](#)
[Youth Health Information Request to Release Records](#)



POLICY DIRECTIVE

Policy:	DOC 1.5.5A OFFENDER SEARCH WEB APPLICATION	
Effective Date:	06/23/2017	Page 1 of 2
Revision Date(s):	04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. INTRODUCTION

The Offender Search web application is an online service that provides public information about adult offenders committed to the Department of Corrections. Offender Search (originally Correctional Offender Network Website) was established in 2002 as part of Montana's E-Government Initiative and was operated by Montana Interactive. In 2021, the State Information Technology Services Division took over operations of Offender Search from Montana Interactive. Offender Search is authorized by the Department Director and maintained according to this policy.

II. GENERAL REQUIREMENTS

A. Content

1. All information displayed in Offender Search is public information contained in the offender management system.
2. The offender information displayed in Offender Search includes:
 - a. DOC ID#
 - b. Name
 - c. Profile photo
 - d. Current correctional status
 - e. Last status change
 - f. Gender
 - g. Supervising office and address (for Interstate Compact offenders on probation or parole, only the supervising state is displayed)
 - h. Physical and demographic characteristics
 - 1) Hair and eye color
 - 2) Height, weight, and build
 - 3) Race
 - 4) Skin tone
 - 5) Left or right-handed
 - 6) Year and place of birth
 - 7) Citizenship
 - 8) MT residency status
 - i. Aliases
 - j. Scars, marks, tattoos, and other physical conditions
 - k. Legal record
3. Information that may be public information but has been specifically excluded from Offender Search includes:
 - a. full birth date (as requested by the FBI for identity theft reasons)
4. All adult offenders under Department supervision will be included in the Offender Search until the end of their supervision unless excluded; *see III below*.
 - a. Deceased offender information will remain for a period of 10 days after the offender management system is updated with this information.

III. EXCLUSIONS

1. Requests for information to be excluded must be submitted to the Communications Director.
2. The Communications Director will forward approved requests to the Information Technology Service Desk for processing.
3. Current exclusions:
 - a. Offenders marked in the offender management system with the Confidential offender flag are suppressed from Offender Search.
 - b. Interstate Compact:
 - 1) inmates in secure facilities are suppressed; and
 - 2) offenders on probation or parole are not.
 - c. Victims who are also offenders under the supervision of the Department are suppressed at the request of the court or law enforcement.
4. Any requests for suppression, removal, or change of information not covered by this policy will be decided by the Department Director on a case-by-case basis.

IV. DECISION-MAKING AUTHORITY

The Department Director has final decision-making authority for the content and management of Offender Search and may confer with the Executive Team and/or Legal Services when making decisions.

V. CLOSING

Questions about this policy should be directed to the Department Legal Services.



POLICY DIRECTIVE

Policy:	DOC 1.5.7 CASE RECORDS AUDITING
Effective Date:	10/01/1996 Page 1 of 1
Revision Date(s):	03/28/2007; 03/21/2011; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

The Department will designate Department employees to audit representative offender case records annually.

II. APPLICABILITY

Department and contracted facilities and programs.

III. REQUIREMENTS

A. Audit Requirements

1. Each facility will:
 - a. establish written requirements that require an annual audit of representative offender case records;
 - b. design the audit process to ensure that records are current, organized, and maintained in accordance with *DOC 1.5.5 Case Records Management*; and
 - c. implement audits in compliance with federal, state, and Department confidentiality guidelines.
2. The audit instrument will refer to Department records management policies and any additional facility procedures to ensure that the content and organization of offender case records comply with the established requirements.
3. Additional offender records subject to audits may include, but are not limited to, the following:
 - a. offender classification information;
 - b. case notes;
 - c. case progress reviews;
 - d. incident or disciplinary reports;
 - e. treatment information;
 - f. medical records; and
 - g. admission documents.

B. Audit Process

1. Each facility will establish its own case records auditing schedule; however, audits must be conducted at least annually on a representative sample of offender records.
2. The Department recommends that designated facility staff and records staff from other Department facilities comprise the audit team.

IV. CLOSING

Questions about this policy should be directed to an administrator.

V. REFERENCES

- A. *DOC 1.5.4 Transfer of Offender Records; DOC 1.5.5 Case Records Management*



POLICY DIRECTIVE

Policy:	DOC 1.5.10 REGISTRATION OF SEXUAL AND VIOLENT OFFENDERS	
Effective Date:	03/17/1997	Page 1 of 2
Revision Date(s):	01/19/2012; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

Department facilities and programs will enforce the applicable provisions of Montana statute regarding release, registration, and notification requirements for sexual and violent offenders.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Offender Registration Applicability

1. Registration provisions apply to the following:
 - a. adult sexual offenders who are sentenced or who are in custody or under the supervision of the Department on or after July 1, 1989;
 - b. adult violent offenders who are sentenced or who are in the custody or under the supervision of the Department on or after October 1, 1995;
 - c. youth sexual or violent offenders who committed the qualifying sexual or violent offense before May 11, 2007, and who the youth court ordered to register as set forth in the order of adjudication; and
 - d. youth sexual offenders who committed the qualifying sexual offense on or after May 11, 2007, and who the youth court did not specifically in the order of adjudication exempt from the registration requirement.

B. Registration of Sexual and Violent Offenders

1. The Montana Department of Justice maintains the Sexual and Violent Offender Registry, and information contained on the registry is disseminated according to 46-23-508, MCA.
2. The Department will follow 46-23-508, MCA when a sexual or violent offender under the custody of the Department is released from Department custody by taking the following actions:
 - a. at least 10 days prior to release of a sexual or violent offender from custody, a Case Specialist or youth correctional facility staff will:
 - 1) inform each sexual or violent offender in writing that when the offender is released from custody, the offender has a statutory obligation to register with local law enforcement within 3 business days of arrival in a county of this State and that an offender who fails to register can be charged with felony failure to register; and
 - 2) record in the offender's records the address where the offender intends to reside upon release.
 - b. prior to a sexual or violent offender's release from adult or youth facility custody, a Case Specialist or youth correctional facility staff will provide to the Department of Justice and

the sheriff of the county in which an offender intends to reside (or, if an offender intends to reside in a municipality, to the chief of police of the municipality):

- 1) the address at which the offender intends to reside upon release from custody;
- 2) the offender's fingerprints and photo, unless they are already in the possession of the Department of Justice, sheriff, or chief of police; and
- 3) a form signed by and read to or by the offender stating that the offender's duty to register under this part has been explained to the offender.

C. Sexual Offenders Without Risk Designation

1. Probation and Parole will:
 - a. identify adult and youth sexual offenders who are on adult probation or parole and who are required to register but did not receive a level of risk designation at the time of sentencing or time of release from a facility; and
 - b. submit a request to the applicable county attorney's office.
 - 1) The request will petition the district court to assign a risk level designation to the offender and include a recommended designation based on the psychosexual evaluation completed prior to sentencing or adjudication.
2. The Department will provide notice prepared by treatment staff to the Department of Justice and local law enforcement of the risk of re-offense by an adult or youth sexual offender released from a state or private correctional facility according to the following:
 - a. when a tier-level assessment exists, the notice will indicate risk in accordance with the following:
 - 1) Level 1 – the risk of a repeat sexual offense is low;
 - 2) Level 2 – the risk of a repeat sexual offense is moderate; and
 - 3) Level 3 – the risk of a repeat sexual offense is high; or
 - b. if a tier-level assessment does **not** exist, the Department will notify the Department of Justice and local law enforcement that the offender was not given a tier level designation by the sentencing court and that no such assessment is on file with the Department.

V. CLOSING

Questions about this policy should be directed to Legal Services.

VI. REFERENCES

A. §§ 41-5-1513; 46-18-201(7); 46-18-255(2); 46-23-501-509; 53-1-203, MCA

VII. FORMS

SVOR Registration

SVOR Change of Information



POLICY DIRECTIVE

Policy:	DOC 1.5.11 REPORTING OF ADMISSION OR RELEASE OF ARSONISTS	
Effective Date:	02/01/1998	Page 1 of 1
Revision Date(s):	11/15/2011; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department requires all Department and contracted facilities and programs to provide written notification to the Department of Justice when they admit or release offenders who are convicted of arson or acquitted of arson on the grounds of mental disease or defect, in accordance with 53-1-104, MCA.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Requirements

1. By statute, 53-1-104, MCA, the following entities must provide written notice prepared on Department letterhead to the Fire Marshal, Department of Justice:
 - a. a Montana prison
 - b. a Montana youth correctional facility
 - c. a county or city detention facility
2. The required *Arson Admit Notice* and *Arson Release Notice* must contain:
 - a. the name of the convicted arsonist
 - b. where the offender is or will be located; and
 - c. the type of fire in which the offender was involved.

V. CLOSING

Questions about this policy should be directed to the appropriate facility administrator.

VI. REFERENCES

- A. §§ 45-6-102; 45-6-103; 53-1-104, MCA

VII. FORMS

Arson Admit Notice
Arson Release Notice



POLICY DIRECTIVE

Policy:	DOC 1.5.12 RISK AND NEEDS ASSESSMENTS FOR CASE PLANS	
Effective Date:	11/01/2016	Page 1 of 7 with attachment
Revision Date(s):	03/12/2024; 08/13/2024	
Signature/Title:	/s/ Brian Gootkin, Director	

I. POLICY

The Montana Department of Corrections will complete risk and needs assessments on all offenders in accordance with the requirements of 53-1-203, MCA and this policy.

II. APPLICABILITY

All Department divisions, facilities, and programs, facility licensees of the Department, and those providing services to the Department as required by contract.

III. DEFINITIONS

Case Plan – An evolving document that outlines case management strategies designed to engage the offender, target individual risks and needs, and track progress as the offender transitions through the correctional system.

Continuous Quality Improvement (CQI) – A structured systematic process that is used to review and monitor the quality, efficiency, and effectiveness of evidence-based practices. The process includes the identification of areas in need of improvement and the development and implementation of coaching plans, including an evaluation of the efficacy of implemented actions.

Criminogenic Needs – Attributes that are directly linked to an offender's risk to re-offend and must be addressed to achieve lower recidivism rates.

Criminogenic Risk – The characteristics, traits, problems, or issues of an individual that directly relate to the individual's likelihood to re-offend and commit another crime.

Current Assessment – A MORRA is current if completed in the past 12 months and the offender has experienced no life-altering events during that period.

Life-Altering Event – Any significant happening in an offender's life that would impact two or more domain areas. Examples of a positive event that could impact two or more domains are completion of programming and establishing stability in employment. Examples of a negative event that could impact two or more domains are job loss and removal from programming/treatment. These impacts can both be positive or negative which would change a domain-specific score.

Quality Assurance of Evidence-Based Practices and Programs Bureau (QAEBPP) – The Bureau that oversees correctional best practices including training, implementation, and adherence to risk assessment instruments as well as core risk-reducing programming offered to offenders.

Responsivity – Addresses the non-criminogenic or non-predictive hurdles or barriers in an offender's life that may influence the offender's response to programming/treatment and thereby affect the offender's risk to reoffend.

Secondary Assessments – Other assessments and/or evaluations used in conjunction with the overall and domain-specific scores of a risk assessment to aid in refining the offender's needs. These include crime-specific risk assessments (for example, sexual, DUI, substance abuse, and intimate partner violence) or clinical evaluations.

IV. DEPARTMENT DIRECTIVES

A. Assessments and Tools

1. The Department of Corrections is required by law (53-1-203, MCA) to conduct standardized, evidence-based, and validated risk and needs assessments on each offender under supervision or custody to drive the department's supervision and correctional practices, including integrating assessment results into supervision contact standards and case management for offenders.
2. The assessment tools approved by the Department are contained in *Attachment 1: Department-Approved Risk and Needs Assessments* and will be reviewed by QAEBPP every 3 years.
3. Only certified assessors may administer risk and needs assessments to offenders.
4. If an offender refuses to participate in an assessment, they will be managed at the highest risk designation. The refusal must be indicated in all release documents (for example, parole reports, conditional release requests, and CDFS requests).

B. Training Requirements for Risk and Needs Assessments

1. Certified Instructors:
 - a. Staff must meet the following prerequisites before being approved to become a certified instructor of risk and needs assessments or secondary assessments:
 - 1) be a certified assessor of the tool, and
 - 2) complete 15 or more offender assessments of the risk and needs assessment or secondary assessment.
 - b. Instructing other staff requires a significant time commitment from the instructor. As such, individuals interested in being certified instructors for risk and needs assessments or secondary assessments must receive approval from their supervisor and the Rehabilitation and Programs Chief, or their designee. Staff will use the *QAEBPP Evidence-Based Instructor Application* webform to apply to become a certified instructor.
2. End User Training:
 - a. Each Division Chief must designate which positions are responsible for administering risk and needs assessments (end users) and share those position titles and locations with the QAEBPP Bureau.
 - b. End users are defined as staff who:
 - 1) have successfully completed all requirements to use the tool;
 - 2) use the tool to case plan from assessments, make placement decisions based on assessments, or enter completed risk assessments; and
 - 3) are direct supervisors of an end user. Direct supervisors of an end user must successfully complete one training on the MORRA tool to learn the research behind the tool and obtain the MORRA manual to be used in the CQI process. This excludes Division Chiefs.
 - c. End users must:
 - 1) complete the risk and needs assessment training course and pass any associated tests to obtain certification to conduct assessments;
 - 2) complete booster trainings annually and be recertified every three years (by the end of calendar year three) – booster and recertification training will be coordinated by the QAEBPP Bureau; and
 - 3) be trained in Motivational Interviewing within 12 months of hire.
 - d. If an end user fails to attend or complete the required training, the QAEBPP Bureau Chief or designee will:

- 1) notify the end user's supervisor prior to privileges being revoked; and
- 2) revoke their privileges to enter assessments into the offender management system until training is completed.

C. Conducting Risk and Needs Assessments and Timelines

1. Each offender in the PSI stage, under supervision, or in custody must have a current MORRA unless there is an acceptable extenuating circumstance (documented in a chronological entry), including if the offender:
 - a. absconded from community supervision;
 - b. is incarcerated out of state and a telephonic interview is not possible;
 - c. is incarcerated in another jurisdiction within the state (a request will be made to the nearest office);
 - d. threatened assessment staff which poses an unnecessary risk of safety to staff; or
 - e. refused to participate in the assessment process.
 - 1) If an offender refuses, the offender and two department staff will complete the *Refusal* form which will be uploaded to the offender management system. Staff must document in a chronological entry that an attempt was made at least every 6 months to complete the assessment with the offender.
2. All offenders will have an initial assessment completed and uploaded into the offender management system within 90 days of sentencing (if on community supervision) or placement into a secure facility or assessment center.
3. Reassessments must be completed annually within 30 days prior to the current MORRA expiring, or when a life-altering event occurs (either positive or negative) as defined in this policy.

D. Developing Case Plans and Timelines

1. Each offender will have an active case plan developed from the domain-specific results of the risk and needs assessment that addresses two or more of the highest dynamic need areas.
 - a. For secure facilities, each offender will have a written case plan.
 - b. For offenders on community supervision, case plans are not required for low-risk offenders; however, staff may develop case plans for low-risk offenders if the offender has high needs.
2. Approved secondary assessments may also be used to help staff identify high-need areas not easily identified by the risk and needs assessment.
3. The case plan will also include dynamic need factors that staff and the offender prioritize as required by court judgments, Department-imposed conditions, BOPP conditions, offender responsivity needs, and any crime-specific requirements. Examples of dynamic need factors that may be present in conditions may include completion of ACT class, payment of restitution, participation in offender/victim dialogue, and completion of anger management.
4. Case plans developed by staff must:
 - a. be created in cooperation with the offender and tailored for that specific offender based on their unique risk and needs;
 - b. address any responsivity issues identified in the risk and needs assessment or secondary assessments;
 - c. identify targets for behavior change, goals and objectives, timeframes for completion, and performance indicators; and
 - d. undergo periodic review and update by staff and offenders as indicated by staff and offender signatures (on paper forms).

5. If an offender refuses to participate in the risk and needs assessment process, a case plan will be developed based on the dynamic need factors that staff and the offender prioritize as required by court judgments, Department-imposed conditions, BOPP conditions, offender responsibility needs, and any crime-specific requirements (as outlined in IV.D.3. above).
6. Supervisors must regularly hold case staffing meetings (for example, weekly, bi-weekly, or monthly depending on program characteristics) on the work-unit level with staff who develop case plans and manage offenders. The case staffing meeting will have a written agenda where offender progress in case plans is discussed. QAEBPP will provide the agenda format to work units.
7. Case plans should ideally follow the offender through subsequent correctional placements. Staff receiving the offender are encouraged to communicate with the previous placement/program staff about the offender's individual characteristics and progress.

E. Recordkeeping

1. All risk and needs assessment forms are copyrighted; therefore, none of the documents will be disseminated to any individual who is not an authorized or certified department or contracted staff member. The only exception to restricted distribution is the proper use of the MORRA self-report form which is intended to be handed to the offender immediately before the assessment interview and collected immediately following the interview.
2. Staff will score the risk and needs assessment, using the scoring guide, immediately following the interview when all information from the specific offender is fresh in their mind. Scoring can be completed by using a paper score sheet or entering directly into the offender management system.
3. Documentation for risk and needs assessments in the offender management system will be completed as follows:
 - a. Within five working days of the assessment interview and scoring, staff must enter the information generated from the interview and scoring into the corresponding module.
 - 1) In the section comments area, for each domain, staff must document which information was used to determine the score for each item (file review, collateral contact, offender interview, and/or self-report).
 - 2) Prior to finalizing the assessment tool in the offender management system, staff must review all scores and notes for accuracy.
 - 3) Once an assessment is finalized in the offender management system, it can only be edited with approval from staff authorized by the QAEBPP Bureau.
 - b. All risk and needs assessment documents must be uploaded into the offender management system assessment module. For MORRA this includes the Interview Guide, Self-Report, and Scoring Sheet (if used). Paper copies of the assessment forms are not required to be kept or maintained and will be destroyed once the forms are uploaded.
4. Documenting secondary assessments in the offender management system will be completed by uploading the assessments into Offender Documents.
5. Documenting case plans in the offender management system will be completed as follows:
 - a. Within five working days of the case plan meeting, staff must enter the information into the system.
 - b. All updates to the case plan over time must also be reflected in the system so that subsequent staff/placements can view the progress.

F. Quality Assurance and Continuous Quality Improvement (CQI)

1. Risk and needs assessment information is used for a variety of offender processes including processes that are designed to reduce recidivism. All staff have a vested interest in ensuring

risk and needs information is accurate and reliable. To that end, all staff are responsible for quality assurance over risk and needs assessments including the specific requirements of staff indicated below.

- a. The QAEBPP Bureau will:
 - 1) approve all qualifying offender assessment tools used by staff;
 - 2) initiate validation of risk and needs assessment(s) as required by statute;
 - 3) coordinate training for the standardized risk and needs assessment, any secondary assessments that require training, and case plan tools used by the Department;
 - 4) upon creation or updates, review any Facility/Bureau procedures pertaining to risk and needs assessments;
 - 5) administer a mandatory CQI Process for supervisors to ensure certified assessors are conducting risk and needs assessments and staff are developing case plans with fidelity;
 - 6) provide regular training to supervisors on the CQI Process;
 - 7) provide coaching and feedback strategies to supervisors for use with staff if there are deficiencies identified in the CQI Process;
 - 8) review all CQI Reports submitted by supervisors to identify areas for ongoing improvement; and
 - 9) review recorded risk and needs assessments conducted by newly trained staff using the information provided by the owners of the assessment systems and provide feedback to staff and their supervisors. Feedback may include recognition of positive techniques or identification of deficiencies with specific improvements staff can make to address deficiencies.
- b. Each Division Chief or designee is responsible for ensuring compliance with this policy and must:
 - 1) oversee the development of any division-specific procedures that may be needed to outline the use of assessments; and
 - 2) verify staff participate in the CQI process by reviewing the CQI Reports on an annual basis.
- c. Supervisors of staff conducting risk and needs assessments and/or developing case plans must:
 - 1) implement the CQI Process with staff after being formally trained and provide the required reports to their Division Chief or designee and the QAEBPP Bureau Chief;
 - 2) coach staff using the CQI Process and obtain additional information and/or resources from QAEBPP Bureau staff if deficiencies are identified;
 - 3) use the tool(s) developed by QAEBPP with staff to ensure risk and needs assessments and case plans meet the requirements of this policy; and
 - 4) regularly review any reports from the offender management system to identify offenders who require risk and needs reassessment and discuss that information with their staff.
- d. Staff conducting risk and needs assessments must:
 - 1) following initial training and completion of a minimum of 10 assessments, record and submit the 11th assessment to CORQAEBPP@mt.gov for review/feedback/final certification (this process should be completed within the initial six-month period following training but may be extended);
 - 2) participate in the CQI Process with their supervisors;
 - 3) participate in booster training annually and maintain certification; and
 - 4) regularly review any reports from the offender management system to identify offenders who require reassessment and discuss that information with their supervisor.
- e. Staff using risk and needs assessment information for developing case plans must:
 - 1) participate in the CQI Process with their supervisors;
 - 2) participate in regular case staffing meetings in their work unit; and
 - 3) participate in booster training annually and maintain certification.

- f. Staff who make placement decisions based on assessments or staff who enter completed risk assessments must participate in:
 - 1) any CQI process as determined necessary by QAEBPP; and
 - 2) booster training annually and maintain certification.

V. CLOSING

Questions about this policy should be directed to the Quality Assurance of Evidence-Based Practices and Programs Bureau Chief.

VI. REFERENCES

- A. 53-1-201, 53-1-203, MCA

VII. ATTACHMENT

- A. *Attachment 1: Department-Approved Risk and Needs Assessments*



Attachment 1: Department-Approved Risk and Needs Assessments

Tool	Description	Validated to Measure
MORRA PIT Prison Intake Tool	Designed to assess offenders' risk as they enter prison or designated assessment centers. (Note: The PIT is not intended to determine an offender's supervision level.)	Risk and need
MORRA SRT Supplemental Reentry Tool	Designed for offenders currently in prison who have been incarcerated fewer than four consecutive years on their current incarceration.	Risk and need
MORRA RT Reentry Tool	Designed for offenders currently in prison who have been incarcerated four or more consecutive years on their current incarceration.	Risk and need
MORRA CSST Community Supervision Screening Tool	Designed to screen offenders in the community. Individuals who score "Moderate/High" should be assessed with the CST.	Risk only
MORRA CST Community Supervision Tool	Designed to be used with offenders in the community, for example, community supervision or in a prerelease center.	Risk and need
OYAS-RES Residential Tool	A tool that is designed to be used with youth who are entering a residential program with an intended length of stay of 3 months or longer.	Risk and need
OYAS-RET Reentry Tool	A tool designed to be used with youth prior to release from a residential facility and as a reassessment tool once in the community on parole.	Risk and need
OYAS-DIS Disposition Tool	A tool designed to be used with youth post-adjudication while on parole prior to a revocation hearing.	Risk and need
AUDIT (Alcohol Use Disorders Identification Test)	An alcohol screen that can help identify offenders who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence).	Domain-specific need only
Static-99R	Used for qualifying adult male sex offenders; completed once by a licensed evaluator at the time of the psychosexual evaluation. If not completed by evaluator, assessment may be completed by a P&P Officer within 45 days of the offender's arrival in the community.	Risk only
Stable-07/Acute	Used for qualifying adult male sex offenders or male offenders with child pornography conviction; may be completed by a P&P Officer within 45 days of offender's arrival in the community and at 12-month intervals thereafter.	Risk, need, and domain-specific need
SOTIPS (Sex Offender Treatment Intervention and Progress Scale)	Used as a rating scale designed to assess dynamic risk among adult male sex offenders and degree of change at 6-month intervals.	Risk, need, and domain-specific need
TCU (Texas Christian University) Drug Screen 5, Opioid Supplement	Screens for mild to severe substance use disorder; helps determine placement and level of care in treatment. Opioid Supplement is not scored, should be used in conjunction with the DSM-V diagnostic impression, and may be used as a tool for treatment planning.	Need and domain-specific need
ODARA (Ontario Domestic Assault Risk Assessment)	Used to calculate how a male who has assaulted his female partner ranks among similar perpetrators with respect to risk and the likelihood that he will assault a female partner again in the future.	Risk only



POLICY DIRECTIVE

Policy:	DOC 1.5.13 DNA SAMPLES
Effective Date:	11/08/1999 Page 1 of 3
Revision Date(s):	07/25/2016; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

In accordance with state law, the Department will collect biological samples in the form of buccal swabs from felony offenders committed to facilities or supervised under programs administered by the Department.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Offenders Required to Provide Biological Samples

1. All adult offenders convicted of any felony offense who are in custody or under supervision of the Department are required to submit biological samples for DNA testing.
2. Youth who are found to have committed a sexual or violent offense and who are in custody or under supervision of the Department are required to submit biological samples for DNA testing.

B. Offenders in Facilities

1. Upon admission of an offender to a facility, the reception unit or designated employee will obtain any required biological sample using the Buccal Swab Collection Kit provided by the Department of Justice.
2. If a biological sample is already documented in the offender's record and/or with the Department of Justice, a sample does not need to be re-collected.
3. The Case Specialist or employee designated by the facility administrator will ensure a biological sample has been obtained before the offender discharges.
4. Process for Obtaining Biological Samples:
 - a. Employee will request that the offender provide the buccal swab sample.
 - 1) If the offender is cooperative, the employee will proceed with obtaining the buccal swab according to IV.D below.
 - b. If the offender refuses, the employee will order the offender to provide the sample.
 - 1) The offender may not disobey the order on the grounds that the offender may refuse medical treatment, as this is not medical treatment.
 - 2) If the offender refuses to obey this direct order, the employee will prepare a severe disciplinary infraction report or major rule violation in accordance with *DOC 3.4.1 Offender Disciplinary System* and local operational requirements and submit the report for processing.
 - 3) If the refusing adult offender is:

- a) discharging to a probation sentence, the Case Specialist or other employee must immediately begin processes to have the suspended or deferred sentence revoked pursuant to 44-6-103, MCA; or
- b) discharging without further Department supervision:
 - (1) a Case Specialist or Case Manager will immediately refer the case to Department legal staff who will pursue legal remedies; or
 - (2) contract facility staff will contact the Contract Manager to pursue legal remedies through Department legal staff.

C. Offenders on Probation, Parole or Conditional Release

1. Probation, parole or conditional release offenders subject to sampling must provide a biological sample to the sheriff in the sentencing jurisdiction or in the jurisdiction in which the offender resides.
2. The supervising P&P Officer will inform the offender at sign-up of the requirement in writing using the *P&P Requirement for DNA Testing* form generated by the offender management system.
 - a. The offender must provide a sample to the county sheriff's office in the appropriate jurisdiction within 10 days.
 - b. Proof that the offender has given the sample is required; therefore, the supervising P&P Officer will provide the *P&P Documentation of DNA Collection* form to the offender at sign-up to return to the officer as proof that the sample was collected.
 - 1) The form must be kept in the offender's file, and a copy will be given to the offender.
 - c. The officer will record in the offender's offender management system DNA Test profile the date, time, and location the sample was taken, name of the person taking the sample, and name of the witness.
 - 1) The resolved date in the offender management system record is the date the documentation was returned.
 - d. Failure to provide the biological sample or required proof within 10 days is grounds for a disciplinary hearing and/or revocation.

D. Collection Process

1. Employee will:
 - a. collect a clear and clean thumbprint from the offender on the card provided in the Buccal Swab Collection Kit;
 - b. complete all information required on the information card and enter the offender's DOC I.D. number and the offender's State Identification (SID) number; if an offender's SID number is unavailable, the offender's Social Security number may be used;
 - c. collect the buccal swab sample;
 - d. place the offender's thumbprint, the offender's information card, and the offender's buccal swab sample in the envelope provided for shipping to the Montana DNA Laboratory;
 - e. mail the envelope to the Montana DNA Laboratory (Forensic Science Division delivery methods such a bulk package mailing and personal delivery may be used as long as the proper chain of evidence is observed); and
 - f. maintain records in the offender's file that the biological sample was obtained, along with the date and name of the person taking the sample.

E. Confidential Criminal Justice Information

1. DNA records are to be considered confidential criminal justice information as per 44-6-108, MCA.

V. CLOSING

Questions about this policy should be directed to the immediate supervisor.

VI. REFERENCES

- A. *Title 44, Chapter 5 Part 1, MCA; §§ 44-6-101-103; 44-6-107-108; 46-18-202; 46-23-215, MCA*
- B. *PFB 6.2.424 Disciplinary Process in Contract Facilities; PPD 6.4.206 Probation and Parole Field Hearings*
- C. *DOC 3.4.1 Offender Disciplinary System*

VII. FORMS

- P&P Documentation of DNA Collection*
- P&P Requirement for DNA Testing*



POLICY DIRECTIVE

Policy:	DOC 1.5.14 CASE MANAGEMENT IN ADULT SECURE FACILITIES
Effective Date:	11/15/2024 Page 1 of 6 with attachment
Revision Date(s):	
Signature/Title:	/s/ Scott Eychner, Rehabilitation and Programs Chief

I. PURPOSE

To provide the framework for case management within adult secure care facilities and how staff will use case management to address and support appropriate institutional behavior, programming, education, treatment, individual program services plan, release planning, system risk, and transition services for inmates.

II. DEFINITIONS: See Glossary

III. PROCEDURES

A. Standard Case Planning

1. Initial case plans for newly admitted inmates will be created by a Case Manager within 45 days after admission and will be updated throughout the inmate's secure facility incarceration. Case plans will include the following:
 - a. Custody Classification;
 - b. Individual program services plan;
 - c. Release Planning (within 5 years of a possible release);
 - d. Secondary Risk Assessments;
 - e. Financial Obligation Worksheet;
 - f. Documentation if previously in foster care (if under age 26);
 - g. Department of Labor and Industry Employment Action Plan;
 - h. Court-ordered conditions; and
 - i. MORRA.
2. Staff review of case plans with inmates may occur any time, but at minimum must:
 - a. occur at the same time as classification reviews and during any scheduled contact in compliance with policy requirements;
 - b. include review of all case plan elements and associated plans of action assigned to the inmate to determine program status, goals established, and accomplishments; and
 - c. be focused on the inmate rather than on file review.
3. The case plan should be updated regularly as changes in the inmate's circumstances and behavior become known, as needs/issues arise, as goals are accomplished, etc.
4. Recording Case Notes:
 - a. Case Managers are responsible for documenting the case management contact and discussion points in the offender management system.
 - b. The following information should be noted after each case management contact:
 - 1) any substantive release plan changes
 - a) address change
 - b) job change
 - c) transportation on day of release
 - d) any changes to aftercare programming or treatment
 - 2) goals and accomplishments

- a) new goals set
- b) progress notes on previously set goals
- c) completed goals
- 3) assessments
 - a) custody classification
 - b) review of next custody level change
 - c) PREA Assessment
 - d) PREA Retaliation Monitoring as applicable
 - e) Inmate PREA education
 - f) Transgender checks twice per year as applicable
 - g) MORRA

B. Caseload Management by Risk Level

1. Inmates will be assigned to one of the following case management levels, as determined by the inmate's MORRA risk classification:

MORRA Risk Categories for Males		MORRA Risk Categories for Females	
Scores	Rating	Scores	Rating
0-14	Low	0-14	Low
15-23	Moderate	15-21	Low/Moderate
24-33	High	22-28	Moderate
34+	Very High	29+	High

2. Required minimum contact standards for Very High/High risk inmates:
 - a. the Case Manager must have a minimum of 2 case management contacts per year;
 - b. beginning at least 1 year prior to the inmate's parole eligibility date, and until the inmate's release, the Case Manager must meet with the inmate at least 1 time per month; and
 - 1) Note: Case management contacts required for Restrictive Housing may be used to fulfill this requirement.
 - c. at least 6 months prior to the inmate's parole eligibility date, the Case Manager must review and confirm the inmate's release plan with collateral contacts.
 - 1) Note: The Case Manager may request assistance from the Case Management Supervisor to schedule a high needs multi-disciplinary meeting when conducting release planning for Very High/High risk inmates.
3. Required minimum contact standards for Moderate risk inmates:
 - a. the Case Manager must have a minimum of 1 case management contact per year;
 - b. beginning at least 6 months prior to the inmate's parole eligibility date, and until the inmate's release, the Case Manager must meet with the inmate at least 1 time per month; and
 - c. at least 6 months prior to the inmate's parole eligibility date, the Case Manager must review and confirm the inmate's release plan.
 - 1) Note: The Case Manager is encouraged to contact the Case Management Supervisor for assistance with challenging cases.
4. Required minimum contact standards for Low/Moderate and Low risk inmates:
 - a. the Case Manager must have a minimum of 1 case management contact per year; and
 - b. at least 6 months prior to the inmate's parole eligibility date, the Case Manager must meet with the inmate to:
 - 1) review the inmate's progress; and
 - 2) review and confirm their release plan and preparations for release.
5. Case Managers are required to review all case plans for inmates at least 6 months prior to their parole eligibility date, regardless of their level, to verify the inmate has a Social Security card, birth certificate, driver license or state ID (if eligible), and DD-214 status (if eligible), and

- completes the Montana Medicaid application form (if eligible as determined by DPHHS and willing).
- a. Case Managers will document in the release plan the status of the inmate's identification documents, or the date the inmate applied for the documents.
 - b. Six months prior to release, IPPOs/Correctional Case Specialists and Case Managers will initiate work with the high needs multi-disciplinary case work group for any inmates with significant medical or mental health issues that require:
 - 1) coordination of services or care planning; or
 - 2) assistance to place them in the community based on these identified needs.
6. Case Managers are required to review all release plans for inmates at least 3 months prior to their parole eligibility date, regardless of their level, to determine whether the inmate is appropriate for referral to the Department of Public Health and Human Services, Veterans Administration, Vocational Rehabilitation Services, Department of Labor and Industry, and other community partners as appropriate on a case-by-case basis.
- a. Case Managers will document the status of the inmate's needs in the offender management system.
 - b. In collaboration with Health Services staff, Case Managers will initiate a discharge plan for an inmate with medical, dental, or mental health conditions when notified of the inmate's anticipated release. If the notification is not provided, Case Managers must still ensure continuity of care is extended into the community for that inmate. All aspects of medical discharge planning processes will be documented in the electronic health record.
 - 1) Any inmate refusal during the medical discharge process will be documented:
 - a) in the electronic health record or in a chronological entry in the offender management system; and
 - b) for medical refusals, on a *Refusal of Treatment* form.
 - c. Case Managers will gather information from the electronic health record for upcoming community-based post-discharge appointments and communicate it to the inmate at discharge. Case Managers who have received a release of information will also share electronic health records and any relevant case plans with any in-reach and/or post-discharge Case Manager assigned to the inmate.
 - d. The Case Manager will emphasize the importance of post-discharge follow-up care and assure the inmate's understanding of follow-up care. The inmate will sign an acknowledgement of the discharge plan.
 - e. Case Managers will notify the offender that Health Services will provide a 30-day supply of current medications and information concerning how to access health records at the time of release.
 - f. Case Managers will initiate a release of medical information form within the electronic health record when requested to facilitate exchange of clinically relevant information to community services upon discharge.
7. Thirty days prior to release, when the inmate is transitioning to supervision status, a transition meeting will occur with the following parties in attendance at a minimum: Case Manager, Probation and Parole Officer, and inmate. These meetings may occur virtually.
8. Case Managers are required to meet with the inmate, unless one of the following occurs:
- a. the inmate declines to appear; or
 - b. the inmate is housed in a contract facility or out-of-state.
 - 1) Note: Inmates housed in contract facilities or housed out-of-state will receive case management by current facility-assigned staff as required in contract.
9. Case Managers are required to participate in all parole board hearings for inmates assigned to their caseload (including inmates identified for possible parole release).
- a. Case Managers may assist the inmate during a parole hearing and provide information to the parole board regarding the inmate's current status and preparations for release. The

information provided will at minimum include the following:

- 1) proposed residence;
 - 2) employment plan;
 - 3) institutional behavior since last hearing;
 - 4) specific needs, care, and most recent treatment history;
 - 5) goals and progress;
 - 6) Case Manager recommendation related to whether the proposed plan mitigates identified risk areas identified through the MORRA, screening tools, and secondary assessments if applicable; and
 - 7) active warrants and detainers, if any.
- b. When a scheduling conflict arises involving multiple inmates, Case Managers should attend the hearing of the inmate with the highest risk.
 - c. If the Case Manager is unable to attend a scheduled parole hearing for Very High/High risk inmates, the Case Management Supervisor or designee must attend in place of the Case Manager.
 - d. In accordance with *DOC 4.6.7 Medical Parole*, medical parole reports are initiated and composed by the IPPO/Correctional Case Specialist. The supervisor of these staff will track and document progress of each case. Case Managers will coordinate resources as necessary for these cases.

C. Case Management Training and Evaluations

1. The Case Management Supervisor is responsible for coordinating training for Case Managers and ensuring that any new training topics are coordinated with the training team. Case management training sessions will occur at least twice per year. Training will be provided to Case Managers and other designated staff and may include, but is not limited to, the following topics:
 - a. prioritizing and managing caseloads;
 - b. classification;
 - c. evidence-based programming;
 - d. case planning;
 - e. individual program services plan;
 - f. release planning;
 - g. offender placement options;
 - h. assessments; and
 - i. motivational interviewing.
2. The Case Management Supervisor ensures training objectives are being met.
3. Performance evaluations will be completed by Case Management Supervisors annually.

D. Case Management Audits

1. The Rehabilitation and Programs Division Program Services Manager or designee will be responsible for coordination of regular case management audits using a standardized audit format.
 - a. Audits will be conducted bi-annually and will include a minimum of 10% of a Case Manager's caseload.
 - b. The Program Services Manager or designee will be responsible for appointing staff as auditors to assist with the bi-annual audit; the auditors must be proficient in case management and related requirements.
2. The audit team will provide a report to the Rehabilitation and Programs Chief and the respective facility administrator. The report will include an analysis of the following:
 - a. case plans;
 - b. custody classification; and
 - c. recidivism tracking.

IV. CLOSING

Questions about this policy should be directed to the Rehabilitation and Programs Chief.

V. REFERENCES

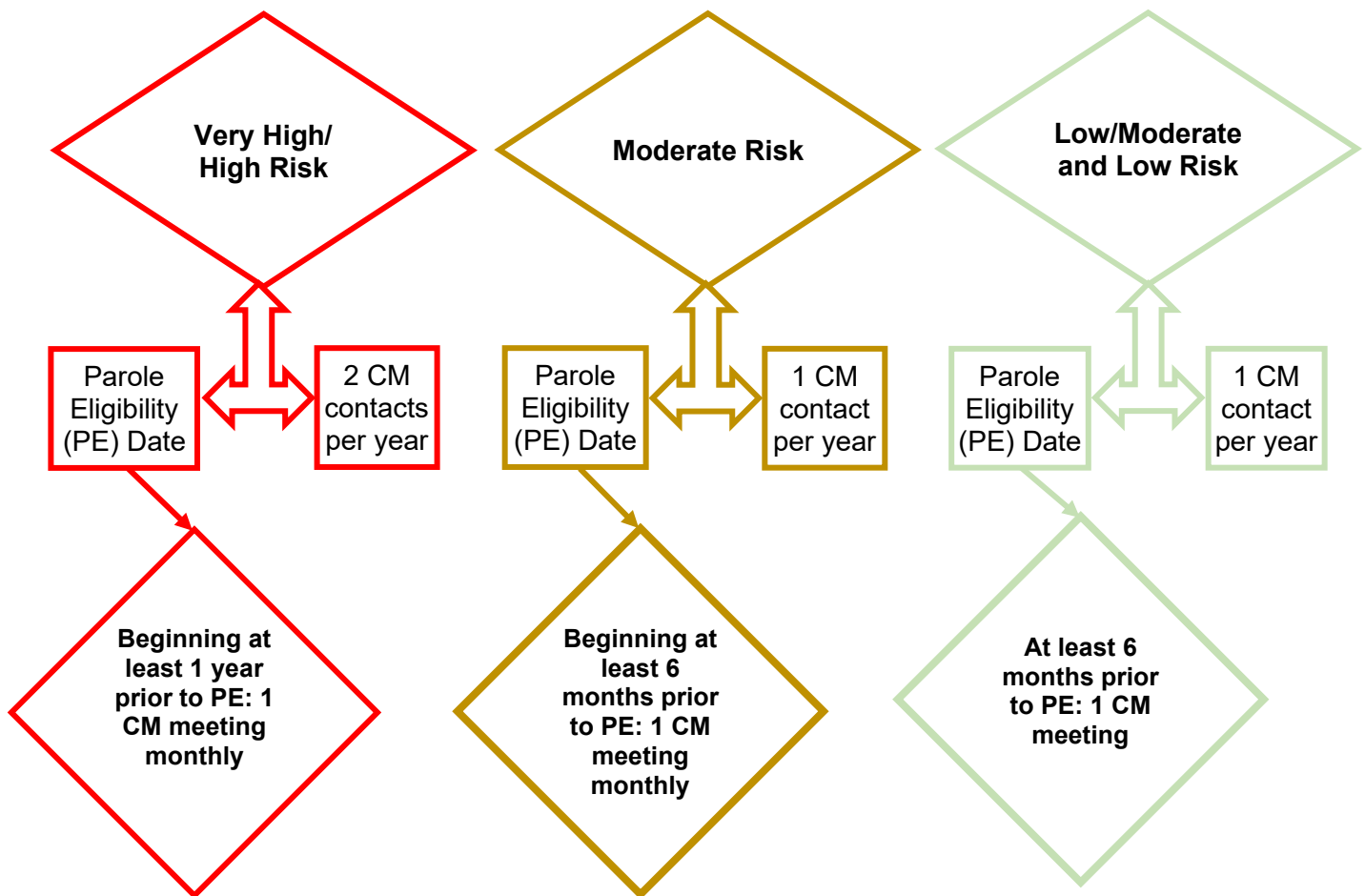
- A. 53-1-203, MCA
- B. DOC 1.5.12 *Risk and Needs Assessment for Case Plans*; DOC 4.6.7 *Medical Parole*

VI. ATTACHMENT

- A. *Attachment A: Inmate Caseload Management by Risk Level*



ATTACHMENT A: INMATE CASELOAD MANAGEMENT BY RISK LEVEL



At least 6 months prior to PE Date – CM reviews and confirms inmate's release plan and verifies ID credentials

At least 3 months prior to PE Date – CM reviews for referral to DPHHS, VA, Voc. Rehab, and/or Dept. of Labor and Industry



POLICY DIRECTIVE

Policy:	DOC 1.5.20 RECORDS RETENTION	
Effective Date:	01/15/2026	Page 1 of 3
Revision Date(s):		
Signature/Title:	/s/ Eric Strauss, Director	

I. PURPOSE

The Department of Corrections will manage the retention, transfer and destruction of official records according to state and federal laws. The Department will manage retention schedules according to state general retention schedules or within agency-specific retention schedules

II. DEFINITIONS (see Glossary)

III. PROCEDURES

A. General Requirements

1. Retention, transfer and destruction of Department records will be managed according to ARM 44.14.107.
2. The Department will follow the State Records Retention and Disposition schedule for appropriate public records, unless the records are not covered under the Secretary of State's (SOS) General Schedule.
3. For records not listed in the Secretary of State's General Schedule:
 - a. The Department must have complete, current, disposal plans on file with the SOS office, and,
 - b. The Department will submit the "Records and Information Management Agency Delegation of Authority" form to the Secretary of State's Office every five years.
 - c. On records older than 25 years, with possible historical value, the records must first be offered to the Montana Historical Society. If the Montana Historical Society declines the records, then the agency must receive approval from the SOS subcommittee for destruction of those records.
4. Records subject to state or federal regulation or licensure or that are managed as other agency records will be maintained under those regulatory records managements (i.e., Boilers, Elevators, Education, Drivers' License Services).
5. Access and disclosure to any format of records are to be managed under state and federal laws, ARM and *DOC 1.5.5 Offender Records Management, Access, and Release*.
6. Listing(s) of destroyed records will be documented, and documentation will be kept for 30 years.

IV. SCHEDULING

A. Retention Schedules

1. **Digital Records** are identified as records the Department maintains in a digital format. Digital format could be items maintained in a "cloud" storage or physical storage medias (i.e., hard drives, memory cards, USB drives, etc.). Digital Records include emails, chat, and cloud-based data collaboration tools. Digital Records, other than those listed below, will be retained, transferred and destroyed, according to state laws and policies.

2. **Financial Records** are identified as records on agency financial management. These records can be in a paper or digital form.
 - a. General Agency Financial Records are managed for retention and destruction under State General Schedule Sections 1 and 2. An RM88 will be used by the agency to track which documents were destroyed.
 - b. Financial Records for Offender Accounting are managed under Offender Management Records.
3. **(Offender) Health Records** are identified as records the agency maintains on offender health information. These records can be in a paper or digital form. The agency's official Offender Health Record is recognized as *TechCare*.
4. **Human Resource Records (Staff)** are identified as the records the agency maintains on agency staff employment. These records can be in a paper or digital form.
 - a. General Human Resource Records are managed under State General Schedule Section.
5. **Legal Service Records** are identified as records that are generated during legal defense, litigation, representation, or general solicitation and dissemination of information to render legal advice. These records can be in a paper or digital form.
 - a. Legal Services Records are managed under State General Schedule Section 3.
6. **Investigative Records** are identified as records that are maintained during and to the conclusion of potential criminal proceedings. The product of Investigative Records will be maintained as part of the Criminal Case Files of the prosecution jurisdiction. These records can be in a paper or digital form.
 - a. Investigative Records are managed under RM3 Agency Records Retention Schedule.
 - b. Investigative Records may be records that include PREA, STG and Institutional Security.
7. **Offender Management Records** are identified as records that are used to assess or determine offender management plans. The Department's recognized Offender Management Records are; the agency's "official" digital Offender Management System (OMS), the Main File, the Mini File, the Probation and Parole File, the Board File, the Facilities/Placement Bureau File. These records can be in a paper or digital form.
 - a. Offender Management Records are managed under RM3 Records Retention Schedule.
 - b. Historically valuable records can be offered to Montana Historical Society when they have reached agency retention expiration.
 - c. Offenders that were/are supervision only offenders for other state's must have any documents, that originated from the other state, suppressed upon the offender's discharge from Montana supervision.
8. **Security Records** are identified as records that log and record the supervision of groups of individuals subject to incarceration. These records include special housing records management. These records can be in a paper or digital form.
 - a. Security Records are managed under RM3 Agency Records Retention Scheule.
9. **Youth Offender Management Records** are identified as agency records on offenders that are adjudicated for a felony crime committed under the age of 18 and the case remains in a Youth Court, including Extended Jurisdiction cases, or 4 misdemeanors committed within one year and sentenced to the Montana Department of Corrections, and the case remains in Youth Court. These records can be in a paper or digital form.
 - a. Youth Offender Management Records are managed under RM3 Records Retention Schedule.

V. CLOSING

Questions about this policy should be directed to the Records Bureau Chief.

VI. REFERENCES

A. *ARM 44.14.107*

B. *DOC 1.5.5 Offender Records Management, Access, and Release*



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy:	DOC 1.7.1 INFORMATION TECHNOLOGY SERVICES	
Chapter 1:	ADMINISTRATION AND MANAGEMENT	
Section 7:	Information Systems	
Effective Date:	Dec. 1, 1996	Page 1 of 2
Revised:	11/8/18	
Signature:	/s/ Reginald D. Michael, Director	

I. POLICY

The Department of Corrections complies with the Montana Code Annotated, the Montana Operations Manual, the Administrative Rules of Montana, and the Department of Administration Enterprise-Wide policies that regulate the use of state computers and information technology.

II. APPLICABILITY

All Department divisions, facilities and programs.

III. DEFINITIONS

None.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. The Administrative Services Division (division) will monitor the Montana Code Annotated, the Administrative Rules of Montana, Montana Operations Manual, and all relevant state information technology policies to ensure that Department information technology (IT) policies comply with the law and state policy.
2. The division may adopt procedures as necessary to manage, maintain, and protect the Department's computer and information technology resources. The division will maintain the procedures on the Intranet so they are accessible to staff.

V. CLOSING

Questions concerning this policy should be directed to the Department's Administrative Services Division Administrator.

VI. REFERENCES

- A. 2-15-112, MCA; 2-17-504 through 2-17-561, MCA; 18-4-313, MCA; 45-6-311, MCA; 53-1-203, MCA
- B. Montana Operations Manual
- C. Title 2, Chapter 12, Sub-Chapters 1 & 2; Administrative Rules of Montana

Policy No.: DOC 1.7.1	Chapter 1: Administration and Management	Page 2 of 2
Subject: INFORMATION TECHNOLOGY SERVICES		

VII. ATTACHMENTS

None.



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 1.7.2	Subject: IT HARDWARE, SOFTWARE AND CONTRACTED SERVICES STANDARDS
Chapter 1: ADMINISTRATION AND MANAGEMENT	Page 1 of 2 and Attachments
Section 7: Information Systems	Effective Date: Dec. 1, 1996
Signature: /s/ Mike Ferriter, Director	Revised: 04/24/12

I. POLICY

The Department of Corrections establishes and follows standards in the acquisition and installation of computer hardware and software to ensure compatibility within and between Department divisions or programs and other State entities; this includes contracting for information services when fiscal and operational issues suggest contracts are the most appropriate method of acquisition. All contracts for information services will be handled in compliance with all applicable state laws and policies.

II. APPLICABILITY

All divisions, facilities, or programs Department-owned or contracted, as specified in contract.

III. DEFINITIONS

Acquisition – To purchase, lease, rent, or acquire hardware and/or software by any method.

Contracts for Information Services – Include, but are not limited to, contracts for system analysis, design, development, maintenance, enhancement, operation or administration. Systems include data systems and any networks or communications facilities supporting such systems.

IV. DEPARTMENT DIRECTIVES

1. The Department of Corrections (the “Department”) will collaborate with the Department of Administration (DOA) and/or the DOA’s State Information Technology Services Division (SITSD) for review and approval of the following:
 - a. specifications and procurement methods pursuant to [2-17-512, MCA](#);
 - b. all contracts for information services;
2. The DOA enters into term contracts with various vendors to procure standard hardware and software at discounted prices. To purchase computer hardware and software in accordance with DOA standards, the Department will:
 - a. purchase computer hardware and software by utilizing DOA approved term contracts;
 - b. the Department may establish its own standards for purchase, which must be approved by DOA if the DOC has chosen not to set standards in the software category; and
 - c. orders to purchase or lease computer hardware and software, including free or no-cost software, must be requested using the [Information Technology Purchase Request](#) and following the [Procurement Request Process Flowchart](#), and must be reviewed and approved by the Network Support Bureau chief prior to issuing purchase orders.

Policy No. DOC 1.7.2	Chapter 1: Administration and Management	Page 2 of 2
Subject: IT HARDWARE, SOFTWARE AND CONTRACTED SERVICES STANDARDS		

3. The Department and DOA recognize the occasional need to purchase hardware and/or software that are “nonstandard.” The general criteria that will be applied to the approval of nonstandard purchases are that the hardware and/or software incorporate some necessary capability not present in standard hardware and/or software. In this case the DOA will review the request and issue an exception in writing.
4. Department divisions interested in contracting for information services should contact the Department’s Information Technology Division (ITD) which will assist in the coordination with SITSD. If it is determined that an existing term contractor cannot provide the services desired in a timely or cost-effective manner, the ITD will work with the requestor and SITSD to secure a suitable vendor following state law and policies governing the RFP and contracting processes.
5. Department staff must consult the ITD before installing any nonstandard equipment or software.
6. Department acquisitions will be made according to the following:
 - a. acquisitions of computer hardware and software will be in accordance with applicable Department and DOA State purchasing policies and procedures, including *DOC Policy 1.2.8, Procurement*; and
 - b. acquisitions of products or services will be formally reviewed during the Information Technology Purchase Request (ITPR) process to ensure compliance with security policy, state and federal laws.

V. CLOSING

Questions concerning this policy should be directed to the Department’s chief information officer (CIO).

VI. REFERENCES

- A. [2-15-112, MCA](#); [2-17-504, MCA](#); [2-17-512, MCA](#); [2-17-532, MCA](#); [18-4-313, MCA](#); [53-1-203, MCA](#)
- B. *Title 2, Chapter 12, Sub-Chapters 1 & 2; Administrative Rules of Montana*
- C. *DOC Policy 1.2.8, Procurement*

VII. ATTACHMENTS

[Information Technology Purchase Request](#) [PDF](#)

Procurement Request Process Flowchart [PDF](#)

Procurement Request Process Narrative [PDF](#)



POLICY DIRECTIVE

Policy:	DOC 1.7.3 DATA QUALITY
Effective Date:	04/26/2007 Page 1 of 2
Revision Date(s):	08/26/2019; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

Department and state-owned Information Technology resources are used to provide information, both internally and externally, that is vital for operations, budgeting, and public safety. The quality of that information is the responsibility of every employee.

II. APPLICABILITY

All Department divisions, facilities, and programs.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Staff will use the *Information Systems Change Request* maintained by Department IT to request any change to a production platform and service provided by IT.
2. Designated Department staff serve on committees related to the maintenance of data quality and related production platforms and services, including but not limited to the change management committee, consisting of administrators who set priorities regarding requested changes and approve or deny requests.
3. Individuals who enter or maintain data in the offender management system will follow *DOC 1.5.5 Offender Records Management, Access, and Release* and this policy.
4. For information not entered into the offender management system, such as medical and mental health records or administrative information, each administrator is responsible for ensuring that data quality is maintained by relevant staff through procedures, training, management tools, or any other appropriate method.
5. Administrators are responsible for maintaining public records and implementing retention schedules in accordance with *DOC 1.2.7 Inventories and Public Records Management*.
6. Staff who violate this policy may be subject to disciplinary action, up to and including termination in accordance with *DOC 1.3.2 Employee Performance and Conduct Guidelines*.

B. Data-Related Responsibilities

1. Administrators will ensure that staff are assigned roles and permissions necessary for their data-related functions, receive adequate training to perform those functions, and are held accountable for maintaining data quality.
2. Each staff member who enters, modifies, or deletes data is the data owner and is responsible and accountable for the completeness, accuracy, and timeliness of the data that they handle.

3. Data owners will:
 - a. enter information in a timely manner;
 - b. verify the accuracy of the information entered;
 - c. check for spelling and transposition errors;
 - d. check data for reasonableness (for example, offenders are unlikely to be 377 years old);
 - e. review data that was entered by others for obvious errors;
 - f. report errors they find but are unable to correct to the IT Service Desk;
 - g. verify they are not creating a duplicate record;
 - h. not violate the intent of data fields (for example, putting data in the wrong data fields);
 - i. enter data correctly into data fields (for example, applying the rules);
 - j. correct errors of which they are made aware;
 - k. restrict data entry to records pertinent to their area of responsibility;
 - l. keep their knowledge of the systems current by attending training; and
 - m. ask “how to,” “what to,” or “where to” if in doubt about any data entry issues.
4. Data stewards will monitor data entered by staff, ensure that corrective actions are prepared and executed as appropriate, and recommend or take appropriate management or disciplinary action to ensure data quality.

V. CLOSING

Questions about this policy should be directed to the Department Chief Information Officer (CIO).

VI. REFERENCES

- A. 2-15-112, MCA
- B. *DOC 1.3.2 Employee Performance and Conduct Guidelines*



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy:	DOC 1.7.7 Computer Security
Chapter 1:	ADMINISTRATION AND MANAGEMENT
Section 7:	Information Systems
Effective Date:	May 1, 1997 Page 1 of 6
Revised:	January 24, 2020
Signature:	/s/ Reginald D. Michael

I. POLICY

In accordance with section 2-15-114, MCA, the security responsibilities for Department data lie with the department director. The director adopts the Enterprise POL-Information Security Policy and the policy's appendices as the Department's standard information security policy.

II. APPLICABILITY

All divisions, facilities, and programs of the Department of Corrections.

III. DEFINITIONS

Department Employee – The term includes paid employees or contracted persons (temporary or permanent), volunteers and interns who are paid or donate time or services to the Department, contractors, on-site vendors and individual service providers, e.g. delivery, maintenance, vendors, etc. who may not be contracted to the Department and whose assignment is primarily on Department premises, e.g. facility or program offices.

Device – Any electronic device including a computer, laptop, tablet, and smartphone. When the term is used in reference to a computer, a device is any internal or external hardware peripheral that attaches to a computer to send, receive, or process data.

Download – To copy software programs, games, screen savers and other such items from the Internet to a Department IT resource. Download does not include the copying of text documents from the Internet to a Department IT resource.

External Media Device – USB drives, digital cameras, multimedia players, smartphones and tablets, DVD's or CD's.

Information Technology (IT) Resources – Any computer system, including but not limited to, computers, servers, printers, smartphones, tablets, laptops, and networks.

Internet – An electronic communications network that connects computer networks and organizational computer facilities around the world.

Public Record – Information that is fixed in any medium and is retrieval in usable form for future reference, and designated for retention by the state records committee, judicial branch, legislative branch, or local government records committee.

Policy No. DOC 1.7.7	Chapter 1: Administration and Management	Page 2 of 6
Subject: COMPUTER SECURITY		

SummitNet – The State of Montana’s telecommunications nucleus network or backbone connecting agency, university, grades K-12, library, and local government networks. SummitNet provides connectivity to the Internet.

IV. DEPARTMENT DIRECTIVES

A. Acceptable Uses for IT Resources

1. Department employees may only use IT resources to carry out their official duties in accordance with 2-2-103(1)(2), MCA. Employees who deviate from these standards are subject to the penalties provided for in 2-2-103(1)(2), MCA.

B. Device Use

1. Access to IT resources in the form of devices and facilities are issued in accordance with performing assigned duties for the benefit of the people of Montana. Users of State of Montana IT resources and facilities are personally responsible for their conduct and behavior in the use of assigned resources.
2. Acceptable personal use includes e-mail for essential personal communication such as messages to family members, significant others, teachers, doctors and day-care providers to communicate work schedule changes, status, or other personal business. Acceptable Internet use includes personal information gathering during lunch breaks and nonworking hours, as long as it does not interfere with staff productivity or preempt any business activities. Violation of this section may lead to employee discipline, up to and including termination. There is no expectation of privacy while using the State IT resources. All activity can be logged, monitored, and reviewed.
3. Employees are expected to comply with all applicable IT-related contractual and license agreements. Staff should check with the IT bureau for guidance.
4. Work related files and electronic information pertaining to official Department related business must be stored on State approved storage services to ensure the document(s) are backed up. Storing data solely on a local computer drive including the desktop is prohibited.
5. Use of cloud-based services unapproved for department related data storage, transfer, etc. is prohibited.
6. Employees must never attempt to gain access to, disclose, or remove any user ID, information, software, or file that is not their own and for which they have not received explicit authorization to access.
7. Staff may not interfere with, encroach on or disrupt others’ use of the State’s shared IT resources. For example, by
 - a. playing computer games, streaming non-work-related video, sending excessive messages, attempting to crash or tie up a State computer; and
 - b. damaging or vandalizing State computing facilities, equipment, software, or computer files.

Policy No. DOC 1.7.7	Chapter 1: Administration and Management	Page 3 of 6
Subject: COMPUTER SECURITY		

8. Staff shall not transfer, or allow to be transferred to, from or within the agency, textual or graphical material commonly considered to be child pornography or obscene as defined in 45-8-201(2), MCA.
9. Staff shall not intentionally transmit, display, view, archive, store, transfer, edit, or record nudity, erotic content or sexual content, unless the information is needed to conduct official duties deemed appropriate by the Department.
10. All hardware and software, including downloaded software, must be authorized, and purchased and installed by authorized staff prior to use.
11. Employees may not connect non-State-owned storage media (USB storage devices, external or internal hard drives), including personal mobile devices (iPads, Kindles, smartphones, etc.) to the workstation or internal network.
12. IT resources may not be used for private, commercial, or political purposes.
13. Remote Access including VPN services to the State's internal network must be authorized by a supervisor and utilize State approved software. Utilizing VPN services to connect to state networks and resources from personally owned computing devices is prohibited.
14. Employees must report missing or stolen IT hardware immediately to their supervisor and the Department's Service Desk.
15. Staff must notify the Service Desk and their supervisor in the event of a security incident or if the IT device is acting unusual, e.g. slow performance or response times, unexpected pop-up advertisements, etc.
16. Devices must be locked before leaving them unattended. Staff must log off devices at the end of the day unless permission has been received to run a job or process.

C. Passwords

1. Passwords will be strong, with a minimum of 12 characters. Staff are required to have a combination of upper and lower case with special and numerical characters contained in their passwords.
2. Passwords may never be shared with anyone.
3. Personal information should never be used in a password (e.g., SSN or date of birth).
4. Staff must always secure their password(s). Passwords may not be written down (e.g., taped to monitor or under keyboard).

D. Internet

1. Internet usage is provided for the opportunity it gives state employees and contractors to accomplish their job duties.
2. Internet access must be used for conducting state business, however, employees are allowed non-excessive personal use of internet.

Policy No. DOC 1.7.7	Chapter 1: Administration and Management	Page 4 of 6
Subject: COMPUTER SECURITY		

3. Department system administrators, management, and appropriate Department of Administration personnel may monitor Internet usage for planning and managing network resources, performance, troubleshooting purposes, or if abuses are suspected.

E. Electronic Mail (Email)

1. Email may only be used for conducting state business, however, supervisory staff may allow incidental, non-excessive personal use of Email.
2. Email is considered public record. Employees should have no expectations of privacy.
3. State email accounts may not be used to sign up for non-work-related website accounts, mailing lists, etc.
4. Personal email account(s) may not be used for work-related business.
5. State email may not be used to circulate chainmail, spam, etc.
6. State email may not be used to send sensitive information to other parties unless authorized by agency and appropriately encrypted.
7. Employees may not use email to send inappropriate materials such as:
 - a. sexually offensive, explicit; or
 - b. harassing or discriminatory; or
 - c. gruesome, violent, or sadistic.

F. Social Media

1. If staff use of social media is authorized it may only be used for work-related purposes.
2. Work-related social media communications should be professional and consistent with the agency's mission and the position's responsibilities,

G. Mobile Device Management

1. Granting of Mobile Device access to State of Montana IT resources will be managed by the Department's IT bureau.
2. State information managed from a mobile device requires authentication, which must include either a device passcode or user password.
3. Passcodes are required to follow the state policy for passwords. This includes biometrics. See previous section regarding appropriate password information.
4. Jailbroken or "rooted" devices will not be allowed to enroll in the enterprise MDM solution.
5. If a device becomes compromised while it is enrolled, state information will be removed, and the device will not be allowed access to the State network or State information. Access will not be restored until the device has been wiped or receives a factory reset.

H. Security Training

Policy No. DOC 1.7.7	Chapter 1: Administration and Management	Page 5 of 6
Subject: COMPUTER SECURITY		

1. The Department provides mandatory security awareness training to new employees, as well as annual security training to all staff.

I. Sensitive Information

1. State of Montana Level 2 and 3 data classifications must be appropriately handled, marked, stored, and transmitted. See [*Montana Operations Manual, GDE-Data Classification*](#).
2. Staff must ensure any personally identifiable information is saved to an appropriate location (e.g. encrypted location).
3. Sensitive information may not be stored, transferred, or copied to unauthorized locations.
4. Employees must utilize the State of Montana File Transfer Service or OneDrive for Business or Enterprise Approved encrypted email for any transfer needs of sensitive information.
5. Information that is sensitive, may only be stored on State-owned portable devices and portable storage if there is an approved business need or requirement.
6. If a position requires access to sensitive information, an Elevated Privileges Acknowledgement form will be signed by designee and approved by management prior to being granted access.
7. Sensitive information may not be transported outside of the United States on portable devices or portable storage.
8. Protect IT devices containing sensitive information (e.g. flash drives, computers, cell phones, etc.) until the device is destroyed or sanitized using approved tools or equipment.
9. Report lost, stolen or compromised information to immediate supervisor and Information Security Manager.

J. Multi-Factor Authentication

1. Multi-Factor authentication is the state standard for access to State of Montana computer systems. It is achieved through use of RSA physical fob or soft token.
2. The Department in partnership with the State Information Technology Services Division (SITSD), is responsible for distributing and managing RSA fobs. One fob will be issued to each employee or service provider who requires it for their position along with their User ID.
3. Fobs are not to be shared with other individuals.
4. Employees and service providers are responsible for the physical security of the fob at all times in order to prevent unauthorized access.

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Subject: COMPUTER SECURITY		

5. Lost, stolen or misplaced fobs must be reported immediately by calling the Service Desk or SITSD Service Desk at (406) 444-2000. The employee's manager must request a replacement fob or temporary passcode.

K. Compliance

1. Compliance is shown by implementing this Enterprise Acceptable Use of IT Resources as described above. Policy changes or exceptions are governed by the Procedure for Establishing and Implementing Statewide Information Technology Policies and Standards. Requests for a review or change to this document can be made by submitting an Action Request form. Requests for exceptions are considered by submitting an Exception Request form to DOA_SITSD. Changes to policies and standards will be prioritized and acted upon based on impact and need.

V. CLOSING

Questions concerning this policy should be directed to the Department's Chief Information Officer (CIO).

VI. REFERENCES

This section contains content or links to supporting documents or sources.

POL-Information Security Policy POL-Information Security Policy - Appendix A (Baseline Security Controls)

POL-Information Security Policy - Appendix B (Security Roles and Responsibilities)

POL-Information Security Policy - Appendix C (Blocked Sites and Rules of System Usage forms) POL-Information Security Policy - Appendix D (Cyber Security Framework link to Baseline Security Controls)

Section 2-15-114, MCA

Section 2-17-534, MCA

VII. ATTACHMENTS

None



POLICY DIRECTIVE

Policy:	DOC 1.7.11 WEBSITES	
Effective Date:	12/01/1996	Page 1 of 2
Revision Date(s):	08/28/2019; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department disseminates information through the Department's internet and intranet sites. The purpose of the internet site is to provide direct citizen access to information and resources related to support of the Department's mission of creating a safer Montana through accountability, rehabilitation, and empowerment. The purpose of the intranet site is to provide employees direct access to the Department's internal information.

II. APPLICABILITY

All Department divisions, facilities, and programs.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The Department Communications Director will develop and assist in the maintenance of the Department's internet and intranet websites.
2. The Department of Administration hosts and maintains the Content Management System (CMS) used for the Department's internet and intranet websites. Content owners will maintain appropriate information on the internet site including, but not limited to:
 - a. rulemaking notices;
 - b. board vacancy notices as required by 2-15-201, MCA;
 - c. agency reports mandated by statute;
 - d. requests for bids or proposals;
 - e. public meeting notices and agendas; and
 - f. Department policies, procedures, and forms available to the public.
3. Content owners maintain the information on the intranet site including, but not limited to:
 - a. organizational information;
 - b. resource management information and guides;
 - c. internal forms;
 - d. Department policies and procedures with restricted access; and
 - e. Human Resource documents, guides, and forms
4. Content owners and administrators are responsible for ensuring that new content on the internet is referred to the Communications Director for final approval prior to placement; content will be submitted at least two weeks prior to the date of importance to the public (meeting date, RFP close, etc.).
5. Information to be placed on the secure intranet site will be developed by subject matter experts, presented to the appropriate administrator for approval, and submitted to the Communications Director for publication or to other entities authorized to publish to the intranet. Administrators may appoint a content manager who is responsible for:
 - a. publishing and managing division-specific intranet pages; and
 - b. only publishing content that is consistent with the current intranet site design.

6. Content that is published to the internet and intranet will be:
 - a. accessible to internet users as mandated by state and federal laws and regulations;
 - b. accessible through hand-held devices, such as smartphones and tablets;
 - c. maintained as a single site with many unique parts rather than as a portal to many separate websites; and
 - d. organized in a way that does not require knowledge of the Department's administrative structure.

V. CLOSING

Questions about this policy should be directed to the Communications Director.

VI. REFERENCES

- A. §§ 2-15-112; 2-15-201; 2-17-532, *MCA*



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy:	DOC 1.7.13 OFFENDER ACCESS TO COMPUTERS
Chapter 1:	ADMINISTRATION AND MANAGEMENT
Section 7:	Information Systems
Effective Date:	Dec. 1, 1996 Page 1 of 3
Revised:	Dec. 7, 2018
Signature:	/s/ Reginald D. Michael

I. POLICY

The Department of Corrections allows offenders controlled access to state-owned computers. This access is allowed for training, legal research, educational purposes, and as needed for work that offenders may perform in Department facilities and programs.

II. APPLICABILITY

All Department secure facilities.

III. DEFINITIONS

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility, or program operation and management.

Computer Peripherals – Any equipment that can be attached to a computer, including but not limited to: printers, monitors, scanners, digital cameras, and removable data storage media such as pen drives, DVD/CD drives, tape drives, and zip drives.

Freestanding Isolated Network – A group of computers networked only to each other. The freestanding isolated network will not have access to any other network.

Inmate Computer Network (ICON) – Department network that provides computer and resource access for inmate work and education programs.

Offender – Any individual in the custody of the Department of Corrections.

Password – An alphanumeric combination of characters unique to individual users that allow access to a specific computer, network or computer system.

Portable Electronic Storage Media (Portable Storage) – Includes floppy disks, CDs, DVDs, optical platters, flash memory drives, backup tapes, external hard drives, and other electronic storage media or devices that provide portability or mobility of data.

Server – A computer that serves programs, files, and printing services to other computers on the network.

Stand-Alone Computer – A computer that is not attached to any network.

Subject: OFFENDER ACCESS TO COMPUTERS

User ID – Used generically to refer to CI number, login ID, user account, or any other term used to describe a user's unique identifier which is used to grant rights and privileges on a computer, computer system or network. User IDs are never reused.

IV. DEPARTMENT DIRECTIVES**A. Prohibitions**

1. Under no circumstances will facilities allow any offender to access:
 - a. the internet on unapproved or staff use systems;
 - b. e-mail; or
 - c. unapproved or non-offender computers or servers;
2. Under no circumstances will facilities allow offenders to save or maintain personal files on a state owned computer or server.
3. Any unauthorized inmate use of a state owned computer is strictly prohibited.

B. Computer Labeling

1. Each facility will:
 - a. conspicuously label all computers and peripherals, which are located in offender-accessible areas, with a laminated card, designating them as either *Offender Use* or *Staff Use Only* to ensure visual identification;
 - b. permit offenders to only access computers labeled *Offender Use*; and
 - c. ensure the laminated card attached to each *Offender Use* computer includes all authorized programs allowed on that specific computer.

C. Offender Access to Stand Alone Computers or Free Standing Isolated Networks

1. The work area supervisor may allow an offender to access stand-alone computers and freestanding isolated networks; however, the computers must be labeled as outlined in Section IV.B above.
2. The administrator and CIO must approve in writing the creation of any new, free-standing, isolated networks.

D. Offender Access to ICON

1. The Administrative Services Division Network Services Unit, in conjunction with the Department of Administration's Information Technology Services Division, will manage ICON.
2. Each facility/program will designate staff to manage the offender accounts for access to work or educational computers.
3. Each facility/program with inmates utilizing ICON will create a process for authorizing offender access. All offender access to any offender use system will be provided for through the facility/program inmate access procedure.

Subject: OFFENDER ACCESS TO COMPUTERS

4. Once an offender is approved for ICON access, the designated facility/program staff will assign the offender the appropriate rights on ICON. The offender's User ID will be their OMIS DOC ID.
5. When an offender leaves a job assignment, the work area supervisor must notify the designated facility/program staff to remove the offender from ICON access.
6. When an offender leaves a classroom assignment, the instructor must notify the designated facility/program staff to remove the offender from ICON access.
7. At no time will an offender use network credentials (user ID and password) other than their own or provide another offender their credentials. Violations will result in disciplinary action in accordance with *DOC 3.4.1 Offender Disciplinary System* and facility disciplinary procedures.

E. Offender Access to Peripherals and Disks

1. Each facility/program will ensure that offender access to peripherals is limited and closely supervised.
2. Each facility/program will develop specific procedures regarding the use of all peripherals. In the case of scanners and digital cameras, the supervisor must review and approve the project in writing prior to allowing the offender access to the equipment.
3. Supervisors may allow offenders to use portable electronic storage media for appropriate work-related assignments and educational programs in coordination with Department policies and procedures and the area supervisor.
4. Under no circumstances will supervisors allow offenders to move portable electronic storage media from their assigned work area to another area without staff approval.
5. Possession of portable electronic storage media in offender living areas or use of disks for personal needs is strictly prohibited. Violations will result in disciplinary action in accordance with *DOC 3.4.1 Offender Disciplinary System* and facility disciplinary procedures.

V. CLOSING

Questions concerning this policy should be directed to the Administrative Services Division Administrator.

VI. REFERENCES

- A. 2-15-112, MCA; 2-15-114, MCA; 53-1-203, MCA
- B. Montana Operations Manual – Information Security Policy

VII. ATTACHMENTS

None.



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy:	DOC 1.7.14 SOFTWARE LICENSES
Chapter X:	ADMINISTRATION AND MANAGEMENT
Section X:	Information Systems
Effective Date:	December 1, 1996 Page 1 of 2
Revised:	June 12, 2018
Signature:	/s/ Reginald D. Michael

I. POLICY

The Department of Corrections requires that software used on Department computers have a current and legal license authorizing its use and that software is used in accordance with the terms and conditions of its license.

II. APPLICABILITY

All Department divisions, facilities, or programs.

III. DEFINITIONS

Acquisition – To purchase, lease, rent, or acquire hardware and/or software by any method.

ITPR – Information Technology Purchase Request; the Department form used to request the acquisition, installation and use of IT resources, such as software or hardware.

NIST – National Institute of Standards and Technology; standards group whose policies and procedures have been adopted by the State of Montana in regard to electronic data.

NSU – The Network Support Unit of the Department of Corrections.

State Networked Machines – Any Department owned device attached to any Department of Administration/State Information Technology Services Division managed network which includes SummitNet and ICON.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. The NSU configures new computers with an operating system and standard set of productivity software on state networked machines.
2. If additional software is required to perform job functions on any computing device, an ITPR must be submitted in accordance with *DOC Policy 1.7.2 IT Hardware, Software, and Contracted Services Standards*.
3. Upon approval of an ITPR for a directly supported NSU system, the NSU will arrange:
 - a. the acquisition and tracking of the software license; and
 - b. installation on a networked device, upon receipt of the software license.

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Subject: SOFTWARE LICENSES		

4. A program administrator, or designee, acquiring software for offender-use, non-networked computers will:
 - a. track the software license; and
 - b. install the software on the offender-use computer(s).
5. When a computer is to be disposed of, the NSU will remove all data from the computer prior to pick up in accordance with *Montana Operations Manual Policy 1240x04, Disposal of Computers*.
6. Software licenses must be acquired in accordance with *DOC Policy 1.7.2 IT Hardware, Software, and Contracted Services Standards*.

V. CLOSING

Questions concerning this policy should be directed to the Department's Chief Information Officer (CIO).

VI. REFERENCES

- A. 2-17-504, MCA; 53-1-203, MCA
- B. DOC Policies 1.7.2 IT Hardware, Software, and Contracted Services Standards; 1.7.9 Acceptable Use of IT Resources
- C. POL-Information Security Policy

VII. ATTACHMENTS

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No.: DOC 1.8.1	Subject: VICTIM SERVICES
Chapter 1: ADMINISTRATION AND MANAGEMENT	Page 1 of 4
Section 8: Victim Services	Effective Date: June 1, 1998
Signature: /s/ Mika Batista, Director	Revised: 10/20/2014

I. POLICY

The Department of Corrections treats crime victims with dignity and respect, complies with victim notification and restitution statutes, offers programs that promote healing, and encourages victim awareness training.

II. APPLICABILITY

Victims of adult offenders under Department supervision.

III. DEFINITIONS

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Facilitator – A person who meets the Department's requirements to facilitate a victim-offender dialogue or victim impact panel.

Restorative Justice – A criminal justice concept that focuses on offender accountability and healing for victims, families, communities, and offenders.

Victim – The person against whom a felony crime has been committed, or a family member of that person. Other individuals may be recognized as victims on a case-by-case basis.

Victim Information and Notification Everyday (VINE) – An automated telephone, email and text message notification system that DOC purchases on contract from Appriss, Inc., which provides location and custody status updates about adult offenders under DOC supervision.

Victim Information Officer (VIO) – A facility or program staff person who provides information about offenders in the facility or program and about DOC programs for victims.

Victim Programs Manager (VPM) – A Department employee located in the Director's Office who manages victim programs and policies, responds to victims' requests for information and referrals, educates victims about the post-conviction criminal justice system, provides victim services training, and represents victim interests in all Department matters.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. The Department may allow victims to have facilitated contact with offenders through

Policy No. DOC 1.8.1	Chapter 1: Administration and Management	Page 2 of 4
Subject: VICTIM SERVICES		

victim service programs. Facilities and programs participating in victim service programs must comply with the provisions of this policy and [1.8.1\(A\) Victim Services Standard Operations Procedure Guide](#).

2. Administrators, or designees, will determine if a victim services program is permitted at the facility or program.
3. Participation in victim services is voluntary.
4. Offender participation in victim restorative justice programs has no effect on an offender's parole eligibility, release date, or conditions of supervision.
5. Administrators, or designees, and victim services staff, must approve offender eligibility to participate in victim services programs.
6. The Department will not allow participation in a victim restorative justice program if such participation is in violation of a sentencing order or a current legal order of protection.
7. Travel expenses incurred during participation in a victim service program by the victim and/or facilitator may be reimbursed by the Department.

B. Victim Programs Manager (VPM)

1. The VPM will:
 - a. collaborate with facility and program staff to ensure Department compliance with victim notification;
 - b. respond to victim information requests via email and a toll-free phone line;
 - c. manage the Department's victim services programs;
 - d. manage the Department's VINE service contract and collaborate with the Information Technology Division and Appriss, Inc. to ensure the system is functional; and
 - e. recommend new or expanded programs to respond to the needs of victims.

C. Victim Notification

1. If victims request notification, the Department will communicate all changes in offender custody status and location to the victim.
2. The Department will maintain an automated electronic notification system, known as Victim Information and Notification Everyday (VINE), to provide custody status and location information about offenders under DOC supervision.
3. The Department will maintain a separate process by which direct victims, immediate family members and witnesses to a crime may register directly with the Department to receive letter or telephone notification from designated Department employees when an offender's custody status or location changes.
4. Offenders may not appeal any delay of case decisions or actions caused by statutory victim notification requirements or the processing of such notifications.

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Subject: VICTIM SERVICES		

D. Victim Support

1. The Department assists victims of offenders under Department supervision by providing referrals to services within the Department and in the community, training staff to respond to concerns regarding safety, collecting court-ordered restitution, providing prompt notification of changes in offender location and custody status, and facilitating victim-initiated contact with offenders.
2. Each facility or program administrator may designate a staff member as the Victim Information Officer (VIO); the VIO will provide information about offenders in the facility or program and provide referrals to DOC victim programs.

E. Victim Restorative Justice Programs

1. Victim Impact Panels (VIPs) provide victims an opportunity to speak to offenders about how crime has affected them, and serves to influence future offender behavior.
2. The Victim-Offender Dialogue (VOD) program allows a victim, or an adult acting on behalf of a victim who is under age 18, to discuss the impacts of the crime with the offender in the presence of a trained facilitator. Participation in the program is voluntary for all participants and may only be initiated by the victim.
3. The offender Accountability Letter Program (ALP) allows offenders to write to the victim(s) of the crime for which the offender was sentenced, reflecting responsibility for the crime and remorse for the harm caused to the victim(s) without excuses or requests for forgiveness or pardon.

F. Rights and Responsibilities of Victims

1. Victims are not obligated to participate in victim services or programs.
2. Victims who choose to participate in victim services and programs must provide their current contact information, agree to complete all evaluations, and sign all forms required by the Department.
3. Victims, support person(s), and facilitators must pass visitor background checks in accordance with [DOC 3.3.8, Offender Visiting](#) and follow normal facility entrance procedures.
4. Victims involved in legal proceedings involving the offender may not participate in the VOD program or ALP.

G. Facilitator Requirements

1. Facilitators must meet the requirements of, and complete paperwork required in [DOC Policy 1.3.16, Volunteer Services](#).
2. Facilitators must meet all qualifications as outlined by the Department.

H. Offender Requirements

1. Offenders involved in legal appeals or other legal proceedings involving the victim, may

Policy No. DOC 1.8.1	Chapter 1: Administration and Management	Page 4 of 4
Subject: VICTIM SERVICES		

- not participate in the VOD program or ALP.
2. Offenders must agree to complete all evaluations and sign all forms required by the Department.
 3. Participation in a victim restorative justice program does not constitute permission for the offender to make additional contact with the victim.

I. Training

1. The VPM provides training about victim information requests, VINE and other notification procedures, victim sensitivity and staff communications, and programs for victims within the community, when requested, and within the Department.
2. VIOs provide victim services training at respective facilities.

V. CLOSING

Questions concerning this policy should be directed to the Department's Victim Programs Manager.

VI. REFERENCES

- A. [2-15-112](#), MCA; [41-5-1416](#), MCA; [46-18-241](#), MCA; [46-24-101](#), MCA; [46-24-102](#), MCA; [46-24-203](#), MCA; [46-24-212](#), MCA; [46-24-213](#), MCA; [53-1-203](#), MCA
- B. 4-4447-1, ACA Standards Supplement, 2008
- C. DOC Policies [1.1.1](#), Purpose, Mission and Management Philosophy; [1.3.16](#), Volunteer Services; [1.5.6](#), Offender Records Access and Release
- D. [Victim Services Standard Operations Procedure Guide 1.8.1A](#)

VII. ATTACHMENTS

None

Procedure No. DOC 1.8.1A	Effective Date: 10/20/2014	Revised:
Signature: /s/ Judy Beck		Position Title: Communications Director



VICTIM SERVICES STANDARD OPERATIONS PROCEDURE GUIDE

APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

**VICTIM SERVICES STANDARD OPERATIONS PROCEDURE GUIDE
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I. Introduction to Department of Corrections Victim Services

A. Victim Services at a Glance

The Montana Department of Corrections serves crime victims whose offenders are under Department custody or supervision. The Department maintains notification systems to provide information to victims, family members, and witnesses regarding offender custody and location changes. The Department also offers restorative justice programs which provide a voice for crime victims, promote healing for all parties affected by the crime, and hold offenders accountable with the goal of successful re-entry into society.

Brochures, program manuals and other information can be found at the Victim Programs website at: <http://cor.mt.gov/Victims/default.mcp>

B. Victim Programs Manager (VPM)

The Department Victim Programs Manager may be contacted at:

shilander@mt.gov

406-444-7641

P.O. Box 201301, Helena, MT 59620-1301

Responsibilities of the VPM include, but are not limited to:

- a. collaborate with facility and program staff to ensure Department compliance with victim notification;
- b. respond to victim information requests via a toll-free phone line;
- c. facilitate the Department's victim services programs;
- d. provide victim services training and technical assistance to facilities and programs upon request;
- e. manage the Department's VINE service contract and collaborate with the Information Technology Division and Appriss, Inc. to ensure the system is functional; and
- f. recommend new or expanded programs to respond to the needs of victims.

C. Victim Information Officer (VIO)

Each facility or program administrator may designate a staff member as the Victim Information Officer (VIO); the VIO will provide information and referrals for victims.

II. Victim-Offender Dialogue (VOD)

The Victim-Offender Dialogue (VOD) program allows a victim, or an adult acting on behalf of a victim who is under age 18, to discuss the impacts of the crime with the offender in the presence of a trained facilitator.

A. VOD Criteria

1. The administrator will determine if a VOD program is permitted at the facility.
2. Only victims may initiate the VOD process and offender participation is voluntary.
3. All requests from victims will be forwarded to the VPM.

4. The administrator, or designee, will meet with the offender to discuss participation in the VOD process.
5. The administrator, or designee, will consider the following issues before rendering a decision:
 - a. the safety of all participants;
 - b. facility security issues;
 - c. the offender's disciplinary record; and
 - d. the offender's stability.
6. VOD will not generally be approved in cases of domestic violence or stalking; the VPM may consider exceptions on a case-by-case basis after separate consultations with the victim, the offender, and at least one person directly involved in the offender's treatment plan.
7. Participants must be at least 18 years old; parents or legal guardians of victims under 18 may represent the minor's interest in a VOD.
8. Approved volunteers may participate in a VOD.
9. The victim and offender may each have a support person present throughout the process; attorneys who provide legal representation for the crime relevant to the VOD generally may not act as support persons.
10. Victims and facilitators will be responsible for their own expenses associated with the VOD; the Department may approve travel expenses for victims and facilitators, not to exceed the state employee per diem and personal vehicle mileage rate, on a case-by-case basis.
11. The victim, offender, facilitator, or administrator may end the VOD process at any time.
12. The offender may not participate in the VOD unless he or she admits guilt and accepts responsibility for the crime as described in the final court judgment and pre-sentence investigation. The VPM may consider exceptions to this rule on a case-by-case basis after consultation with the victim, the offender, and at least one person directly involved in the offender's treatment plan.
13. Victims or offenders involved in legal appeals or other legal proceedings may not participate in a VOD.
14. The victim and offender must agree in advance that they will complete an initial evaluation immediately following the VOD and a follow-up evaluation within three months.
15. VOD participation will not be noted in offender files.

B. VOD Preparation

1. The victim and offender must sign the [Release of Liability](#) form agreeing that:
 - a. they are participating in the process voluntarily; and

- b. they will not hold the Department liable for any negative consequences of the VOD process.
2. The victim and offender must sign the [Acknowledgment of Understanding](#) to indicate they understand the purpose and potential outcomes of the VOD process.
3. The VPM will conduct initial interviews with the victim and offender to evaluate their emotional stability and expectations.
4. The victim, facilitator, and support person(s) will receive advance notice of the facility rules and entrance procedures.
5. The administrator, or designee, will review the request for a VOD with the VIO and VPM and sign the appropriate paperwork authorizing entrance into the facility for the victim, support person(s), and facilitator.
6. Victims, support person(s), and facilitators must pass visitor background checks and follow normal facility entrance procedures.
7. The victim and support person(s) will be encouraged to take a facility tour prior to the dialogue; the VIO, or designee, will assist with arrangements for this visit.

C. VOD Process

1. The VOD will occur at a facility location designated by the administrator.
2. The facilitator(s) will brief the offender and victim separately before the dialogue occurs and debrief both parties separately afterward.
3. A correctional officer or designee will be stationed immediately outside the VOD meeting room.

D. VOD Follow-up

1. The facilitator(s) will complete a separate debriefing in person or via telephone with the victim and offender within one week of the dialogue.
2. The facilitator(s) and/or the VPM will complete evaluations in person or via telephone with the victim and the offender at two months, six months, and one year after the dialogue.
3. The administrator will monitor the offender after the VOD to detect emotional consequences requiring intervention.

E. VOD Facilitators

1. Facilitators must meet all qualifications for VOD as outlined in the [Facilitator Guidelines](#).
2. Facilitators must meet the requirements of, and complete paperwork required in, [DOC Policy 1.3.16, Volunteer Services](#).
3. The VPM assigns facilitators to dialogue cases.

III. Victim Impact Panel (VIP)

The primary purpose of a Victim Impact Panel (VIP) is to provide victims an opportunity to share with offenders how crime has affected them, and to influence future offender behavior.

A. VIP Criteria

1. Offender benefits of attending a VIP are secondary to the victims' needs.
2. The facility administrator will determine if a VIP program is included in offender programming.
3. The Department has minimum standards for prerequisite offender victim-impact programming. Offenders may attend VIPs only after completing prerequisite victim-impact programming.
4. Offenders may not participate in a VIP unless they demonstrate a basic understanding of how their criminal behavior affects others.
5. Offenders will not attend VIPs on which their victims have volunteered to speak.
6. Victims who speak on a VIP may be reimbursed personal vehicle mileage, meals and lodging at the Montana state government rate. Speaker reimbursement may be provided by the facility hosting the VIP or by the Department, on a case-by-case basis.
7. Approved volunteers may participate in VIPs.

B. VIP Program Manual

The Department has prepared a manual as a resource for correctional program managers who would like to host VIPs in their facilities. It is available at

<http://cor.mt.gov/content/Victims/VIPManual.pdf>

IV. Accountability Letter Program (ALP)

The offender Accountability Letter Program (ALP) supports victims of crime and promotes positive change in offender behavior. The ALP is a restorative justice program that allows offenders to demonstrate responsibility for crimes committed and express remorse for harm caused.

A. ALP Criteria

1. The Department encourages victims to make initial contact with offenders through the VPM.
2. Participation in the process is voluntary for offenders and will have no effect on their parole eligibility, release date, or conditions of supervision.
3. A victim's decision to receive a letter does not constitute an agreement to read or respond to the letter.
4. The Department will not deliver an accountability letter in violation of a sentencing order

or a current legal order of protection.

5. Victims or offenders involved in legal appeals or other legal proceedings may not participate in the ALP.

B. Accountability Letter Requirements

1. The offender:
 - a. may access the [Accountability Letter Guidelines](#) and the [Offender's Request to Participate](#) via libraries in Department facilities, caseworkers, treatment specialists, VIOs or other staff;
 - b. must sign the [Offender's Request to Participate](#) form if they wish to send accountability letters to their victims; failure to comply with this provision may violate no-contact orders;
 - c. must comply with the [Accountability Letter Guidelines](#) and submit the letter to designated facility/program staff or to the VPM;
 - d. may never mail or otherwise deliver an accountability letter to the victim directly;
 - e. participation in the accountability letter process does not constitute permission for the offender to make additional contact with the victim; and
 - f. will sign the original letter once approved by the VPM and facility letter screener prior to delivery.
2. The Department encourages facilities/programs to:
 - a. when possible, designate a staff member(s) qualified to screen offender accountability letters to ensure compliance with the ALP Letter Guidelines; and
 - b. establish treatment prerequisites for offender participation in the process.
3. The designated facility/program letter screener will:
 - a. review the draft letter and suggest changes when necessary; and
 - b. upon approval, submit the letter to the VPM, with documents that describe the offender's crime(s).
4. The facility screener and/or VPM will determine whether an offender achieved the level of responsibility and remorse required to write an appropriate accountability letter; if not the letter will be returned to the offender with an explanation of denial.
5. The VPM will:
 - a. determine if a sentencing order or legal order of protection prohibits contact between the offender and victim;
 - b. will return the letter to the facility letter screener or to the offender with recommendations for revisions if it is deemed inappropriate;
 - c. maintain the Accountability Letter Bank;
 - d. attempt to deliver and/or notify the victim when a letter is available; and
 - e. assist victims requesting to receive accountability letters from offenders not participating and contact the offender's treatment staff to determine if the offender will voluntarily participate.
6. The victim may:

- a. access information about the offender accountability letter process through community victim advocates, the VPM and other Department staff, and the Department website;
- b. participate voluntarily;
- c. inform the Department whether or not the offender should be notified if letter is received;
- d. if a sentencing order or legal order of protection exists, a letter may only be received if a modification of the order, signed by the judge, and filed with the appropriate court is obtained; and
- e. receive a letter from the VPM in a sealed envelope with contact information for local victim services.

V. Definitions

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Facilitator – A person who meets the Department’s requirements to facilitate a victim-offender dialogue or victim impact panel.

Restorative Justice – A criminal justice concept that focuses on offender accountability and healing for victims, families, communities, and offenders.

Victim – The person against whom a felony crime has been committed, or a family member of that person. Other individuals may be recognized as victims on a case-by-case basis.

Victim Information and Notification Everyday (VINE) – An automated telephone, email and text message notification system that DOC purchases on contract from Appriss, Inc., which provides location and custody status updates about adult offenders under DOC supervision.

Victim Information Officer (VIO) – A facility or program staff person who provides information about offenders in the facility or program and about DOC programs for victims.

Victim Programs Manager (VPM) – A Department employee located in the Director’s Office who manages victim programs and policies, responds to victims’ requests for information and referrals, educates victims about the post-conviction criminal justice system, provides victim services training, and represents victim interests in all Department matters.

VI. Attachments

[Accountability Letter Guidelines](#)
[Acknowledgment of Understanding](#)
[Facilitator Guidelines](#)
[Offender’s Request to Participate](#)
[Release of Liability](#)



STATE OF MONTANA DEPARTMENT OF CORRECTIONS POLICY DIRECTIVE

Policy:	DOC 1.9.1 GENERAL STATE ADMINISTERING AGENCY FUNCTIONS	
Chapter 1:	ADMINISTRATION AND MANAGEMENT	
Section 9:	Crime Control Bureau	
Effective Date:	July 12, 2018	Page 1 of 2
Revised:	April 16, 2020	
Signature:	/s/ Reginald D. Michael	

I. POLICY

The Department of Corrections and the Montana Board of Crime Control (Board or MBCC) are separate entities with administrative ties. The Board is the designated State Administering Agency responsible for comprehensive criminal justice and policy development and, as such, exercises policymaking and grant-related functions independent from the Department. The Department is committed to the full support of the Board by Crime Control Bureau staff

II. APPLICABILITY

Department Staff assigned to the Crime Control Bureau

III. DEFINITIONS

Application Review Committee (ARC) – the specific Board subcommittee charged with reviewing grant applications in a particular program area, i.e. the Anti-Drug Subcommittee, Victims Subcommittee, Prevention/Treatment Subcommittee.

Crime Control Bureau – assigned within the Administrative Services Division, the Crime Control bureau provides staff and support to the Board as established in [21-15-2306, MCA](#).

Montana Board of Crime Control (MBCC)– 18 members appointed by the Governor, representing law enforcement, public safety, and criminal and juvenile justice stakeholders and citizens. The Board administers grants dedicated to preventing and addressing crime and supports efforts to promote innovation, best practices and collaboration statewide.

Youth Justice Council (YJC) – 15 to 33 members appointed by the Governor, committed to providing Title II Formula Grant funds, training and technical assistance to Montana communities to reduce juvenile delinquency and keep our youth from entering the juvenile justice system and, ultimately, the adult justice system. The purpose of the YJC is to provide advice to the MBCC, not for legislative advocacy.

IV. DEPARTMENT DIRECTIVES

A. General Provisions

1. As the State Administering Agency, the Board of Crime Control allocates resources statewide and distributes, monitors, and reports on federal grant dollars that address the needs of statewide and local criminal justice systems.

Subject: GENERAL STATE ADMINISTERING AGENCY FUNCTIONS

2. The Crime Control Bureau is a staff dedicated to the support of the mission and goals of the Montana Board of Crime Control including, but not limited to, the following supportive roles:
 - a. record and translate all formal Board meetings;
 - b. provide all necessary communications to subgrantees and contractors including notification of Board funding decisions;
 - c. create requests for proposals for grant solicitations in accordance with the Board's directions and maintains a functioning process with transparency;
 - d. provide support for ARC meetings. Staff will support ARC meetings in the following ways:
 - 1) score subgrantee applications;
 - 2) provide, when requested, recommendations for funding; and
 - 3) provide historical information, proposals, reports, and other documents to inform ARC members about programs requesting funding;
 - e. upload documents into necessary systems to ensure transparency and compliance with federal requirements, including agendas, review material, applications, recommendations, and reports;
 - f. maintain functioning business systems that support Board processes;
 - g. provide travel reservation assistance;
 - h. provide training to subgrantees and contractors for required grant and contract management including financial and programmatic reporting;
 - i. provide assistance with the Montana Board of Crime Control Annual Conference, training events, vendor fairs, etc.
 - j. provide communication to Board members at formal meetings regarding grant opportunities, updates and financial reports;
 - k. ensure Board members are apprised of data reporting to the Statistical Analysis Center;
 - l. adhere to designated Board support functions listed within the Board's [Policies and Bylaws](#)
 - m. coordinate updates to policies and operational procedures, and ensure updates are made available to Board members.

V. CLOSING

Questions concerning this policy should be directed to the Crime Control Bureau Chief.

VI. REFERENCES

A. 21-15-2306, MCA

VII. ATTACHMENTS

None



POLICY DIRECTIVE

Policy:	DOC 2.1.1 FACILITY MAINTENANCE
Effective Date:	02/01/1997 Page 1 of 2
Revision Date(s):	03/15/2011; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

The Department will ensure safe and efficient maintenance of all facilities and comply with applicable codes, ordinances, and policies.

II. APPLICABILITY

All Department divisions, facilities, and programs excluding contracted facilities and employees of contracted facilities.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Code Compliance

1. Facilities will comply with all applicable federal, state, and local building codes and ordinances and will maintain current records on all code compliance/non-compliance issues including violations and corrective actions.
 - a. Non-compliance issues should be directed to the administrator who will take measures to comply at the earliest possible date.

B. Maintenance-Related Documents

1. The facility administrator, or designee, is responsible for maintaining blueprints, drawings, and specifications to include the following:
 - a. alterations or additions;
 - b. dates and authorization of alterations or additions;
 - c. secure document storage; and
 - d. availability for emergency use.

C. Facility Modifications

1. Excluding regularly scheduled maintenance, written approval will be obtained from the Department Director or designee before alterations or additions are made to facilities that either require a building permit or will affect:
 - a. any life safety system;
 - b. security of the facility;
 - c. esthetic appearance;
 - d. housing capacity; or
 - e. welfare of the staff or offenders.

D. Preventive Maintenance Programs

1. Each facility administrator or designee will outline a system of preventive maintenance including:
 - a. persons responsible for the preventive maintenance program;

- b. schedule for periodic inspection, lubrication, minor adjustment, and servicing of plant equipment and systems;
- c. inspection documentation including:
 - 1) date of inspection;
 - 2) name of inspector;
 - 3) significant findings; and
 - 4) repairs necessary;
- d. inspection documents shall be forwarded to the manager of maintenance;
- e. equipment that affects human habitation will receive frequent inspections and preventive maintenance; and
- f. logbooks and/or files will be maintained to serve as permanent records of inspections and repairs.

V. CLOSING

Questions about this policy shall be directed to the facility administrator.

VI. REFERENCES

- A. 53-1-203, MCA
- B. DOC 3.2.10 Fire and Life Safety; DOC 3.2.13 Safety Inspections



POLICY DIRECTIVE

Policy:	DOC 2.1.3 LAND USE RESTRICTIONS
Effective Date:	07/07/2001 Page 1 of 1
Revision Date(s):	03/29/2011; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

The Department shall ensure the safe, secure, and efficient operation of its Department-owned land.

II. APPLICABILITY

All Department-owned property.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Specific Requirements

1. Department facilities, divisions, or programs containing or adjoined to department-owned land shall develop written requirements to outline access and potential public use.
2. In a fire hazard, disaster, or emergency, the facility administrator will consult with the Department of Corrections Director (Director), Department of Natural Resources and Conservation, and other appropriate state and federal agencies to determine whether land use restrictions such as limited or closed access to facility property may be warranted.
3. The Director may issue a proclamation to limit or close Department property for all non-essential use if the Governor issues an Executive Order.
4. Public notice(s) of land closure will be posted on affected property and in local newspapers.
5. The facility administrator responsible for Department-owned property shall immediately implement processes to enforce compliance with any restriction.

V. CLOSING

Questions about this policy should be directed to the facility administrator.

VI. REFERENCES

- A. *Executive Order No. 19-00*
- B. §§ 2-15-112; 53-1-203; 76-13-102, MCA
- C. *DOC 3.2.10 Fire and Life Safety*



POLICY DIRECTIVE

Policy:	DOC 2.2.1 FACILITY DESIGN AND CAPACITY
Effective Date:	01/01/1997 Page 1 of 3
Revision Date(s):	08/15/2011; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

The Department will ensure that the design, renovation, and construction of its facilities comply with all applicable policies, codes, and standards and that the offender population is managed in accordance with facility operational capacities, security considerations, and facility needs.

II. APPLICABILITY

Secure facilities that are Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The Department, in coordination with the Department of Administration, Architecture and Engineering Division, when required by statute, will exercise direct control over all facility design and construction features, whether new or renovated.
 - a. This includes overseeing contracts or agreements between the Department and architects, engineers, building contractors, building material installers, built-in security equipment suppliers, or other consultants performing work related to the physical plant in Department facilities.
 - b. The applicable facility administrators will coordinate and supervise any design and construction work at their facilities.

B. Population Capacities and Emergency Capacity Action

1. Administrators will establish population capacity figures for the facilities under the administrator's authority based on design, available beds and cells, housing unit occupancy, classification system, personal inspection, and input on capacity from appropriate facility staff.
 - a. Figures are used for the Department *Offender Population Management Plan* and updated as needed for existing or new facilities.
 - b. The administrator will provide information on capacities to the Department Director and Department Offender Population Management Plan committee.
2. In facilities with an operational population capacity greater than 500 beds, the operational and emergency capacities will reserve a minimum of 5% of those capacities to address offender management problems (for example, disciplinary, mental health, separation needs).
3. When the offender population of a secure facility reaches emergency capacity, the facility administrator, or designee, will:
 - a. advise the Department Director;
 - b. complete the applicable portion of the *Notification of Facility at Emergency Capacity*; and
 - c. forward a copy to the Department Director for information and assistance.

4. If the facility emergency capacity exceeds 30 consecutive days, the facility administrator will complete the appropriate portion of the *Notification of Facility at Emergency Capacity* form and submit it to the Department Director.
 - a. The Director will review the notification and indicate the action to be taken and may outline steps to reduce and manage the facility population in accordance with 53-30-106, MCA.
5. The facility administrator of the facility at emergency capacity and Department Director will:
 - a. document the information on the *Notification of Facility at Emergency Capacity*; and
 - b. conduct a review of the Department corrections system to determine if adjustments within the system can be made prior to implementing the provisions of 53-30-106, MCA.

C. Design Considerations

1. Consistent enforcement of design standards and construction codes will provide offenders and staff with safe, secure, and humane living and working conditions.
 - a. All facilities will be of a design that facilitates contact between offenders and staff, provides for supervision and separation of different classifications, and plans for the minimum staffing levels needed for effective supervision of offenders.
 - 1) Physical plant modifications in existing facilities will occur with these concepts in mind.
2. New facility construction will support the concept of distinct, semi-autonomous management units that facilitate staff and offender contact, managed by staff assigned to that specific unit and group of offenders.
3. Lighting and ventilation throughout each facility will be determined by the tasks performed in that area.
 - a. Interior finishes and colors, the type and placement of windows, and ventilation and lighting will take into account the needs of staff and offenders and will comply with all applicable regulations and codes.
4. In all newly constructed facilities, all living and activity areas will comply with the applicable requirements of the Americans with Disabilities Act.
 - a. All areas of the facility open to the public will be accessible to the disabled.
5. Each facility will contain adequate space for:
 - a. administrative, managerial, and clerical offices;
 - b. interview and counseling areas adjacent to offender living areas;
 - c. secure storage for supplies, records, and offender property;
 - d. toilets and other necessary support and functional areas; and
 - e. a public lobby.
6. All facilities will be equipped with adequate, well-ventilated janitorial space that includes sinks and cleaning implements, as well as emergency water shut-off valves. Separate space will be included in the design for all mechanical and electrical equipment.
7. All contracts with non-Departmental providers housing state offenders will ensure compliance with state and national correctional standards for renovation or new facility construction and design.

V. CLOSING

Questions about this policy should be directed to the Department Director.

VI. REFERENCES

- A. §§ 18-2-101; 18-2-105; 53-1-203; 53-30-106, MCA
- B. *DOC 1.1.3 Organization and Responsibility*

VII. FORMS

Montana State Prison and Contract Facilities Capacities

Montana Women's Prison Capacities

Pine Hills Youth Correctional Facility Capacities

Riverside Correctional Facility Capacities

Notification of Facility at Emergency Capacity



POLICY DIRECTIVE

Policy:	DOC 2.3.1 STATE-OWNED HOUSING
Effective Date:	02/01/1998 Page 1 of 3
Revision Date(s):	12/23/2016; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

The Department will exercise all the rights of any landlord in renting state-owned housing at Department-approved locations.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Approval of State-Owned Housing

1. The Department Director, Department housing officer, and facility administrator must review and approve all housing lease agreements and housing assignments.
2. The Department housing officer will maintain a copy of all signed housing lease agreements.
3. All housing lease agreements will be reviewed and renewed every two years by the Department housing officer.
4. Tenants must adhere to this policy in its entirety.

B. Tenant Selection and Responsibilities

1. Tenants will be selected for state-owned housing based on:
 - a. key management and supervisory responsibilities;
 - b. ability to oversee facility operations on a 24 hour-a-day, seven day-a-week basis; or
 - c. approval by the facility administrator on an individual basis.
2. The responsibilities of key managers and supervisors will include:
 - a. oversight of facility operations and industries;
 - b. availability to respond to emergencies that may arise on or near facility property; and
 - c. capacity to help with activities or responsibilities that are deemed beneficial to the Department and Department operations.
3. Employees with round-the-clock oversight of facility operations will provide:
 - a. assistance with the security of outlying facility areas;
 - b. response to maintenance and animal-related issues or problems outside of normal business hours; and
 - c. help with activities and emergencies that may arise in or near the facility including escapes and disturbances.

C. Housing Lease Agreement

1. The Department housing officer and facility administrator will ensure that divisions providing state-owned housing comply with the following provisions:
 - a. provide a Department-approved *Housing Lease Agreement*;
 - b. ensure the *Agreement* is in effect as long as the tenant occupies state housing; and
 - c. as part of the *Housing Lease Agreement*, unless an exception is approved by the Department Director, the tenant must agree to all conditions contained in the *Housing Lease Agreement*.
2. Violations of Department policy or the *Housing Lease Agreement* may result in eviction with a 30-day notice. Violations of criminal statutes or security policy may result in immediate eviction.
3. Employees renting state-owned property will vacate the property no more than 14 calendar days after termination of employment following resignation or retirement. Employees terminated for cause will have 10 calendar days to vacate the premises.

D. Rental Amounts

1. The Department will charge fair market rental rates, when applicable.

E. Rental Discounts/Waivers

1. The Department Director, in consultation with the Department housing officer and facility administrator, may approve rental discounts or rental waivers for employees who are required to live on the premises or in state-owned housing as a part of their compensation package or have current lease agreements with the Department.
2. The Department Director will:
 - a. determine, with input from the Department housing officer and facility administrator, whether the rental discounts continue to serve the legitimate interests of the Department; and
 - b. approve or deny rental discounts.

F. Animals

1. Generally, tenants may have pets, but must be considerate of others in maintaining them.
2. The division housing officer:
 - a. will approve the number and type of pets and the location and types of pet structures in accordance with established requirements.
 - b. must approve all structures intended for animals (for example, large doghouses, kennels, dog runs, hutches, and sheds) prior to construction in accordance with established requirements.
3. Tenants will:
 - a. obtain authorization for pets from the division housing officer;
 - b. license all dogs at the applicable county or city office;
 - c. contact the Department of Livestock to ensure compliance with inspection and disease control regulations for all livestock (for example, cattle, horses, and sheep);
 - d. ensure all animals, when appropriate, are vaccinated for rabies;
 - e. maintain control of dogs and other large animals at all times; and
 - f. reimburse the Department or others for damage caused by animals; this may include damage to persons or property.

G. Property Modifications or Replacements

1. Prior to construction, the division housing officer must approve any modification or construction of a residence or structure located on the property, and will comply with operational requirements in the approval process.
2. The division housing officer will approve and administer routine maintenance and repairs, other than those due to misuse, and comply with operational procedures regarding maintenance procedures and costs.
3. Specific requirements will identify the specific types of appliances, window coverings, and maintenance responsibilities associated with state-owned housing.

V. CLOSING

Questions about this policy should be directed to the Department housing officer or appropriate administrator.

VI. REFERENCES

- A. §§ 39-3-205; 53-1-203; 70-24-104, MCA

VII. FORM

Housing Lease Agreement



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No.: DOC 2.3.2	Subject: OFFENDER HOUSING/CONSTRUCTION
Chapter 2: PHYSICAL PLANT	Page 1 of 1
Section 3: Housing	Effective Date: June 1, 1998
Signature: /s/ Loraine Wodnik, Deputy Director	Revision Date: 12/12/2016

I. POLICY

The Montana Department of Corrections will ensure that minimum space, furnishings, and other related requirements for offender housing areas will comply with all applicable local, state, and federal codes and statutes and nationally accepted correctional standards.

II. APPLICABILITY

All Department divisions, facilities, and programs housing offenders.

III. DEFINITIONS

None

IV. DEPARTMENT DIRECTIVES

- A. All correctional facility housing areas will be built, equipped, and maintained in compliance with applicable local, state and federal codes and statutes as well as the intent and operational philosophy of the facility.
- B. New construction and renovation of offender housing units and cells will, to the extent possible, comply with all applicable correctional standards established by the American Correctional Association.
- C. New construction and renovation of offender housing units and cells will comply with all applicable standards intended to ensure accessibility for offenders with disabilities, including but not limited to, any standards made applicable by the Americans with Disabilities Act and its implementing regulations. See *DOC Policy 3.3.15 Americans with Disabilities Act (ADA) Offender Accommodations* for the definition and explanation of disability.
- D. Any new construction estimated to cost over \$150,000 must be submitted to the Department of Administration, Architecture and Engineering Division Long Range Building Process.

V. CLOSING

Questions concerning this policy should be directed to the Facility Administrator.

VI. REFERENCES

- A. 53-1-203, MCA; 18-2-101 through 18-2-105, MCA
- B. DOC Policies 1.1.3 Organization and Responsibility; 3.3.15 Americans with Disabilities Act (ADA) Offender Accommodations



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 3.1.1	Subject: MANAGEMENT OF THE SECURITY PROGRAM
Chapter 3: FACILITY/PROGRAM OPERATIONS	Page 1 of 2
Section 1: Security Operations	Effective Date: Feb. 1, 1997
Signature: /s/ Mike Ferriter, Director	Revised: 03/15/11

I. POLICY

The Department of Corrections secure facilities will maintain correctional facilities that ensure public safety, provide safe employee working environments, and offer humane and safe offender living conditions. To accomplish this, each facility will employ an organized system of inter-related Department policies, operational procedures, emergency plans, and systematic manpower practices.

II. APPLICABILITY

The secure facilities that include Riverside and Pine Hills Youth Correctional Facilities, Montana State Prison, Montana Women's Prison, Montana Correctional Enterprises, Treasure State Correctional Training Center, and the private and regional facilities contracted to the Department of Corrections.

III. DEFINITIONS

Chief of Security – The staff person, regardless of local title (security major, director of operations), designated by the facility administrator to manage the facility security program.

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

IV. DEPARTMENT DIRECTIVES

A. Chief of Security

1. The chief of security will develop a security and staff management plan to include the following information:
 - a. complete set of Department security-related policies;
 - b. written operational procedures necessary to develop and facilitate security policy implementation; the chief of security will maintain this information and the facility administrator will review and approve facility procedures;
 - c. all applicable memoranda and other instructional materials to facilitate operational procedure implementation;
 - d. a system of permanent logs to record and document searches, audits, and security inspections in accordance with *DOC Policy 3.1.3, Logs and Record-keeping Systems*;
 - e. all necessary staff assignments, roster, and timekeeping records in accordance with Department policy;
 - f. current and readily accessible operations manuals to include employee post assignments in accordance with *DOC 3.1.2 RD, Facility Security Manuals*;
 - g. operational procedures that outline a system of cell and other living quarter searches

Policy No. DOC 3.1.1	Chapter 3: Facility/Program Operations	Page 2 of 2
Subject: MANAGEMENT OF THE SECURITY PROGRAM		

- in accordance with *DOC Policy 3.1.15, Security Inspections*;
- h. annual review of use of force and other procedures related to offender control to evaluate effectiveness and staff accountability in accordance with *DOC Policy 3.1.8, Use of Force and Restraints*, Section M., Administrative Review;
- i. copies of all emergency plans; the chief of security is responsible for the facility emergency preparedness plans as specified in Department policies that regulate this area;
- j. annual training records on all emergency preparedness plans in accordance with Department policies;
- k. documentation that no offenders or group of offenders will be given authority over other offenders, manage any facility program, or have any policy or procedure management role in the facility;

B. Staff Visibility

1. Administrators and other facility staff must maintain regular and frequent visibility in all facility programs and housing units. Administrators must be available to offenders, line staff, and mid-level managers for regular, ongoing communication.
2. The administrator, or designee, shall identify positions of supervisors and managers who visit housing and activity areas and the frequency of visits, based on available staff and facility needs, to encourage informal contact with staff and offenders and to observe working and living conditions.
3. The shift supervisors will tour their areas of responsibility at least once each shift every day, unless frequency has been designated otherwise by administrator, based on available staff and facility needs. Unoccupied areas will be toured once a week unless administrator has designated otherwise.
4. The chief of security will ensure a record-keeping system is maintained to document administrative and supervisory visits, any observed deficiencies, and recommendations for corrective action.

V. CLOSING

Questions concerning this policy should be directed to the chief of security.

VI. REFERENCES

- A. [2-15-112](#), MCA
- B. 4-4174, 4182, 4184, 4185; *ACA Standards for Adult Correctional Institutions*, 4th Edition
- C. *DOC Policies 3.1.2 RD, Facility Security Manuals*; [3.1.3](#), *Logs and Record-Keeping Systems*; [3.1.8](#), *Use of Force and Restraints*; [3.1.15](#), *Security Inspections*

VII. ATTACHMENTS

None.



POLICY DIRECTIVE

Policy:	DOC 3.1.2 FACILITY SECURITY MANUALS	
Effective Date:	02/01/1997	Page 1 of 3
Revision Date(s):	09/19/2011; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

Department secure facilities will maintain facility security manuals for all line and supervisory staff to reference applicable general and specific requirements and critical emergency information for each facility area or post.

II. APPLICABILITY

All secure facilities Department-owned and contracted, as specified in the contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Security Manual

1. The chief of security will be responsible for the development of security manuals that contain general and specific instructions for the operation of each facility area or post.
2. To facilitate revisions, security manuals will be maintained in computerized form and available to staff.
3. Hard copy manuals will be used as necessary at specific posts and will contain the following:
 - a. post orders;
 - b. operational procedures and related memos; and
 - c. applicable Department policies.
4. Correctional supervisors will ensure that all correctional staff have read and understood the security manual for the facility area or post to which they are assigned.
5. The chief of security will ensure that staff review of security manuals is adequately documented.

B. Post Orders

1. The post orders will cover the chronological duties of the post:
 - a. specifically advising assigned staff of the major events that occur throughout each shift; and
 - b. organized to be specific to each shift.
2. Assigned staff and supervisors are required to use post orders to familiarize themselves with the post duties and review changes in duties or operations as they occur.
3. The post order section will contain a signature sheet that each person assigned to the post must legibly sign or initial to verify they have read and understood the post orders.
4. A supervisor may give staff oral quizzes or written tests on post order assignments in accordance with requirements established by the facility administrator.
 - a. The testing will be recorded on the post order sign-off sheet.

5. Each post will maintain current post orders specific to the post operations.
6. Supervisory staff will notify line staff of all changes in post orders.
7. Following any significant policy, procedural, or process change, the facility administrator must ensure that all post orders are modified in a timely manner, not to exceed 30 days.
8. Post orders will be adapted to the standardized *Facility Post Order* form to ensure the various post tasks are outlined in a clear and concise format.
9. Post orders will address the following categories, as applicable:
 - a. duties and responsibilities
 - b. inventory control
 - c. key control
 - d. use of force
 - e. offender movement
 - f. control of traffic in and around each post
 - g. count processes for staff and offenders
 - h. escort processes
 - i. relief processes
 - j. incident reporting processes
 - k. recordkeeping
 - l. scheduled activities
 - m. emergency processes for each post
 - n. general emergency processes for the entire facility
 - o. hazardous material control
 - p. maintenance and repair requests

C. Department Policies

1. Security manuals will contain the Department policies related to the facility area or post.

D. Operational Procedures

1. The computerized or hard copy manuals will contain the facility's operational procedures and any directives or memos related to procedural changes.

E. Availability and Review

1. All current security manuals will be available in the office of the chief of security and the offices of each shift supervisor.
2. The chief of security will:
 - a. review security manuals annually,
 - b. make or recommend appropriate changes,
 - c. ensure administrative review and approval, and
 - d. include this documentation in the front of each manual.
3. Rescinded or revised operational procedures, processes, and post order duty information must be archived for a minimum of three years in accordance with *DOC 1.2.7 Inventories and Public Records Management*.
4. The shift supervisor must inform each staff member that they have an opportunity to submit written proposals for changes that occur on shift or suggestions for changes in the operation of any facility area or post.
 - a. The shift supervisor will review these suggestions and submit them to the chief of security for review and possible action.
5. Only the facility administrator may authorize changes in the facility security manual.

F. Security

1. Security manuals contain privileged and sensitive documents and will be maintained in a secure area at all times.
 - a. Under no circumstances will the manuals be accessible or shown to offenders or other unauthorized persons.

V. CLOSING

Questions about this policy should be directed to the chief of security.

VI. REFERENCES

- A. 2-15-112, MCA
- B. DOC 1.2.7 *Inventories and Public Records Management*
- C. 4-4174, 4-4178, 4-4179; *ACA Standards for Adult Correctional Institutions*

VII. FORMS

Facility Post Order



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 3.1.3	Subject: LOGS AND RECORD-KEEPING SYSTEMS
Chapter 3: FACILITY/PROGRAM OPERATIONS	Page 1 of 3
Section 1: Security Operations	Effective Date: Feb. 1, 1997
Signature: /s/ Mike Batista, Director	Revised: 6/7/2013

I. POLICY

The Department of Corrections secure facilities will maintain a complete system of logs and records that document important operational features. These records are internal documents of the Department and considered confidential.

II. APPLICABILITY

Secure care facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Chief of Security – The staff person, regardless of local title (associate warden of security, director of operations), designated by the facility administrator to manage the facility security program.

IV. DEPARTMENT DIRECTIVES

A. Record-Keeping

1. General procedures for each facility's log and record keeping system are outlined below. Site-specific operational procedures will be contained within each facility's operations manual.
2. The chief of security will ensure that records are kept, at a minimum, on the following subject areas:
 - a. staff on duty including rosters and time-keeping;
 - b. offender population and counts;
 - c. offender admissions and releases;
 - d. shift activity;
 - e. entrance and gate traffic;
 - f. use of force;
 - g. searches, with the exception of routine pat searches that do not result in the discovery of contraband or result in a disciplinary write-up;
 - h. discovery of contraband;
 - i. security audits and inspections; and
 - j. unusual occurrences.
3. Staff will keep records according to the following guidelines:
 - a. entries will be made in black ink;
 - b. count changes and emergencies will be entered only in red ink;
 - c. information will be legibly printed or written;
 - d. entries will indicate the date and time;

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Subject: LOGS AND OTHER RECORD-KEEPING SYSTEMS		

- e. entries will be legibly initialed or signed by staff; and
- f. record-keeping errors may be corrected by drawing a single line through the incorrect entry, initialing, dating, and recording the correct entry on the next available line;
- g. staff may not correct record-keeping errors with erasures or white-out (liquid paper);
- h. highlighting and other extraneous markings on records are prohibited; and
- i. pages may not be torn from logbooks or other records.

B. Logs

1. Logs will be maintained on a shift-by-shift basis and reflect activity, emergencies, unusual incidents, and pertinent information about offenders, the unit, or the facility.
2. At the beginning of each shift, staff will:
 - a. make the first entry on a new page in the log;
 - b. date and sign each entry; and
 - c. draw a diagonal line through the remainder of the page.
3. Supervisors are required to review and sign the log at the end of each shift.
4. Permanent, bound logs will be established in the following locations:
 - a. shift supervisor's office;
 - b. control center;
 - c. armory;
 - d. entrances;
 - e. housing units; and
 - f. other locations identified by the administrative staff.
5. Staff may utilize electronic logs when the following criteria are met:
 - a. the electronic system must ensure that entries cannot be modified or deleted;
 - b. entries must clearly identify who made the entry;
 - c. corrected entries must be annotated as such; and
 - d. the electronic system must have a backup system to ensure information retention.
6. Staff must submit full logbooks to the shift supervisor who will store the logbook in a designated storage area.
7. Logs may be destroyed after three years if no incident requires the log as evidence.

C. Specialized Records

1. In addition to logs, certain posts require specialized records including the following:
 - a. entrances require additional records on visitors, vehicles, and deliveries in accordance with [DOC Policy 3.1.5, Entrance Procedures and Detainment of Non-offenders](#);
 - b. locked housing units require additional individualized offender records in accordance with [DOC Policy 3.5.1, Locked Housing Unit Operations](#); and
 - c. control centers and armories require specialized records of entry and key and equipment issue in accordance with [DOC Policies 3.1.6, Control Center Operations](#) and [3.1.7, Emergency Equipment and Armory Operations](#).

V. CLOSING

Policy No. DOC 3.1.3	Chapter 3: Facility/Program Operations	Page 3 of 3
Subject: LOGS AND OTHER RECORD-KEEPING SYSTEMS		

Questions concerning this policy should be directed to the chief of security.

VI. REFERENCES

- A. 2-15-112, MCA
- B. 4-4183; *ACA Standards for Adult Correctional Institutions*, 4th Edition
- C. DOC Policies [3.1.5, Entrance Procedures and Detainments of Non-offenders](#); [3.1.6, Control Center Operations](#); [3.1.7 Emergency Equipment and Armory Operations](#); [3.5.1, Locked Housing Unit Operations](#)

VII. ATTACHMENTS

None



POLICY DIRECTIVE

Policy:	DOC 3.1.4 PERIMETER SECURITY	
Effective Date:	02/01/1997	Page 1 of 2
Revision Date(s):	09/19/2011; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

Department secure facilities will maintain secure perimeters that are consistent with the security and control needs of the offender population and necessary to prevent offender escapes and unauthorized public access.

II. APPLICABILITY

Secure facilities that are Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Security System

1. Each facility administrator will develop specific requirements to ensure adequate perimeter security consistent with the facility's physical plant design and the multi-level custody of the confined offenders.
2. The chief of security and the maintenance supervisor are jointly responsible for the maintenance and support of the perimeter security system described in this policy.
3. The security system will use barriers, detection systems, lighting, patrols, and surveillance, or their functional equivalents.

B. Barriers

1. There will be a minimum of a 20-foot separation between fences and sufficient rolled and tape-type razor ribbon in place on all perimeter fences to deter penetration or scaling.
2. Weeds and other vegetation will be suppressed through mowing, trimming, and the use of sterilized, graveled areas between the fences, with dark plastic under the gravel to prevent weed infestation.
3. To deter aircraft landings, the facility administrator may authorize, with the approval of the Department Director, the installation of "ground clutter" in the form of trees, light standards, or cables strung between high mast poles and interior compound buildings.
4. Front and rear entrances will incorporate sally port or vestibule-type doors or gates that are interlocked or operated in such a way that only one of the two doors or gates is opened at any one time.
5. In facilities with less secure or unfenced perimeter, the facility administrator will ensure that adequate measures are in place to prevent unauthorized offender exit or public entry.

C. Detection Systems

1. An electronic intrusion detection system may be employed to further strengthen the perimeter. These systems will be designed to meet the security needs of each individual facility and may incorporate a combination of closed-circuit television or other technology-based systems.
2. These systems will be monitored in the control center or other continuously staffed post.
3. In the event a correctional facility does not have the staff or expertise to maintain these sophisticated electronic systems, the facility administrator may establish a maintenance contract to provide 24-hours-a-day, 365-days-a-year repair services.

D. Lighting

1. There will be adequate lighting of the perimeter and all adjacent areas.
 - a. This may be through the use of high-intensity, high-mast lighting, or the equivalent, and sufficient to provide visibility on the perimeter and in the facility's compound under all reasonably foreseeable weather conditions.
2. The perimeter lighting will be connected to the generator backup system unless the lighting is generated by the city power system.
3. If the facility maintenance staff is unable to maintain these lighting systems, the facility administrator may establish a contract to provide 24-hours-a-day, 365-days-a-year repair services.

E. Patrols and Surveillance

1. Direct perimeter surveillance will be accomplished through daily physical perimeter checks or the use of vehicular patrols and staffed towers.
2. Armed staff may be used to provide perimeter security in adult correctional facilities. Armed staff may not be used to provide perimeter security at youth correctional facilities.
3. Additional posts or supplementary lighting may be instituted in the event of fog, smoke, or other limited visibility conditions.
4. Facility staff will ensure control over pedestrian and vehicular traffic at the front and rear entrances by identification and search processes outlined in *DOC 3.1.5 Secure Facility Entry and Exit* and *DOC 3.1.17 Searches and Contraband Control*.

V. CLOSING

Questions about this policy should be directed to the facility administrator.

VI. REFERENCES

- A. 2-15-112, MCA
- B. *DOC 3.1.5 Secure Facility Entry and Exit; DOC 3.1.17 Searches and Contraband Control*



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy:	DOC 3.1.5 ENTRANCE PROCEDURES AND DETAINMENT OF NON-OFFENDERS
Chapter 3:	FACILITY/PROGRAM OPERATIONS
Section 1:	Security Operations
Effective Date:	February 1, 1997 Page 1 of 6
Revised:	August 3, 2021
Signature:	/s/ Brian Gootkin

I. POLICY

The Department of Corrections secure facilities will maintain facility physical security through procedures that ensure authorized entrance and egress of pedestrians and vehicles through designated points in the perimeter.

II. APPLICABILITY

All secure facilities Department-owned and contracted, as specified in the contract.

III. DEFINITIONS

Chief of Security – The staff person, regardless of local title (security major, director of operations, associate warden of security), designated by the facility administrator to manage the facility security program.

Department Employee – A person employed by the Department of Corrections who has attained permanent status or is eligible to attain permanent status, as provided in § 2-18-101(20), MCA; a volunteer, an intern, or a temporary or short-term worker. This term does not include service providers.

Facility Administrator – The official, regardless of local title (administrator, warden, superintendent), ultimately responsible for the facility or program operation and management.

Mobile Device – Includes a laptop computer, tablet computer, cellphone, smartphone, smart watch, or any device that performs similar functions.

Official Visitors – Visitors to a facility acting in an official capacity, e.g., law enforcement, correctional personnel, judges, licensed attorneys, legislators, and others on official business.

Proper Identification – A government-issued identification card with photograph, physical description, and dates of issue and expiration.

Secure Perimeter – The outer portions of a facility that provide for secure confinement of offenders. The perimeter design may vary depending on the facility security classification.

Vendors – Individual service providers who sell goods or services to the facility including delivery, maintenance, or other service providers not contracted to the Department of Corrections.

Policy No. DOC 3.1.5	Chapter 3: Facility/Program Operations	Page 2 of 6
Subject: ENTRANCE PROCEDURES AND DETAINMENT OF NON-OFFENDERS		

Visitors – Individuals visiting or touring the facility in an unofficial capacity.

Volunteer – Any person who has been approved to provide services for Department programs without compensation.

IV. DEPARTMENT DIRECTIVES

Each facility administrator will develop operational procedures that address the visitor approval process to include site-specific requirements for entrance inside and outside the secure perimeter in accordance with the following guidelines:

A. Visitor Approval

1. All visitors, including volunteers and vendors, must receive clearance through a criminal history background check before entrance to the secure facility is granted. The facility administrator must approve any exceptions to this policy.
2. Official visitors, in possession of state identification, may enter the secure facility without advance clearance through a criminal history background check.

B. Required Identification

1. All persons 16 years or older will submit picture identification upon entry to the facility unless approved in advance by the facility administrator.
2. Entrance staff will not allow anyone inside the secure facility without proper identification.
3. Staff are required to wear their official identification at all times while in the facility.
4. No one will be permitted to leave the facility unless properly identified by the entrance and exit post staff.
5. Upon entry, service personnel, e.g., delivery, maintenance, vendors, and other service providers, must provide personal identification and appropriate documentation of the nature of their business in the facility.
6. Offenders' visitors may be subject to additional verification and approval procedures in accordance with *DOC Policy 3.3.8, Offender Visiting*.

C. Mobile Devices

1. All department employees, representatives of other state agencies, contractors, vendors, or other individuals who enter secure facilities must receive approval from facility administrators prior to entering a secure facility with a mobile device
2. All mobile devices entering a facility must be password protected at all times and never left unattended. Loss of any device while at a secure facility must be immediately reported to security staff.
3. All mobile devices entering a facility will be documented by entrance staff.

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Subject: ENTRANCE PROCEDURES AND DETAINMENT OF NON-OFFENDERS		

D. Sally Ports

1. Entrance gates and doors will include appropriate sally port configurations and procedures that prevent both doors or gates from being opened at the same time.
2. Remotely activated, electromechanically operated interlocked doors will control all perimeter gates where practical. Manual override capacity will be available at all of these locations.

E. Staffing of Entrance Posts

1. Staffing of entrances and exits will be sufficient to ensure proper supervision and secure operation of all perimeter doors or gates.
2. At a minimum, all entrance areas will be sufficiently staffed to allow for direct identification and searches of persons entering the facility.

F. Front Entrance

1. The front entrance will be the major pedestrian traffic control point for the facility. Staff on this post will maintain records to include the following:
 - a. a complete, separate record of all persons entering or exiting the facility who are not facility employees;
 - b. a complete, separate record of all offenders' visitors entering and leaving the facility; and
 - c. a complete, separate record of all offenders who pass through the entrance.

G. Vehicular Sally Port

The vehicular sally port is used primarily for vehicular traffic entering and leaving the facility. To ensure a high level of security and control over the introduction of contraband and offender escape, the chief of security will require the staff in charge to:

1. Monitor all vehicular traffic to determine the purpose for entry.
2. Review the delivery vehicle cargo manifest to determine if any weapons, drugs, or hazardous materials may be on board for other destinations.
3. Make a detailed search of the vehicle by checking the passenger compartment, under the hood, and under the vehicle underbody frame to locate possible contraband.
4. Obtain confirmation of destination from staff at the intended delivery point and through other records maintained at the gate.
5. Search all vehicle occupants by using a hand-held detector. Staff will not allow offenders in the area when searches are being conducted.
6. The staff in charge of departing vehicles will:
 - a. halt departing vehicles at an indicated point well within the inner sally port gate;
 - b. require the vehicle occupants to exit and stand clear of the vehicle;

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Subject: ENTRANCE PROCEDURES AND DETAINMENT OF NON-OFFENDERS		

- c. search the vehicle thoroughly; and
- d. after a complete search, provide a positive signal to the officer controlling the gate that will, in turn, open it and admit the vehicle to the sally port.

H. General Entrance Searches

- 1. Each facility will establish entrance and search procedures that prohibit the use or conveyance of wireless messaging devices inside the secure portion of the facility.

I. Package Searches

- 1. Staff will thoroughly search all packages carried into the entrance area before they are permitted into the secure portion of the facility. This will include the search of briefcases, lunches, or other personal items.
- 2. Staff will advise all persons entering the facility of prohibited items.
- 3. A list of restricted items will be posted outside each facility entrance.

J. Visitor Searches and Identification

- 1. In secure facilities, all official and non-official visitors are subject to search in accordance with *DOC Policy 3.1.17, Searches and Contraband Control & 3.1.35 Body Scanners*.
- 2. Additional identification procedures such as visitor identification badges or UV-reflecting hand stamps may be used to ensure an offender does not leave the facility disguised as a visitor.
- 3. Each facility will establish entrance procedures to include escort and search requirements for the following types of visitors:
 - a. official visitors
 - b. offenders' visitors
 - c. vendor and repair persons
 - d. volunteers
 - e. persons approved for facility tours

K. Offender Searches

- 1. All offenders moving through entrances must be searched in accordance with *DOC Policy 3.1.17, Searches and Contraband Control & 3.1.35 Body Scanners*.
- 2. Offenders returning from off-site transports or outside details will be searched according to facility operational procedures.

L. Staff Searches

- 1. All staff are subject to search in accordance with *DOC Policy 3.1.17, Searches and Contraband Control*.

M. Rear Entrance Pedestrian Traffic

Policy No. DOC 3.1.5	Chapter 3: Facility/Program Operations	Page 5 of 6
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1. Offender pedestrian traffic may proceed through the rear entrance or vehicular gate when:
 - a. the offender has appropriate identification and is escorted by a full-time staff member, or proceeds by a method that ensures the appropriate level of supervision; and
 - b. the offender has been thoroughly searched.
2. In the event there is a question about offender entrance, the chief of security must provide additional documentation to authorize the entrance.

N. Records

1. Staff will maintain records on each entrance post to enable the reconstruction of all non-staff traffic through that point for the past 30 days. These records will include date, name, the times in and out, the department visited, and by whose authority the entry was granted.
2. Supervisory staff will maintain the log in bound form and review and initial it when they visit the post.
3. Supervisory staff will forward the logbook to the chief of security for review and storage when it is full.
4. All logbooks will be retained in accordance with *DOC Policy 3.1.3, Logs and Record-Keeping Systems*.

O. Weapons Storage

1. Under normal circumstances, law enforcement officers may not bring weapons, ammunition, or chemical agents inside a department facility unless authorized by the facility administrator.
2. A weapons storage area must be provided for law enforcement officers and Department staff who are required to carry a weapon in the course of their official duties.

P. Detaining Non-Offenders

1. Under applicable state law, Department staff who are not sworn law enforcement officers do not have the authority to detain an individual against his or her will.
2. Facility staff may detain non-offenders who introduce or attempt to introduce contraband into the facility, e.g., narcotics, intoxicants, lethal or poisonous gases, guns, knives, or other weapons, or engage in conduct that violates facility policy. The following guidelines must be followed:
 - a. the facility administrator must establish a written agreement on detainment procedures with the law enforcement of jurisdiction in advance of any action;
 - b. facility staff will not detain non-offenders for an unreasonable period of time pending the notification and arrival of appropriate law enforcement officials; and
 - c. staff will employ the minimum amount of force necessary to detain the individual(s).

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3. In the event an individual is found to convey contraband, is disruptive or is judged by staff to have the potential to be disruptive if admitted, entrance staff will defer the entry decision to supervisory staff. Under these circumstances, the supervisor, or designee, may deny the visit and, if so, will promptly notify the immediate supervisor of this action and document the incident in accordance with facility procedures.
4. If there is an incident with the detained individual or facts emerge to suggest a possible criminal violation has occurred, entrance staff must notify the supervisor or control center staff at once. If possible, this notification will be made without alerting the individual involved. The supervisor, or designee, will determine whether to involve local law enforcement officials or continue an inquiry.
5. In a case where the decision to deny entry is appealed to supervisory staff and the individual is granted approval for entry, he or she must stay in the public area of the facility under staff supervision.
6. The individual must be permitted to leave if he or she so chooses. If the individual stays and is waiting while law enforcement officials arrive, then facility staff will fully cooperate to describe events that led to the incident. Typically, the individual will identify him or herself and provide information to the officials. Facility staff may not detain civilians against their will.

V. CLOSING

Questions concerning this policy should be directed to the facility administrator.

VI. REFERENCES

- A. 2-15-112, *MCA*
- B. 4-4172, *ACA Standards for Adult Correctional Institutions, 4th Edition*
- C. 3-JTS-2G-02, *ACA Standards for Juvenile Correctional Facilities, 2003*
- D. *DOC Policies 3.1.3, Logs and Record-Keeping Systems; 3.1.17, Searches and Contraband Control; 3.3.8, Offender Visiting, 3.1.35 Body Scanners*

VII. ATTACHMENTS

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 3.1.6	Subject: CONTROL CENTER OPERATIONS
Chapter 3: FACILITY/PROGRAM OPERATIONS	Page 1 of 3
Section 1: Security Operations	Effective Date: Feb.1, 1997
Signature: /s/ Mike Ferriter, Director	Revised: 09/19/11

I. POLICY

The Department of Corrections secure facilities will each maintain a control center that serves as the communications and movement center for the entire facility.

II. APPLICABILITY

The secure facilities that include Riverside and Pine Hills Youth Correctional Facilities, Montana State Prison, Montana Women's Prison, and secure facilities contracted to the Department of Corrections, as specified in contract.

III. DEFINITIONS

Chief of Security – The staff person, regardless of local title (security major, director of operations), designated by the facility administrator to manage the facility security program.

Control Center – The facility area, or non-centralized functional equivalent, that monitors and coordinates facility safety and security systems and supervises staff and offender movement.

IV. DEPARTMENT DIRECTIVES

A. Operational Procedures

1. Each facility will develop control center procedures that may include the following staff functions:
 - a. maintain all necessary count records and supervise facility count in accordance with [*DOC Policy 3.1.21, Offender Count and Supervision*](#);
 - b. issue keys to appropriate employees and provide other key accountability functions as described in [*DOC Policy 3.1.13, Key Control*](#);
 - c. maintain inventory on all control center keys, equipment, and emergency supplies;
 - d. issue emergency equipment items;
 - e. control all electronic security equipment, e.g., doors, grilles, and gates that are actuated from this post;
 - f. monitor radios, telephones, intercoms, and other communication systems;
 - g. maintain a mechanical or audio communication system as a supplement to direct staff supervision between the control center and offender housing areas;
 - h. conduct and log checks on all communication systems and emergency alarms;
 - i. record all appropriate information in the control center log;
 - j. notify the shift supervisor of any emergencies; and
 - k. maintain a current list of all employee's telephone numbers.

B. Staffing

Policy No. DOC 3.1.6	Chapter 1: Facility/Program Operations	Page 2 of 3
Subject: : CONTROL CENTER OPERATIONS		

1. Control centers that operate 24 hours-a-day will be continuously staffed by trained correctional personnel who monitor and coordinate the facility's security, life, safety, and communications systems. Officers assigned to the control center will have access to a toilet and washbasin.
2. The appropriate supervisor will identify those periods that may require more than one control center officer on duty.
3. Supervisors may also assign additional staff during peak activity such as shift changes, counts, and facility emergencies.

C. Access

1. The control center officer will:
 - a. only allow staff with official duties to access this post;
 - b. require positive identification and ascertain the purpose for entry before permitting anyone in the control center; and
 - c. not permit entrance to the control center when offenders are in the vicinity.

D. Movement Control

1. In most cases, control center officers will regulate movement through critical gates and doors and ensure all video and audio equipment function properly to enable positive identification of all persons passing through these points.
2. The control center officer will ensure that all gates, doors, or grilles are closed at all times when authorized traffic is not passing through these areas and, in the case of a sally port, that only one gate is opened at a time.

E. Emergency Response

1. If there is a facility incident, staff will immediately notify the control center officer(s) who will respond to the incident in accordance with facility procedures.

F. Training Issues

1. Control center operations will be part of initial and annual training curricula and will include on-the-job training assignments.
2. Training will include a thorough knowledge of security policies and control center operations as outlined in the facility operations manual.

G. Logs and Records

1. The control center officer will maintain logs and records which may include the following categories:
 - a. counts;
 - b. alarms, both tests and actual;
 - c. visitors;
 - d. key inventories;

Policy No. DOC 3.1.6	Chapter 1: Facility/Program Operations	Page 3 of 3
Subject: : CONTROL CENTER OPERATIONS		

- e. equipment inventories;
- f. equipment tests;
- g. offender movement;
- h. assigned officers;
- i. fire drills;
- j. security inspections; and
- k. any other information deemed necessary by supervisory staff.

V. CLOSING

Questions concerning this policy should be directed to the chief of security.

VI. REFERENCES

- A. [2-15-112](#), MCA
- B. 4-4175; ACA Standards Supplement, 2008
- C. DOC Policies [3.1.13, Key Control](#); [3.1.15, Security Inspections](#); [3.1.21, Offender Count and Supervision](#)

VII. ATTACHMENTS

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 3.1.7	Subject: EMERGENCY EQUIPMENT AND ARMORY OPERATIONS	
Chapter 3: FACILITY/PROGRAM OPERATIONS	Page 1 of 3	
Section I: Security Operations	Effective Date: Feb. 1, 1997	
Signature: /s/ Mike Ferriter, Director	Revised: 04/24/12	

I. POLICY

The Department of Corrections secure care facilities will ensure that communication equipment, firearms, ammunitions, chemical agents, and related items such as batons and protective clothing, are available for emergency preparedness and response.

II. APPLICABILITY

Secure care facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Chief of Security – The staff person, regardless of local title (security major, director of operations), designated by the facility administrator to manage the facility security program.

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. The facility administrator, or designee, is responsible for the following:
 - a. approve the type and quantity of security equipment based on an analysis of the physical plant and offender population profile;
 - b. provide written authorization for the purchase of firearms, munitions, or other security equipment;
 - c. authorize firearms for posts such as patrols, towers, and specific escort activities;
 - d. approve the conveyance or use of firearms inside a facility;
 - e. ensure the facility maintains a written record of routine and emergency distribution of security equipment; and
 - f. ensure staff receive training in the safe handling and use of security equipment.
2. The chief of security, or designee, is responsible for the following:
 - a. appoint, in writing, an armory officer who will receive training in all duties pertaining to the facility's armory operation and will be responsible for the facility's security equipment; and
 - b. ensure that systems are in place to document the issuance, use, and return of all security equipment items.

Policy No. DOC 3.1.7	Chapter 3: Facility/Program Operations	Page 2 of 3
Subject: EMERGENCY EQUIPMENT AND ARMORY OPERATIONS		

3. The armory officer, or designee, is responsible for the following tasks:
 - a. implement a routine inspection program for use and storage of security equipment;
 - b. ensure security equipment is accurately accounted for by a monthly inventory system that inventories expendable munitions, supply items, and each weapon separately and includes recording and tracking firearm serial numbers and equipment and supply quantities;
 - c. supervise delivery of all armory items to the facility;
 - d. ensure the necessary rotation of stocks so that ammunition and gas munitions do not become outdated;
 - e. establish an inspection and maintenance program and will keep the essential, related records; and
 - f. verify a quarterly inventory of all items and issue a report to the chief of security for review.
4. The use of facility security equipment will be in accordance with *DOC Policies [3.1.8, Use of Force and Restraints](#), and [3.1.31, Firearms](#)*.

B. Storage, Access, and Issue

1. Facilities will store emergency security equipment according to the following:
 - a. in authorized facility locations with temperature and humidity control to maximize shelf life, effectiveness, and condition;
 - b. riot gear must be stored allowing for rapid issue and adequate space to enable staff to outfit themselves quickly; and
 - c. armories containing firearms will be equipped with emergency lighting, a telephone, and a secure pass-through or split door through which to issue equipment.
2. Armory access must adhere to the following:
 - a. the control center officer will maintain a log including date and time of individuals who enter the armory and will maintain a set of emergency armory keys;
 - b. the armory officer or assistant armory officer will be the only persons with general armory access;
 - c. the armory must be readily accessible to authorized staff in emergencies; and
 - d. inaccessible to offenders at all times.
3. The Department requires that each facility utilize a positive identification system to ensure emergency equipment will only be issued to staff qualified according to Department policies including *[DOC 1.4.1, Staff Development and Training](#)* and that facilities issue security equipment according to the following:
 - a. equipment will only be issued upon exchange of a chit; and
 - b. when equipment is returned, the receiving officer will return the chit and note the condition of the returned equipment.
4. Munitions with an expired shelf date will be issued for training use only, will be

Policy No. DOC 3.1.7	Chapter 3: Facility/Program Operations	Page 3 of 3
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marked “for training use only,” and will be stored separately.

5. Expendable munitions, or the containers in which munitions are shipped, will be marked with an expiration date.

C. Maintenance

1. Authorized Department staff will clean and test weapons and ammunition regularly and repair as needed to keep equipment in safe operating condition.
2. Records of any commercial firearm repairs will be marked on a card kept on each weapon that charts its history, issue pattern, and normal maintenance, as well as major repairs or rebuilds.

D. Additional Security Equipment

1. Facilities may utilize additional security equipment that includes, but is not limited to, the following:
 - a. telephone systems with the capability of setting off an alarm in the control center if left off the hook for a specified period of time;
 - b. intercom systems that link the control center to other key posts;
 - c. personal body alarms for staff in housing units and other key areas, with monitoring equipment in the control center;
 - d. two-way radios and mobile units in any vehicles used by the facility; and
 - e. additional fixed security equipment as deemed necessary by the facility.

V. CLOSING

Questions concerning this policy should be directed to the chief of security.

VI. REFERENCES

- A. [2-15-112](#), MCA
- B. 4-4173; 4-4200, 4-4201; *ACA Standards for Adult Correctional Institutions*, 4th Edition
- C. DOC Policies [1.4.1, Staff Development and Training](#); [3.1.8, Use of Force and Restraints](#); [3.1.31, Firearms](#)

VII. ATTACHMENTS

None



POLICY DIRECTIVE

Policy:	DOC 3.1.8 USE OF FORCE AND RESTRAINTS	
Effective Date:	04/01/1997	Page 1 of 4
Revision Date(s):	11/28/2011; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department, in accordance with state statutes, will provide employees with direction and training on the use of force to ensure force is used only when reasonable and essential to the degree necessary to control offenders, protect offenders, staff, or the public or to restore order.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. REQUIREMENTS

A. General Requirements

1. Administrators will ensure that operational procedures are consistent with the guidelines established within this policy and related Department policies.
2. Use of force may be necessary:
 - a. in self-defense;
 - b. in defense of others;
 - c. for enforcement of Department policy and operational procedure;
 - d. to prevent self-harm;
 - e. to prevent criminal activity;
 - f. to prevent destruction of public property; and
 - g. to prevent an escape or abscond.
3. Staff who are trained in the use of force based on job responsibilities are expected to recognize and be able to apply the proper level and type of force needed; training will be administered in accordance with *DOC 1.4.1 Staff Development and Training*.
4. Except in emergencies or situations approved by the division or facility administrator or incident commander, and as provided by emergency operation plans, firearms are not permitted inside any secure facility.
5. Force will not be used to punish, harass, coerce, or abuse offenders.

B. Operational Procedure Requirements

1. The administrator, or designee, will establish operational procedures that include:
 - a. the availability, control, and use of security equipment designated for staff use while considering facility or program type, history and culture, population type, and age of offenders in accordance with *DOC 3.1.7 RD Emergency Equipment and Armory Operations (Restricted Distribution)*;
 - b. mandated successful completion of an approved training curriculum that includes initial and in-service training and required certification and re-certification for staff in the use of security equipment and approved types of force in accordance with *DOC 1.4.1 Staff Development and Training*;

- c. requirements for adequate staff documentation and prompt reporting of use of force incidents;
 - d. protocol for administrative evaluation and investigation of use of force incidents;
 - e. detailed requirements for the spectrum of use of force control measures;
 - f. detailed requirements providing staff with clear understanding of the cautions and circumstances under which they will consider the use of deadly force;
 - g. communication to staff that each use of force incident is a critical event and the related administrative review process expresses that importance;
 - h. a requirement that disciplinary or corrective actions are taken for malicious or excessive use of force; and
 - i. administrators and supervisors share information and formally review all use of force incidents by examining documents, viewing video documentation, and interviewing involved staff, when necessary.
2. Operational procedures will include the following medical care provisions:
 - a. a decontamination process for exposed individuals and facility areas relative to the use of specific chemicals or inflammatory agents; and
 - b. medical review and examination requirements for offenders involved in and affected by use of force actions.

C. Planned and Immediate Use of Force

1. Planned use of force will:
 - a. be approved by the applicable on-site supervisor who will determine the type and amount of force to be used;
 - b. be accompanied by nonphysical efforts to resolve the issue;
 - c. be video documented by facilities for the clearest possible record of the event; if circumstances prevent video documentation, the shift supervisor must provide the reason in the submitted *Use of Force Information Sheet*;
 - d. require involved staff to utilize available staff protective equipment that may include vests, shields, helmets and appropriate pads; and
 - e. require involved staff to alert applicable medical personnel to stand by; medical staff will review medical records prior to the use of chemical or inflammatory agents and/or conductive energy devices.
2. The Department authorizes the immediate use of force by a staff member in a situation that constitutes a threat to themselves, the safety of staff, offenders, the public, or facility security and when there is no time to formulate a plan or to notify an immediate supervisor.

D. Nonphysical Use of Force

1. Techniques or strategies may be used by staff to maintain control or gain compliance of an offender without forcible physical contact including, but not limited to:
 - a. officer presence to indicate staff is present and attentive;
 - b. verbal communication to problem-solve, de-escalate and resolve a situation;
 - c. video documentation of the offender(s) to record the factual events; and
 - d. show of force by the movement of appropriate staff, equipment, and weapons to an incident site to convince an offender that adequate staff and measures are available and will be used to resolve the situation.

E. Non-Deadly Physical Use of Force

1. Physical force may be used to:
 - a. stop potentially dangerous and unlawful behavior;
 - b. protect a staff member or another from injury or death; and
 - c. support the process of implementing lawful orders when the offender offers resistance.

2. Physical force may include, but is not limited to, the following:
 - a. pain compliance and leverage techniques;
 - b. use of appropriate restraints and empty-hand control techniques; and
 - c. use of safety equipment, which may include the following:
 - 1) oleoresin capsicum (OC) handheld aerosols and restraint devices such as riot shields and conductive energy devices; and
 - 2) specialty exact impact munitions such as bean bags or foam batons, impact weapons such as batons and water hoses, or chemical agents.

F. Deadly Use of Force

1. Staff are justified in the use of deadly force in accordance with 45-3-102, MCA, 45-3-104, MCA, and 45-3-106, MCA if they reasonably believe that the force is necessary to prevent the commission of a forcible felony:
 - a. prevent escape from a correctional institution;
 - b. prevent damage or destruction of property when the loss of property would directly lead to an escape or attempted escape from a correctional institution, serious bodily injury, or death; and
 - c. defend oneself or others against an imminent threat of serious bodily injury; or
 - d. imminent danger of death determined by the following three criteria:
 - 1) ability: the offender possesses the ability or apparent ability to cause serious injury or death to an individual;
 - 2) opportunity: the Department employee or a third party is within effective range of the offender's weapon(s); and
 - 3) intent: a reasonable person would conclude that the offender will likely cause death or serious bodily injury at any moment.

G. Physical Use of Force Review

1. Each division or facility administrator will establish physical use of force documentation and reporting procedures to ensure a complete historical record of each physical use of force incident and ensure staff accountability through administrative review. Reporting procedures must include the following elements:
 - a. initial incident reports and medical reports, when applicable, will be completed by staff involved in a use of force incident by the end of the shift in which the incident occurred and submitted to the shift supervisor;
 - b. supplemental information and final reports will be submitted by staff involved within 72 hours of the incident;
 - c. video documentation, incident reports, and medical reports will be attached to a *Use of Force Information Sheet*, completed by the shift supervisor;
 - d. the *Use of Force Information Sheet* and subsequent documents will be submitted to the administrator;
 - e. the administrator will review the *Use of Force Information Sheet* and complete the *Use of Force Evaluation Report*;
 - f. if, upon review of the incident, the administrator determines excessive force may have been used, a request for investigation may be made in accordance with *DOC 3.1.19 Investigations*; and
 - g. the administrator, or designee, will report to the Department legal staff and Department Communications Director, incidents involving use of force that may bring media attention or public safety concerns or involve significant Department liability because of the nature of the incident, parties involved, or other circumstances.
2. In order to evaluate Department use of force incidents, the Investigations Bureau will review and analyze Priority I and Priority II incidents in accordance with *DOC 3.1.19 Investigations* and *DOC 1.1.6 Priority Incident Reporting* as follows:
 - a. Priority I incidents will be investigated automatically and include use of force resulting in:

- 1) death;
 - 2) discharge of a firearm; and
 - 3) injuries resulting in emergency room or hospital treatment.
- b. Priority II incidents will be investigated upon request by an administrator and include all use of force not classified as Priority I.

IV. CLOSING

Questions about this policy should be directed to the Division Chief or Warden.

V. REFERENCES

- A. §§ 45-3-101; 45-3-102; 45-3-104; 45-3-106, MCA
- B. DOC 1.4.1 Staff Development and Training; DOC 3.1.7 *RD* Emergency Equipment and Armory Operations (*Restricted Distribution*); DOC 3.1.19 Investigations

VI. FORMS

Use of Force Evaluation Report
Use of Force Information Sheet



POLICY DIRECTIVE

Policy:	DOC 3.1.11 OFFENDER MOVEMENT CONTROL	
Effective Date:	03/01/1997	Page 1 of 2
Revision Date(s):	04/18/2006; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

Department secure facilities will develop and enforce internal movement controls to ensure that offenders do not evade staff supervision, plan escapes, or engage in other impermissible activities.

II. APPLICABILITY

All Department secure facilities.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Each facility will follow operational procedures to regulate offender movement in accordance with the provisions of this policy.
2. Controlled movement requirements may vary according to the physical plant and custody level of the facility or program.
3. Movement processes will:
 - a. comply with the accountability requirements of *DOC 3.1.21 Inmate Count and Supervision*;
 - b. provide staff with the necessary instructions to control and supervise all individual and group offender movements;
 - c. include, where applicable, use of a callout program, scheduled movement, radio or telephone communication, video cameras, and an individual pass system;
 - d. ensure movement is regulated for such activities as work, sick call, meals, recreation, education, and other programs; and
 - e. require that movement records are maintained for 30 days to provide a means of reconstructing offender activities and locations.

B. Callouts

1. Facility staff will use a callout system to schedule offender appointments that typically include classification interviews, medical or dental appointments, chaplain visits, and other regularly scheduled interviews or appointments.
 - a. The chief of security has the option to also require a pass for these movements.
2. The shift supervisor will authorize the master listing of all offender daily scheduled activities each day.
3. Facility callout list requirements will include names, times, assignments, and destinations, and will indicate by when and to whom this information must be sent in advance of movements.
4. Requirements will be established to verify that offenders reached their scheduled destinations.
5. Callout systems for small facilities or programs may be less complex, in which case processes will be developed to meet the facility or program needs.

C. Scheduled Movement

1. The facility will:
 - a. outline the requirements for individual and group scheduled movements;
 - b. use the scheduled movement system to limit the times during the regular business day when offenders may move from area to area (for example, to work, school, meals, or recreation);
 - c. establish exact times for movements, ordinarily at 60-minute intervals for 10-minute durations; and
 - d. secure all corridors, housing unit doors, and other traffic control points between movements.

D. Unscheduled Movements and Pass System

1. Facility staff may:
 - a. issue individual passes for activities not regularly scheduled (for example, activities not appearing on either the callout or the scheduled movement list); or
 - b. utilize another system to control unscheduled offender movements.
2. Facility plans will outline the unscheduled movement requirements and determine by which method passes are accounted for, reviewed, and reconciled.
3. Staff will:
 - a. typically issue passes to offenders for visits, unscheduled staff interviews, and legal visits;
 - b. maintain passes in a secure location (for example, in a locked desk or file cabinet) when not in the staff member's possession;
 - c. issue a pass only when an offender's presence is required by another staff member and never at an offender's request; and
 - d. immediately report to the shift supervisor any indication that an offender's pass has been altered or any excessive time delay between an offender's departure and arrival.

E. General Staff Observation

1. Every employee must observe and monitor offender movement.
 - a. This includes examining passes and ensuring that offenders follow the authorized requirements for individual and group movements.
2. Employees must be especially alert to individual or group offender movements that appear to be out of context with scheduled activities.
3. Employees assigned to corridor, housing unit, shop, and program posts will examine offender passes and the daily callout list to verify proper authorization of all offender movement.

V. CLOSING

Questions about this policy should be directed to the chief of security.

VI. REFERENCES

- A. *DOC 3.1.2 Facility Security Manuals; DOC 3.1.21 Inmate Count and Supervision*



POLICY DIRECTIVE

Policy:	DOC 3.1.12 OFFENDER ESCORT AND TRANSPORT	
Effective Date:	02/01/1997	Page 1 of 4
Revision Date(s):	09/09/2016; 03/04/2026	
Signature/Title:	/s/ John Schaffer, Public Safety Division Chief	

I. POLICY

The Department of Corrections will ensure offender escorts and transports are conducted in a safe and humane manner using trained staff and the necessary level of security, supervision, and control to ensure public safety.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. If an offender becomes ill, medical assistance should be provided as soon as possible; transport officers will inform their supervisor as soon as possible.
2. Inmates shall be notified of travel no more than 15 minutes prior to departure and are not allowed to make phone calls after notification.

B. Use of Firearms

1. Department officers will carry a firearm for all types of transports in accordance with *DOC 3.1.31 Firearms*, and:
 - a. officers who are not in an armed duty position will utilize the firearm checkout process at their respective facility; and
 - b. exceptions may be made by Sergeant/Shift Commander or higher in situations where carrying a firearm is not possible, for example, air transport.
2. During transport, each administrator will ensure that:
 - a. firearms are used in accordance with applicable state and federal law;
 - b. firearms are safeguarded to ensure an offender never has the opportunity to seize a weapon;
 - c. armed officers are securely separated from offenders during the transport, for example, by a law-enforcement grade barrier; and
 - d. all associated equipment, holsters, magazine pouches, and duty belts are maintained in a serviceable condition.

C. Restraints

1. Administrators will ensure that restraint processes comply with *DOC 3.1.8 Use of Force and Restraints* and related Department policies and procedures.

2. Restraint equipment will not eliminate the need for continuous, alert supervision during transport and must never be used as punishment, in a way that causes undue physical pain, or to restrict the offender's blood circulation or breathing.
3. The following factors will be considered when determining the level of offender restraint:
 - a. offender security classification;
 - b. anticipated contact with the public;
 - c. offender physical and mental health;
 - d. pregnancy status;
 - e. demonstrated offender behavior; and
 - f. trip purpose and destination.
4. Inmates of all custody levels will be restrained during transport with belly chains and leg irons.
 - a. The use of additional restraints or limited restraints for special needs may be used at the discretion of the Sergeant/Shift Commander or higher.
5. Community supervision offenders will be restrained with handcuffs.
 - a. Belly chains and leg irons may be used at the discretion of the P&P Officer.
6. Transfer of offenders from one vehicle to another will only occur in a secure location such as a jail sally port.

D. Vehicles

1. Transport vehicles will be:
 - a. equipped with appropriate security features such as law enforcement grade barriers, deactivated rear window and lock, and two-way radios and/or cell phone;
 - b. thoroughly searched for contraband before and after each transport; and
 - c. regularly inspected and maintained to ensure proper working order;
 - d. wheelchair-accessible for offenders who are unable to transfer in and out of their wheelchair to a vehicle.
2. The use of seatbelts is mandatory for offenders and staff.
3. In the event of an accident, officers will:
 - a. contact the nearest law enforcement agency for assistance;
 - b. contact supervisor or higher for an incident report;
 - c. maintain constant supervision of the vehicle and offender;
 - d. secure and observe offenders in the vehicle to the extent possible and render first aid as necessary while waiting for law enforcement assistance; and
 - e. in the event of a minor vehicle problem that can be repaired on the spot, secure and observe offenders in the vehicle to the extent possible.

E. Pre-Transport

1. Offenders will have all the necessary paperwork for transport:
 - a. if in a facility, the inmate will need a travel packet that includes a gate pass; and
 - b. if in the community, the offender will need placement paperwork.
2. Offenders will be thoroughly searched and restrained:
 - a. if in a facility, the inmate will be searched, changed out, fully restrained, and kept separate from other inmates; and
 - b. if in the community, the offender will be restrained accordingly.
3. Offenders will be transported with two staff members unless:
 - a. approved by the Shift Commander (secure facilities); or
 - b. approved by P&P Sergeant (community supervision).

V. APPOINTMENTS

A. Off-Site Health Care

1. Authorized Department employees will provide safe and timely escort and transport for offender health care consistent with *DOC 4.5.23 Offender Health Care Escort and Transportation*, with consideration for:
 - a. health care advice and information provided to escort officers regarding the need for medical attention, medications, and maintaining patient confidentiality on offender transports;
 - b. requirements for the transport of ill or disabled offenders, or in the event of illness enroute;
 - c. prioritization of health care need;
 - d. urgency, for example, an ambulance vs. standard transport;
 - e. use of a medical escort to accompany security staff; and
 - f. transfer of medical information.
2. Transport Officers who are transporting inmates will:
 - a. remain with the inmates at all times;
 - b. inspect the inmate examination/treatment area for escape routes;
 - c. identify routes that must be physically or visually monitored and
 - d. maintain restraints on inmates during all medical appointments (unless otherwise requested by the medical advisor and approved by the Shift Commander or higher):
 - 1) inspect the inmate examination/treatment area for potential weapons for removal in case it becomes necessary to remove the restraints;
 - 2) explain the risks associated with removing restraints; and
 - 3) if there is any threatening or inappropriate inmate behavior, maintain or reapply the restraints and immediately return the inmate to their secure facility.

B. Hospital Admissions

1. For planned hospital admissions, the statewide Transportation Manager will arrange for transport to and from the hospital when necessary.
2. Transport officers will:
 - a. inspect the inmate examination/treatment area for potential weapons for removal should it become necessary to remove the restraints;
 - b. maintain restraints on all inmates unless conditions or injuries preclude their use;
 - c. ride in the ambulance if ambulance transport is necessary;
 - d. not remove restraints at the hospital unless requested to by the attending health care provider and approved by a higher authority:
 - 1) for secure facility, contact the Shift Commander
 - 2) for community facilities, contact Community Corrections Facilities and Programs Bureau
 - 3) for community supervision, contact a P&P Sergeant or higher
 - e. remain with the offender unless otherwise instructed by the supervisor;
 - f. position themselves to prohibit direct contact between officer and offender (refer to post orders for more detail)
 - g. consult the Shift Commander or Transportation Staff Sergeant if questions arise about security; and
 - h. disable phone in the hospital room if possible or otherwise prohibit offender from using the phone
3. Offenders are not allowed visitors in the hospital except for deathbed visits or other visits as approved by:
 - 1) Facility Administrator or Designee (secure and community facilities)
 - 2) Captains or higher (community supervision).

4. Transport staff will refer hospital staff to the Department Health Services Bureau regarding conversations about inmate health/wellness and to make decisions related to care.

C. Court Appearances

1. The Department Records Unit will electronically sign a gate pass for every inmate leaving a facility and distribute it to the necessary individuals.
2. Two transport officers shall accompany an offender to court appearances; one officer will remain with the inmate while the other officer will post at a strategic point to monitor the courtroom.
3. Inmates must be kept in restraints unless the judge orders removal.
4. The court will be notified as soon as possible if the inmate demonstrates behavioral traits that are concerning (for example, hostility, aggression, unamenable) prior to court appearance.

D. Out of State Transport

1. Commercial airline transport:
 - a. the decision to utilize air transport will be determined by management;
 - b. officer must check with the airlines for allowable equipment and must complete any necessary forms;
 - c. the use of restraints and weapons will be determined by airline policy;
 - d. if the airline prohibits use of restraints, consideration must be given to transporting known inmate escape risks or disruptive inmates by ground;
 - e. transport officers must ensure they possess the necessary credentials to present to airline officials;
 - f. while on the airplane, inmates will be dressed in clothing provided by the transport officer.
2. Out-of-state vehicle transport:
 - a. follow the above requirements in IV.D as applicable; and
 - b. if overnight accommodations are necessary during transportation, a county jail will be used to house the inmates, and transport officers must:
 - 1) inspect the cells that will hold the inmates to determine if they are adequate;
 - 2) ask the jailers to isolate the inmates, if possible;
 - 3) strip search the inmates prior to cell placement;
 - 4) ensure the inmates are provided meals; and
 - 5) inform the jailers of the scheduled departure time and provide the jailers with a phone number and location where the officers can be reached.

VI. CLOSING

Questions about this policy should be addressed to the Transportation Manager or Facility Administrator.

VII. REFERENCES

- A. 46-19-101, MCA
- B. ACA Standards for Adult Correctional Institutions
- C. DOC 1.1.6 Priority Incident Reporting and Acting Director; DOC 3.1.8 Use of Force and Restraints; DOC 3.1.17 Searches and Contraband Control; DOC 3.1.31 Firearms; DOC 4.5.20 Emergency Medical Services; DOC 4.5.23 Offender Health Care Escort and Transport



POLICY DIRECTIVE

Policy:	DOC 3.1.13 KEY CONTROL	
Effective Date:	02/01/1997	Page 1 of 4
Revision Date(s):	04/23/2012; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

Department secure facilities will follow procedures and establish practices that govern the control and use of keys in accordance with the provisions of this policy.

II. APPLICABILITY

All secure facilities Department-owned and contracted, as specified in the contract, and Montana Correctional Enterprises.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Key Responsibility

1. The chief of security will:
 - a. oversee the facility key control program;
 - b. ensure all key and lock operations effectively secure the facility;
 - c. require maximum staff control over locks, keys, and locking devices;
 - d. approve any keys permanently issued to staff;
 - e. restrict access to sensitive keys;
 - f. enable prompt emergency response; and
 - g. identify and train an employee to manage the key control program.
2. Each facility will follow written requirements that describe in detail the inventory, storage, issue, distribution, and handling of keys, including the staff positions responsible for key control at specific posts.
3. Where applicable, lockshop operations may be located in or adjacent to the armory; if so, the facility will follow access controls as described in *DOC 3.1.7 Emergency Equipment and Armory Operations*.

B. Key Categories

1. Facilities will account for keys in two basic key categories:
 - a. security keys are keys that if lost, or duplicated by offenders, would jeopardize the safety or security of the facility, employees, visitors, or offenders, or directly or indirectly facilitate an escape that may jeopardize public safety; and
 - b. non-security keys are those that do not control access to security-type doors, grilles, or areas with hazardous or sensitive materials and, if lost, would not require urgent security action.

C. Key Storage and Issue

1. The facility will maintain a control center key board, or its automated equivalent, as the prime issue point and the main repository for all assigned general issue, emergency, and restricted keys.

2. Facilities may have an automated key issue and inventory system that reasonably duplicates key issue, accountability, and security as described in this policy.
3. The key board will:
 - a. be of sufficient size to accommodate all keys and key rings routinely used;
 - b. contain rows of hooks that are lettered vertically and numbered horizontally;
 - c. provide one hook for each key ring identifiable by its location in the matrix of letters and numbers; and
 - d. be filled at all times with one of the following:
 - 1) a set of keys;
 - 2) an employee key chit indicating drawn keys; or
 - 3) an appropriately numbered and stamped key chit indicating the hook is presently unused.
4. The facility will:
 - a. use a durable chit-based system to issue a suitable supply of metal or plastic receipt chits inscribed with the name of each staff member authorized to draw keys;
 - b. prohibit the use of temporary chits to draw keys from the control center unless authorized by the shift supervisor;
 - c. affix small metal tags to each key ring, indicating the hook number of the key ring and the number of keys on the ring;
 - d. solder or epoxy shut all key rings in circulation to prevent tampering or removal;
 - e. follow procedures for key exchange between staff on post and relief staff, including reporting any discrepancies to the shift supervisor; and
 - f. where applicable, establish a secondary secure emergency key storage area outside the facility to include keys that access the control center, armory, and lockshop area.

D. Emergency Keys

1. The facility will:
 - a. establish emergency key rings to provide access to every facility area in case of fire, riot, or other major emergency;
 - b. color-code red and store emergency key rings in a separate section of the control center key board;
 - c. configure and color-code each key ring to identify the doors and locks each key will open;
 - d. stamp on each key ring the number of keys and whether the keys are emergency or regular issue;
 - e. solder the ring shut to prevent easy removal;
 - f. test the working order of emergency key rings at least quarterly and submit the inspection results in writing to the chief of security;
 - g. regularly use and rotate the keys on the emergency rings to prevent uneven wear, ensure locks are properly functioning, and familiarize staff with the key system operation;
 - h. forward a record of issue to the chief of security whenever a set of emergency keys is drawn;
 - i. maintain a duplicate set of emergency key rings in a secure location separate from the area containing operational keys, unless the issuing point is outside the perimeter; and
 - j. train all staff in the use of the emergency key system.

E. Restricted Keys

1. The facility will:
 - a. classify certain keys as restricted (for example, keys to the pharmacy, records office, business office, and warehouse);
 - b. issue keys only to designated, authorized employees;
 - c. ensure that any restricted key issue is approved in writing by the shift supervisor;
 - d. ensure a copy of the authorization is forwarded to the chief of security;
 - e. color-code all restricted keys yellow; and
 - f. store restricted keys on a separate section of the key board.

2. The administrator must approve the issue of any facility keys for staff personal key rings and restrict the practice to an absolute minimum.

F. Key Accountability

1. Facilities will have:
 - a. a complete accountability system that is automated and provides key issue and tracking information; or
 - b. a manual accountability system for all keys that meets the following requirements:
 - 1) a daily manual inventory of all control center keys;
 - 2) an accounting of all emergency and restricted keys;
 - 3) a call-in system for all keys on posts;
 - 4) tracking the number of keys on each key ring;
 - 5) determining at all times who has possession of keys; and
 - 6) recording the key board and post inventories in a control center logbook.
2. The chief of security must authorize any and all changes that may affect the inventory.
3. Control center staff will contact and require any employee who may have inadvertently taken keys home to return them to the facility promptly.
4. Facility staff will:
 - a. immediately inform the shift supervisor of any lost or misplaced key ring, including facts of the discovery, circumstances, and keys involved;
 - b. submit the report in writing to the shift supervisor and chief of security as soon as possible;
 - c. immediately take proper security precautions to guard against unauthorized access to sensitive areas or facility escape; and
 - d. change locks at once if security keys are lost, unaccounted for, or if offenders may have made key impressions, and immediately notify other facilities that may use the same keys.

G. Duplication of Keys

1. The facility administrator will strictly prohibit staff from the unauthorized possession, alteration, marking, duplication, manufacture, or impression making of keys and will require staff to report any such incidents in writing to the chief of security for investigation of the alleged incident.
2. Any staff involved in key duplication will be subject to disciplinary action.
3. If criminal acts are involved, the chief of security will refer the matter for prosecution.

H. Lockshop Operations

1. Lockshop operations will reside in a secure location outside the offender area of the facility or, in the case of small facilities, may be contracted locally.
2. The lockshop operation will:
 - a. store and maintain an inventory of locks, keys, and parts;
 - b. use a Telkee or similar proprietary storage system to maintain patterns and spare keys for each lock;
 - c. issue only duplicate keys and retain pattern keys in secure storage;
 - d. employ a cross-reference system to identify which locks and keys are in use, in what locations, and on which key rings they are found;
 - e. cross-index all "three-way" fits by alphabetical location of key use, cabinet hook numerical listing, and key numerical listing;
 - f. identify a staff member to develop a system to regularly test and repair all locking devices and retire compromised or worn keys and locks;

- g. maintain blueprints or maps showing the location of all permanent locks; and
 - h. keep accurate records of the location of all padlocks.
3. The chief of security must authorize any change in lock location or key duplication.

I. Staff Training

1. All staff must be trained in the key control system, particularly in the emergency key system, so that in a time of crisis any staff issued keys can use them as intended.
2. Employees will be trained in the following key control principles:
 - a. carry and use keys as inconspicuously as possible;
 - b. fasten keys securely to the belt with a chain and carry them in pant pockets or on a wrist strap that is securely fastened to the wrist;
 - c. check the count when exchanging keys from one employee to another, confirming the actual key count with that on the tag;
 - d. avoid references to key numbers or any identifying information in the presence of offenders;
 - e. do not drop keys; keys must be exchanged hand-to-hand, never tossed or thrown;
 - f. do not use force to operate locks; if a lock does not easily function, report the malfunction to the shift supervisor;
 - g. do not attempt to repair locks; this should be done only by the locksmith or other qualified employee; and
 - h. do not permit an offender to handle any security keys under any circumstances.

V. CLOSING

Questions about this policy should be directed to an immediate supervisor.

VI. REFERENCES

- A. 4-4186; *ACA Standards Supplement, 2008*
- B. 4-4195; *ACA Standards for Adult Correctional Institutions, 4th Edition*
- C. 3-JTS-3A-22, *ACA Standards for Juvenile Correctional Facilities*
- D. DOC 3.1.7 *Emergency Equipment and Armory Operations*



POLICY DIRECTIVE

Policy:	DOC 3.1.14 TOOL CONTROL
Effective Date:	02/01/1997 Page 1 of 6
Revision Date(s):	01/05/1998; 01/07/1999; 11/15/2001; 11/07/2002; 04/18/2006; 03/15/2011; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

Department and contracted facilities will maintain and control all tools, culinary, and medical equipment necessary for facility operations in a safe and secure manner to ensure against loss, damage, or use for other than intended purposes.

II. APPLICABILITY

The secure facilities that include Montana State Prison, Montana Women's Prison, Montana Correctional Enterprises, Riverside, and Pine Hills Youth Correctional Facilities, and private and regional facilities contracted to the Department of Corrections.

III. DEFINITIONS (See Glossary)

IV. REQUIREMENTS

A. Responsibility

1. The chief of security will:
 - a. oversee the tool control program operation;
 - b. appoint a tool control officer responsible for tool inventory, marking, storage, accountability, and use;
 - c. where applicable, establish a committee to classify each facility tool; and
 - d. require all employees to maintain accountability and control of each tool in their specific work areas.
2. Staff or offender failure to follow facility tool control procedures constitutes a serious security breach and may result in disciplinary action.

B. Tool Categories

1. Each facility will classify all tools in accordance with the following categories:
 - a. Class 1 "Restricted" Tools – A category of items that present inherent safety and security risks and may be used as weapons, effect an escape, or compromise security.
 - 1) Class 1 tools will be used by staff, or by offenders under constant "Direct Staff Supervision."
 - b. Class 2 "Hazardous" Tools – A category of tools that without alteration present a significant safety and security risk but are deemed to be a lesser risk than Class 1 tools.
 - 1) Offender use will therefore be monitored with "General Staff Supervision."
 - c. Class 3 "Non-hazardous" Tools – A category of tools that without alteration are reasonably considered to pose a minimal safety and security risk.
 - 1) Offender use may be monitored with "Indirect Staff Supervision" as specified by this policy.

C. Tool Use Supervision

1. Each facility will follow procedures for tool supervision according to tool classification and offender location inside and outside the secure perimeter.
2. Staff will comply with the following supervision levels:
 - a. Direct Staff Supervision – For the purpose of this policy, requires staff to supervise an offender or group of offenders by remaining in the immediate area, directly observing offender movement and tool use, and ensuring tools are not lost, damaged, or used for other than intended purposes.
 - b. General Staff Supervision – For the purpose of this policy, requires staff to supervise an offender or a group of offenders by remaining in the general area and observing offender location and tool use intermittently and on at least an hourly basis.
 - c. Indirect Staff Supervision – For the purpose of this policy, requires staff to supervise an offender or group of offenders by observing their location and tool use on an intermittent basis. The majority of offender activities are performed independent of staff direction and observation.
3. When staff supervise tool use with offenders of multiple custody levels, they must follow requirements for the higher custody level.
4. Within locked housing units:
 - a. offenders may use only Class 3 tools and only under direct staff supervision; and
 - b. offender tool use must be pre-approved by the chief of security.

D. Tool Storage

1. Each facility will:
 - a. establish secure storage areas;
 - b. enforce restrictions on offender tool issue;
 - c. maintain rigid inventories of all tools;
 - d. address the classification and accountability of all tools not in use, including tools stored outside the secure perimeter; and
 - e. address the classification and storage of ladders, lifts, ropes, cables, hoses, and extension cords to ensure these items cannot be used in an unauthorized manner.
2. Facilities will follow procedures for the use of tool shadow boards:
 - a. Tools must be hung on shadow boards within a tool crib.
 - b. Only one tool may hang in front of each corresponding tool shadow and will be identical in size and shape to that tool.
 - c. Shadow boards will have shadow colors, according to tool class, as follows:
 - 1) Class 1 tools will be stored over a red shadow;
 - 2) Class 2 tools will be stored over a yellow shadow; and
 - 3) Class 3 tools will be stored over a black shadow.
 - d. Class 1 tools will be enclosed inside a locked, shadowed tool crib located inside a secure tool room and separated from Class 2 and Class 3 tools by a secure door.
 - e. When staff remove a tool from permanent inventory, they must immediately remove the corresponding shadow and follow procedures that indicate the tool has been permanently removed.
 - f. Tools that are not adaptable to a shadow board must be stored in locked drawers, cabinets, chests, or rooms.
 - g. Staff will store tool pouches and carts in a secure area and maintain an inventory sheet with each pouch and cart at all times.

E. Tool Issuance

1. Facilities may use a system of tool checkout logs, tool chits, or a combination of both.

2. Regardless of method, staff must record which tool is used, who issues the tool, who receives the tool, and who is responsible for the security, safe usage, and return of the tool.
3. Tools must be immediately returned to a shadow board or secure storage area after use.
4. When staff removes a tool from inventory for repair purposes, a repair chit will be placed on the corresponding hook indicating it is out for repair.
5. Only staff will issue Class 1 tools. Depending on the offender's custody classification, either staff or offenders may issue Class 2 and Class 3 tools.
6. The chief of security may authorize offenders to work inside a Class 2 and Class 3 tool room for purposes of issuing tools.

F. Tool Quotas

1. The chief of security will:
 - a. establish the number of tools to be stored in each tool storage area in the facility;
 - b. regularly evaluate tool numbers and quotas to eliminate any excess tools; and
 - c. transfer all work area tools not used on a consistent basis (for example, seasonal tools) from the tool inventory to the tool control officer.
2. The tool control officer will:
 - a. maintain a tool list according to original work locations; and
 - b. store the tools in a safe and secure area in accordance with facility requirements pending disposal or reassignment.

G. Tool Procurement and Receipt

1. The tool control officer will:
 - a. pre-approve all facility tool orders and deliveries;
 - b. receive, mark, and inventory all tools before issue;
 - c. complete the receiving report and distribute copies as required;
 - d. destroy the receiving report when a tool is eliminated from a work area inventory; and
 - e. secure a supply of extra tools to replace or replenish broken or worn-out tools and include these on the master inventory list.
2. If staff must purchase tools without prior approval due to emergency circumstances, they must report the purchases to the tool control officer by the next working day.

H. Tool Inventories

1. The tool control officer will:
 - a. maintain a master inventory of all tools and their locations;
 - b. maintain area inventory lists where tools are stored or used, signed by the work area supervisor, and kept in loose-leaf sheets or binders;
 - c. maintain sub-inventories in all storage areas, including tool cribs, tool cabinets, toolboxes, and tool drawers;
 - d. ensure lists are kept with the tools, are current, filed, and readily available for tool inventory and daily tool accountability; and
 - e. keep master inventory lists in the offices of the chief of security and tool control officer.
2. Each facility will follow requirements for tool inventory control that include documented tool inspections as follows:
 - a. daily supervisory checks of assigned tools;
 - b. an established schedule for the physical inventory of all tool storage areas, including a report issued to the chief of security; and

- c. an established schedule for complete tool audits conducted by the tool control officer to check area inventories, markings, and storage, with findings forwarded to the area supervisor and chief of security.

I. Tool Marking

1. Facilities will:
 - a. mark all tools with an etching tool prior to issue and color-code in accordance with tool classifications; and
 - b. determine a tool marking system to ensure proper identification of assigned tools.
2. Tools that cannot be marked without damage (for example, surgical instruments) must be inventoried and kept in locked storage when not in use.

J. Tool Exchange

1. When a work area supervisor requests a replacement because a tool becomes unserviceable, worn out, or broken, no inventory change will be made; the replacement tool will be numbered the same as the replaced tool.
2. The work area supervisor will send a receipt with the replaced tool to the tool control officer for filing and tool disposal.

K. Lost or Missing Tools

1. If a tool is lost or missing:
 - a. missing or lost tools will be immediately reported to supervisory staff (for example, the shift supervisor, tool control officer, and chief of security);
 - b. a written report describing the tool and circumstances of loss must be submitted before the end of the shift to the chief of security with copies forwarded to the appropriate supervisors and retained until the tool is found;
 - c. a time period, not to exceed 3 months, will accrue before a missing tool is removed from the master tool inventory;
 - d. any offenders with access to lost or missing tools in all tool categories will be detained at the location pending a thorough body and area search;
 - e. replacement tools will be assigned a new number with the inventory adjusted accordingly;
 - f. a list of lost tools will be maintained by the tool control officer against which confiscated contraband tools may be cross-checked;
 - g. recovered identifiable and serviceable tools will be forwarded to the tool control officer, with written notice to the chief of security; and
 - h. recovered tools, already replaced, will be secured in storage; unserviceable tools will be destroyed.

L. Hobby Craft Tools

1. The offender hobby program supervisor will:
 - a. establish a list of all offender hobby craft tools;
 - b. ensure all tools are marked with the offender DOC ID number; and
 - c. supervise, inventory, store, and require all hobby tools to be used in accordance with the provisions of this policy.

M. Food Service Tools

1. Each facility food services area will follow tool safety and management requirements:
 - a. all food service tools must be classified;
 - b. food service tools (including, but not limited to, knives, cleavers, ice picks, knife sharpeners, and meat saws) will be stored on a shadow board in a securely anchored cabinet with an inventory list maintained with the tools at all times;

- c. all hazardous tools and knives will be marked with the food service identification symbol and knives will be consecutively numbered to facilitate inventory;
 - d. a chit or log system will be used for tool issue;
 - e. items such as extra cutting saw blades and knives will be kept in secure storage under the supervision of the tool control officer and issued as required; and
 - f. kitchen knives may be used in specific locations without direct supervision only when they are secured by cable or chain to a table or other immovable fixture.
2. Each facility will follow requirements for tool inventory and accountability before and after shifts.
3. Tool inventory sheets must be signed by arriving and departing employees to verify tool accountability, initialed by the food service manager, and retained on file for 30 days.
4. Lost or missing tools will be reported according to IV.K above.
5. Food items that may be misused (for example, poppy seed, nutmeg, cayenne pepper, and fermentable items such as yeast and uncooked bread dough) will be maintained by a perpetual inventory and kept in secure locations in accordance with *DOC 4.3.1 General Food Service Operations*.

N. Medical Tools

1. Facility medical departments will follow tool control requirements:
 - a. medical staff will have primary responsibility for needles, syringes, and controlled medications;
 - b. medical department tools may not be marked because of size but must be kept in a locked storage area or containers with only minimum amounts dispensed for daily use;
 - c. the chief facility health officer will ensure an accurate, daily inventory of instruments such as scalpels and other tools is maintained at all times;
 - d. the ordering and receiving of all instruments, controlled medications, needles, and syringes will be done through processes that ensure none of these items enter the facility without proper inventory and physical control;
 - e. each shift will maintain a daily perpetual inventory of all current-use needles and syringes by size; when instruments are replenished from bulk supply, the inventory will be adjusted accordingly;
 - f. inventory processes for bulk supply will include a documented joint monthly reconciliation of amounts by the chief facility health officer and shift supervisor;
 - g. used needles and syringes will be maintained in secure interim storage and disposed of off-site according to methods approved by local health authorities; and
 - h. narcotics and other controlled substances will be stored, dispensed, and inventoried in compliance with state regulations.

O. Non-Facility Worker Tools

1. A correctional officer or other designated staff member will directly supervise contract and non-facility workers at all times.
2. The tool control officer will:
 - a. inspect and inventory contractor and non-facility worker incoming tools upon facility entry;
 - b. re-inspect and reconcile the inventory upon exit; and
 - c. ensure inventory sheets are filed and retained for 30 days.

P. Ramset Guns and Ammunition

1. If explosive-driven tools such as Ramset or Hilti guns are used in the facility, they will be stored with their ammunition in a secure area approved by the chief of security.

2. These tools will be issued to and used only by employees.
3. Expended shells must be returned to the armory for accountability and disposal after use.

V. CLOSING

Questions about this policy should be directed to the chief of security.

VI. REFERENCES

- A. *DOC 3.1.15 Security Inspections; DOC 3.1.17 Searches and Contraband Control; DOC 4.3.1 General Food Service Operations*
- B. *4-4196; ACA Standards Supplement, 2008*
- C. *3-JTS-3A-23; ACA Standards for Juvenile Correctional Facilities, 2003*
- D. *2-C1-2A-2; Performance-based Standards for Correctional Industries, 2nd Edition*



POLICY DIRECTIVE

Policy:	DOC 3.1.15 SECURITY INSPECTIONS	
Effective Date:	03/01/1997	Page 1 of 3
Revision Date(s):	05/18/2011; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department mandates a system of facility inspections to ensure that the security of the facility and safety of staff and offenders are in no way compromised.

II. APPLICABILITY

Department and contracted secure facilities.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The chief of security is responsible for the overall management of the facility inspection program.
2. Security inspections will be separate from all other search systems and will be documented separately.
3. Written procedures require:
 - a. that the chief of security conduct at least weekly inspections of all security devices, noting the items needing repair or maintenance and submitting written documentation to the chief of security and/or facility administrator; and
 - b. hands-on inspections to ensure the complete integrity of the devices and physical features that make up the physical security of the facility.
4. Administrators will ensure that the written requirements that support the security inspection system are reviewed and revised when portions of the facility are assigned different purposes or actual physical plant changes take place.

B. Inspection System

1. Facility requirements will identify specific areas of the facility and specific staff members who will inspect the assigned areas on a strict timetable.
2. Each area identified for inspection will be of reasonable size (for example, not so large as to overburden a staff member or encourage shortcutting).
3. Inspections will cover every area of the facility, including the perimeter.
4. Written requirements and supporting forms will address the following details for each area:
 - a. timing of inspections (for example, those that require inspection on every shift, or at daily or weekly intervals);
 - b. methods of inspection (for example, which areas and security features will be inspected visually, which will be tapped, and which will be probed or checked by other means); and

- c. techniques for inspecting each type of security feature (for example, bars to tap with a certain type of mallet and force sufficient to generate a solid sound that verifies structural integrity).
5. Items to be inspected will include, at minimum:
 - a. locks and lockboxes;
 - b. security fittings such as screws, bolts, hinges, bars, window mullions, and sashes;
 - c. doors, screens, grilles, braces, brackets, windows and frames, fences, walls, ceilings, and floors;
 - d. drains, maintenance hole lids, air chambers, tunnels, and key mortar joints;
 - e. exits, gates, and internal cutoff fences;
 - f. perimeter wire and detection and surveillance systems;
 - g. electrical junction and transformer equipment servicing perimeter lighting and detection systems, as well as the perimeter fence or wall itself; and
 - h. areas related to locked housing units such as recreation yards and rooms used by high security offenders.
6. The chief of security will ensure the facility's control center receives special security considerations, including daily checks on the integrity of the following:
 - a. ballistic-resistant glazing and any attendant grillwork;
 - b. ventilation grilles and other avenues of access;
 - c. emergency lighting and power backup units;
 - d. wall, floors, and ceilings, and
 - e. security vestibule entrance.
7. Facility staff will be alert to other security, safety, or process problems, such as fire hazards, accumulation of excess property, or hidden contraband.

C. Equipment and Supplies

1. Appropriate equipment will be readily available to the staff conducting inspections. The following are examples of items that may be used in inspections:
 - a. a bar-tapping mallet, made of wood, plastic, leather, or other material of local preference;
 - b. mirrors on extendible handles or poles, to inspect out-of-the-way locations such as the underside of beds, insides of ventilator openings, and other less-accessible portions of the facility; and
 - c. metal probes and shims, to detect tampered bars, screens, and other security fixtures and to re-inspect bars that may have sounded irregular when tapped.
2. In some locations, or for inspections of selected areas, overalls, jumpsuits, or other protective clothing items may be provided to search staff.
3. When not in use, inspection equipment will be secured in areas inaccessible to offenders. When in use, such equipment must be under staff control at all times.

D. Recordkeeping and Follow Up

1. There must be an accountable reporting system that includes verification of inspections and timely or immediate corrective action plans for necessary repairs and serious security breaches.
2. Facilities will use basic security inspection forms that contain essential items such as name of area, inspecting staff member, components of assigned area, results of inspection of each component, and a signature certifying inspection of each specific area noted on the form.
3. Processes will indicate where and to whom to submit completed inspection forms; these forms must be promptly reviewed for compliance and any noted discrepancies must be immediately addressed.

4. The chief of security must bring to the appropriate administrator any persistent unrepaired breaches.

E. Staff

1. Since facility security is the responsibility of all staff members, the inspection system will include not only correctional officers, but also job supervisors and other employees who are responsible for inspections in their specific areas of the facility.
 - a. Security staff will also conduct periodic searches of these areas.
2. The chief of security will consult with supervisors and maintain a list of staff assignments for security inspections that reach all areas of the facility.
3. New employees require training in professional inspection techniques; more experienced staff require a regular program of refresher training.
 - a. Training sessions will cover not only the mechanics of searches, but methods of contraband production and escape technologies devised by offenders so that staff are better prepared to detect breaches of security.

V. CLOSING

Questions about this policy should be directed to the chief of security.

VI. REFERENCES

- A. *DOC 3.1.1 Management of the Security Program*



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 3.1.17	Subject: SEARCHES AND CONTRABAND CONTROL
Chapter 3: FACILITY/PROGRAM OPERATONS	Page 1 of 6
Section 1: Security Operations	Effective Date: March 1, 1997
Signature: /s/ Loraine Wodnik, Interim Director	Revised: 02/02/2017

I. POLICY

The Department of Corrections divisions and facilities will develop, implement, and enforce procedures that detect and control the introduction, fabrication, possession, and transmission of contraband and ensure the safety of employees, the general public and offenders.

II. APPLICABILITY

All divisions, facilities and programs Department-owned and contracted, as specified in the contract.

III. DEFINITIONS

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the facility or program operation and management.

Body Cavity Search – A manual or instrument inspection of an offender's anal or vaginal body cavities.

Chief of Security – The staff person, regardless of local title (associate warden of security, director of operations), designated by the administrator to manage the facility security program.

Clothed Body Search – The manual body search of an individual that requires the removal of outer clothing, e.g., coats, hats, gloves; emptying of pockets; and inspection of papers, bags, books, or other carried items (also referred to as a pat search).

Contraband – Any item possessed by an offender or found within the facility that is illegal by law, prohibited by policy or procedure, or unauthorized by those legally charged with the administration and operation of the facility.

Disability – A physical or mental impairment that substantially limits one or more of a person's major life activities, a person who has a history of such an impairment, or a person who is perceived by others as having such an impairment. See *Americans with Disabilities Act of 1990 42 USC 12010*, as amended.

Dry Cell Procedures – Procedures for placing and observing an offender in a room or cell without plumbing fixtures or running water to intercept contraband inserted inside a body cavity in order to prevent the contrabands transfer into the facility.

Exigent Circumstances – Any set of temporary and unforeseen circumstances that require immediate action in order to combat a threat to security or institutional order.

Facility – A place, institution, building (or part thereof), set of buildings, structure, or area that is

Policy No. DOC 3.1.17	Chapter: Facility/Program Operations	Page 2 of 6
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used for the confinement of offenders.

Reasonable Suspicion – A conclusion drawn from specific, objective facts which would permit a reasonable and experienced correctional staff person to suspect that an individual or set of circumstances poses a threat to security, or to the health, safety, and security of offenders, staff, visitors, contractors, or community members, including, but not limited to, committing, or conspiring or attempting to commit a crime or rule violation.

Reasonable Suspicion Search – The search of person, property, or area where there is a reasonable suspicion that a law or policy has been violated.

Unclothed Body Search – A visual inspection of an individual’s unclothed body and thorough search of the unworn clothing to detect concealed contraband (also referred to as a strip search).

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. The facility administrator will ensure search plans and procedures include the following:
 - a. unannounced and irregularly timed searches of cells, offenders, and offender work areas;
 - b. searches of all vehicular traffic and supplies coming into the institution;
 - c. perimeter searches, including specific areas outside the secure perimeter;
 - d. prohibited use or transfer of wireless messaging devices inside the secure portion of the facility, unless authorized by the administrator;
 - e. use of metal detectors at compound entrances and, if used, at entrances into housing units;
 - f. complete search of each cell prior to occupancy by a new offender;
 - g. requirements for the search of offender religious items;
 - h. avoidance of unnecessary force, embarrassment, or indignity to the offender;
 - i. staff training in effective search techniques that protect both offenders and staff from bodily harm;
 - j. use of non-intrusive sensors, e.g., x-ray machines or other techniques, whenever feasible;
 - k. established procedures for offender placement on dry cell status;
 - l. conduct of searches to control contraband, recover missing or stolen property, and prevent escapes or other disturbances;
 - m. respect for offenders’ personal property;
 - n. provisions ensuring reasonable accommodations for offenders with disabilities during clothed and unclothed body searches; and
 - o. annual review of search procedures with updates as necessary.

B. Documentation

1. Facility procedures must require staff to document all searches, excluding routine clothed body searches that do not result in the discovery of contraband or result in a disciplinary write-up; itemize any found contraband; and maintain the documentation.
2. Cross gender clothed body searches of all residents in juvenile facilities, juveniles and

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adult females will be documented.

C. Clothed Body Searches

1. Facility procedures will include that all offenders, visitors, and staff are subject to clothed body searches at any time.
2. Staff who conduct clothed body searches will:
 - a. conduct full body clothed body searches in accordance with facility training requirements;
 - b. pass his/her hands deliberately and carefully in and around the groin area;
 - c. carefully search for items that may be concealed in females' bras; and
 - d. inspect shoes, insoles and heels as time and circumstances allow.
3. Staff will conduct clothed body searches of individuals of the same gender as themselves whenever possible.
4. Cross gender clothed body searches of residents in juvenile facilities, juveniles and adult females are not permitted unless an exigent circumstance requires a cross gender clothed body search.

D. Unclothed Body Searches

1. Facility procedures will outline appropriate unclothed body search requirements and techniques applicable to both offenders and non-offenders.
2. Written procedures will provide that, except in emergency situations, staff of the same gender as the offender will conduct offender unclothed body searches in a private area and based on a reasonable suspicion that the offender is carrying contraband or other prohibited material.
3. Reasonable suspicion is not required for unclothed body searches when offenders return from contact with the general public or from outside the facility.
4. Trained staff will conduct unclothed body searches and do so in a respectful and dignified manner.
5. Staff are prohibited from searching or physically examining a transgender or intersex offender for the sole purpose of determining the offender's genital status.

E. Body Cavity Searches

1. Facility procedures will govern the restricted use of offender body cavity searches in compliance with the following requirements:
 - a. only health care providers, excluding facility health care providers, will conduct body cavity searches when there is a reason to do so and only with the written authorization of the administrator;
 - b. in such cases, a physician must authorize the instrument or surgical examination of body cavities, including the use of an anal scope or vaginal speculum;
 - c. health care providers must:
 - 1) conduct body searches in private;

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- 2) fully document the search and its results;
- 3) forward documentation and authorizations to the offender record; and
- 4) whenever possible, have security staff available to ensure safety and proper handling of contraband.

F. Visitor Searches

1. Facility staff will identify and search all visitors, volunteers, and vendors in accordance with *DOC Policy 3.1.5 Entrance Procedures and Detainment of Non-Offenders*, and corresponding procedures.

G. Area Searches

1. Procedures will require frequent searches of all facility areas, which include housing, visiting, and general areas, to prevent serious incidents or escape and uncover contraband.
2. Facility staff will conduct housing unit searches in a manner that:
 - a. respects offenders' personal property;
 - b. handles offender property judiciously using care not to willfully discard, break, or misplace items; and
 - c. leaves the area as close to the way it was found as possible.
3. Facility staff who damage or destroy personal property will submit a report with the property to the appropriate supervisor.
4. Staff assigned to visiting areas must:
 - a. complete a thorough search of the visiting area immediately before visitors and offenders are permitted in the area; and
 - b. complete a thorough search of the area immediately after visiting hours.

H. Vehicle and Delivery Searches

1. Facility staff will:
 - a. conduct vehicle searches in accordance with *DOC Policies 3.1.5 Entrance Procedures and Detainment of Non-Offenders* and *3.1.12 Offender Escort and Transport*;
 - b. search and escort all vehicles entering and leaving facility grounds to and from their destinations within the secure perimeter;
 - c. search all supplies and food stocks delivered to the facility before allowing offender access to them;
 - d. store and control all supplies and food stocks prior to use; and
 - e. inspect mail and package deliveries for contraband in accordance with *DOC Policy 3.3.6 Offender Mail*.

I. Contraband Control

1. Facility procedures will instruct staff to intercept movement of weapons and other contraband through:
 - a. use of metal detectors at fixed posts;
 - b. searches of movable equipment such as utility and food carts;
 - c. use of dry cell procedures;

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Subject: SEARCHES AND CONTRABAND CONTROL		

- d. routine and recurring cell searches; and
- e. routine and random searches of offenders in housing units and as they move from one area to another.

J. Disposition of Contraband

1. Facility procedures will address the discovery, confiscation, reporting, storage, disposal, and record-keeping of contraband.
2. Contraband that may be used as evidence in a court proceeding will be managed in accordance with *DOC 3.1.28 Crime Scene and Physical Evidence Preservation*.
3. Facility procedures must address:
 - a. the confiscation and deposit of intercepted cash in an offender welfare fund; and
 - b. the deposit of any receipts from the sale of contraband in an offender welfare fund to be used for the intended purposes of that fund.

K. Staff Contraband Issues

1. Staff who are found to introduce contraband into a Department or contracted facility will be subject to *DOC Policy 3.1.19 Investigations*.

L. Staff Training

1. Facility administrators will require staff training to include the following procedures:
 - a. proper techniques to detect prohibited items, uncover potential security breaches, and protect both offenders and staff from undue harm;
 - b. use of security equipment such as hand-held and walk-through metal detectors;
 - c. preventive measures and proper safeguards to use during searches, such as methods to avoid the danger of “needle sticks” that may lead to infection;
 - d. proper responses to other potentially hazardous conditions, e.g., that potential explosive devices must not be moved;
 - e. methods of contraband fabrication, control of raw materials, and offender tool access in accordance with *DOC Policy 3.1.14 Tool Control*;
 - f. provision of reasonable accommodations to offenders with disabilities and how to document those accommodations in OMIS; and
 - g. how to conduct cross gender clothed body searches, and searches of transgender and intersex inmates, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

M. Probation and Parole

1. The Probation and Parole Division and Youth Community Corrections will develop procedures for searches necessary to ensure officer, community and offender safety and to ensure offenders are compliant with conditions of supervision.
2. Procedures must address:
 - a. documentation of searches;
 - b. allowable searches and circumstances under which they will be conducted, including searches of the person, personal possessions and searches of residences;

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- c. the disposition of contraband including discovery, confiscation, reporting, storage, disposal, and record-keeping; and
 - d. training in proper search techniques and how to conduct searches in a professional and respectful manner
- 3. Staff will conduct clothed body searches of individuals of the same gender as themselves whenever possible.
- 4. Cross gender clothed body searches of residents in juvenile facilities, juveniles and adult females are not permitted unless an exigent circumstance requires a cross gender clothed body search.
- 5. Vehicle searches will be conducted in accordance with *3.1.12 Offender Escort and Transport*.

V. CLOSING

Questions concerning this policy should be directed to the appropriate administrator.

VI. REFERENCES

- A. *53-1-105, MCA*
- B. *4-4192, -4193, -4194; ACA Standards for Adult Correctional Institutions, 4th Edition; 3-JTS-3A-19, -3A-20, -3A-21; ACA Standards for Juvenile Correctional Facilities, 2003*
- C. *ACA Guidelines for the Development of a Security Program, 2007*
- D. *National Commission on Correctional Health Care Standards, 2003*
- E. *DOC Policies 3.1.3 Logs and Record-Keeping Systems; 3.1.4 Perimeter Security; 3.1.5 Entrance Procedures and Detainment of Non-Offenders; 3.1.12 Offender Escort and Transport; 3.1.14 Tool Control; 3.1.19 Investigations; 3.1.28 Crime Scene and Physical Evidence Preservations; 3.3.6 Offender Mail; 3.3.15 Americans with Disabilities Act (ADA) Offender Accommodations*

VII. ATTACHMENTS

None



POLICY DIRECTIVE

Policy:	DOC 3.1.19 INVESTIGATIONS	
Effective Date:	05/01/1997	Page 1 of 4
Revision Date(s):	02/18/2020; 04/25/2023; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

This policy provides the requirements for reporting and investigating criminal conduct involving Department employees, service providers, and/or offenders in accordance with Department policies, procedures, and state and federal law.

II. APPLICABILITY

All Department divisions, facilities, and programs.

III. DEFINITIONS

IV. REQUIREMENTS

A. General Requirements

1. Department employees must:
 - a. report immediately, in writing, any received information or personal knowledge regarding sexual abuse or sexual harassment of an offender or any crime to their supervisor or Investigations;
 - b. ensure information regarding investigations is kept confidential and disclosed only with the approval of the Investigations Chief; and
 - c. cooperate with an investigation and not provide erroneous and/or malicious information in a complaint or statement which they know or suspect to be false; such employees may be subject to:
 - 1) disciplinary or corrective action in accordance with *DOC 1.3.2 Performance and Conduct*; and
 - 2) criminal sanctions in accordance with 45-7-205, MCA.
2. The Investigations Chief is responsible for:
 - a. delegating all Department criminal investigations and assigning investigators accordingly;
 - b. reviewing all requests for investigation (RFI) of allegations of sexual abuse and sexual harassment of an offender and assigning them for either criminal or administrative investigation;
 - c. notifying the Law Enforcement Agency of Jurisdiction (LEAJ) upon receipt of criminal complaints involving Department property, employees, and offenders; and
 - d. restricting access to any investigative material and pertinent resources to protect the integrity of the investigation and maintain confidentiality.
3. Investigators must:
 - a. conduct prompt, thorough, fair, and objective criminal investigations and exercise professionalism during an investigation;
 - b. keep information confidential and disclose it only with the approval of the Investigations Chief;
 - c. administer warnings to employees who are the subject of an investigation or participating in an investigation;

- d. employ sound investigative techniques in accordance with state and federal law, Department rules, policies, and procedures;
 - e. when they have reason to believe that false allegations were made, or uncover new allegations, refer such issues to the Investigations Chief; and
 - f. complete specialized training prior to conducting sexual assault investigations or other specialty-type investigations.
4. Department employees are prohibited from engaging in racial profiling in accordance with 44-2-117, MCA.
 5. Administrators must provide investigators with unrestricted access to Department records including but not limited to documents; electronic recordings; and correspondence materials relevant to any criminal investigation.
 6. Only authorized persons shall make reports of allegations or investigations to the news media in accordance with *DOC 1.1.8 Media Relations*.

B. Reporting and Handling Complaints

1. When a supervisor receives information that alleges sexual abuse or sexual harassment of an offender or any crime, the supervisor must submit or direct the complainant to submit a *Request for Investigation (RFI)* to the Investigations Chief.
2. The Investigations Chief may, on a case-by-case basis, authorize an investigation when a verbal complaint or written allegation other than an RFI is received.
3. Criminal investigations and administrative investigations are conducted separately.
 - a. When it is unclear whether an incident is criminal or administrative in nature, Department employees will report the incident to the Investigations Chief, who will:
 - 1) determine if a criminal investigation is warranted; or
 - 2) forward the information to Human Resources or the division or facility for administrative investigation.

C. Assignment of Investigations

1. The Investigations Chief will delegate all Department criminal investigations.
2. Only investigators from Investigations and the LEAJ may be used to conduct criminal investigations.

D. Rights of Employees

1. Department employees are guaranteed constitutional and administrative protections.
 - a. Within the boundaries of those protections, employees will:
 - 1) cooperate with any authorized investigation or inquiry; and
 - 2) relate fully and truthfully their knowledge of all issues pertaining to any criminal investigation.
2. When applicable, investigators will consult with Human Resources to provide a Garrity Warning to employees.
 - a. Employees will be advised that answers will not be used against them in a criminal proceeding.
 - b. If the employee refuses to answer or testify they will be subject to Department discipline up to, and including, termination.
3. Information obtained during a criminal investigation may be jointly shared and utilized.
 - a. However, a self-incriminating statement made in an administrative investigation may not be utilized in a criminal investigation against an individual who has been provided with a Garrity Warning.

4. In accordance with *DOC 1.3.2 Employee Performance and Conduct*, individuals who report a crime will not be subjected to retaliation by anyone within or outside of their chain of command.
5. Before interrogating an employee who is the subject of a criminal investigation and who is in custody, a criminal investigator will provide a Miranda warning as set forth in 46-6-107, MCA.
6. The subject of a criminal investigation may not have a representative present during an interview other than an attorney as provided for in the Miranda warning.
7. Interviews will be conducted in a private setting during normal business hours, and allow for periods of rest unless justifiable cause exists or mutual agreement is made to change time and/or location.
8. Investigators will advise all Department employees who are the subject of a criminal investigation that the investigation is criminal in nature.

E. Conducting Investigations

1. Criminal investigations may be generated by receipt of an incident report, Request for Investigation (RFI), or other forms of communication.
2. Upon receipt of the above information, the Investigations Chief will deny or approve the initiation of the investigatory process and, if approved, appoint an investigator.
3. An investigation initiated by the Investigations Chief must be completed promptly and at all times within the time frame required by the statute of limitations.
4. Investigative materials including but not limited to incident reports, statements, and investigative reports will be stored in a designated investigative case file.
 - a. Investigative case files must be submitted to the Investigations Chief.
5. Confidential criminal justice information may only be shared with criminal justice agencies and those authorized by law or court order.
 - a. Anyone receiving confidential criminal justice information assumes equal responsibility for the security of the information.

F. Notification Requirements

1. All criminal investigations will result in a written report to be reviewed by the Investigations Chief.
2. The Investigations Chief will provide substantiated criminal investigations to the county attorney having jurisdiction for a determination of whether a case will be prosecuted.
3. Information obtained from criminal investigations of offender behavior will be forwarded to the appropriate division or facility for relevant follow-up and any appropriate disciplinary proceedings.
4. Information obtained from criminal investigations that does not result in prosecution but may result in administrative discipline will be forwarded to Human Resources.

V. CLOSING

Questions about this policy should be directed to the Investigations Chief.

VI. REFERENCES

- A. *Garrity v. State of New Jersey*, 385 U.S. 493 (1967); *Gardner v. Broderick*, 392 U.S. 273 (1968); *Uniformed Sanitation Men Assoc., Inc. v. Commissioner of Sanitation of the City of New York*, 392 U.S. 280 (1968)
- B. §§ 44-2-117; 44-5-303; 53-1-203, MCA
- C. *Montana Operations Manual*
- D. *DOJ Memorandum of Understanding with DOC for Peace Officer Status and Crime Analyst Services*
- E. *DOC 1.1.6 Priority Incident Reporting; DOC 1.1.8 Media Relations ; DOC 1.1.17 Prison Rape Elimination Act (PREA); DOC 1.3.2 Performance and Conduct ; DOC 1.3.12 Staff Association and Conduct with Offenders; DOC 1.4.1 Staff Development and Training ; DOC 3.1.28 Crime Scene and Physical Evidence Preservation*



POLICY DIRECTIVE

Policy:	DOC 3.1.20 OFFENDER DRUG TESTING PROGRAM	
Effective Date:	03/01/1997	Page 1 of 3
Revision Date(s):	05/07/2020; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department mandates offender drug testing to help offenders abstain from illicit substances and assist them to live crime-free lives.

II. APPLICABILITY

All divisions, facilities, and programs of the Department.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Department staff will conduct drug testing using test supplies provided by a Department-approved vendor.
2. Department staff will use a Portable Breath Test Device (PBT) that is approved by the Department to measure the alcohol content of an offender's breath.
3. Division Chiefs will ensure drug testing processes are in place in accordance with this policy to promote:
 - a. a drug-free standard;
 - b. offender accountability;
 - c. offender self-admissions;
 - d. recovery from drug and alcohol dependence;
 - e. treatment options where indicated;
 - f. successful community reintegration; and
 - g. a safe correctional and community environment.
4. Each administrator will designate a staff person as the facility or program drug testing liaison (DTL) to coordinate required drug testing
5. Administrators will ensure employees responsible for conducting drug testing are trained in the appropriate methods of collection, testing, and reporting requirements.
6. Administrators will ensure that, at minimum, adult offenders approved for community corrections programs are drug tested before transfer or upon entry into a new program.

B. Drug Testing Liaison (DTL) Duties

1. The administrator, or designee, will appoint a DTL for their facility or program responsible for:
 - a. overseeing drug testing operations;
 - b. researching current drug trends and staying current with evolving drug testing technology;
 - c. networking with the Department-approved vendor and the State Crime Lab;
 - d. advising on selection and purchase of drug tests; and
 - e. monitoring the division's testing results and data entry.

C. Specimen Collection, Testing, and Reporting

1. Department employees responsible for drug testing offenders will:
 - a. solicit self-admission following a positive drug test (confessed drug use may be used as a substitute for sending a sample for confirmation testing);
 - b. use a test kit provided by the Department-approved vendor;
 - c. comply with the specimen collection procedures recommended by the Department-approved vendor;
 - d. for purposes of urine collection, be the same gender as the offender;
 - e. collect specimens in a private setting;
 - f. observe the offender's urine flow from body to collection cup to avert adulteration or substitution of urine;
 - g. establish the chain of evidence for the sample at the point of collection to confirm the locations of the evidence at all times;
 - h. fully complete the *Drug and Alcohol Screening Information* form each time a drug test is completed or a self-admission is provided by an offender and ensure the form is uploaded into the offender management system;
 - i. accurately input all appropriate testing data in the offender management system;
 - j. submit positive samples for confirmatory testing;
 - k. initiate disciplinary actions when an offender is unwilling to provide a specimen, a test result is positive, or upon self-admission; and
 - l. ensure offenders are strongly sanctioned for tampering with specimen collection.

D. Random Testing

1. Facilities and programs will use fully randomized testing systems to:
 - a. maximize detection and deterrence;
 - b. minimize the predictability of scheduled tests; and
 - c. defeat attempts to manipulate the test by substitution, flushing, or adulteration.
2. Random testing must be frequent enough that offenders understand urine may be tested at any time.
3. Random testing will be established on a schedule that tests a minimum of 5% of the offender population each month.

E. For-Cause Testing

1. Facilities and programs may administer drug testing at any time for reasons including, but not limited to, the following:
 - a. any time there is reason to suspect an offender has recently used drugs;
 - b. testing is a requirement of a treatment or training program;
 - c. an incarcerated offender has had community contact; or
 - d. a probationer or parolee misses a commitment or meeting.

F. Financial Responsibilities of Offenders

1. Offenders may be charged the cost of the preliminary test kit when the offender refuses to admit drug use and a preliminary positive result is confirmed positive by laboratory testing.
2. Offenders will only be charged the unit price associated with the preliminary Department approved test kit; offenders may be exempt if offender is on indigent status or is current on all restitution and supervision fees.

V. CLOSING

Questions about this policy should be directed to the facility or program drug testing liaison.

VI. REFERENCES

- A. 50-32-101, MCA
- B. DOC 3.1.28 Crime Scene and Physical Evidence Preservation

VII. FORMS

Drug and Alcohol Screening Information



POLICY DIRECTIVE

Policy:	DOC 3.1.21 INMATE COUNT AND SUPERVISION	
Effective Date:	03/01/1997	Page 1 of 4
Revision Date(s):	12/16/2016; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department will maintain safe and secure facility operations through a comprehensive inmate accountability system that includes scheduled and unscheduled physical counts, accurate recordkeeping, and effective staff supervision.

II. APPLICABILITY

All secure facilities Department-owned and contracted, as specified in the contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Facility administrators will ensure that written requirements:
 - a. require 5 counts per 24-hour period, with a minimum of 2 official counts per 24-hour period;
 - b. account for all inmates in legal custody on a master count record compiled by the control center officer that includes written documentation of inmates on temporary absence from the facility;
 - c. require staff counting inmates to see a "living, breathing body;"
 - d. specify under what circumstances picture and stand-up counts may be used;
 - e. require staff to report the area and unit counts and outcounts to the control center on official count slips in ink without any changes or erasures;
 - f. require a recount when the accuracy of a count cannot be verified and specify how many recounts are necessary after staff reports an inaccurate number;
 - g. prohibit clearing count activity until all inmates are accounted for and all area and unit count slips and outcount totals are reconciled with the master count sheet;
 - h. prohibit inmate movement from areas and units until the count is officially cleared by the control center unless an emergent situation arises;
 - i. prohibit inmates from participating in the preparation, documentation, or operation of the count process, including preparation of picture cards or any other identification and accountability records; and
 - j. require that inmates with disabilities be provided reasonable disability related accommodations during count.

B. Count Records

1. The facility control center will be the central repository of all master count records for up to 30 days from the time the count was taken.
2. Respective staff are responsible to know and document the locations of all inmates at all times.

3. Staff will provide the control center officer with an up-to-the-minute accounting of any changes that affect inmate accountability including, but not limited to, housing unit moves, work assignments changes, off-site appointments, admissions, and releases.

C. Official Count

1. Staff will notify inmates of official count times and require that inmates are counted at specific locations, typically in housing units and in assigned cells.
2. Two officers will conduct count; however, processes will allow for cross counts to double-check the accuracy of the initial count.
3. Inmates who do not immediately cease activity during an official count, or who delay or disrupt count, will face disciplinary action.
4. Staff will cease unnecessary activity during the counting process.

D. Cross Count

1. A minimum of 1 cross count per 24-hour period is required.
2. Two staff members will conduct a separate visual count of each inmate, compare findings to verify the accuracy of the count, and both sign the count slip.

E. Outcount

1. When inmates are out of their housing units during official counts for work assignments or other approved activities, supervisory staff will verify inmate presence at these locations and approve the outcount prior to the official count.
2. Staff must limit outcounts to the number necessary and submit the count numbers to the control center officer on a signed count slip.

F. Census Check

1. Periodic daily census checks taken between official counts help determine whether inmates are in their assigned locations and help staff learn if inmates may be hiding, perfecting escape routes, engaging in sexual misconduct, or fabricating contraband.
2. To keep staff and inmates aware of accountability requirements, staff may randomly conduct census checks over the entire facility by stopping inmate movement and counting inmates where they are located at that time.
3. Staff must document census numbers in the unit log; documentation to the control center is not required unless the census check reveals missing inmate(s), inmate(s) out of bounds, or other improper activity and may require immediate investigation.

G. Picture Count

1. Picture counts are necessary in the event of a missing inmate or suspected escape, or in other circumstances specified by facility requirements.
2. Staff will directly compare every inmate with the inmate's picture identification card and identification card information to verify identities.
3. Identification cards will be periodically reviewed to ensure inmate photos accurately portray the inmate's appearance.

H. Stand-Up Count

1. Staff may use stand-up counts as an option in circumstances where achieving accurate numbers and identification requires a regimented approach.
2. Facilities will require a minimum of 1 stand-up count per 24-hour period.

I. Emergency Count

1. Staff will conduct emergency counts:
 - a. in response to an immediate need to account for all inmates present at the facility; and
 - b. in circumstances such as a missing inmate, after a lengthy power failure, or when indicated by a facility disturbance.
2. Inmates will return to their housing units at once, provided the emergency does not prohibit such movement and that the facility shift supervisor has cleared the movement.
3. Control center staff will organize records so that an emergency count may be completed quickly and accurately (for example, the master count sheet is prepared immediately, with verbal or telephone outcounts approved by the designated supervisor).

J. Direct Supervision

1. While the count process is integral to inmate accountability, direct staff supervision is equally integral and especially critical to facility and inmate security. Staff will:
 - a. assume duty in housing areas and other critical posts 24 hours each day to supervise, observe, and interact with inmates;
 - b. actively patrol housing units and be alert to unusual incidents, changes in inmate behavior, or any signs of unusual activity or behavior in the facility;
 - c. stay out of office areas to the extent duties will allow in order to maintain personal contact with inmates in their units and surrounding areas;
 - d. frequently observe key, possibly problematic, facility areas as part of an effective internal surveillance program;
 - e. conduct irregularly scheduled rounds in locked or special management housing units to provide adequate checks on inmates with mental health, suicide, or behavioral management issues;
 - f. use electronic supervision to augment, but not replace, direct staff supervision;
 - g. maintain voice communication capability with inmates at all times;
 - h. devise systems to provide additional staff supervision when necessary or recommended (for example, at shakedown points outside activity, kitchen, or dining hall areas);
 - i. provide supplemental levels of supervision when required for random, comprehensive census checks for the entire facility; and
 - j. ensure post orders and supervisory training describe actions to take in the event of planned movements or drills, emergencies, or unauthorized mass movements in any part of the facility.
2. Facilities will ensure that inmates are able to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when viewing is incidental to routine cell checks.
3. Facilities will require staff of the opposite gender to announce their presence when entering an inmate housing unit.

V. CLOSING

Questions about this policy should be directed to the facility administrator.

VI. REFERENCES

- A. *DOC 3.1.11 Offender Movement Control*
- B. *4-4187; ACA Standards for Adult Correctional Institutions, 4th Edition*
- C. *ACA Guidelines for the Development of a Security Program, 2nd Edition*
- D. *3-JTS-3A-13; ACA Standards for Juvenile Correctional Facilities, 2003*



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy:	DOC 3.1.24 SECURITY THREAT GROUP MANAGEMENT
Chapter 3:	FACILITY/PROGRAM OPERATIONS
Section 1:	Security Operations
Effective Date:	Dec. 1, 1997 Page 1 of 5 and Attachments
Last Revised:	Dec. 21, 2023
Next Review:	Dec. 21, 2024
Signature:	/s/ Brian Gootkin, Director

I. POLICY

The Department of Corrections maintains zero tolerance in its facilities/programs for offender behaviors and activities relating to security threat groups. These behaviors and activities compromise the safety, security, and order of facilities/programs and public safety.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Associate – An offender who has accrued a minimum of five and less than ten validation points of validation criteria and maintains ties with a security threat group.

Contact Staff – Staff who have frequent offender contact as a routine job function including, but not limited to administrators, correctional officers, drill instructors, correctional counselors, investigators, teachers, work supervisors, probation and parole officers, mental health and health care providers and staff, and staff working in offices where offenders may be assigned full-time work.

Facility/Program – Refers to any division, prison, secure care correctional facility, correctional or training program, or community-based program under Department jurisdiction or contract. This term includes the facility building or residence, including property and land owned or leased and operated by the Department.

Moniker – A slang expression used as a nickname for a security threat group member to denote membership.

Montana Analysis and Technical Information Center (MATIC) – Multi-agency entity operating through the Montana Department of Justice that collects, stores, and analyzes crime information and disseminates information to first responders, law enforcement leaders and government officials.

Probation and Parole Regional Intelligence Liaison (RIL) - A staff member of the Probation and Parole Bureau appointed by the Public Safety Division Chief to track street gang activity within a specific region and/or city and is the liaison to MATIC.

Security Threat Group (STG) – A group within a secure care facility consisting of three or more individuals with a common interest, bond, or activity typically characterized by criminal or

Policy No. DOC 3.1.24	Chapter 3: Facility/Program Operations	Page 2 of 5
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delinquent conduct.

Security Threat Group (STG) Activity – Offender behavior that poses a significant threat to the safe and secure operation of the facility/program including but not limited to STG recruitment, threatening or inflicting bodily injury on another person, promoting or engaging in disruptive group behavior, distributing controlled substances, or maintaining STG paraphernalia.

Security Threat Group (STG) Analyst/Specialist – An employee located at a facility/program designated to investigate and validate STG activity, disseminate information to staff and criminal justice agencies, and manage STG recordkeeping.

Security Threat Group (STG) Member – An offender identified and validated as a member of a STG by having accumulated ten or more points in validation criteria.

Street Gang – Any organization, association, or group of three or more persons within the community, whether formal or informal, which has continuity of purpose, seeks a group identity, and has members who individually or collectively engage in or have engaged in a pattern of criminal activity.

Validation – A process by which a security threat group (STG) member or associate is officially recognized through accumulation of validation points by completion and signature of the STG Validation Worksheet by STG Analysts or STG Specialists.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. Offender involvement in Security Threat Group (STG) activity may serve as the basis for disciplinary, classification action, or placement in specific housing designed to address offender behavior issues.
2. Secure facilities will attempt to maintain some separation or balance of STG members or associates within living units.
2. The Department prohibits engaging in STG activity and displaying paraphernalia and such behavior will result in disciplinary action.
3. All Department contact staff will receive STG training annually to include, at minimum, identification and management of STG members and associates.
4. Staff appointed as STG Analyst/Specialists will receive formal training, at minimum of 120 hours.
5. The Department will appoint STG Analyst/Specialists to serve on the Security Threat Group Management committee. This committee will routinely meet to collectively review/approve STG appeals and renunciations.

C. STG Validation

1. During the intake/orientation at a facility/program, staff will utilize the Security Threat Group Membership Questionnaire for STG detection. If an offender is new to DOC and has been convicted of a crime relating to gang activity, a questionnaire will be completed

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during the pre-sentence investigation process. The questionnaire includes the following information:

- a. physical appearance including tattoos or marks;
 - b. STG association;
 - c. rank in STG;
 - d. alias or moniker;
 - e. hometown;
 - f. geographic location of STG;
 - g. length of time in STG;
 - h. rival STGs; and
 - i. membership requirements.
2. Following the questionnaire, if staff have a reason to believe that an offender is a STG member or associate, staff must report this information to a STG Analyst using the STG Review Request. All pertinent investigative and supporting documentation must be attached with the request.
 3. The STG Analyst will review the information submitted in the STG Review Request to make a determination of whether an offender is a STG member or associate by completing a STG Membership Validation Worksheet and conducting follow-up interviews with the offender.
 4. The STG Membership Validation Worksheet establishes criteria to designate an offender a STG member or associate. Using a point system, an offender may be classified as an associate (5-9 points) or a member (10 points and above). For offenders scoring below 5 points, the STG Analyst will notify the reporting staff member that a designation will not be established.
 5. Following a validation, STG Analysts/Specialists will:
 - a. complete and sign the STG Validation Worksheet;
 - b. ensure that the appropriate entries are made in the Department's Offender Management Information System (OMIS);
 - c. advise the offender classification unit and housing unit staff, in writing, of the offender validation results so that the classification assessment report reflects the offender's status; and
 - d. communicate validation results to Facility/Program leadership.
 5. Offenders will be notified of their validation status via the Offender STG Validation Notification/Appeal form and in-person by a STG Analyst/Specialist:
 - a. offenders may request their initial status to be reviewed by the Security Threat Group Committee within 30 days of validation to ensure accuracy;
 6. Offenders may renounce their association with an STG Group at any time. Offenders must submit their renunciation and supporting evidence in writing. The Security Threat Group Management Committee will work together to determine the validity of a renunciation:
 - a. the Department may reject or grant renunciation following an investigation. Once granted, STG Analyst/Specialist must enter an end date of the validation in the offender management system with supporting documentation/notes;

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- b. offenders will be notified of the renunciation determination in writing;
 - c. for an accepted renunciation, the Department will take the appropriate steps in updating records and classifications. Facility/Programs will also consider potential changes to housing and work assignments; and
 - d. an offender may be reinstated as a STG member or associate following an accepted renunciation at any time if the offender displays STG activity/behavior.
7. For youth offenders, youth correctional facilities will utilize the same processes outlined in this policy. Youth STG files and information will be maintained within the Youth Management System.

D. STG Information

- 1. Department's Analyst/Specialists and Probation and Parole Regional Intelligence Liaison will facilitate communication within the Department, law enforcement, intelligence, and government agencies concerning STG member or associate discharge destinations, general STG information collected, and potential STG activity.
- 2. STG Analyst/Specialists will monitor STG activity throughout the State of Montana, and nationwide to track movement, and recognize trends that could potentially affect the Department.
- 3. Information regarding youth offender involvement with a STG will be released and disseminated pursuant to *Title 41, ch. 5 Youth Court Act, MCA*.

V. CLOSING

Questions concerning this policy should be directed to the Public Safety Chief.

VI. REFERENCES

- A. *Title 41, ch. 5 Youth Court Act, MCA; 44-5-103, MCA; 44-5-303, MCA; 46-18-101, MCA*
- B. American Correctional Association. (2018). *Standards Supplement, 2018 (5-ACI-5B-19, 5-ACI-1A-20)*

VII. ATTACHMENT

[STG Intake Questionnaire](#)
[STG Activity Questionnaire](#)
[STG Validation Worksheet](#)



POLICY DIRECTIVE

Policy:	DOC 3.1.26 POLYGRAPH TESTS FOR OFFENDERS	
Effective Date:	12/01/1997	Page 1 of 1
Revision Date(s):	06/01/2011; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department cooperates with law enforcement agencies that conduct criminal investigations or prosecutorial activities that may include polygraph examinations for offenders. The Department's response to polygraph examination requests are guided by applicable federal and state statutes.

II. APPLICABILITY

Department and contracted secure facilities, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Approval

1. Upon notification from an authorized law enforcement agency, the facility administrator may request that the chief of security arrange for an offender polygraph examination.
2. Facility administrators will work with local, state, and federal law enforcement to facilitate a polygraph examination when informed by the law enforcement jurisdiction that an offender has agreed to a polygraph exam.

B. Location

1. The chief of security will accommodate the scheduling of a polygraph at the request of an investigating law enforcement officer or jurisdiction to the extent possible.
 - a. If staffing problems make scheduling an immediate polygraph exam impossible, then a mutually agreeable time will be arranged.
 - b. Security will only be assigned for an exam at:
 - 1) the request of the polygraphist; or
 - 2) the recommendation of the chief of security.
2. The facility administrator will assist off-site polygraph examinations.
3. The Department will not provide escort services for off-site polygraphs, unless the escort is mutually agreed between the facility administrator and the law enforcement jurisdictions requesting the polygraph exam, or otherwise stipulated in a court order.

C. Civil Cases

1. Facility administrators will not grant permission for offenders to submit to polygraph examinations in civil matters while in secure facility custody.
2. The facility administrator will honor the order of a court of competent jurisdiction in granting civil case requests after conferring with Department Legal Services.

V. CLOSING

Questions about this policy should be directed to the Department Legal Services.

VI. REFERENCES

- A. 53-1-203, MCA



POLICY DIRECTIVE

Policy:	DOC 3.1.27 CAMERA SURVEILLANCE SYSTEM	
Effective Date:	04/28/2017	Page 1 of 3
Revision Date(s):	04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department will ensure camera surveillance is conducted in a manner consistent with legal requirements and establish guidelines for the appropriate use of surveillance within or on the grounds of a Department facility, office, or building.

II. APPLICABILITY

All Department divisions, facilities, and programs.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Guidelines

1. Surveillance cameras are used in Department facilities, offices, and other buildings to ensure safe, secure, and humane operations.
 - a. They will only be used by authorized individuals and only for approved Department business purposes.
2. Division chiefs and facility administrators are responsible for managing camera surveillance systems in accordance with this policy.
3. In accordance with *DOC 1.1.17 Prison Rape Elimination Act (PREA)*, when surveillance cameras or the associated monitoring software are installed or updated in a Department facility, the facility PREA Specialist and the Department PREA Coordinator will be consulted to consider how the camera and software technology may enhance the Department's ability to protect inmates from sexual abuse.
 - a. This consideration will be documented in writing and retained by the Department's PREA Coordinator.
4. Employees who misuse camera surveillance equipment or video images will be subject to disciplinary action. Misuse includes disseminating images without proper authorization, viewing video footage to satisfy curiosity, or other violations of this policy.

B. Purchasing, Installation, and Maintenance

1. To maintain necessary camera equipment and software technology, all surveillance cameras, servers, and/or associated software and hardware purchases for the Department will require prior approval from the Information Technology CIO or designee.
2. The location, viewing area and/or camera settings of existing surveillance cameras will not be moved, altered, or changed without the written approval of the Division Chief or facility administrator.
3. Administrators are responsible for ensuring maintenance of the camera surveillance system. Department employees or contracted companies may conduct maintenance.

C. Surveillance

1. Employees may monitor live video for building security and offender movement and behavior.
2. Division Chiefs and facility administrators will identify positions with the ability to live monitor remotely from a desktop.
3. Division Chiefs and facility administrators will identify staff positions with authority to retrieve recorded video images to review incidents and assess potential problems impacting security.
 - a. These staff positions may show recorded video images to employees for the following reasons:
 - 1) pre-approved training; or
 - 2) an immediate security need, such as staff assisting with identifying offenders in an incident.
4. Employees may only view recorded video images if a legitimate business-related need exists.
5. Employees may not view recorded video images of any incidents that may have potential for criminal prosecution, staff discipline, or involving staff or offender injury for safety related investigation purposes unless written approval has been given by the facility administrator or Investigations.

D. Access

1. The following positions have the authority, within the scope of their position, to allow or block access to Department surveillance camera systems:
 - a. the Director and Deputy Director;
 - b. the Chief General Counsel;
 - c. the Investigations Bureau Chief;
 - d. the Department PREA Coordinator;
 - e. the Information Technology CIO; or
 - f. the Division Chief or facility administrator.
2. The level of access for each employee designated and approved by the above individuals must be identified, including whether the individual is allowed to view, save, copy, store, or delete video images.

E. Record Retention

1. Video images captured on Department surveillance cameras will be copied, saved, and/or stored only on approved and physically secure Department devices such as a server, desktop computer, mobile computing device or media, and only when approved by:
 - a. the Director or Deputy Director;
 - b. the Chief General Counsel;
 - c. the Investigations Bureau Chief;
 - d. the Department PREA Coordinator;
 - e. the Information Technology CIO;
 - f. the Division Chief or facility administrator; or
 - g. any of these individual's designees.
2. All video images reviewed as part of an official investigation or official administrative process, including but not limited to use of force reviews, inmate disciplinary process, PREA investigations, and employee discipline, will be:
 - a. noted or referenced, even if not relied upon, in the investigative or administrative record or report; and
 - b. copied, saved, and/or stored and retained as part of the investigative or administrative record.

3. When video images captured by surveillance cameras are part of any matter being litigated or a hold is issued for video images, the video images will not be destroyed and will be retained until released by Department Legal Services.
4. Video images that are not reviewed or copied, saved, and/or stored will be retained for a minimum of time as determined by the system's storage capabilities.

V. CLOSING

Questions about this policy should be directed to the appropriate administrator.

VI. REFERENCES

- A. 53-1-203, MCA
- B. DOC 1.1.17 Prison Rape Elimination Act (PREA)



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 3.1.28	Subject: CRIME SCENE AND PHYSICAL EVIDENCE PRESERVATION	
Chapter 3: FACILITY / PROGRAM OPERATIONS	Page 1 of 6	
Section 1: Security Operations	Effective Date: April 1, 1998	
Signature: /s/ Mike Batista, Director	Revised: 10/09/2015	

I. POLICY

The Department of Corrections divisions and facilities will establish procedures to preserve crime scenes and physical evidence for crimes that occur within Department jurisdiction to maximize the possibility of successful prosecutions and convictions.

II. APPLICABILITY

Probation and parole and secure care facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Boundaries – The perimeter or border surrounding potential physical evidence related to the crime.

Chain of Custody – A process used to maintain and document the chronological history of the evidence.

Crime – An action or incident that may result in the filing of criminal charges.

Crime Scene – The location where an illegal act took place, and comprises the area from which most of the physical evidence found in the planning, execution, or commission of a crime is retrieved.

Documentation – Written notes, audio/videotapes, printed forms, sketches, and/or photographs that form a detailed record of the scene, evidence recovered, and actions taken during the search of the crime scene.

Dying Declaration – Statements made by a person who believes he or she is about to die, concerning the cause or circumstance surrounding his or her impending death.

Physical Evidence – Any tangible object, material, or impression that connects a perpetrator to the commission of a crime.

IV. DEPARTMENT DIRECTIVES

A. Secure Care Facility Initial Response

1. If a facility staff member believes a crime has been committed, he or she will immediately notify the shift supervisor; the shift supervisor will assign staff to secure the crime scene.
2. The initial response to an incident will be expeditious and methodical to preserve the

Policy No. DOC 3.1.28	Chapter 3: Facility/Program Operations	Page 2 of 5
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scene with minimal contamination and disturbance of physical evidence.

3. The safety and physical well-being of staff and other individuals in and around the crime scene will be the staff's first priority.

B. Responsibilities of On-Site Secure Care Facility Staff

1. Upon arrival, staff will complete the responsibilities detailed within this section unless the incident commander dictates otherwise or until the law enforcement or Department investigators arrive.
2. Initial staff responsibilities include:
 - a. approach the scene in a manner designed to reduce risk of harm to staff while maximizing the safety of victims, witnesses, and others in the area;
 - b. ensure that there is no immediate threat to other responders by scanning the area for sights, sounds, and smells that may present danger to personnel (e.g., hazardous materials such as gasoline, natural gas), if the situation involves extremely dangerous chemical, biological or radiological threats the appropriate personnel/agency will be contacted for instructions prior to entering the scene;
 - c. notify supervisory personnel and call for assistance as necessary;
3. After controlling any dangerous situations or persons, staff will ensure that medical attention is provided to injured persons while minimizing contamination of the scene, responsibilities include:
 - a. assess individual(s) for signs of life, medical needs, and provide necessary immediate medical attention;
 - b. call for medical personnel;
 - c. guide medical personnel to the victim to minimize contamination/alteration of the crime scene;
 - d. point out potential physical evidence to medical personnel, instructing them to minimize contact with such evidence (e.g., ensure that medical personnel preserve all clothing and personal effects without cutting through bullet holes, knife tears), and document movement of persons or items by medical personnel;
 - e. instruct medical personnel not to "clean up" the scene and to avoid removal or alteration of items originating from the scene;
 - f. if medical personnel arrived first, obtain the name, unit, and telephone number of attending personnel, and the name and location of the medical facility where the victim is to be taken;
 - g. if there is a chance the victim may die, attempt to obtain a dying declaration;
 - h. document any statements/comments made by victims, suspects, or witnesses at the scene; and
 - i. if the victim or suspect is transported to a medical facility, send a staff member or law enforcement official with the victim or suspect to document any comments made and preserve evidence.
4. After ensuring the safety of present individuals and facilitating emergency care, staff must maintain crime scene integrity, safeguard evidence and minimize contamination.
5. To protect and secure the crime scene, staff will:

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- a. begin establishing boundaries by identifying and surrounding the focal point of the crime scene(s);
 - b. initiate boundaries beyond the initial scope of the crime scene and include:
 - 1) potential paths of exit and entry of suspects and witnesses; and
 - 2) places where the victim/evidence may have been moved, keeping in mind impression evidence.
 - c. set up physical barriers, e.g. ropes, cones, barrier tape, vehicles, personnel, etc.;
 - d. protect possible evidence from contamination related to persons or weather conditions; and
 - e. avoid activities including, but not limited to: smoking, chewing tobacco, use of the telephone or bathroom, eating, drinking, moving any crime scene items unless necessary for safety, adjusting a thermostat or opening windows or doors, littering, touching anything unnecessary, or repositioning moved items.
6. To maintain crime scene integrity, safeguard evidence, and minimize contamination, staff will secure and control individuals at the scene with the following actions:
- a. document the identity and authority of all people entering and leaving the scene;
 - b. exclude unauthorized and nonessential personnel from the scene, administrators and command staff will wait for law enforcement or investigators to arrive before entering the crime scene;
 - b. restrict the movement, location, and activity of individual(s) around the scene;
 - c. identify, secure, and separate suspects and witnesses;
 - d. remove bystanders from the scene; and
 - e. use compassion while controlling victims and family or friends of victims.
7. Staff will brief investigator(s) and law enforcement responding to the scene, assist in controlling the scene, and remain on-site until relieved of duty.

C. Documentation for a Secure Care Facility

1. Staff will immediately document all information clearly and methodically, complete an incident report, and submit documentation to the Office of Investigations including:
 - a. observations at the crime scene including locations of individuals and items;
 - b. conditions upon arrival, e.g. lights, windows, smells, ice, liquids, weather, temperature, etc.;
 - c. information from witnesses, victims, suspects, and additional statements; and
 - d. personal actions and actions of others.

D. Evidence Handling for a Secure Care Facility

1. Designated staff will notify law enforcement officials anytime a crime scene has been established.
2. If law enforcement is unable to respond, a staff member will be designated as the temporary custodian of evidence gathered from the crime scene and will maintain custody of evidence until it is placed in the evidence locker. The staff member will complete all entries on the chain of evidence tag, which must include, at minimum, the following:
 - a. date and time the previous staff took custody of the evidence;

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- b. date and time the previous staff relinquished custody of the evidence;
 - c. description of evidence;
 - d. how and where the evidence was found;
 - e. location and disposition of evidence;
 - f. type of crime alleged or type of incident;
 - g. condition of evidence;
 - h. identity and signature of the individual currently maintaining custody; and
 - i. sequential names of other individuals handling evidence.
3. Chain of custody documents accompanying evidence will include:
 - a. name or initials of the individual collecting evidence and each person subsequently maintaining custody;
 - b. dates evidence items were collected and/or transferred;
 - c. agency and case number;
 - d. victim or suspect names; and
 - e. brief description of evidence.
4. Staff will place evidence in a secure evidence locker at the earliest opportunity and comply with the following guidelines:
 - a. access to the evidence storage area will be strictly limited to authorized personnel;
 - b. staff will maintain an evidence log at the site of each evidence locker and submit a detailed report with the evidence;
 - c. log the disposition or disposal of evidence including:
 - 1) name of person handling evidence;
 - 2) date;
 - 3) method of disposition or disposal; and
 - 4) witness(es) to the disposition or disposal.
5. Disposal of evidence and illegal drugs or contraband as defined in 46-5-307, MCA will only be accomplished after the prosecutor files a petition with the court alleging that the items no longer have evidentiary value and the court issues an order for destruction and disposal.

E. Probation and Parole Requirements

1. The division administrator will ensure procedures are implemented and maintained for crime scene preservation and evidence handling.

V. CLOSING

Questions concerning this policy should be directed to the appropriate administrator or the Office of Investigations.

VI. REFERENCES

- A. 2-15-112, MCA; 46-5-307, MCA; 53-1-203, MCA
- B. 4-4207; ACA Standards for Adult Correctional Institutions, 4th Edition
- C. ACA Guidelines for Development of a Security Program, 3rd Edition, 2007
- D. [Crime Scene Investigation: A Guide for Law Enforcement, Technical Working Group on Crime Scene Investigation, U.S. Department of Justice, Office of Justice Programs, 2000](#)

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VII. ATTACHMENTS

None



POLICY DIRECTIVE

Policy:	DOC 3.1.30 OFFENDER ESCORTED LEAVE	
Effective Date:	02/01/1998	Page 1 of 3
Revision Date(s):	09/07/2011; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department, giving due consideration to public safety, will provide escorted leave for eligible offenders to visit a critically ill immediate family member, or to attend funeral services of a deceased immediate family member.

II. APPLICABILITY

Except prerelease center residents, all adult and youth secure care facilities and adult community corrections programs, Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The administrator will inform the offender in a timely manner of the verifiable death or critical illness of a confirmed immediate family member.
2. Administrators will carefully consider both community safety and the needs of immediate family members when authorizing a request for leave to a bedside visit or funeral service.
3. Unless pre-approved by a Department administrator on a case-by-case basis, escorted leave must meet the following:
 - a. may not exceed the boundaries of the State of Montana;
 - b. an offender may attend a bedside visit or a funeral service, but not both;
 - c. bedside visits may occur with a family member in imminent danger of death as determined by a physician or other medical professional and take place in a hospital, hospice care center, or nursing home; visits at a private residence will not be approved;
 - d. bedside or funeral service visits will not exceed two hours in length; the total leave time, including travel, will not exceed 16 hours; and an escorted visit should be between 0800 and 1700 hours; and
 - e. escorted leave to a graveside service will not be permitted unless the only funeral service is at the cemetery.
4. The administrator may deny an offender's request for escorted leave if approval would result in a staff shortage that may affect the safe and orderly operation of the facility.

B. Requirements for Adult Offenders in Community Corrections and Youth in Secure Care

1. Administrators will follow operational requirements, using adult secure requirements as a guide, that address, at minimum, the following:
 - a. offender notification;
 - b. eligibility requirements;
 - c. the application process;
 - d. limitations governing leave;
 - e. escort and transportation security; and
 - f. leave-related expenses.

C. Requirements for Adult Offenders in Secure Facilities

1. The facility will provide the *Escorted Leave Eligibility* form for offenders to complete upon admission in accordance with *DOC 4.1.1 Inmate Admissions Process* to declare the names of immediate family members whose bedside visit or funeral the offender may request to attend if the immediate family member becomes seriously ill or dies during the offender's incarceration.
 - a. Administrators will consider family members who were not part of the offender's family at the time of incarceration and not declared on the *Escorted Leave Eligibility* form.
2. Administrators will establish offender eligibility with consultation from appropriate Department staff (for example, a Victim Information Officer (VIO), Case Manager, security threat group coordinator, and American Indian liaison) on a case-by-case basis. Administrators may determine ineligibility based on the following eliminating criteria:
 - a. a documented criminal history that includes an escape or escape attempt or a history of absconding from community supervision;
 - b. unresolved felony warrants or detainers;
 - c. a documented prison history that includes possession of contraband for escape or materials used to remove restraints;
 - d. a documented history of physical assault against Department staff or law enforcement officers;
 - e. the offender's presence in the community could threaten the safety of the offender, staff, or general public;
 - f. the offender has had a mental status evaluation by Department mental health staff that indicates that the leave would not be in the best interest of the offender or of public safety;
 - g. the offender is in close or maximum-security status or scores in a high-risk category;
 - h. the offender is currently in detention status, is pending discipline for a serious major rule violation, or has had 2 or more serious rule violations within the past 6 months;
 - i. the offender has failed to demonstrate program compliance; or
 - j. the offender is currently housed in a contract bed out-of-state or has been transferred to another state through interstate compact.
3. Staff is provided a period of at least 48 hours to verify eligibility and grant escorted leave.
4. An offender who wishes to apply for an escorted leave must submit the request through the offender's unit manager or appropriate supervisor.
5. The VIO will review offender requests, submit a report to the administrator, contact the prosecuting county attorney, and comply with victim notification requests.
6. Administrators will determine whether a request for offender escorted leave is approved and will issue a decision in writing.
7. Facility requirements must include, as appropriate, the following:
 - a. two Department or facility employees will supervise each adult offender on escorted leave;
 - b. Department or facility caged vehicles will be used during transport;
 - c. employees will be outfitted with safety and security equipment as determined necessary by the facility;
 - d. offenders are required to wear facility-issued transport clothing as determined necessary by the facility;
 - e. adult offenders will be restrained at all times in accordance with *DOC 3.1.12 Offender Escort and Transport*;
 - f. restraints will not be removed from adult offenders at any time during escorted leave; and
 - g. officers will remain within arm's length of offenders and maintain visual contact with the offender at all times.
8. The use of restroom facilities will be provided to offenders on trips of an extended length.

- a. Transport officers will utilize restrooms at Department facilities and law enforcement or probation and parole offices as a first preference for offender restroom breaks.
 - b. Commercial buildings, hospitals, churches, or hospice centers should not be used for offender restroom breaks.
9. The escorting officers are authorized to terminate the escorted leave at any time if they determine they cannot maintain their own, the public's, and/or the offender's security or safety.
 - a. If escort officers terminate the escorted leave, they must file an incident report when they return to the facility.
10. Upon the offender's return to the facility, escorting staff will brief the appropriate supervisor regarding the offender's demeanor and behavior following the visit.
 - a. The supervisor will notify the facility chaplain or mental health staff if the offender's demeanor indicates a need for religious or mental health counseling.
11. Offenders will be strip-searched prior to leaving and upon returning to the facility in accordance with *DOC 3.1.17 Searches and Contraband Control*.
12. Officers will complete a search of the vehicle prior to departure and before they place the offender back in the vehicle if it is necessary to remove the offender from the transport vehicle.

D. Expenses

1. Offenders are required to reimburse the Department or facility for expenses incurred during the offender's escorted leave including the salaries of the escorting officers and travel and mileage costs.
2. The facility accounting office will provide the unit manager with an estimate of the cost of the trip and the funds available on the offender's account.
3. If the adult offender does not have available funds, inmate welfare funds may be used as a secondary funding source.
4. If the youth offender does not have available funds, the Department may provide funding.

V. CLOSING

Questions about this policy should be directed to the administrator.

VI. REFERENCES

- A. 2-15-112, MCA
- B. *DOC 1.8.1 Victim Services; DOC 3.1.12 Offender Escort and Transport; DOC 3.1.17 Searches and Contraband Control; DOC 4.1.1 Offender Admissions Process*
- C. 4-4443, 4-4445; *ACA Standards for Adult Correctional Institutions, 4th Edition*
- D. 4-4500-1; *ACA 2008 Standards Supplement*
- E. 3-JTS-5I-02, 3-JTS-5I-06; *ACA Standards for Juvenile Correctional Facilities, 2003*

VII. FORM

Escorted Leave Eligibility



POLICY DIRECTIVE

Policy:	DOC 3.1.31 FIREARMS	
Effective Date:	06/01/1998	Page 1 of 3
Revision Date(s):	10/01/2024; 04/30/2025	
Signature/Title:	/s/ John Schaffer, Public Safety Division Chief	

I. POLICY

All Department of Corrections employees authorized to carry firearms will follow this policy and established requirements for the lawful and judicious use of firearms. This policy does not apply to issues related to the use of firearms that are addressed in use of force or incident response policies.

II. APPLICABILITY

All Department division and facility personnel whose responsibilities include carrying a firearm. Unless otherwise specified, the term “firearms” in this policy refers to department-issued firearms.

III. DEFINITIONS (See Glossary)

IV. REQUIREMENTS FOR AUTHORIZATION TO CARRY A FIREARM

A. Training and Qualification

1. All firearms training must include approved lesson plans outlining safety considerations. The Public Safety Training Supervisor or designee must approve and maintain records of lesson plans and firearms courses.
2. Employees must successfully complete an initial firearms qualification course to become authorized to carry a firearm. Further, employees must qualify annually through an approved course and complete any required training to remain authorized to carry a firearm.
3. An employee who fails the annual firearms qualification course may be given two additional attempts to qualify if time and circumstances allow during that training session.
 - a. If the employee fails to qualify during that training session, the employee will have 30 days to complete approved remedial training and must successfully qualify.
 - b. If the employee fails to qualify through remedial training, the employee is prohibited from carrying a firearm while performing official duties until such time as qualification requirements are met.
4. After each attempt at qualification, the *DOC 3.1.31 (A) Firearms Qualification* form is completed and filed in the employee's training file.
5. An employee's authorization may be revoked or suspended by a Bureau Chief or Facility Administrator as recommended by a supervisor and/or Firearms Instructor. Records of revocation or suspension will be maintained in the employee's personnel file.
6. An employee with a physical or mental health condition preventing them from carrying a firearm and/or participating in the firearms qualification will provide Human Resources or the designated Americans with Disabilities Act Coordinator with a written statement from their physician, psychiatrist, or other medical/mental health provider specifying the expected length of time for the condition if determinable, including the start and end date.

V. FIREARMS

A. Carrying a Firearm

1. While assigned to an armed duty position, employees shall carry a Department-issued firearm at all times while on duty. Firearms will be carried in the approved retention device when applicable and will be duty ready. Employees are also required to carry handcuffs and their badge. **The badge will be clearly visible whenever the firearm is visible.**
 - a. Variations from these requirements may be approved in writing by an employee's supervisor and must be documented by the supervisor.
2. Employees carrying a Department-issued firearm either on or off-duty will refrain from using mood-altering and/or intoxicating substances and are subject to all the conditions of this policy.
3. Employees who wish to carry a concealed personal firearm while on duty are subject to applicable Montana Operations Manual (MOM) concealed carry firearm policy requirements.
4. Any time an employee points a firearm at anyone, or discharges a firearm outside of a training exercise, it will be reported and may be investigated pursuant to priority incident reporting requirements.

B. Storing Firearms and Ammunition

1. During work hours the Department-assigned firearm must be kept on the employee or in a secure location. Upon shift completion, employees will secure the firearm in the armory, a safe, or locked box. Any time a firearm is stored in a vehicle, the vehicle must be locked and the firearm stored out of sight. If the firearm is taken outside of the workplace, it will be stored in a secure location when not under the employee's control. The Department is not responsible for providing secure storage for any firearm taken outside of the workplace by an employee.
2. At secure facilities, the storage and issuing of all firearms and ammunition will follow applicable armory requirements.

C. Approved Firearms, Ammunition, and Equipment

1. Makes, models, and brands of firearms, ammunition, and equipment will be reviewed and approved by the firearms committee prior to being purchased or utilized.
2. Only accessories approved by the firearms committee may be attached. No modifications or alterations may be made to any Department-issued firearm other than grips approved by the firearms committee. No lettering, wording, or permanent alterations may be added to the firearm.
 - a. The Department may purchase equipment for task force officers at the firearms committee's discretion.
3. Red Dot Sights (RDS)
 - a. The firearms committee must approve all RDS systems.
 - b. Optics and approved retention devices will be purchased by the individual officer. Reimbursement requests will not be authorized. The Department is not liable for damage to officer purchased items. All officer purchased equipment remains the property of the officer.
 - c. Officers wishing to carry a Red Dot Sight system on their issued handgun must first complete an approved in-house, or other department approved RDS or Pistol Mounted Optic (PMO) specific training course and qualify with their weapon using the RDS prior to carrying the weapon.

- d. RDS systems must be installed by a qualified armorer. Any maintenance will be the sole responsibility of the individual officer.
- e. Iron Sights:
 - 1) Iron sights must co-witness through the optic window and be useable in the event of an optic or battery failure.
 - 2) Officers approved to carry RDS system must also demonstrate proficiency with the use of their back-up iron sights during the required transitional training course. Officers must qualify with both RDS and iron sights (Optic off).

D. Maintenance and Inspection of Firearms

- 1. Employees authorized to carry Department-issued firearms will be trained and responsible for the routine care, cleaning, and maintenance of firearms.
 - a. Repairs will be made by a Department-certified armorer or their designee.
- 2. All Department-issued firearms will be inspected annually by a Department-certified armorer, and the inspection will be documented.
- 3. If a Department-issued firearm or related equipment is lost, stolen, or otherwise unusable, it must be immediately reported to a Firearms Instructor and a supervisor. For lost or stolen firearms, the employee must notify local law enforcement or staff of the Department's Investigations Bureau for NCIC entry. A replacement can be issued and an employee does not need to re-qualify with the replacement if it is of the same make, model, generation, and caliber as the original.

VI. CLOSING

Questions about this policy should be directed to the Firearms Committee.

VII. REFERENCES

- A. 45-8-316, MCA; 45-8-328, MCA; 45-8-356 MCA
- B. *Montana Operations Manual, Permitted Conceal Carry Firearm Policy*
- C. *DOC 1.1.6 Priority Incident Reporting and Acting Director*

VIII. FORMS

<i>DOC 3.1.31 (A)</i>	<i>Firearms Qualification</i>
<i>PPD 1.1.600 (A)</i>	<i>Incident Report (P&P)</i>



POLICY DIRECTIVE

Policy:	DOC 3.1.32 ELECTRONIC MONITORING SYSTEM (EMS)	
Effective Date:	07/01/2008	Page 1 of 3
Revision Date(s):	07/07/2016; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department monitors certain offenders through use of electronic technology as a cost-effective means to hold them accountable for their behavior, prioritize the use of valuable state and local resources, and provide a viable alternative to incarceration when appropriate.

II. APPLICABILITY

Divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Offender Participation

1. After July 1, 2005, a sentencing judge is required to sentence all tier level 3 sex offenders to participate in continuous satellite-based monitoring as a condition of probation, parole or conditional release.
2. The Board of Pardons and Parole or the sentencing court may order an offender to be placed on satellite-based monitoring as a condition of probation or parole.
3. The Department may require an offender to be supervised using electronic monitoring as a condition of conditional release, juvenile parole, or in order to participate in certain programs including, but not limited to, living at the Montana State Prison work dorm.
4. The Community Corrections Facilities and Programs Chief may require offenders to participate in a sanction or the Intensive Supervision Program (ISP) using radio frequency monitoring.

B. Residence Plan

1. Community corrections facilities will establish requirements for a residence plan for offenders under electronic monitoring that include, but are not limited to:
 - a. residence location and telephone services;
 - b. orientation to EMS features and limitations; and
 - c. supervisory inspections and monitoring.
2. Department residential work and prerelease programs will establish orientation and supervision requirements for offenders using electronic monitoring devices.

C. EMS Orientation/Activation

1. Supervising officers will require offenders to review and sign the conditions of the EMS and any other appropriate forms (for example, schedules, itineraries, etc.)

2. If the offender's circumstances are incompatible with the EMS, the supervising officer may order any necessary changes to the offender's case plan.
3. P&P Officers will conduct an offender orientation, including but not limited to:
 - a. EMS background information;
 - b. oral and written instructions for the proper maintenance and operation of the EMS equipment;
 - c. proper conduct while the offender is participating in the EMS (see IV.D below); and
 - d. an opportunity for offender questions.
4. For satellite-based monitoring, all applicable restrictions and limitations including exclusion zones must be clearly defined and the offender must acknowledge, in writing, that the offender understands the nature and limitations of each as well as the possible consequences for violating the determined boundaries.

D. Offender Conduct and Responsibilities

1. Offenders are expected to know, understand, and comply with the requirements of the EMS.
 - a. These requirements will be reviewed with the offender at the time of activation and include, but are not limited to:
 - 1) for satellite-based monitoring, all restrictions and limitations, including exclusion zones;
 - 2) proper maintenance and operation of all EMS equipment;
 - 3) disciplinary action for potential violations; and
 - 4) any schedule itinerary requirements.
2. Offenders must notify their supervising officer of emergencies, equipment failures, itinerary changes, host or residence problems, and any and all other situations that may affect their status on the EMS.
3. To prevent possible collaborated tampering and/or evasion efforts, offenders participating in the EMS are not allowed to contact or reside with other EMS participants unless approved by their supervising officer.

E. EMS Supervision

1. The supervising officer must perform an onsite field test of the proposed residence, prior to residence plan approval, to ensure that the EMS technology can properly function in the geographical location.
2. For RF monitoring, the level of offender supervision is determined by the conditions of their sanction in the Intensive Supervision Program.
3. The administrator will establish criteria for levels of supervision for offenders on satellite-based monitoring.

F. Violations

1. The supervising officer must investigate the following occurrences:
 - a. equipment tampering;
 - b. for satellite-based monitoring, violation of restrictions or limitations such as exclusion zone boundaries;
 - c. power and/or equipment failure;
 - d. damage or theft of the EMS equipment;
 - e. evidence of willful evasion of the tracking system;
 - f. violation of other predetermined stipulations;
 - g. failure to pay the cost of services; and
 - h. any other suspicious or abnormal occurrences.

2. If a violation alert is received, the supervising officer will:
 - a. attempt to contact the offender by telephone or by personal contact to resolve the alert and/or discuss how to avoid future alerts;
 - b. go to the offender's residence to determine the cause of the alert, if necessary;
 - c. alert authorities, supervisors, and victims if the alert is confirmed as a violation, if necessary; and
 - d. review the violations with the appropriate supervisory staff and write a violation report when appropriate.
3. Alerts that result in violation may be cause for sanctions or termination of the violating offender from the EMS.
4. Equipment reliability is crucial to the success of the program; frequent non-violation alerts (for example, equipment failure, system interruption, power outage, etc.) may indicate that:
 - a. either the offender or the offender's residence is unsuitable for the EMS; and
 - b. termination from the EMS may still be an option.
5. For offenders on **satellite-based monitoring**, the following are grounds for immediate termination from the EMS:
 - a. exclusion zone violations involving victims or their families;
 - b. re-incarceration;
 - c. violation reports; or
 - d. sanctions.

G. Records/Reports

1. The monitoring service company or vendor is required by contract to provide records and reports to the Department. The supervising officer will maintain these records and reports.

H. Victim Notification

1. Victims who have registered for notification through the Department must be notified before the offender is released to, and released from, EMS.
2. Depending on the victim's desired involvement, reasonable measures will be taken to keep the victim informed of offender movements within exclusion zones.

I. EMS Termination

1. Offenders may be terminated from the EMS for the following:
 - a. their length of sentence has been completed;
 - b. their place of residence is no longer suitable for EMS and a suitable replacement cannot be found;
 - c. they have serious or repeated violations;
 - d. their violations returned them to a high level of custody; or
 - e. they have fulfilled the requirements of EMS participation.
2. If an offender is terminated from the EMS, it is the offender's responsibility to arrange to return all EMS equipment to the supervising officer. Failure to do so is criminal theft.

V. CLOSING

Questions about this policy should be directed to appropriate administrator.

VI. REFERENCES

- A. §§ 46-18-202; 46-18-206; 46-23-509; 46-23-1010; 46-23-1031, MCA
- B. ARM 20.7.402
- C. DOC 1.8.1 Victim Services



POLICY DIRECTIVE

Policy:	DOC 3.1.33 RADIO COMMUNICATION SYSTEMS
Effective Date:	03/12/2001 Page 1 of 2
Revision Date(s):	07/25/2016; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

The Department maintains radio communication systems for effective internal and external staff communication in accordance with standards set by the Federal Communications Commission, Montana Code Annotated, and the Montana Department of Administration, Public Safety Services Bureau.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and Department employees at contract facilities.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The personal safety and security of staff, offenders, and communities are dependent on Department staff properly using established radio communication systems.
2. Department staff must:
 - a. be appropriately trained;
 - b. understand communication procedures and protocols; and
 - c. maintain serviceability and accountability of assigned communication systems.
3. Department staff who have been trained and certified by the Department approved radio vendor or who received specialized training will provide maintenance or programming of radios.
 - a. Approved vendors will provide maintenance and programming at the discretion of the Department Radio System Manager (DM).
4. All divisions will use *DOC 3.1.33A Radio System Logistic Support* for maintaining radio system components.

B. Responsibilities

1. Administrators are responsible for the following:
 - a. developing and maintaining processes in accordance with this policy;
 - b. assigning a local radio system manager (LM); and
 - c. ensuring Department staff are properly trained on assigned communication systems.
2. Responsibilities of the DM include:
 - a. ensuring all divisions, facilities, and programs adhere to applicable policy and procedure requirements;
 - b. maintaining necessary radio documents (for example, inventories, programming information, MOUs, code plugs) in a secure central repository;

- c. providing required reports to the Department Director and management team;
 - d. coordinating budget, inventory management, and procurement with the Information Technology (IT) Chief Information Officer; and
 - e. immediately reporting to the state system administrator any loss of a radio, base station, or console.
3. Responsibilities of the LM include:
- a. collaborating with the DM and division, facility, or program security personnel regarding radio issues and management strategies;
 - b. properly accounting for equipment by item, serial number, and location;
 - c. ensuring each employee issued a radio reads, understands, and signs a *Radio Equipment Issue Agreement* prior to issuance;
 - d. maintaining copies of signed *Radio Equipment Issue Agreement* forms;
 - e. maintaining an accountability inventory of radio equipment (excluding accessories, for example, headsets and microphones) to document equipment;
 - f. completing an inventory of all radios each January and submitting the inventory to the DM; and
 - g. maintaining and submitting to the DM all radio-related documents.
4. Department employees must immediately report any missing, lost, or inoperable radio equipment to their division, facility, or program LM.
- a. The LM will notify the DM or IT Chief Information Officer and provide the type of radio equipment, serial number, last known user, and last known location.

C. Radio Communication Standards

1. Radio communication system standards include:
- a. selected Department leadership will have access to the appropriate statewide mutual aid channels;
 - b. personal two-way radios and walkie-talkies are prohibited unless approved in writing by the DM;
 - c. "plain talk" is the standard form of verbal communication;
 - d. call signs are assigned to radios and base stations; and
 - e. use of 24-hour military time in radio communications

V. CLOSING

Questions about this policy should be directed to Department IT.

VI. REFERENCES

- A. §§ 2-15-112; 2-17-544; 2-17-545; 53-1-203, MCA
- B. DOC 3.1.33A *Radio System Logistic Support*

VII. FORMS

Radio Equipment Issue Agreement



POLICY DIRECTIVE

Policy:	DOC 3.1.33A RADIO SYSTEM LOGISTIC SUPPORT	
Effective Date:	08/27/2012	Page 1 of 5
Revision Date(s):	07/25/2016; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. PURPOSE

The purpose of this policy is to establish the repair and maintenance process and responsibilities for the Department radio system.

II. DEFINITIONS (see Glossary)

III. APPLICABILITY

All divisions, facilities, and programs Department-owned and Department employees at contract facilities.

IV. REQUIREMENTS

A. General Requirements

1. Department communications are integrated with the statewide public safety radio communications system that is connected through a high-capacity protected digital microwave network.
 - a. The Department also lends and receives mutual aid assistance across jurisdictional boundaries during emergency response incidents that exceed local resources.
 - 1) In addition, the Department works closely with local law enforcement agencies and dispatchers to ensure officer safety.
2. Divisions, facilities, and programs will obtain repair and maintenance services for radio equipment due to normal wear and tear, environmental events, technological issues, and human error.
3. Replacement costs of any subscriber units (portable handheld and mobile) that are not funded through the central fund are the responsibility of the division, facility, or program.

B. Operations

1. Administrators and Local Radio System Managers (LMs) are responsible for the repair, programming, and/or replacement of any subscriber units (portable handheld and mobile).
 - a. LMs may ask Central Office to evaluate sharing the cost for upgrades, repairs, or new infrastructure equipment (repeaters, consoles, and base stations).
 - 1) The request must address the criticality of need and why the division, facility, or program cannot internally fund the repair or purchase of equipment.
2. All code-plugin development, radio programming, and re-programming must be coordinated with and approved by the Department Radio System Manager (DM) to ensure integration and interoperability.
3. There are two separate repair processes for the radio system: one for radio subscriber units and another for infrastructure equipment. Both processes are outlined below.
 - a. Radio subscriber units:

- 1) When an issue is identified, the LM submits the radio to a local, certified servicer (see *Attachment A: Approved Vendor List*) for repair, or requests service using the internet.
 - a) This will generate a service request and tracking number.
 - 2) The LM ships the radio to the servicer and may track the repair order.
 - 3) If the returned unit is new, the LM will ensure the updating of inventories and notify the DM in writing of the event and the radios involved (including the replaced and new radios' models and serial numbers).
 - 4) The DM will ensure the replaced unit is removed from the tracking system and a tracking ID is assigned to the new unit and entered into the trunking management system.
 - 5) The LM will:
 - a) check the firmware level on all returned units and update the inventory as necessary; and
 - b) work with the DM and local vendor to ensure the appropriate code plug and encryption keys are loaded on the returned radio and test its functionality prior to reissuing.
 - 6) If the replaced unit was trunking compatible and enabled, the DM will ensure that it is removed from the Master Controller and the new unit is added.
 - b. Infrastructure:
 - 1) When an issue is identified, the LM initiates a service request with a local, certified servicer (see *Attachment A: Approved Vendor List*). The LM will coordinate a repair and/or replacement plan with the selected servicer. This may include the shipment of the equipment to the servicer.
 - 2) The LM will work with the DM and local vendor to ensure appropriate code plug and encryption keys are loaded on the equipment and test its functionality prior to reissuing.
 - 3) If the returned unit is new, the LM will ensure inventory documents are updated accordingly.
4. Excess or unusable supplies will be turned into the DM for disbursement or disposal.

C. Future Reprogramming and Code-Plug Development Needs

1. As divisions, facilities, and programs use radios, it is anticipated that functions will need to be added and deleted.
 - a. The LM will work in conjunction with the DM to coordinate the new code-plug development and re-programming actions.
2. At no time are staff permitted to develop a new code-plug or reprogram any subscriber unit or infrastructure equipment without prior approval of the DM.

D. Equipment and Accessory Ordering

1. Nothing herein diminishes the State of Montana and/or Department procurement rules.
 - a. In the event of any discrepancy, the State of Montana and Department procurement rules supersede the requirements below.
2. Equipment: LMs may order equipment (subscriber units and infrastructure) under the following conditions:
 - a. Any purchase order request or pro-card purchase must first be reviewed and approved by the administrator prior to a procurement attempt.
 - b. Equipment will meet Original Equipment Manufacturer (OEM) specifications.
 - 1) Repair and/or replacement of equipment with other than OEM items is strictly prohibited and can result in item(s) not being allowed integration into the radio system.
 - c. The LM will annotate the new equipment on their inventory which is to be maintained in the Department Intranet Facility Radio Management folder.
 - d. All purchases of infrastructure or subscriber units must be reported to the DM.

3. Accessory purchases: LMs may order accessories under the following conditions:
 - a. Accessories will meet OEM specifications as outlined by manufacturer product specification data sheets.
4. It is preferred that the organization order through a certified Motorola servicer; however, it is not required as some items, such as replacement batteries, are provided by other companies at a lower cost in certain instances.

V. REFERENCES

- A. §§ 2-15-112; 2-17-544; 2-17-545; 53-1-203, MCA
- B. MOM 335, *Capital Asset Accounting*
- C. DOC 3.1.33 *Radio Communication Systems*

VI. ATTACHMENT

- A. DOC 3.1.33 *Attachment A: Approved Vendor List*



ATTACHMENT A: APPROVED VENDOR LIST

1. Capital Communications (Gary Schmidt)
783 Carter Drive
Helena, MT 59601
406.422.1220
Website: capphanes.com
2. Centanna Communications (Gil Lehfeldt/Quincy Goodberry)
115 West Aztec Drive
Lewistown, MT 59457
406.538.8233
Email: centana(at)middrivers.com
3. Comtech (Mark Cosner)
33 Lower Valley Road
Kalispell, MT 59901
406.752.8822
Email: comtechlmc(at)centurytel.net
4. Dunne Communications (Tom Dunne)
204 East Commercial
Anaconda, MT 59711-2324
406.563.7115
Email: Tpdunne(at)rfwave.net
5. Highline Communications (Steve McKelvey)
N 202 Central
Cutbank, MT 59427
406.873.2984
Email: highcomm(at)theglobal.net
6. Industrial Communications Electronics (Thomas Miller)
PO Box 31632
Billings, MT 59107
406.259.1212
Email: brian.hamilton(at)icemt.com
7. Industrial Communications & Electronics (Kristi Harper)
406 Bryant St.
PO Box 4437
Bozeman, MT 59715
406.585.7780
Email: kristi.harper(at)icemt.com
8. Montana Electronics (Dale Hickman)
1314 N Russell
Missoula, MT 59802
406.721.2255
Email: angh(at)meco-opp.com
9. Mountain Communications (Max Pangburn)
406 Bryant Street

Bozeman, MT 59715
406.228.8203
Email: maxp(at)mountaincom.com

10. Priority Communications (Eric Seyfert)
200 2nd Avenue South
Glasgow, MT 59230
406.228.8203
Email: priority(at)nemontel.net

11. TAB Electronics (Bob Brenner)
PO Box 1346
Glendive, MT 59330
406.365.4310
Email: tabelect(at)midrivers.com

12. Western Electronics (Al Kale)
PO Box 7036
Kalispell, MT 59904
406.257.1953
Email: alkali(at)digisys.net



POLICY DIRECTIVE

Policy:	DOC 3.1.35 BODY SCANNERS	
Effective Date:	05/24/2021	Page 1 of 2
Revision Date(s):	07/19/2023; 07/01/2025	
Signature/Title:	/s/ Brian Gootkin, Director	

I. PURPOSE

Department secure facilities with the capability will utilize electronic body scanners to provide a safer and more secure environment by detecting contraband in the possession of those in custody and by preventing the introduction of contraband into secure facilities.

II. APPLICABILITY

All Department secure facilities.

III. DEPARTMENT DIRECTIVES

A. General Requirements

1. Inmates, employees, visitors, volunteers, and service providers may be required to go through a body scanner at facilities with the capability in place.
2. Body scanners will only be used for legitimate purposes pertaining to the safety and security of the institution and will not be used as a form of harassment, embarrassment, or punishment.
3. The use of body scanners may be utilized in addition to, or instead of, a clothed or unclothed body search.
4. Saved images will be utilized solely for investigative or training purposes, confirmation of contraband, etc., and should be preserved as necessary.
5. Cross-gender body scans of inmates, employees, visitors, volunteers, and service providers are prohibited, except in exigent circumstances. When the full-body scanner is used in exigent circumstances, staff will document the reason for the cross-gender body scan.
6. Cross-gender viewing of saved images is prohibited except during exigent circumstances for investigative purposes, confirmation of contraband, etc. Cross-gender viewing of saved images will be documented.
7. Those persons unable to be scanned due to physical limitations will be searched by other means to ensure contraband does not enter the facility.
8. If a technical error occurs during the scanning process, a person may be required to be rescanned until a proper image is captured.
9. The Department will ensure body scanner exposure and limitations comply with the American National Standards Institute/Health Physics Society standards.
10. Wardens will ensure the location/relocation and operation of body scanners are in compliance with the manufacturer's recommendations and safety specifications.
11. Wardens will ensure:
 - a. only qualified personnel perform maintenance on body scanners;

- b. all maintenance is in accordance with manufacturer's specifications; and
- c. maintenance records are properly maintained.

B. Training

1. Each operator will be provided training on the operation and use of the body scanner in accordance with the manufacturer's specifications. All training records will be maintained by the Department's Training Unit.
2. Operators will be provided annual radiation safety training.
3. All employees will be provided with an annual basic radiation awareness training.

C. Scanning of Inmates

1. Staff will ensure the necessary identifying information for inmates scanned is entered into the scanner console.
2. Each inmate will be instructed on the proper manner in which to enter the body scanner for scanning. No property shall be allowed in the scanner at the time of the scanning.
3. The operator will ensure that any bystander is outside of the inspection zone.

D. Scanning of Employees

1. In accordance with *DOC 1.3.15 Americans with Disabilities Act*, any employee with physical limitations that do not enable the employee to stand independently without an assistive device, or any employee who is otherwise unable to independently transfer into the body scanner, will not be scanned. Employees unable to be scanned due to physical limitations may be searched by other means to ensure contraband does not enter the facility.
2. No forcible body scans of employees will be conducted. Any employee who refuses to submit to a body scan may be subject to disciplinary action, to include termination.
3. If an employee refuses to submit to a body scan, and there is reasonable suspicion to believe the employee may be concealing contraband, see *DOC 3.1.5*.

E. Scanning of Visitors, Service Providers, and Volunteers

1. At the discretion of the Warden or designee, visitors, service providers, and volunteers may be denied entry for refusing a body scan.
2. If contraband is detected during the scanning process (an object is clearly identifiable as a weapon, drugs, or other contraband), the contraband will be confiscated and the visit terminated.
3. Visiting terminations, suspensions, or revocations will be handled in accordance with *DOC 3.3.8 Offender Visiting*.

IV. CLOSING

Questions about this policy should be directed to the Warden.

V. REFERENCES

- A. *The American National Standards Institute/Health Physics Society (ANSI/HPS)*
- B. *DOC 1.3.15; DOC 3.1.5; DOC 3.3.8; DOC 3.3.15*



POLICY DIRECTIVE

Policy:	DOC 3.1.37 BODY WORN CAMERAS	
Effective Date:	03/31/2026	Page 1 of 5
Revision Date(s):		
Signature/Title:	/s/ John Schaffer, Public Safety Chief	

I. POLICY

Establish proper use guidelines for Probation and Parole (P&P) officers and facility staff members employed by the Department utilizing Body Worn Cameras (BWCs) and requirements for the management and retention of the information and evidence created by these recording devices.

II. DEFINITIONS (see Glossary)

III. APPLICABILITY

All Department, division, and facility staff members whose responsibilities include the use of a BWC in the formal execution of their duties as defined by their employment with the Department.

IV. GENERAL REQUIREMENTS

A. Department Use of BWCs

1. It is the policy of the Department to use BWCs to effectively and accurately document interactions with offenders, with due consideration for individual privacy interests, officer and public safety, and constitutional rights.
2. Any features related to Department approved BWCs that may become available in the future will be assessed to determine if there is an appreciable impact on working conditions.
 - a. No features impacting working conditions will be implemented until negotiated with the Montana Federation of Public Employees DOC Consortium and approved through this policy.

B. Training

1. The Department shall ensure that all personnel who operate or perform functions in support of the authorized use of BWCs and BWC data and data integrity have received all appropriate training in the use and maintenance of BWCs and all relevant requirements.
2. Training shall take place prior to the Probation and Parole officer's, or facility staff member's use of the BWC or accessing BWC data.
3. The Department shall document the completion of all requisite training and refresher training.
4. At minimum, training shall include:
 - a. BWC operation and maintenance;
 - b. proper handling, storage, use, and dissemination of BWC data;
 - c. compliance with privacy requirements, Freedom of Information Act (FOIA) policy, and when appropriate, the correct practices for redacting, sharing, and disclosing data originating from the BWC;
 - d. mandatory, optional, and non-permissible uses of the BWC and BWC data;
 - e. officer and public safety considerations when wearing BWCs;
 - f. laws, regulations, and policies governing the use of BWCs; and

- g. relevant civil rights and civil liberties considerations, as applicable.

C. BWC Use Guidelines

1. BWCs shall be made available to eligible P&P officers and staff members trained in their use.
2. P&P officers and facility staff members who are expected to wear and utilize a BWC during the normal course of their duties may remove the BWC or power down the BWC in circumstances where passive or active recording would unreasonably infringe upon a person's right to privacy, including, but not limited to:
 - a. using sanitary facilities;
 - b. meeting with supervisors;
 - c. in the office; and
 - d. while riding in a state vehicle with other state employees, unless they are transporting an offender.
3. P&P officers and facility staff members utilizing a BWC must use the system consistent with applicable laws, their training, and Department requirements.
4. The BWC shall be worn above the middle torso in a place that allows for efficient recording.
 - a. Members of a Specialized Response Team (SRT) or a Cell Extraction Team may wear the BWC in another position best suited for tactical advantage and providing the clearest view of the event, with a preference for helmet placement.
5. P&P officers, facility staff members, and Department employees shall not intentionally obstruct the view of the camera or interfere with the audio recording functions of the BWC.
6. When equipped, the BWC should be powered on and remain in passive mode until a qualifying event occurs, at which point it should be switched to active recording mode.

D. Active Recording and Mandatory Recording of Qualifying Events

1. The BWCs must be manually activated to begin recording both video and audio.
 - a. The BWCs are also automatically triggered for activation by drawing the following:
 - 1) the firearm from the officer's holster with Signal Sidearm™, if equipped; and
 - 2) a TASER.
2. When a qualifying event occurs, the P&P officer or facility staff member is required to activate the BWC and begin recording.
3. P&P officer qualifying events include, but are not limited to:
 - a. conducting arrests and serving warrants;
 - b. conducting field interactions with offenders;
 - c. conducting collateral interactions in the field;
 - d. during meaningful office interactions with offenders, family members, etc.;
 - e. performing compliance checks or searches of an offender's residence;
 - f. providing assistance to another law enforcement agency; and
 - g. providing public safety assistance to the general public.
4. Facility staff member qualifying events include, but are not limited to events involving either suspected or evident misconduct and prohibited activities:
 - a. while on the floor of a unit;
 - b. in the dining area;
 - c. during any activity involving use of force;
 - d. any planned use of force;
 - e. during any activity or interaction in which physical contact with an offender may occur;
 - f. gym or yard supervision;
 - g. searches, crime scene preservation, and physical evidence collection; and
 - h. any contact with an inmate that might suggest an anticipated or known need to record.

E. Transport and Hospital Duty

1. P&P Officers and facility staff members escorting or transporting an offender, or while on a hospital duty rotation, must ensure the BWC remains in passive recording mode unless a qualifying event necessitates activation.

F. Passive Recording General Guidelines

1. Department BWCs are designed to passively record video.
 - a. Passive video recordings are stored on the camera and are not transferred to Department contracted storage.
 - b. No audio recording will occur without the recording system being activated.
2. BWC passive recording capacity is a rolling 18 hours of video data, without audio recording.
3. Reviewing passive recording data at officer request:
 - a. P&P Officers will be able to request access to passively recorded information in order to assist with, but not as a primary tool in, writing a report about an incident; and
 - b. Facility staff members wearing body cameras will not have access to any recorded data from the BWC system.
4. P&P officers who want to review their passive recordings for a justifiable purpose may submit a request for review through their immediate supervisor.
5. Passive recording must be downloaded using the View XL™, or equivalent desktop application and may not be viewed or downloaded remotely.

G. Reviewing Passive Recording Data for Department Interest

1. Passive recording data will only be accessed and reviewed with the authorization of the Warden or Associate Warden or designee, Operations Manager, P&P Major, the Public Safety Chief or designee, or higher.
2. Recordings will only be accessed and reviewed for legitimate purposes, including but not limited to a public safety threat, or:
 - a. to address an identified training opportunity; and
 - b. other purposes and circumstances as determined by the Warden, Associate Warden, or designee, Operations Manager, P&P Major, or Public Safety Chief or designee or higher.
3. The Department shall exercise discretion and confidentiality when undertaking a criminal investigation relating to incidents involving an employee in order to ensure the integrity and impartiality of the investigation.
 - a. P&P officers and staff who are part of an active criminal investigation shall not receive notification prior to the Department accessing video and audio records from devices such as the BWC in furtherance of the investigation; and
 - b. information related to a criminal investigation shall be disclosed only with the approval of the Warden or Associate Warden or designee, Operations Manager, P&P Major, or the Public Safety Chief or designee and in accordance with *DOC 3.1.19 Investigations*.
4. Employees, P&P officers, or facility staff members who are involved in activities captured by passive recording will be notified when the department intends to review the recording and they may be present during the access and review of the recording.
 - a. If there is a public safety emergency that requires immediate review of the recording, and the employee, officer, or staff member is not immediately available, the Department may download, review, and use the information from the review.

H. When Not to Record with a BWC

1. An officer or facility staff member shall not record when:
 - a. Officer, facility staff member, or citizen safety would be jeopardized by activating a recording device.
 - b. Engaged in tactical, command, or strategic planning.
 - c. The recording may capture any confidential privileged discussions, including attorney/client privilege for any person, including other Department employees.
 - d. The officer is in a location where individuals have a reasonable expectation of privacy, for example, staff-only restrooms, locker rooms, etc.
 - e. There is an articulable threat to the officer, the facility staff member, or public safety concern in which recording would unnecessarily delay response to a priority incident.
 - f. Attending community events, public meetings, gatherings, or general assemblies, unless the P&P officer believes a crime has been or is about to be committed or there is another qualifying circumstance that necessitates recording.
 - g. During urinalysis or unclothed searches, P&P officers and facility staff members will not record an offender.
 - 1) an unclothed search may be recorded at the request of the offender.
 - h. Facility staff members and P&P officers are prohibited from using the BWC to record minors who are in a state of undress or undergoing an unclothed body search, unless other factors are present that require video documentation.
 - 1) in the event that a minor is captured in an unclothed state, any video footage of a minor in such a state may only be reviewed by staff of the same gender, and reviewers must obtain authorization from a Lieutenant or higher prior to viewing.

I. Review or Use of Recordings

1. With approval, P&P officers may review recordings that capture the officers' own perspective (for example, location) prior to preparing written reports, testifying in any court proceeding, or being interviewed during an investigation. This excludes internal or criminal investigations.
2. P&P officers and facility staff members shall not review another officer's recordings.
3. P&P officers and facility staff members may not rely on the existence of a recording to write reports that do not appropriately document the circumstances.
4. Recordings may be used for training purposes as approved by a Warden or designee, Bureau Chief or designee, or the Public Safety Chief or designee.
5. Recordings shall never be used for any purpose outside of a legitimate Department need, and as defined in this policy .
6. Upon reviewing BWC footage for any reason, the officer, staff member, or employee initiating access to the data must enter a comment into the comment box clearly describing the justification for reviewing the data.
7. The personal use, possession, or distribution of a recording obtained during an officer's duties is prohibited without Department approval.
8. Video recordings that capture minors are subject to rigorous security protocols and restrictions. Only authorized investigators or senior administrators of the same gender may access such footage unless it is part of an official sexual abuse investigation, in which case access is subject to strict oversight.
9. In cases where a BWC recording captures an offender in a state of undress, facility staff members are required to follow applicable review protocols in *DOC 3.1.3 MSP Logs and Record Keeping Systems*. Any cross-gender staff viewing such content must document the review in the *PREA Cross-Gender Camera Viewing Logbook*.

J. Release of Recordings

1. A public request for release of video will be evaluated on a case-by-case basis and will be approved or denied in compliance with the FOIA, the Montana Public Records Act, and any other relevant state or federal law, case law or court order. All requests will be responded to under consultation with the Department's Legal Services.
2. Routine requests for the release of evidentiary recordings that may contain Confidential Criminal Justice Information (CCJI) pursuant to Title 44, Chapter 5 of MCA, shall be processed in accordance with standard discovery processes.
3. Recordings of critical or sensitive incidents with considerable community interest or ramifications may be promptly or proactively disseminated at the discretion of the Department Director or designee, and upon approval of the release of CCJI by a District Court Judge.
 - a. Prior to the release of CCJI, the following should be considered:
 - 1) privacy rights of all involved individuals;
 - 2) the public's right to know;
 - 3) impact on any court proceedings related to the incident; and
 - 4) community benefit of releasing the recording.

K. Deleting, Editing, and Redacting Recordings

1. No Department employee shall have sufficient system permissions to delete any recording. Recordings shall only be deleted per the established retention schedule in accordance with *DOC 1.5.20 Records Retention*.
2. Only the Director or their designee may authorize the editing or redaction of BWC audio or video data and must do so under the guidance of Department legal counsel, and in accordance with all applicable laws and Department policies.
3. Any editing, clipping, and/or redacting of BWC data shall only be performed on a "child file" and never to the "parent file" or recording.
4. Editing, clipping, and/or redacting will only be performed:
 - a. in coordination with the relevant prosecuting attorney if a criminal case is involved; or
 - b. with coordination of the Montana Attorney General's Office.

L. Maintenance and Inspection of BWCs

1. All P&P Officers, and facility staff members who are trained and authorized to wear a BWC are responsible for routine care, cleaning, and maintenance of the BWC.
2. All Department-issued BWCs will be inspected on a recurring schedule to ensure proper operation.
3. If a Department-issued BWC is lost, stolen, or damaged so as to render it unusable, the P&P officer, or facility staff member shall report the issue immediately to a supervisor.

V. CLOSING

Questions about this policy should be directed to the Public Safety Chief or designee.

VI. REFERENCES

- A. *DOC 1.5.20 Records Retention; DOC 3.1.19 Investigations; DOC 3.1.3 MSP Logs and Record Keeping Systems*
- B. *44-5-303, MCA*



POLICY DIRECTIVE

Policy:	DOC 3.2.1 EMERGENCY MANAGEMENT
Effective Date:	11/18/2009 Page 1 of 3
Revision Date(s):	12/23/2016; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

The Department will ensure that a plan for continual prevention and preparedness for emergencies be maintained. The Department Emergency Preparedness Program will be compatible with the National Incident Management System (NIMS) and the National Incident Command System (ICS) set forth by the Department of Homeland Security and Montana Disaster and Emergency Services.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General

1. The Department Emergency Preparedness Manager (EPM) will maintain a *Department Emergency Operations Plan (DEOP)* that provides a comprehensive emergency management program to comply with NIMS and a means to meet the following goals:
 - a. use available resources;
 - b. mitigate or prevent potential emergencies or disasters whenever possible;
 - c. prepare to deal efficiently with the effects of inevitable events;
 - d. respond to needs and save lives;
 - e. ensure the protection of communities and property; and
 - f. promote a means to recover rapidly from damages.
2. Emergency responses will:
 - a. isolate and contain emergency situations as quickly as possible;
 - b. establish control and restore order as quickly as possible;
 - c. maintain the safety of all persons;
 - d. minimize the impact of the emergency situation on the rest of the institution;
 - e. resolve violent or potentially violent emergencies without force when possible; and
 - f. prevent escapes during emergency operations.
3. The *DEOP* will define all hazard-specific plans, outline staff roles and responsibilities within the Department, and include the basic plan, relevant appendices, and hazard-specific appendices.
4. Each site must develop local processes that describe site-specific implementation activities that comply with this policy and the *DEOP*.
5. The emergency operations template will be used by all Department-owned and contracted facilities to ensure consistency and integration with the *DEOP*.
6. All Department and contract facilities and sites will develop a Continuity of Operations Plan. The plan may be independent of the site EOP or included as an appendix.

B. Responsibilities and Training

1. The administrator or designee is responsible for the following:
 - a. development of an EOP;
 - b. adhering to the standards set forth in the *DEOP*, NIMS, and Incident Command System (ICS);
 - c. identifying and designating a primary and alternate staff person as the Facility Emergency Management Coordinator;
 - d. ensuring emergency management coordinators coordinate emergency preparedness activities with the EPM;
 - e. ensuring facility Emergency Management Coordinators receive training to carry out their responsibilities;
 - f. providing contact information for the appointed emergency management personnel to the EPM; and
 - g. conducting an annual review of the EOP, documenting the review in writing, and providing results of the review to the EPM.
2. The EPM is responsible for:
 - a. developing and maintaining the *Department Emergency Operations Plan (DEOP)*;
 - b. ensuring Department-wide adherence to the NIMS and ICS;
 - c. monitoring compliance with the *Department of Corrections Exercise and Evaluation Program (DOCEEP)*;
 - d. providing the Director with monthly written reports of emergency preparedness activities, exercises, and progress reports;
 - e. establishing minimum training requirements for Facility Emergency Management Coordinators;
 - f. reviewing facility emergency plans on an annual basis; and
 - g. coordinating Central Office Continuity Planning in collaboration with the Department of Administration.
3. Facility Emergency Management Coordinators (EMCs) are responsible for but not limited to the following:
 - a. coordination of all phases of facility emergency management activities with the EPM;
 - b. developing and being the primary point of contact for facility EOP, Continuity of Operations Plans, Annexes, and Checklists;
 - c. development of the facility Incident Command Post operations capability as per the *DEOP*;
 - d. obtaining certification as a Department trainer on the Incident Command System or arranging for such training to be provided by a certified trainer;
 - e. planning and delivering or arranging individual and organizational training in accordance with the National Incident Management System, the *DEOP*, and other requirements;
 - f. coordinating facility exercise design, development, conduct, and evaluation activities in accordance with the *DOCEEP*;
 - g. conducting and/or coordinating post-incident damage assessments;
 - h. ensuring emergency planning documents are maintained in facility folders on the Department Emergency Preparedness Intranet Site;
 - i. providing monthly exercise activity reports to the EPM in accordance with the *DOCEEP*;
 - j. conducting an annual review of emergency plans and submitting plans to the EPM for review;
 - k. representing their facility at the quarterly Department Emergency Management Committee meetings or summits;
 - l. planning and executing their facility's emergency management budget; and
 - m. providing the EPM with emergency management operational plans as requested.

4. Staff will receive National Incident Management System training as outlined in the *DEOP* and maintain proficiency in its application.
5. Secure sites will establish an exercise program consistent with 3.2.1 (B) of the *DOCEEP*.

C. Role of Emergency Operations Center

1. After a Priority I incident as defined in *DOC 1.1.6 Priority Incident Reporting and Acting Director* occurs or is deemed to be imminent at any facility, the Director, Deputy Director, or designee may activate the Department Emergency Operations Center (EOC) in support of the affected facility. The EOC will;
 - a. provide logistical support and other assistance to the facility;
 - b. monitor the course of the emergency; and
 - c. notify and update other agencies within and outside the Department.
2. The Director, Deputy Director, or designee will serve as the EOC Incident Manager (IM) and will oversee resource coordination and support for each facility IC from the EOC as appropriate.

V. CLOSING

Questions about this policy should be directed to the Department Emergency Preparedness Manager.

VI. REFERENCES

- A. §§ 2-15-112; 7-33-2108; 10-3-101; 10-3-103; 10-3-104; 10-3-406; 10-3-703; 10-3-1203; 45-7-306; 53-1-203, MCA
- B. 42 U.S.C. Sections 5121-5206
- C. *Homeland Security Exercise and Evaluations Program (HSEEP)*
- D. *The National Preparedness Goal*

VII. FORMS

- DOC 3.2.1 (A) **RD** *Department Emergency Operations Plan (DEOP) – Restricted Access*
- DOC 3.2.1 (B) **RD** *Department of Corrections Exercise and Evaluation Program (DOCEEP) – Restricted Access*



POLICY DIRECTIVE

Policy:	DOC 3.2.2 RESPONSE TEAMS
Effective Date:	09/01/1998 Page 1 of 2
Revision Date(s):	03/01/2016; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

It is the policy of the Department to establish response teams capable of responding to situations that compromise safety and security.

II. APPLICABILITY

All secure facilities and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. All facilities will establish and maintain Initial Response Teams to meet the specific needs of the facility.
2. Facility processes must provide for isolation, containment, and control of situations during initial response, long term situations, and special situations such as hostage negotiation.
3. Each facility with a Specialized Response Team will develop written processes including the following:
 - a. a selection process for all team positions;
 - b. the number of required personnel for each team;
 - c. methods to ensure teams are available when needed;
 - d. methods for maintaining records of activations and operations;
 - e. a multi-year training and exercise strategy included in the facility's *Emergency Preparedness Training and Exercise Plan*; and
 - f. an organizational structure that includes, at minimum, a team commander and assistant team commander; team commanders will be responsible for maintaining the following records:
 - 1) an active member roster that includes 24-hour contact telephone numbers;
 - 2) member applications;
 - 3) qualification testing records and applicable certificates; and
 - 4) issued equipment.

B. Equipment and Training

1. Response teams will be equipped to perform their assigned tasks and provided personal protection while considering facility or program type, history and culture, and offender population profile in accordance with *DOC 3.1.7 Emergency Equipment and Armory Operations*.
2. All response teams will be trained appropriately for their assigned tasks in accordance with *DOC 1.4.1 Staff Development and Training*.

C. Response Team Assistance

1. A facility may request assistance to respond to situations from the Department as outlined in *DOC 1.1.6 Priority Incident Reporting*.

D. Mutual Aid Deployment

1. If an agency outside the Department requires response team assistance, the administrator must approve the mutual aid request.
2. The administrator will provide the Department Director a briefing regarding the details of the incident and deployment as soon as practical following deployment.
3. A written *After-Action Report* will be provided to the Department Director within 30 days of the activation.
4. The Director must review and approve all Department *Special Response Team Mutual Aid* agreements.

V. CLOSING

Questions about this policy should be directed to the Department Emergency Preparedness Manager.

VI. REFERENCES

- A. §§ 2-15-112; 53-1-203, MCA
- B. *DOC 1.1.6 Priority Incident Reporting; DOC 1.4.1 Staff Development and Training; DOC 3.1.7 Emergency Equipment and Armory Operations; DOC 3.1.31 Firearms*



POLICY DIRECTIVE

Policy:	DOC 3.2.3 AIRSPACE SECURITY
Effective Date:	09/01/1998 Page 1 of 2
Revision Date(s):	01/09/2012; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

It is the policy of the Department to establish criteria for airspace security.

II. APPLICABILITY

Secure facilities and programs Department-owned and contracted, as specified in contract.

III. REQUIREMENTS

A. General Requirements

1. Facility administrators will ensure operational requirements are implemented and maintained in compliance with this policy.
2. A facility administrator may clearly identify and mark aircraft landing areas outside the security perimeter with direct visual surveillance for emergency landings, rescue flights, and public official and media visits.
3. The shift commander will alert all perimeter staff and others with a need-to-know status in advance of any authorized aircraft landing at the facility.

B. Temporary Air Restrictions

1. The facility administrator may apply for temporary airspace restriction through the Federal Aviation Administration to protect persons or property from danger during disaster relief, or to prevent an unsafe congestion of sightseers and other aircraft above the site of an emergency.
 - a. The facility administrator will alert the Department duty officer and facility control centers, perimeter posts, and other appropriate individuals when temporary air restriction(s) is placed and/or canceled.

C. Emergency Landings

1. If an aircraft is attempting to land within the secure perimeter of a facility, staff will complete the following actions immediately:
 - a. alert the control center;
 - b. attempt to wave off the aircraft to discourage landing;
 - c. evacuate offenders and staff from the immediate area in accordance with *DOC 3.2.5 Internal Evacuations*;
 - d. treat the landing site as a crime scene and preserve evidence in accordance with *DOC 3.1.28 Crime Scene and Physical Evidence Preservation*;
 - e. render first aid and summon medical staff, if necessary;
 - f. ensure occupants are detained in accordance with *DOC 3.1.5 Secure Facility Entry and Exit*; and
 - g. notify law enforcement.
2. Staff will not fire upon the aircraft in the air or on the ground.

D. Unauthorized Entry into Airspace

1. Any staff who observe an aircraft flying close to the facility that is a potential threat to security will immediately notify the control center and communicate the following:
 - a. Identification Number of the aircraft (this number will start with an “N” in all aircraft except for military aircraft);
 - b. type, size, and color of aircraft;
 - c. location of aircraft in relation to the facility;
 - d. activities of aircraft (for example, attempting to land, hovering, circling);
 - e. number of persons on board;
 - f. number of offenders in close proximity to aircraft;
 - g. approximate altitude of aircraft; and
 - h. direction of flight.

IV. CLOSING

Questions about this policy should be directed to the Department Emergency Preparedness Manager.

V. REFERENCES

- A. §§ 2-15-112, MCA; 53-1-203, MCA
- B. *DOC 3.1.5 Secure Facility Entry and Exit; DOC 3.1.28 Crime Scene and Physical Evidence Preservation; DOC 3.2.5 Internal Evacuations*



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 3.2.5	Subject: INTERNAL EVACUATION
Chapter 3: FACILITY/PROGRAM OPERATIONS	Page 1 of 2
Section 2: Safety and Emergency Procedures	Effective Date: June 1, 2002
Signature: /s/ Mike Ferriter, Director	Revised: 09/19/11

I. POLICY

It is the policy of the Department of Corrections to establish guidelines for the internal evacuation of staff, visitors and offenders within correctional facilities.

II. APPLICABILITY

Department-owned and contracted facilities and programs, as specified in contract.

III. DEFINITIONS

Incident Commander (IC) – The individual with overall authority and responsibility for conducting all incident activities and managing all operations at the incident site.

Internal Evacuation – Organized, phased, and supervised withdrawal, dispersal, or removal of staff, visitors, and offenders from dangerous or potentially dangerous areas, and the relocation of those individuals in safe areas within the Department-owned property on which the incident occurred.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. Each facility will develop operational procedures for internal evacuations consistent with the guidelines established within this policy and related Department policies including [*DOC Policy 3.2.1\(A\), Emergency Operations Plan*](#).
2. The incident commander (IC) must authorize all internal evacuations unless an urgent situation with immediate threat to health and safety is present, at which time staff may initiate evacuations to prevent loss of life or great bodily harm to themselves or others.
3. Staff and offenders will utilize predetermined internal evacuation routes unless such routes present a clear and present danger to health and safety.
4. The IC will determine when visitors and/or staff will be permitted to leave the facility following an internal evacuation; each individual must be identified upon exit to prevent the escape of an offender.
5. Evacuated offenders will be maintained with the following provisions, when possible:
 - a. access to adequate sanitary facilities;
 - b. held in a secure area,
 - c. held in small, compatible groups;
 - d. held indoors; and
 - e. offenders who may be a threat to each other will be kept separated.

Policy No. DOC 3.2.5	Chapter 3: Facility/Program Operations	Page 2 of 2
Subject: INTERNAL EVACUATION		

B. Responsibilities

1. Responsibilities of the facility administrator, or designee, include:
 - a. ensure that primary and alternate evacuation routes and meeting areas are established and posted;
 - b. oversee development of plans for the complete evacuation of each living unit;
 - c. establish a plan for the alternate housing of offenders including:
 - 1) indoor and outdoor housing locations;
 - 2) maximum capacity for each location; and
 - 3) staffing requirements for each location.
2. Responsibilities of the IC, or designee, in the event of an internal evacuation include:
 - a. direct and manage all internal evacuations;
 - b. assign perimeter staff as necessary;
 - c. record the names of all staff members and ensure staff are accounted for;
 - d. initiate an emergency offender count;
 - e. coordinate efforts to locate missing visitors, staff, and/or offenders, when necessary; and
 - f. determine staff requirements.

V. CLOSING

Questions concerning this policy should be directed to the Department Emergency Preparedness Planning Manager.

VI. REFERENCES

- A. [2-15-112, MCA; 53-1-203, MCA](#)
- B. [DOC Policy 3.2.1\(A\), Emergency Operations Plan](#)

VII. ATTACHMENTS

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 3.2.6	Subject: EXTERNAL EVACUATION
Chapter 3: FACILITY/PROGRAM OPERATIONS	Page 1 of 2
Section 2: Safety and Emergency Procedures	Effective Date: June 1, 2002
Signature: /s/ Mike Ferriter, Director	Revised: 09/19/11

I. POLICY

It is the policy of the Department of Corrections to establish guidelines for the external evacuation of staff, visitors and offenders from correctional facilities.

II. APPLICABILITY

Department-owned and contracted secure facilities and programs, as specified in contract.

III. DEFINITIONS

External Evacuation – Organized, phased, and supervised withdrawal, dispersal, or removal of staff, visitors, and offenders from dangerous or potentially dangerous areas, and the relocation of those individuals in safe areas outside the Department-owned property on which the incident occurred.

Incident Commander (IC) – The individual with overall authority and responsibility for conducting all incident activities and managing all operations at the incident site.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. Each facility will develop operational procedures for external evacuations consistent with the guidelines established within this policy and related Department policies including [DOC Policy 3.2.1\(A\), Emergency Operations Plan](#).
2. An external evacuation may be authorized by the incident commander (IC), when lesser options are clearly inappropriate in response to a catastrophic incident that renders the facility entirely unsafe and/or unsecured.
3. Offenders evacuated from the facility will be counted and transported in accordance with [DOC Policy 3.1.12, Offender Escort and Transport](#).
4. Each facility will establish compatible groups of offenders for transport and housing based on security needs.
5. When conditions exist that exceed the resources of the facility and Department, the Department of Emergency Services will be contacted along with local mutual aid agreements to provide additional personnel, equipment, alternate housing, transportation, feeding, or other incident specific needs.
6. A clear transportation route will be established and assistance will be arranged along the route from local law enforcement and the Montana Highway Patrol.

Policy No. DOC 3.2.6	Chapter 3: Facility/Program Operations	Page 2 of 2
Subject: EXTERNAL EVACUATION		

B. Responsibilities

1. The facility administrator, or designee, will:
 - a. establish a priority list of possible external evacuation sites that include Department-owned and contracted facilities; and
 - b. determine the emergency short-term capacity of the facility.
3. The IC will:
 - a. determine the order of evacuation;
 - b. identify evacuation vehicles, vehicles must be equipped with a two-way radio and may include public, private, or Department-owned vehicles;
 - c. designate a transport team including trained staff and a team leader;
 - d. approve assigned weapons, when applicable;
 - e. ensure that medical staff maintain control of all drugs and controlled substances while in transport;
 - f. assign staff to the evacuated facility to provide security and prevent trespassing;
 - g. ensure that a damage assessment team conducts a survey of the facility to identify damage to the evacuated facility; and
 - h. prepare an action plan for reoccupation of the evacuated facility.

C. Records

1. When possible, offender records, including transport information, will be secured, maintained with confidentiality, and removed from the evacuated facility.
2. The facility administrator will develop a plan to protect facility records (particularly fiscal and personnel records), computer files, logs, and inventories including removal and storage of records to an alternate secure location.
3. When necessary, emergency equipment including firearms, ammunition, and chemical agents, not required during the evacuation will be secured at a site on or off facility grounds.

V. CLOSING

Questions concerning this policy should be directed to the Department Emergency Preparedness Planning Manager.

VI. REFERENCES

- A. [2-15-112, MCA](#); [53-1-203, MCA](#)
- B. [DOC Policies 3.2.1\(A\), Emergency Operations Plan](#); [3.1.12, Offender Escort and Transport](#)

VII. ATTACHMENTS

None



POLICY DIRECTIVE

Policy:	DOC 3.2.7 EMERGENCY PERIMETER SECURITY	
Effective Date:	06/01/2002	Page 1 of 2
Revision Date(s):	10/24/2011; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

It is the policy of the Department to respond quickly and efficiently to any incident that threatens the perimeter security of a facility.

II. APPLICABILITY

Department-owned and contracted facilities and programs, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Each facility will follow written requirements for maintaining perimeter security consistent with this policy, related Department policies, and plans including *DOC 3.2.1 (A) RD Emergency Operations Plan (Restricted Distribution)*.
2. Threats to perimeter security that may facilitate an escape or compromise facility security will be responded to and remedied as quickly as possible.
3. Threats include, but are not limited to, the following:
 - a. inclement weather resulting in reduced visibility;
 - b. unauthorized vehicles;
 - c. external assaults;
 - d. damage reducing perimeter visibility or the ability to contain offenders;
 - e. alteration to grounds that may aid in escape or concealment of an offender; and
 - f. placement of any object adjacent to or on grounds that may allow unauthorized entry into the perimeter or egress from the facility.
4. Whenever a member of the public is engaged in an attempt to breach perimeter security, law enforcement will be immediately notified; staff may arrest the person and may use reasonable force to detain the person until law enforcement takes custody of the person in accordance with 46-6-502, MCA.

B. Responsibilities

1. The facility administrator will:
 - a. designate trained staff members responsible for emergency perimeter security; and
 - b. establish emergency post locations to provide additional perimeter coverage and control vehicle traffic during an emergency.
2. The incident commander will:
 - a. in the event that adequate staff members are not available to maintain perimeter security, seek the assistance of local law enforcement and brief responding personnel;
 - b. establish and maintain operations; and
 - c. brief assigned staff members.

V. CLOSING

Questions about this policy should be directed to the Department Emergency Planning Manager.

VI. REFERENCES

- A. 2-15-112, MCA; 46-6-502, MCA; 53-1-203, MCA
- B. DOC 3.2.1 (A) RD Emergency Operations Plan (*Restricted Distribution*)



POLICY DIRECTIVE

Policy:	DOC 3.2.8 FACILITY LOCKDOWN
Effective Date:	06/01/2002 Page 1 of 2
Revision Date(s):	01/03/2012; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

It is the policy of the Department to establish processes for securing offenders in a facility lockdown to limit offender movement and activity in order to contain an emergency.

II. APPLICABILITY

Department-owned and contracted secure facilities and programs, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Each facility will develop operational requirements for total and partial facility lockdowns consistent with this policy and related Department policies including *DOC 3.2.1 (A) RD Emergency Operations Plan (Restricted Distribution)*.
2. Total facility lockdowns consist of securing all entry and exit doors and offenders in cells or designated staging areas and completing a count of staff, visitors, and offenders.
 - a. A total facility lockdown may be authorized by the facility administrator or incident commander (IC).
3. Partial facility lockdowns consist of securing entry and exit doors and a portion of offenders in cells or designated staging areas, and completing a count of staff, visitors, and offenders.
 - a. A partial facility lockdown may be authorized by the facility administrator or IC.
4. A total or partial facility lockdown may be authorized in order to accomplish any of the following:
 - a. isolate an incident;
 - b. prevent injury to offenders, staff, or visitors;
 - c. prevent or limit property damage;
 - d. ensure the continued orderly operation of a facility; or
 - e. preserve a crime scene.
5. When a total facility lockdown extends over 24 hours, the following information needs to be relayed to the Department duty officer:
 - a. estimated duration of the lockdown; and
 - b. plan of action to resolve the incident that caused the lockdown.
6. For extended lockdowns, each facility will develop requirements to track basic human needs for each offender involved in the lockdown including, but not limited to, meals, showers, linen exchange, and medical attention.
7. Each facility will determine if increased supervisory ratios during a lockdown status are necessary.
8. All staff involved with a total or partial facility lockdown will file incident reports.

B. Responsibilities of the Incident Commander

1. Responsibilities of the IC during a facility lockdown include:
 - a. in the event of a total facility lockdown over 24 hours in duration, ensure a daily walk-through of each housing unit is conducted by a shift supervisor or higher authority, when possible;
 - b. develop an action plan to include lockdown conditions;
 - c. brief staff daily;
 - d. ensure offenders receive information about modifications to their normal living conditions;
 - e. establish a list of available staff and/or authorized offenders to perform necessary tasks; and
 - f. determine the frequency and type of searches to be conducted for the duration of the lockdown.

V. CLOSING

Questions about this policy should be directed to the Department Emergency Preparedness Manager.

VI. REFERENCES

- A. §§ 2-15-112; 53-1-203, MCA
- B. DOC 3.2.1 (A) *RD Emergency Operations Plan (Restricted Distribution)*



POLICY DIRECTIVE

Policy:	DOC 3.2.12 CONTROL AND USE OF HAZARDOUS MATERIALS	
Effective Date:	04/01/1997	Page 1 of 2
Revision Date(s):	09/26/2013; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department is committed to providing staff and offenders handling hazardous materials the information required to handle such material safely and deal effectively with incidents.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted facilities and programs, as specified in the contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Each facility or program will develop requirements for the following:
 - a. maintaining hazardous materials;
 - b. consideration for the location of highways and railroads where hazardous materials may be transported and the proximity of factories or other industrial installations outside the facility that manufacture or store materials that could pose a threat in the event of a spillage or incident;
 - c. in the event of an incident:
 - 1) how the facility or program will contain the hazardous materials to limit the spread of the substance and minimize exposure to staff and offenders; and
 - 2) how the facility or program will decontaminate staff, offenders, and affected areas.
2. Each facility or program will designate a safety officer responsible for hazardous material control including storage, issuance, and supervision of toxic, corrosive, flammable, and explosive compounds.
3. Each facility or program should maintain the following information:
 - a. a list of locations, type, approximate quantities, and MSDSs of hazardous material; and
 - b. names and phone numbers of local, state, and federal authorities who may respond to specific hazardous material incidents.

B. Inventory and Storage

1. MSDSs will be maintained and available in areas where hazardous substances are stored or used.
2. An inventory of all hazardous materials will be maintained at the storage location.
3. Appropriate storage containers will be available and properly labeled in areas where hazardous materials may be used.
4. Under the guidelines of the Code of Federal Regulations (CFR) 29.1910.1200, (b) (ix), general use materials and chemicals may be exempt from MSDS standards if they are

considered common “household” items and are used as directed by the manufacturer’s original packaging

C. Training

1. Staff and offenders working with, in the proximity of, or having the potential to work with hazardous materials will complete training, at minimum, annually, including:
 - a. interpretation of labels and MSDSs;
 - b. effects of hazardous materials; and
 - c. safe handling, use of protective equipment, first-aid treatment, cleanup, and disposal processes for hazardous materials.

D. Notification and Evacuation

1. In the event of a hazardous material incident, the facility administrator, safety officer, and maintenance and medical staff must be promptly notified.
 - a. If the incident requires evacuation of staff or offenders or requires outside involvement, the response will be consistent with *DOC 1.1.6 Priority Incident Reporting*, *DOC 3.2.5 Internal Evacuation*, and *DOC 3.2.6 External Evacuation*.
2. Safety officers will maintain a current list of agencies requiring notification in the event of a hazardous material incident including agencies with hazardous material experts, law enforcement agencies, and the local fire department.

V. CLOSING

Questions about this policy should be directed to the chief of security.

VI. REFERENCES

- A. §§ 50-78-101; 75-10-701, MCA
- B. 42 U.S.C. 9601 (14)
- C. 29 CFR 1910.1200, OSHA; 40 CFR 262, OSHA
- D. *DOC 1.1.6 Priority Incident Reporting; DOC 3.2.5 Internal Evacuation; DOC 3.2.6 External Evacuation*



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 3.3.2	Subject: OFFENDER LEGAL ACCESS TO COURTS
Chapter 3: FACILITY/PROGRAM OPERATIONS	Page 1 of 3 and Attachment
Section 3: Rights and Privileges	Effective Date: Oct. 1, 1997
Signature: /s/ Mike Ferriter, Director	Revised: 07/13/11

I. POLICY

The Department of Corrections will assist incarcerated offenders who desire to access the courts.

II. APPLICABILITY

All Department-owned and contracted adult secure facilities, as specified in contract.

III. DEFINITIONS

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Offender Library Worker (OLW) – An offender assigned to work in a facility library in the Offender Legal Assistance Program to perform the duties outlined in the OLW job description.

Pro se – The offender represents himself or herself in court without an attorney.

IV. DEPARTMENT DIRECTIVES

A. Electronic Legal Research and Legal Forms

1. Each facility will provide, at a minimum, the following legal reference materials to offenders:
 - a. the Montana Code Annotated;
 - b. the published decisions of the Montana Supreme Court;
 - c. the decisions of the Ninth Circuit Court of Appeals;
 - d. the decisions of the United States Supreme Court;
 - e. the United States Code, Titles 28 and 42; and
 - f. federal and state rules of court.
2. Each facility will have the following forms available to provide to offenders who request them:
 - a. notice of appeal;
 - b. motion to withdraw guilty plea;
 - c. petition for post conviction relief, memorandum and affidavit;
 - d. petition for habeas corpus relief;
 - e. petition for DNA testing;
 - f. form 28 U.S.C. 2254;
 - g. federal complaint;
 - h. in forma pauperis form;

Policy No. DOC 3.3.2	Chapter 3: Facility/Program Operations	Page 2 of 3
Subject: OFFENDER LEGAL ACCESS TO COURTS		

- i. petition for executive clemency; and
- j. application for sentence review.

B. Assistance Provided to Offenders

1. Each administrator will designate a staff member to oversee offender access to legal materials and to assist offenders to access the appropriate forms and perform legal research.
2. Each facility will assist illiterate, disabled, and non-English speaking offenders who wish to file a form identified in Section A.2 above. Each administrator will designate a staff member to assist these offenders in obtaining the required legal materials.
3. The designated staff member may designate one or more offender library workers to assist in the provision of legal access for other offenders. If the facility employs offender library workers, the OLWs may help disabled offenders and perform other duties to assist the Offender Legal Assistance Program.
4. Each facility will have procedures that allow for attorney access to offenders in accordance with [DOC Policy 3.1.5, Entrance Procedures and Detainment of Non-Offenders](#).

C. Photocopies and Other Services

1. At the discretion of the administrator, the facility may provide a copy machine for offenders to make photocopies for litigation purposes.
 - a. the facility may establish the cost for copies of legal research or court pleadings, which may include an administrative fee, but may not exceed \$.25 per page; and
 - b. the cost of the copies will be deducted from the offender's account.
2. Upon request, a designated staff member will provide copies of legal research or court pleadings free of charge to indigent offenders when there is a demonstrated need for such copies in an amount not to exceed 30 pages per month.
3. Each facility will offer notary service to offenders free of charge for the first five (5) documents per month. Any additional notarizations may be charged up to \$2.00 per document.
4. Offenders who are indigent may request first class postage for legal mailings not to exceed eight mailings or a maximum of \$10.00 postage per month.

D. Prohibited Activities

1. Except as provided in Section B.3 above, an offender may not provide legal work or write a legal document for another offender, to do so may result in disciplinary action.
2. An offender may retain only his or her own personal legal papers, in accordance with [DOC Policy 4.1.3, Offender Personal Property](#).
3. Facility staff will not retaliate against or penalize any offender who chooses to access the courts.

Policy No. DOC 3.3.2	Chapter 3: Facility/Program Operations	Page 3 of 3
Subject: OFFENDER LEGAL ACCESS TO COURTS		

V. CLOSING

Questions concerning this policy should be directed to the Department's Legal Services Bureau.

VI. REFERENCES

- A. [2-15-112](#), MCA; [37-61-201](#), MCA; [37-61-210](#), MCA; [37-61-418](#), MCA
- B. 4-4274, -4275, -4276, *ACA Standards for Adult Correctional Institutions*, 4th Edition
- C. DOC Policies [3.1.5](#), *Entrance Procedures and Detainment of Non-offenders*; [3.3.6](#), *Offender Mail*; [4.1.3](#), *Offender Personal Property*; [4.1.4](#), *Indigent Status*

VII. ATTACHMENT

None



POLICY DIRECTIVE

Policy:	DOC 3.3.3 INMATE GRIEVANCE PROGRAM	
Effective Date:	04/01/1997	Page 1 of 4
Revision Date(s):	09/06/2007; 06/18/2012; 06/08/2016; 06/28/2016; 11/15/2024	
Signature/Title:	/s/ Brian Gootkin, Director	

I. POLICY

The Department of Corrections provides all inmates housed in secure facilities and offenders in Department-operated prerelease centers (collectively referred to as “inmates” in this policy) with a grievance and appeal process to report alleged violations and resolve complaints in a timely and confidential manner in accordance with the provisions of this policy.

II. APPLICABILITY

All secure facilities and Department-operated prerelease centers.

III. DEFINITIONS (see Glossary)

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. This grievance policy follows federally-mandated requirements and national correctional standards.
2. At intake, the Grievance Manager or designee provides a copy of this policy and the grievance manual to inmates.
3. At each level of the inmate grievance process, the established time periods are uniform.
4. Grievances encompass a broad scope of complaints that include, but are not limited to, policies and procedures, services and conditions, staff misconduct, and inmate rights.

B. Grievance Manager

1. In addition to complying with the general requirements of this policy, the Grievance Manager ensures that:
 - a. the grievance program supplements, but does not replace, the informal communication system or the inmate disciplinary process;
 - b. newly admitted inmates are informed of the grievance process in accordance with *DOC 4.1.2 Offender Reception and Orientation*;
 - c. staff are trained to understand the inmate grievance process and, if required, participate in the resolution of grievances; and
 - d. the grievance manual includes clear, easily understandable information instructing inmates on proper initiation of grievance action at the following levels:
 - 1) informal resolution of grievances;
 - 2) formal standard grievances;
 - 3) formal emergency grievances;
 - 4) grievance appeals to the Administrator; and
 - 5) grievance appeals to the Department Director.

C. Grievance Coordinator

1. The Grievance Manager assigns and trains a staff member as a Grievance Coordinator who is readily available to inmates and staff and ensures that:
 - a. the written grievance policy and associated manual are reviewed by inmates and staff upon intake or hire with opportunity provided for questions and answers;
 - b. the grievance policy and manual are accessible to youth and adult inmates in facilities and programs regardless of classification, status, or disability;
 - c. the grievance policy and manual are available in the language spoken by a significant portion of the inmate population and appropriate provisions exist to assist visually impaired, hearing impaired, or otherwise disabled inmates, as well as inmates who have limited reading skills, to understand and complete the necessary forms;
 - d. necessary forms are readily available, provide clear and concise instructions, and are standardized for all facilities;
 - e. inmates who use the grievance process are guaranteed protection from reprisals;
 - f. the grievance manual includes the specific complaints that may be grieved and not grieved (for example, parole decisions and classification and disciplinary decisions that are subject to a separate appeal process);
 - g. the grievance manual outlines the options to resolve issues informally and gives direction for meaningful, reasonable remedies;
 - h. responses to grievances are provided according to fixed time limits for each level of the process;
 - i. designated staff respond in writing to each grievant at each level of the review by clearly and fully stating the reasons for the decisions reached;
 - j. staff process grievances expeditiously to prevent the grievance from becoming moot;
 - k. unless the grievant is notified of a time extension for a response, the expiration of the time limit without a response entitles the grievant to move to the next stage of the grievance process;
 - l. inmates may file emergency grievances if adhering to established time frames would subject them to a substantial risk of personal injury or cause other serious and irreparable harm;
 - m. emergency grievances are immediately forwarded without substantive review to the level at which corrective action can be taken;
 - n. the grievance process affords all inmates at least one level of review or appeal;
 - o. when further review is available to the grievant, the response informs the grievant of that fact and includes instructions on how to obtain review;
 - p. the grievance process provides for an independent review of grievance dispositions, including alleged reprisals, by a person not under the facility or program's supervision or control;
 - q. facilities provide locked grievance boxes in areas accessible to inmates and retrieved by the Grievance Coordinator, or designee, on a routine basis but no less than once per week;
 - r. grievances are processed from initiation to final disposition within 180 days (except grievances alleging sexual abuse as outlined in IV.E below);
 - s. staff who participate in the disposition of a grievance are allowed access to records essential to its resolution;
 - t. grievance programs have the option to permit in-person hearings that include staff or inmates, or both, so long as no inmate participates in the resolution of any other inmate's grievance over the objection of the grievant; and
 - u. no inmate or staff member who appears to be involved in a grievance participates in the grievance resolution process.
 - v. No inmate will be allowed to abuse the grievance process. If an inmate demonstrates a pattern of abuse, the grievance manager will notify the inmate in writing that such actions are creating an administrative burden at the expense of legitimate complaints. The notice

will contain specific reasons for the decision and the steps taken due to the abuse. The notice is not subject to appeal.

2. The Grievance Coordinator's administrative duties include:
 - a. maintaining accurate, complete, and separate records of each formal grievance, and providing reports and statistics as required by policy and operational procedures;
 - b. screening grievances for emergencies, referrals, and consultation with other staff, for example, health care providers on medical issues, investigators for allegations of sexual abuse or sexual harassment, and Americans with Disabilities Act (ADA) coordinators on issues of inmate accommodations and rights;
 - c. maintaining a log of all grievances and appeals at all levels of the process;
 - d. tracking and adhering to all established time frames;
 - e. returning incomplete or inappropriately filed grievances to inmates with explanations within the prescribed time frames, except grievances alleging sexual abuse which are immediately processed according to IV.E below;
 - f. assigning a case number to each grievance for consistency throughout the process;
 - g. coordinating investigations and explaining decisions in responses;
 - h. maintaining files that include all forms and documents pertaining to each grievance case;
 - i. maintaining confidentiality when handling grievance submissions; and
 - j. providing training on a routine basis to Department staff.
3. Grievance Coordinators are required to document and submit monthly reports to the Grievance Manager that include the following data:
 - a. The number of informal resolutions filed, including category details, complaint type, unit grievated, and result.
 - b. The number of formal grievances filed, including category details, complaint type, unit grievated, and result.
 - c. The number of appeals submitted to the Warden and Director and result.

D. Emergency Grievances

1. The grievance manual must provide clear information and direction to inmates and staff on the use of emergency grievances, including the following:
 - a. what constitutes emergency grievances;
 - b. the options inmates have for reporting emergency grievances, for example, verbally or in writing to any staff member;
 - c. the stipulation that emergency grievances receive immediate attention and are verified for legitimacy and inmate safety without undue delay; and
 - d. such grievances are expeditiously channeled to the appropriate individual who can take corrective action.

E. Grievances Alleging Sexual Abuse

1. This part is required under PREA standards.
2. Inmates alleging sexual abuse must not be required to use an informal grievance system nor must they be required to resolve such a grievance with staff or submit the grievance to the staff member who is the subject of the complaint. Such grievances are not referred to the staff member who is the subject of the complaint.
3. There is neither a time limit on the filing of a grievance alleging sexual abuse, nor a limit on the number of open grievances alleging sexual abuse. Applicable limits may be applied to any portion of a grievance that does not allege an incident of sexual abuse.
4. A final decision on the merits of any portion of a grievance alleging sexual abuse must be issued within 90 days of the initial filing of the grievance.
5. If the 90-day decision deadline is insufficient to make an appropriate decision, an extension of up to 70 days may be permitted for a final decision. The inmate must be notified in writing of any such extension and provided a date by which a decision will be made.

6. At any level of the process, including the final level, if the inmate does not receive a response within the time allotted for reply, including any properly noticed extension, the inmate may consider the absence of a response to be a denial at that level.
7. Processes for the filing of an emergency grievance alleging that an inmate is subject to a substantial risk of imminent sexual abuse must include:
 - a. the grievance form, or any portion of it that alleges the substantial risk of imminent sexual abuse, is immediately forwarded to a level of review at which immediate corrective action may be taken;
 - b. an initial response is provided within 48 hours;
 - c. a final Department decision is made within 5 calendar days; and
 - d. the initial response and final decision documents the determination whether the inmate is at substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.
8. Third parties are permitted to assist inmates in filing requests for administrative remedies relating to allegations of sexual abuse, and are permitted to file such requests on behalf of an inmate, with the following exceptions:
 - a. adult inmates must give permission for the third party to file requests and must personally pursue any subsequent steps in the grievance process;
 - b. if the alleged victim is a juvenile, a parent or legal guardian is allowed to file a grievance, including appeals, on behalf of the juvenile without the agreement of the juvenile;
 - c. if the alleged victim is a juvenile and the third party is not a parent or legal guardian, the facility may require the juvenile to agree to have the request filed on the juvenile's behalf and may require the juvenile to personally pursue any subsequent steps in the grievance process; and
 - d. if the inmate declines to have the request processed on the inmate's behalf, the facility documents the inmate's decision.
9. The facility or program may discipline an inmate for filing a grievance related to alleged sexual abuse only if the facility or program demonstrates that the inmate filed the grievance in bad faith.

F. Supervisory Review of the Grievance Program

1. The Grievance Manager reviews the monthly grievance reports, analyzes the collected data, and addresses corrective action that may be required to improve operations and/or inmate services.
2. The Grievance Manager ensures that monthly grievance reports are retained by the facility or program for at least three years following the final grievance disposition.
3. Based on the monthly reports, the Grievance Manager completes a semiannual grievance program report summarizing the Grievance Manager's conclusions and recommendations. The conclusions and recommendations are then shared with the Public Safety Chief.
4. Monthly and semiannual reports provide an internal administrative means to analyze current issues being grieved at facilities and spotlighting areas that need systematic review.

V. CLOSING

Questions about this policy should be directed to the Grievance Manager.

VI. REFERENCES

- A. *28 C.F.R. 40.1 et. seq.; 42 U.S.C. 1997e*
- B. *DOC 1.1.17; DOC 1.3.12; DOC 4.1.2*



POLICY DIRECTIVE

Policy:	DOC 3.3.4 MEDIA ACCESS TO OFFENDERS	
Effective Date:	08/01/1997	Page 1 of 2
Revision Date(s):	06/20/2012; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department will provide news media representatives with access to offenders who are in Department custody or under Department supervision when consistent with the security and the orderly operation of its facilities and programs.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The administrator will provide the facility or program rules and regulations to news media representatives prior to permitting offender interviews.
2. Department and contracted facilities and programs will protect offender confidentiality and comply with the consent requirements in accordance with the provisions of this policy.

B. Incarcerated Adult Offenders

1. Adult facilities will follow applicable procedures for media access to offenders in accordance with the following:
 - a. offenders may choose to accept or reject media interview requests;
 - b. media representatives will submit interview requests in writing through the Department's Public Information Officer (PIO);
 - c. the PIO must obtain approval from the facility administrator before scheduling media access to offenders;
 - d. offenders who agree to an interview will do so in writing, state the purpose, and receive no compensation, in accordance with the *Interview and Photo Consent* form;
 - e. approved offender access must be arranged at reasonable times of day consistent with facility security or operational needs;
 - f. offenders will not be photographed in a manner that allows individual identification without the offender's written consent;
 - g. the PIO will make any necessary arrangements with regard to news media presence in consultation with the division or facility administrators and the news media representative; and
 - h. the PIO will arrange for a staff member to:
 - 1) verify the offender's written consent for an interview;
 - 2) act as a staff representative by accompanying the media representative to the interview; and
 - 3) be present during the interview to ensure the media representative complies with permissions granted on the *Interview and Photo Consent* form.

C. Probation and Parole

1. Offenders who are under community supervision do not ordinarily need to provide written consent or receive Department approval for news media interviews.
2. Offenders will sign a consent form in the following circumstances:
 - a. when the news media interview is arranged by a Department staff member; or
 - b. when the interview occurs at a Department facility, program, or office.

D. Incarcerated Youth Offenders

1. The facility administrator will permit news media access to youth correctional facilities:
 - a. at reasonable times of the day consistent with the security needs of the facility;
 - b. only after news media representatives sign the required *Youth Confidentiality* form and agree not to:
 - 1) identify youth offenders by name either in media reports or in correspondence; or
 - 2) photograph or film offenders in a manner that allows for visual identification.
2. If consent forms are unavailable, the only information facility staff may disclose is whether a specific offender is in residence at the facility.

E. Youth Parole Offenders

1. News media representative access to youth offenders on parole requires the offender's permission and the approval of the offender's legal guardian.
2. The offender and legal guardian must sign the required consent form.

F. Denial of Media Access

1. Media access to offenders may be denied when:
 - a. the facility is operating under emergency conditions as defined in *DOC 3.2.1 Emergency Management* and *DOC 3.2.1 (A) RD Emergency Operations Plan Procedure Guide (Restricted Distribution)*;
 - b. an offender, who ordinarily may be available for a news media interview, is placed in confinement, for example, disciplinary or administrative segregation or maximum custody;
 - c. an offender chooses not to be interviewed, refuses to sign a consent form, or a youth offender does not have legal guardian consent;
 - d. the media representative fails to abide by the rules, regulations, and applicable procedures governing offender access; or
 - e. the media representative behaves in a manner that jeopardizes the safety and/or security of the facility or program.

V. CLOSING

Questions about this policy should be directed to the Department Public Information Officer or the Department Communications Director.

VI. REFERENCES

- A. *DOC 1.1.8 Media Relations; DOC 3.2.1 Emergency Management; DOC 3.2.1 (A) RD Emergency Operations Plan Procedure Guide (Restricted Distribution)*

VII. FORMS

Interview and Photo Consent
Youth Confidentiality



POLICY DIRECTIVE

Policy:	DOC 3.3.5 OFFENDER AND STAFF COMMUNICATION METHODS
Effective Date:	05/01/1998 Page 1 of 2
Revision Date(s):	06/20/2012; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

Department facilities will establish a system for offenders to communicate in writing with facility staff using an approved *Offender/Staff Request (OSR)*. In addition to using the *OSR* process, offenders and staff are encouraged to engage in respectful dialogue to promote the safe and secure operation of the facility.

II. APPLICABILITY

Secure facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Principles

1. Proper and effective communication between offenders and staff is essential to the safe, secure, and orderly operation of facilities and to the successful completion of the offender's corrections plans.
2. Offenders and staff communicate verbally, in writing, and non-verbally via manner, tone, and body language.
 - a. Staff and offenders are jointly responsible for ensuring communication methods are appropriate to properly and effectively convey intended information and ideas to others.
3. Offenders will communicate with staff in a civil and respectful tone and manner.
4. Staff will communicate with offenders in a professional manner appropriate to the circumstances that fosters respect and confidence.
5. Offenders are encouraged to communicate and resolve any concerns at the lowest level possible within the facility organizational structure.
6. If concerns cannot be readily resolved at low levels or using the *OSR* process, offenders have the option to use the Department's internal grievance and appeal process in accordance with *DOC 3.3.3 Inmate Grievance Program*.

B. Facility Responsibilities

1. Each facility administrator is responsible for ensuring:
 - a. the development and maintenance of an offender and staff written communication method that conforms to the general requirements of this policy;
 - b. all offenders are provided information regarding the of the content of this policy; and
 - c. development of a tracking and filing system for *OSR* forms to ensure that safety, security, and case management issues are addressed and retained on file as deemed necessary by appropriate facility staff.

C. Offender Use of OSR Forms

1. Offenders wishing to communicate with staff in writing must use the *OSR* form provided by the facility.
 - a. Exceptions to the use of the *OSR* for offender to staff communication will be made when the correspondence requires use of the following:
 - 1) grievance forms;
 - 2) medical and dental health care requests; and/or
 - 3) classification and disciplinary appeals.
2. Offenders may be subject to disciplinary action for communicating with staff in writing by using other than an approved form (for example, by card, note, or letter).
3. Offenders will limit each *OSR* to one issue, use only the space provided on the form, and may not send attachments with the form. Offenders are prohibited from sending the same or a similar *OSR* to multiple staff members in a manner that burdens the system.
4. The *OSR* is intended for use by an individual offender; an offender may not send an *OSR* form from multiple offenders.
5. Offenders will not use demeaning, threatening, profane, or vulgar language.
 - a. Offenders may be subject to disciplinary action if they misuse the *OSR* process or if they use the system to harass or abuse others.
6. *OSR* forms will be mailed through the facility internal mail system either sealed or unsealed and will be addressed to the appropriate staff member.
7. Offenders may provide additional information pertaining to their *OSR* questions or concerns when requested by staff to do so.
8. Offender noncompliance with the requirements of this policy may result in the *OSR* being returned unanswered to the offender.

D. Staff Use of Request Forms

1. Staff will ensure that *OSR* forms are readily available in each housing unit and from unit management staff.
2. Staff response to the *OSR* may be either written or verbal.
 - a. If staff cannot provide a timely answer to a request, they will acknowledge receipt of the request and provide the offender with an anticipated date of response.
3. If staff determine that the issue addressed in the *OSR* is an emergency or involves safety or security issues, the *OSR* must receive immediate attention. Staff will provide a response to the offender within 24 hours from receipt of the *OSR*.
4. When the receiving staff member determines that an alternative communication method (such as grievance or disciplinary appeal) is more appropriate, the staff member will provide this explanation to the offender on the *OSR* form.
5. No staff member will intercept, stop, destroy, delay or otherwise attempt to interfere with *OSR* forms that comply with the facility's *OSR* process.

V. CLOSING

Questions about this policy should be directed to the facility administrator.

VI. REFERENCES

A. *DOC 3.3.3 Offender Grievance Program*

VII. FORM

Offender/Staff Request (OSR)



POLICY DIRECTIVE

Policy:	DOC 3.3.6 INMATE MAIL IN SECURE FACILITIES	
Effective Date:	01/06/1998	Page 1 of 10 with attachments
Revision Date(s):	08/01/2022; 12/04/2024; 04/30/2025	
Signature/Title:	/s/ John Schaffer, Public Safety Division Chief	

I. POLICY

The Department of Corrections secure facilities permit inmates to send and receive mail in accordance with the provisions of this policy and subject only to the limitations necessary to maintain public safety and facility order, security, health, and rehabilitation.

II. APPLICABILITY

All Department secure facilities.

III. DEFINITIONS

Contraband – Any item possessed by an inmate or found within the facility that is illegal by law, prohibited by policy or procedure, or unauthorized by those legally charged with the administration and operation of the facility.

Electronic Message – An approved electronic means of communications provided through an approved vendor for inmates to send and receive audio and video messages.

Facility Administrator – The official, regardless of local title (administrator, warden, superintendent), ultimately responsible for the facility or program operation and management.

General Mail – All mail not otherwise considered legal or privileged mail.

Legal or Privileged Mail – Confidential communication directly: a. between an inmate and an attorney (to seek or provide legal services); b. from an inmate to a court; c. to any individual or entity designated to receive Prison Rape Elimination Act (PREA) communications; or d. from Department legal counsel or outside legal counsel representing the Department.

Mail – All mail including physical and electronic correspondence, publications, and packages.

Sexually Explicit Material – Material that portrays, depicts, or describes:

1. Nudity, which includes exposed, partially exposed, or transparently exposed male or female genitalia, pubic area, or anus, or female areola. Photographs, pictures, or images that contain blackened dots, stars, or other similar such covering of the areola of the female breast or of human genitalia will also be considered as nudity.
2. Sex act(s), including but not limited to genital to genital, oral to genital, anal to genital, or oral to anal contact or penetration, genital or anal contact or penetration with an inanimate object, masturbation, sadistic or masochistic abuse, bondage, bestiality, and/or bodily excretory behavior that appears to be sexual in nature.
3. Participant(s) who appear to be nonconsenting, dominated, degraded, humiliated, or in a submissive role, and/or acting in a forceful, threatening, dominating, or violent manner that appears to be sexual in nature; and/or
4. Minor(s), or models depicting minors, in a sexually suggestive setting, pose, or attire.

Urgent Situations – Any significant disruption of normal facility or agency procedure, policy, or activity caused by riot, escape, natural disaster, employee action, or other serious incident.

IV. Department Directives

A. General Mail Requirements

1. Outgoing mail must indicate on the envelope the sending inmate's name, identification number, and the proper name and address of the facility in which the inmate is incarcerated. It may be stamped by the facility with the facility name and address.
2. Inmates must leave outgoing general mail unsealed so that it may be reviewed by facility staff.
3. If a recipient of inmate mail notifies the Facility Administrator or designee that the recipient does not wish to receive mail from an inmate, the facility will notify the inmate and return to the inmate any mail addressed to the recipient.
4. For financial transactions, consistent with *DOC 1.2.6 Offender Financial Transactions*, inmates may request that the facility transfer money from their trust account to a person on the inmate's approved mailing or visiting list.
5. General mail that is in a language other than English, completely or in part, will not be treated differently because it is not written in English. The Department uses translation services through an approved vendor; however, the mail may be delayed for translation in accordance with the following:
 - a. staff will exercise due diligence and make a good faith effort to translate and review contents within 10 business days for compliance with this policy;
 - b. if translation will delay the normal mailing of the mail, the inmate will be notified;
 - c. if attempts to translate are unsuccessful within 10 business days, the inmate will be provided a written notice of the undeliverable mail including a description of why the document was rejected and the efforts made to translate the document; and
 - d. mail may be rejected for a reason specified in *Attachment A: Inmate Mail Rejection Reasons*.
6. Inmates may not send or receive mail that contains sexually explicit material including publications that feature on a regular basis or promote sexually explicit material.
7. Sending and receiving mail is not allowed between an inmate and any individual committed to a Department operated or contracted secure facility unless the Facility Administrator(s) approve an exception on a case-by-case basis.
8. General incoming or outgoing mail found to contain any of the following will be held and may be referred to the Investigations Bureau, which will investigate according to Department policy and determine whether the inmate will be informed that the mail is undeliverable pending the investigation:
 - a. threats of physical harm against any person or threats of, or participation in, criminal activity;
 - b. blackmail or extortion;
 - c. plans for activities in violation of Department policy or facility-specific prohibitions, such as riots or plans to escape or assist another to escape;
 - d. contraband including drugs or drug paraphernalia;
 - e. other material which, if communicated, would create a serious danger to facility security; or
 - f. contents that violate U.S. Postal regulations.
9. The Facility Administrator, or designee, is responsible for assigning a staff member to oversee the following requirements:
 - a. requirements governing inmate mail must be available to staff, inmates, and inmates' correspondents;

- b. when an inmate bears the cost of postage, there is no limit on the source, destination, amount, or content of incoming or outgoing mail, within the parameters of this policy, including, but not limited to, air, certified, insured, oversize, and overweight mail services;
- c. the convenient deposit and distribution of mail on every business day;
- d. all incoming and outgoing inmate general mail may be opened, read, and inspected for contraband and prohibited content;
- e. staff inspect, confiscate, and dispose of contraband including, but not limited to, currency and unauthorized enclosures and staff notify inmates of such actions;
- f. methods for identification and handling of prohibited mail;
- g. first-class general mail is not forwarded after an inmate's transfer or release and will be returned to the sender;
- h. if an inmate is transferred to a different Department operated or Department contracted secure facility, the inmate's legal or privileged mail will be returned to sender with a notice of the inmate's new address;
- i. inform inmates on any changes to U.S. Postal Service regulations and rates;
- j. indigent inmates are provided packets monthly, including:
 - 1) envelopes for personal correspondence for the facility to mail out; and
 - 2) 8 legal mailings or up to \$10 of legal mailings, whichever is greater;
- k. handling restricted items, for example, credit cards or credit card applications, or other materials that may be disposed of on the basis of security; and
- l. incoming and outgoing mail inspection processes adhere to the following time frames, (excluding weekends, holidays, urgent situations, and when the inmate is temporarily absent from the facility, for example, in the hospital or on leave to court):
 - 1) non-scanned and legal or privileged mail are held for inspection no longer than 72 hours; and
 - 2) packages are held for inspection no longer than 72 hours.

B. Incoming Mail Requirements

1. Scannable mail that is received at a secure facility instead of at the vendor's mailing address will be returned to the sender.
 - a. Exception: Mail for inmates at Crossroads Correctional Center, Dawson County Correctional Facility, and Saguaro Correctional Center must be sent to those facilities' designated mailing addresses.
2. To prevent contraband from entering secure facilities, all scannable incoming mail must be addressed to the **vendor's** mailing address (*for the mailing address and a list of scannable, non-scanned, and legal or privileged mail items, see Attachment B*).
 - a. Inmates are responsible for providing the vendor's mailing address to senders.
 - b. Incomplete or incorrect **inmate** information will result in mail being returned to the sender with a checked reason indicating that information is missing that is required for processing.
 - c. Mail received without the **sender's** full first and last name and/or return address will be returned undeliverable.
3. Review and approval authority for mail content remains with the secure facility's authorized staff. Scanned mail is reviewed for approval or rejection by secure facility staff. Approved scanned mail is sent electronically to inmates' tablets.
4. For rejections and appeals, see IV.F below.
5. After scannable mail is scanned, the vendor will destroy the original mail unless retention is required for investigative purposes.
6. Except as provided below, inmates may request printing of their electronic content by facility staff. The cost of the printing is 25 cents per page and is paid for by the inmate.

7. Electronic content is not available to inmates from the Department after they discharge from a secure facility.
 - a. Before their discharge from a secure facility, inmates may request and purchase printed copies of their messages, letters, and/or photographs.
 - b. After their discharge from a secure facility, inmates can create an inmate mail account online by going to the mail vendor's website. Inmates who move from a secure facility to another secure facility will not have access to their electronic content at the other secure facility.

C. Non-Scanned Mail

1. All non-scanned mail must be addressed to the **secure facility's** mailing address. Any non-scanned mail incorrectly sent to the **vendor's** mailing address will be returned to the sender. If an envelope or other container that contains scannable mail is received at a secure facility, all contents will be returned to the sender, even if the contents also include non-scanned mail.
 - a. **Publications**
 - 1) The Department Publication Review Committee will review, approve, and deny all publications that enter secure facilities.
 - 2) Facility Administrators will serve on the Publication Review Committee or appoint employees under their supervision to represent their facility. Each facility will have representation on the committee.
 - 3) The Department maintains a rejected publication list in accordance with *Attachment A: Inmate Mail Rejection Reasons*.
 - 4) The Publication Review Committee will meet annually to reevaluate the rejected publication list and *Attachment A*.
 - 5) Following determination that content does not violate *Attachment A*, inmates may receive publications in any language including books, magazines, and newspapers sent directly from the publisher and prepaid publications sent directly from a publisher, book club, or bookstore.
 - 6) Deliveries of books, magazines, newspapers, advertising brochures, catalogs, newsletters, or other published materials may be provided to an inmate when the publication is addressed to the individual inmate and includes the appropriate inmate identification number; if mailings are properly addressed and denied for content, facilities must provide adequate inmate notification.
 - 7) Bulk mailings not addressed as prescribed by this policy may not be delivered and the facility is not required to provide an undeliverable notice to the inmate. Facility Administrators are advised to consult U.S. Postal regulations and the local post office regarding the proper handling of undelivered bulk mailings, such as whether the postal service destroys them or delegates to the facility the permission to destroy them.
 - b. **Financial and ID Mail:** Money orders, cash currency, payment checks, credit/debit cards, prepaid cards, wet signature documents (unless they can be initiated within the facility), birth certificates, passports, and social security cards must be sent directly to the secure facility. (Only **copies** are scannable.)
 - 1) Inmates are only allowed to send money to those persons on their approved visiting list.
 - 2) Inmates may receive funds through the mail from approved parties.
 - 3) Approved parties may send funds to an inmate when funds are in the form of a money order or cashier's check. Funds must meet the following requirements:
 - a) in a separate envelope addressed to "Mailroom inmate funds";
 - b) received within 20 days of the date of purchase;
 - c) include the inmate's first and last name and Department identification number;
 - d) include the completed, printed, legible name and address of the sender (for comparison with the approved list).
 - 4) In addition to mail, the Department maintains an electronic funds and transfer process through which authorized senders may deposit funds into an inmate's account.

- 5) The administrative support supervisor or designee will forward funds such as U.S. Treasury Department checks, refunds, inmate personal savings withdrawals, approved business transactions, or tribal checks to accounting staff to be credited to the inmate's account.
- 6) Unapproved funds or delivery that does not comply with this policy will be returned to sender.
- c. Packages
 - 1) A designated facility staff member will:
 - a) screen and approve all inmate packages;
 - b) process packages in an area inaccessible to inmates;
 - c) dispose of all packaging material outside of the facility; and
 - d) inventory and document package contents.
 - 2) Inmates will pay to ship packages and send them only to persons on the inmate's approved mailing or visiting list.
 - 3) Care packages (only for juveniles) must be sent directly to juvenile correction facilities.

D. Legal or Privileged Mail

1. Legal or privileged mail is defined as confidential communication directly:
 - a. between an inmate and an attorney (to seek or provide legal services);
 - b. from an inmate to a court;
 - c. to any individual or entity designated to receive Prison Rape Elimination Act (PREA) communications; or
 - d. from Department legal counsel or outside legal counsel representing the Department.
2. Any such mail incorrectly sent to the **vendor's** mailing address will be returned to the sender.
 - a. Note: If any mail that is not clearly marked as legal or privileged mail but contains legal or privileged documents is opened by vendor staff as a standard process, it will be processed as non-legal, non-privileged mail. For legal or privileged mail that was scanned because it was not clearly marked, the physical copy will be provided to the inmate if requested by the inmate within 30 days of when the mail was received.
3. Any questionable legal or privileged mail will be verified with the sender before delivery to the inmate.
4. Legal or privileged mail must be marked on the front of the envelope as "Legal Mail," "Privileged Mail," "Legal Correspondence," or "Privileged Correspondence," and must have a mailing address or return address that clearly indicates that the mail is to or from a source listed in the definition of "Legal or Privileged Mail."
5. Staff may not read the content of incoming or outgoing legal or privileged mail. For such mail received by the vendor, the vendor will not open or process the mail; it will be returned to the sender.
6. The following standards apply to legal or privileged mail:
 - a. if outgoing, the inmate must indicate on the envelope the name and official status of the addressee, and present the mail unsealed to staff, who will inspect the enclosed mail by shaking the pages to ensure no contraband is hidden before the inmate seals the envelope; and
 - b. if incoming, the sender must indicate on the envelope the sender's name and official status and the mail will be opened by staff to inspect for contraband in the presence of the inmate, unless waived by the inmate in writing, or in circumstances which may indicate contamination as approved by the Facility Administrator or designee.

E. Electronic Messages

1. Facilities offer electronic text and picture message capabilities to inmates through the Department's vendor-provided electronic messaging service.

2. Inmates will access electronic message services through inmate issued tablets and must adhere to the guidelines set forth in *DOC 3.3.10 Offender Issued Computer Tablets*.
3. Senders may initiate contact with an inmate; the Department will not block electronic messages solely because they did not originate from the inmate. These messages are still subject to review as provided in this policy.
4. Recipients will be able to accept or deny electronic message requests.
5. Recipients will be charged for accepted requests and will incur a fee per electronic message.
6. Electronic messages will be subjected to the same restrictions as physical mail, as applicable.
7. The Facility Administrator may suspend or revoke electronic message services due to violations of Department policy.
8. The Facility Administrator or designee may temporarily or permanently block a sender from transmittal of electronic messages to an inmate if the sender has sent a message in violation of policy.
 - a. Notice of the block shall be sent to the sender after initiation of the block.
 - b. The notice will inform the blocked individual of the opportunity to ask for a review of the decision by an official who did not participate in the original decision to block the individual.
 - c. The decision to block a sender from the transmittal of electronic messages does not impact that sender's ability to communicate by mail, telephone, or video calling.

F. Rejections and Appeals

1. The Department will allow uncensored inmate mail in accordance with this policy.
2. Rejected **outgoing** mail is automatically reviewed by the Facility Administrator or designee, and investigative staff if necessary, and the inmate must be provided notice of the rejection. The notice cites the specific reason(s) for rejection and informs the inmate of their right to an appeal. The notice will be distributed within 10 business days of the facility processing the mail.
3. If mailroom employees censor or reject **incoming** non-scanned mail, scanned mail, or electronic messages:
 - a. within 10 business days of the facility receiving the mail, staff will:
 - 1) send the inmate's tablet a notice of rejection, notice of right to appeal, and an appeal form; and
 - 2) notify the sender, either by postcard or electronically as applicable, with specific reasons for rejection and the option for requesting review of the decision.
 - b. after notification, inmates will have 10 days to submit an appeal.
 - 1) A facility mail room staff member or designee who did not participate in the original disapproval of the mail will review appeals within 10 days of receipt of the appeal and either uphold the rejection or allow delivery. If the rejection is reversed, the mail will be sent to the addressee within 7 days of the reversal.
 - 2) Staff will respond electronically to an inmate's appeal and document the response in the offender management system.
4. Facilities will maintain upheld rejection records.

V. CLOSING

Questions about this policy should be directed to the Facility Administrator or Central Services Operations Bureau.

VI. REFERENCES

- A. 45-7-307, MCA
- B. DOC 1.2.6; DOC 3.1.17; DOC 3.3.10

VII. ATTACHMENTS

- A. DOC 3.3.6 Attachment A: Inmate Mail Rejection Reasons
- B. DOC 3.3.6 Attachment B: Scannable, Non-Scanned, and Legal or Privileged Mail



ATTACHMENT A: INMATE MAIL REJECTION REASONS*

**The rejection reasons below may appear on the rejection notice that is provided to inmates when incoming mail is rejected by the facility mailroom or vendor. Rejections are automatically reviewed by the Facility Administrator or designee or Publication Review Committee.*

Rejection Reasons	
1.	Not specifically authorized, or required for rejection, by <i>DOC 3.3.6 Inmate Mail in Secure Facilities</i> or any other policy, directive, or applicable operational memorandum
2.	Advocates behavior that is detrimental to the inmate or their rehabilitation or to the facility
3.	Attempts to establish contact with a person or their guardian who has requested not to be contacted by the inmate, when the inmate is aware or should be aware of the request
4.	Violates sentencing conditions and/or court order or otherwise attempts to establish prohibited contact between sender and recipient
5.	Contains an unknown substance(s) or contraband, or relates to sending contraband into or out of the facility
6.	Contains items written or drawn in crayon or gel pen, contains excessive marker ink, or contains or has been treated with perfume, glitter, and/or other items that could be easily misidentified
7.	Contains escape plans and/or other information related to escape
8.	Provides technical/detailed information on security systems, equipment, and practices used in the correctional field
9.	Contains plans for activity that violates federal or state law, administrative rules, Department policy, and/or local facility rules
10.	Contains instructional and/or "how to" material for committing illegal activities
11.	Depicts or describes the procedures for constructing or using weapons, ammunition, bombs, and/or other destructive devices, or includes life sized photograph(s)/graphic illustration(s) of these items
12.	Provides instructions on martial arts, fighting/self-defense techniques, and/or how to disable/disarm others
13.	Appears to be in code
14.	Contains written/graphic information on security equipment/operations or facility blueprints/diagrams
15.	Contains detailed maps/charts of Montana, except those received by the facility libraries
16.	Contains information that could create a risk of physical harm to the inmate or another person if the communication were allowed
17.	Contains sexually explicit material or poses and/or references sexually explicit behavior. May include altered images, strategically placed graphics, or airbrushing. Sexually explicit behavior must be the predominant theme when rejecting written and/or audio-based publications or letters
18.	The publication(s) are not in English, and the Publication Review Committee cannot confirm that they comply with Department policy.
19.	Contains publications or documents, other than legal mail sent from a legal entity/agency, that have been altered (for example, pages torn/removed, extraneous markings, etc.)
20.	Advocates violence against others and/or the overthrow of authority
21.	Advocates that a protected class or group of individuals is inferior and/or makes such class/group the object of ridicule and/or scorn, and may reasonably be thought to precipitate a violent confrontation between the recipient and a member(s) of the target group
22.	Purports to be legal or privileged mail, but upon inspection is determined to be general mail
23.	Contains cash or personal check(s) or any form of payment from unapproved individuals
24.	Contains markings of gang symbols or symbols of other unauthorized groups that may reasonably be thought to precipitate violence

25.	Contains multiple or similar copies/photocopies of the same photograph, document, and/or publication/subscription, in whole or part
26.	Contains pre-franked envelopes and/or non-canceled postage stamps without prior approval from the Facility Administrator or designee.
27.	Contains mail, information, or other items relating to another incarcerated inmate(s) without prior approval from the Facility Administrator or designee, or attempts or conveys unauthorized inmate-to-inmate mail
28.	Contains a blank greeting card or postcard, or contains any stickers/labels
29.	Contains a photograph, card, poster, and/or calendar that is padded, laminated/layered, musical, and/or exceeds scannable dimensions
30.	Contains unauthorized audio or video, including public disclosure audio or video
31.	Contains clipping(s)/copies of copyrighted material, including books. Single clippings or copies from public domain publications (for example, newspapers or magazines) are allowed.
32.	Contains or attempts to obtain an item(s) not approved and paid for in advance through facility designated channels
33.	Solicits and/or contains money or anything of value, except as allowed by <i>DOC 1.2.6 Offender Financial Transactions</i> , from anyone other than approved parties without prior approval from the Facility Administrator or designee. This does not preclude authorized purchases through approved vendors.
34.	Requests/directs another person to provide money or anything of value to a third party without prior approval from the Facility Administrator or designee
35.	Contains a metal and/or inflexible binder
36.	Contains sweepstakes, contests, lottery tickets, or other mailings soliciting or offering games of chance. Publications that contain a sweepstakes or contest entry will not be restricted. However, inmates are not authorized to enter sweepstakes or contests of any kind.
37.	Includes a solicitation from an inmate for a "pen pal" or from a third party that matches inmates with potential pen pals
38.	Contains a used publication or a publication from a vendor that has been notified by the Department they are prohibited from sending publications to inmates



ATTACHMENT B: SCANNABLE, NON-SCANNED, AND LEGAL OR PRIVILEGED MAIL

Type	Description	Requirements and Notes
A	Scannable mail includes envelopes and written content other than the content specified in B and C below. Sender must address scannable mail to the scanning vendor as follows: Inmate First and Last Name, Inmate DOC Number, Secure Facility Name, P.O. Box 247, Phoenix, MD 21131. Exception: Mail for inmates at Crossroads Correctional Center, Saguaro Correctional Center, and Tallahatchie County Correctional Facility must be sent to those facilities' designated mailing addresses. For money orders, cash currency, payment checks, passports, social security cards, credit/debit cards, prepaid cards, and birth certificates, only copies are scannable.	To meet vendor mail processing standards, scannable mail sent to an inmate must display the following information: 1) Sender's complete first and last name. Initials for a last name are not acceptable. 2) Sender's complete return address. 3) Inmate's complete first and last name. Initials for a last name are not acceptable. 4) Inmate DOC number. 5) Secure facility full name. Abbreviations are not acceptable. Mail received without the sender's full name and/or return address will be returned undeliverable. Mail received by the vendor with incomplete inmate information will not be processed and will be returned to the sender with a checked reason indicating that information is missing that is required for processing. Note: Any illegal or suspicious drugs received by the vendor in the mail will be separated. The scanning vendor will notify local police to take possession of the substance and notify the secure facility with photographs of the mail and suspicious substance(s).
B	Non-scanned mail must be addressed to the secure facility and includes but is not limited to: 1) books 2) magazines 3) newspapers 4) care packages sent to juvenile correction facilities 5) financial and ID mail, except scannable copies as noted above 6) documents that require a wet signature (<i>unless they can be initiated within the facility</i>)	Any non-scanned mail incorrectly sent to the vendor's mailing address will be returned to the sender. If an envelope or other container that contains scannable mail is received at a secure facility, all contents will be returned to the sender, even if the contents also include non-scanned mail.
C	Legal or privileged mail must be sent to the secure facility. Legal or privileged mail is defined as confidential communication directly: a. between an inmate and an attorney (to seek or provide legal services); b. from an inmate to a court; c. to any individual or entity designated to receive Prison Rape Elimination Act (PREA) communications; or d. from Department legal counsel or outside legal counsel representing the Department.	The vendor will not open or process any incoming legal or privileged mail; it will be returned to the sender If any mail that is not clearly marked as legal or privileged mail but contains legal or privileged documents is opened by vendor staff as a standard process, it will be processed as non-legal, non-privileged mail. For legal or privileged mail that was scanned because it was not clearly marked, the physical copy will be provided to the inmate if requested by the inmate within 30 days of when the mail was received.



POLICY DIRECTIVE

Policy:	DOC 3.3.7 INMATE ACCESS TO AUDIO AND VIDEO CALLING	
Effective Date:	04/01/1998	Page 1 of 3
Revision Date(s):	10/18/2023; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

Secure facilities allow inmates access to public telephones, as well as audio and video calls utilizing inmate-issued computer tablets. This access maintains essential communication between inmates and their community and legal contacts.

II. APPLICABILITY

Secure facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Provisions

1. The Department will use a monitoring and recording system on telephones and inmate issued tablets to:
 - a. enhance facility security;
 - b. increase inmate and public safety; and
 - c. reduce the occurrence of:
 - 1) criminal activities; and
 - 2) activities that could be a threat to the orderly operation of a correctional facility.
2. The use of telephones and tablet audio/video calls by inmates is a privilege, not a right.
3. The Department will ensure inmates have access to reasonably priced communications services and that contracts involving inmate communication services:
 - a. comply with applicable state and federal regulations;
 - b. are based on rates and surcharges that are commensurate with those charged to the general public for similar services, and any deviation from ordinary consumer rates will reflect costs associated with the provisions of services in a correctional setting; and
 - c. provide the broadest range of calling options determined by the Department Director to be consistent with the requirements of correctional management.

B. Inmate-Initiated Personal Calls

1. Inmates will have personal access to designated inmate telephones located in accessible areas with collect call or pre-paid options (where available) and access to their issued tablet to make pre-paid audio or video calls.
2. Facility staff will:
 - a. advise inmates that their calls may be monitored and recorded;
 - b. establish hours of availability and limitations for inmate personal calls;
 - c. ensure inmates do not engage in tablet audio/video calling and messaging during official and stand-up counts; inmates who do not immediately cease tablet activity during these times will face disciplinary action;

- d. allow only calls from a facility approved list where applicable;
 - e. follow requirements to verify and handle incoming emergency calls to inmates (for example, serious family illness or death);
 - f. provide inmates in restrictive housing and secure housing units telephone privileges consistent with their classifications; and
 - g. prohibit unsupervised inmate access to staff telephones.
3. The facility administrator will enforce the prohibition of three-way or third-party phone calls and audio/video calling as well as the ban on use of the telephone system to initiate or conduct criminal activity.
 4. Facility administrators may:
 - a. program telephones or restrict inmate personal calls to reasonable time limits; and
 - b. prohibit or restrict inmates in detention and pre-hearing confinement status from making personal calls.
 5. Inmates with hearing and/or speech disabilities, and inmates who wish to communicate with parties who have such disabilities, will be given access to a Telecommunications Device for the Deaf (TDD) or comparable equipment.
 - a. Public telephones with volume control will also be available to inmates with hearing impairment.
 6. Violations of this policy may result in the loss or suspension of calling privileges in accordance with facility disciplinary or classification requirements.

C. Attorney Calls and Calls to Consular Officers

1. Inmates' constitutional rights will be protected by providing for unmonitored attorney and consular calls.
 - a. The facility will not intercept, record, or monitor inmate calls to attorneys or to consular officers.
2. An inmate will use a telephone or their issued tablet to call the inmate's attorneys.
 - a. The call will not be recorded if the inmate uses the telephone number provided to the designated facility office or unit to prevent the inmate from making fraudulent calls.
 - b. If an inmate calls another telephone number, the call may be recorded.
3. Inmates who are foreign nationals will have access to a diplomatic representative from their country of citizenship.
 - a. Staff supervising calls to consular officers will:
 - 1) verify the contact information;
 - 2) place the call on a designated telephone; and
 - 3) determine whether the call is paid by the inmate or consular officer.

D. Inmate Telephone Use in Work Assignments

1. The facility administrator must review and approve each inmate who may, as part of the inmate's assigned work program, have access to telephones.
2. Staff will monitor the telephone use of inmates who have access to telephones, including:
 - a. inmate workers with a conviction or history of fraud or other predatory behavior, where the inmate has demonstrated a process of grooming the victim through stalking or otherwise laying the groundwork for a criminal act; and
 - b. inmates with access to the names, addresses, or phone numbers of private individuals while performing their duties in an inmate work program.
3. Youth correctional facilities will ensure youth are not allowed to use telephones they may have access to at work assignments.

E. Telephone and Tablet Monitoring

1. Administrators will designate and authorize the staff members who may intercept, record, and divulge any telephone calls from an inmate using the inmate telephone system or tablets.
2. The contents of intercepted and recorded audio and video conversations will be divulged only as necessary to:
 - a. safeguard the orderly operation of the facility;
 - b. in response to a court order; or
 - c. in the prosecution or investigation of a crime.
3. Inmates will not have access to monitored or recorded calls.

F. Blocks on Calls from Inmates

1. Victims of inmates and recipients of unsolicited, unwanted inmate calls may request a facility block on calls from inmates in Department custody.

V. CLOSING

Questions about this policy should be directed to the Public Safety Chief.



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 3.3.8	Subject: OFFENDER VISITING
Chapter 3: FACILITY/PROGRAM OPERATIONS	Page 1 of 6
Section 3: Rights and Privileges	Effective Date: Aug. 1, 1997
Signature: /s/ Loraine Wodnik, Interim Director	Revised: 05/15/2017

I. POLICY

The Department of Corrections provides visiting privileges for offenders consistent with facility security requirements and encourages family ties and supportive relationships important to the stability of offenders while incarcerated and upon release.

II. APPLICABILITY

All facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Chief of Security – The staff person, regardless of local title (security major, director of operations), designated by the administrator to manage the facility security program.

Contact Visit – A visit in which the offender and visitor are permitted limited physical contact.

Contraband – Any item possessed by an offender or found within the facility that is illegal by law, prohibited by policy or procedure, or unauthorized by those legally charged with the administration and operation of the facility.

Clothed Body Search – The manual body search of an individual that requires the removal of outer clothing, e.g., coats, hats, gloves; emptying of pockets; and inspection of papers, bags, books, or other carried items (also referred to as a pat search).

Facility/Program – Refers to any division, prison, secure care correctional facility, correctional or training program, or community-based program under Department jurisdiction or contract. This term includes the facility building or residence, including property and land owned or leased and operated by the Department.

Immediate Family Member – An offender's legal spouse, natural or adoptive parents and children, siblings, grandchildren, grandparents, corresponding in-law, person verified as being primarily responsible for raising the offender in the absence of a parent and any other member of the offender's household.

Non-Contact – A visit in which the offender and visitor are separated by a physical barrier and, therefore, cannot have physical contact.

Official Visitors – Visitors to a facility acting in an official capacity, e.g., law enforcement,

Policy No. DOC 3.3.8	Chapter 3: Facility/Program Operations	Page 2 of 6
Subject: OFFENDER VISITING		

correctional personnel, judges, licensed attorneys, legislators, and others on official business.

Reasonable Suspicion – A conclusion drawn from specific, objective facts which would permit a reasonable and experienced correctional staff person to suspect that an individual or set of circumstances poses a threat to facility security or to the health, safety, and security of offenders, staff, visitors, contractors, or community members, including, but not limited to, committing, or conspiring or attempting to commit a crime or rule violation.

Unclothed Body Search – A visual inspection of an individual’s unclothed body and thorough search of the unworn clothing to detect concealed contraband (also referred to as a strip search).

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. The chief of security, or designee, will oversee the facility’s visiting program.
2. Offender visiting arrangements will permit a degree of informality including the opportunity for limited physical contact when consistent with overall security requirements.
3. The facility administrator, or designee, may permit and restrict visits on a case-by-case basis as deemed necessary to maintain facility security requirements or in the best interest of offender rehabilitation.
4. Facility employees will ensure written information governing visits is available to offenders within 24 hours of arrival at the facility.
5. Facility visiting procedures will categorize which visitation violations are major violations and which are minor violations. Facility procedures will also specify an appropriate notification procedure for notifying visitors and offenders of restrictions, revocations, or suspensions the facility imposes for violations of the visiting procedures.
6. Facility visiting procedures will define:
 - a. schedules that ensure reasonable visiting hours and offender availability;
 - b. methods for notifying and disseminating visiting schedules and rules to prospective visitors;
 - c. methods of retaining official visiting records or logs documenting each visitor’s signature, the date and time of the visit, and unusual incidents;
 - d. steps for documenting and maintaining confidential lists or logs of approved visitors;
 - e. location of visiting space staffed and equipped for effective supervision and surveillance;
 - f. areas in which contact and non-contact visitation will occur and when each type of visit is permissible;
 - g. accommodations for special or official visits and for persons with disabilities;
 - h. visiting as a privilege that may be curtailed as a disciplinary sanction; and
 - i. entrance and search procedures in compliance with *DOC Policies 3.1.5, Entrance Procedures, and 3.1.17, Searches and Contraband Control*.

B. Information for Visitors

Policy No. DOC 3.3.8	Chapter 3: Facility/Program Operations	Page 3 of 6
Subject: OFFENDER VISITING		

1. Facility staff will ensure offenders are provided the following information to communicate to family and friends:
 - a. the process for requesting visits;
 - b. facility/program address, phone number, directions, and local transportation;
 - c. visiting schedule and number of visitors permitted;
 - d. dress code and visitor identification requirements;
 - e. entrance and search procedures;
 - f. rules pertaining to children;
 - g. items permitted within the visiting area and items that visitors may give the offender;
 - h. grounds on which visits may be denied or terminated; and
 - i. reasons for special or extended visits.

C. Approval of Visitors

1. Visitors are subject to a criminal background check in accordance with *DOC Policy 3.1.5, Entrance Procedures*.
2. Unless approved by the administrator, or designee, children under the age of 18 may not visit unless accompanied by a parent or legal guardian or previously approved responsible adult.
3. Persons on probation, parole, or other forms of conditional release may not visit offenders unless approved by the administrator, or designee. Facility procedure may identify specific criteria for exclusion based on relationship to the offender or non-satisfactory adjustment to the community. The administrator, or designee, must contact the appropriate probation and parole officer prior to approval and the officer must provide a copy of the travel permit in advance of the visit.
4. The administrator will not automatically exclude persons with a criminal background from visits; however, the nature and extent of the criminal record, supervision status, and potential threat to facility safety and security will be considered.
5. The chief of security may exclude a person from the approved visitor list for a reasonable suspicion that the visitor may have a detrimental effect on the offender or may constitute a threat to facility safety or security.

D. Visiting Suspensions or Permanent Revocations

1. Visitors who attempt to or successfully introduce contraband will have visiting privileges permanently revoked.
2. Unless approved by the facility administrator, or designee, persons whose visiting privileges have been permanently revoked may not send money to an offender.
3. For a violation of visiting procedures, the facility may, at its discretion, suspend or permanently revoke an offender's visiting privilege with a particular visitor. If a person from the approved visitor list has suspended or revoked privileges, whether proposed or decided, they will be notified in writing and informed of their right to appeal.

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4. Suspension or permanent revocation of privileges from one facility/program automatically applies to any Department-owned or contracted facility or program.
5. An offender's loss of visiting privileges through disciplinary action will not necessarily result in loss of visiting privileges for the offender's visitor when the visitor is not involved in the rule infraction.

E. Current and Former Employee Visiting

1. Current Department employees, or former Department employees who left employment in good standing, may have visiting privileges with offenders who are immediate family members if the offender was an immediate family member before becoming incarcerated or committed to the Department. Current or former employees who are granted visiting privileges pursuant to this section must comply with this policy and facility procedures.
2. Department employees without immediate family ties to an offender prior to incarceration or community supervision may not have visiting privileges.
3. Former employees who were not immediate family members of an offender prior to incarceration or community supervision may not have visiting privileges unless approved by the facility administrator or designee.
4. Any employee terminated from employment for cause, who resigned in lieu of termination due to inappropriate activities with an offender, or who engaged in inappropriate activities discovered after employment discontinued will have a permanent restriction from visiting offenders.

F. Sex Offender Visiting

1. On a case-by-case basis, a facility may restrict visiting between minors and offenders convicted of current or prior crimes involving sexual offenses against a minor or offenses causing bodily injury to a minor. This restriction may be imposed if it is in the interest of visitor safety, the security of the institution, or the offender's rehabilitation. Before restricting all visiting pursuant to this section, the facility will consider non-contact visits, especially if the offender is the legally recognized parent or guardian of the minor and the minor was not the victim of the offense.

G. Searches of Visitors

1. The facility/program will prominently display a sign outside the visiting area entrance stating:
 - a. visitors are subject to search; and
 - b. consequences of introducing contraband into the facility.
2. Staff will identify and search all visitors in accordance with *DOC Policy 3.1.5, Entrance Procedures* and *DOC Policy 3.1.17, Searches and Contraband Control*.
3. Visitors are subject to clothed body searches and metal detector sweeps upon entrance to facility property and while on facility property.

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4. Upon reasonable suspicion that a visitor is in possession of contraband, staff may request the visitor to consent to participate in an unclothed body search. If the visitor does not consent to the unclothed body search, staff will allow the visitor to leave the facility.
5. If a visitor refuses to submit to a required or requested search, staff will deny the visit and submit a detailed incident report to the appropriate supervisor.
6. If contraband is found on a visitor, staff will confiscate the contraband, terminate the visit, and submit a detailed incident report to the appropriate supervisor. Depending on the nature of the contraband, staff may immediately contact law enforcement and detain the visitor in accordance with *DOC Policy 3.1.5, Entrance Procedures*.

H. Searches of Offenders

1. Facility procedures must include unclothed body search requirements in accordance with *DOC Policy 3.1.17, Searches and Contraband Control* for offenders who have contact visits.
2. Staff must be alert to any indication of items hidden in body cavities of offenders and, if such searches become necessary, comply with the body cavity search restrictions in accordance with *DOC Policy 3.1.17, Searches and Contraband Control*.

I. Visiting Area Searches

1. Staff must thoroughly search all areas accessible to visitors and offenders before and after visits including, but not limited to, the following:
 - a. furniture in the visiting area;
 - b. trash containers, requiring staff to remove trash accumulated during visits;
 - c. items or equipment used during visits;
 - d. walls, ceilings, and other structural areas that may have eluded staff observance; and
 - e. bathroom facilities and equipment.

J. Supervision of Visits

1. Adult facilities must provide direct visual supervision of the entire visiting area at all times.
2. Youth facilities must provide, at a minimum, intermittent direct visual supervision of the entire visiting area.
3. Using mirrors or cameras can augment direct supervision and compensate for blind spots; staff must position themselves throughout visits to maintain a direct line of sight on interactions between offenders and visitors.
4. Staff is required to intervene to stop inappropriate behavior including behavior outside the bounds of permitted intimacy or actions in violation of visiting regulations, especially behavior that may make others uncomfortable, that is disruptive, or that is offensive to other offenders and visitors.
5. Inappropriate behavior resulting in an incident report or termination of the visit will require staff to provide reasons for termination in writing to the offender and/or visitor.

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6. Notices informing visitors of monitoring and video surveillance will be posted in the visiting area including a notice that same-gender staff may monitor restrooms during visits if prohibited behavior is reasonably suspected.

K. Special Visits

1. Special visits may be approved in accordance with facility procedures for persons who travel long distances, visit hospitalized offenders upon the offender's deathbed, visit offenders in locked housing status, or for official visits arranged between offenders and attorneys, clergy, social service agency representatives, foreign consular representatives, or other officials. Staff will verify the qualifications of official visitors and may request background information and official assignment documentation from the visitor.
2. Facility procedures will specify conditions and requirements for special visits. Attorney visits will take place where the attorney and offender may be afforded sound privacy, i.e. conference rooms. Staff may not subject such visits to auditory supervision.
3. Facilities that permit extended visits must provide eligibility guidelines and other specifics such as length, location, and conditions of visits.
4. Special visits may require prior time and date approval in compliance with facility procedure.

V. CLOSING

Questions concerning this policy should be directed to chief of security or facility administrator.

VI. REFERENCES

- A. 37-61-418; 45-7-307, MCA
- B. 4-4498, 4-4499, 4-4499-1, 4-4500 through 4-4504; *ACA Standards for Adult Correctional Institutions*, 4th Edition
- C. 3-JTS-2E-03; *ACA Standards for Juvenile Correctional Facilities*, 2003
- D. *DOC Policies 3.1.5 Entrance Procedures and Detainment of Non-Offenders; 3.1.17 Searches and Contraband Control; 3.3.3 Offender Grievance Program*
- E. *Deserly v. Department of Corrections*, 2000 MT 42 (Mont. 2000)

VII. ATTACHMENTS

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 3.3.9	Subject: OFFENDER MARRIAGES
Chapter 3: FACILITY/PROGRAM OPERATIONS	Page 1 of 2
Section 3: Rights and Privileges	Effective Date: May 1, 1997
Signature: /s/ Mike Batista, Director	Revised: 06/26/2015

I. POLICY

It is the policy of the Department of Corrections to consider an inmate's request to be married while incarcerated to an incarcerated or non-incarcerated individual; marriages of juveniles in correctional facilities will be prohibited unless warranted by extraordinary circumstances. Inmate marriages must conform to the laws of the state of Montana.

II. APPLICABILITY

Secure care facilities under the supervision of, or contracted to, the Department of Corrections.

III. DEFINITIONS

Administrator - The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. A request to be married may be granted at the discretion of the administrator, or designee; inmates requesting to be married must request in writing to the administrator.
2. The administrator, or designee, must review the request with clinical and case management staff prior to approval.
3. Expenses and arrangements associated with the marriage will be the responsibility of the inmate or paid through other non-Department resources.
4. Marriage ceremonies will take place on prison property.
5. Conjugal visits or special privileges are not allowed under any circumstance.
6. Co-defendants of an on-going investigation or judicial process will not be allowed to marry until all cases have been fully adjudicated.

B. Eligibility Criteria

1. Minimum qualifications prior to consideration for marriage approval include:
 - a. inmate and potential marriage partner must meet all legal qualifications for marriage;
 - b. participation in a marriage counseling session with the facility chaplain or counselor;
 - c. inmate must exhibit clear conduct for a minimum period of six (6) months; and

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- d. a current custody classification level of Medium or Minimum.
- 3. Inmates with a criminal or civil record of domestic abuse will not be approved for marriage.

V. CLOSING

Questions concerning this policy should be directed to the facility administrator.

VI. REFERENCES

A. 2-15-112, MCA; 53-1-203, MCA

VII. ATTACHMENTS

None



POLICY DIRECTIVE

Policy:	DOC 3.3.10 INMATE ISSUED COMPUTER TABLETS	
Effective Date:	07/12/2018	Page 1 of 3
Revision Date(s):	10/18/2023; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department issues computer tablets to secure facilities for inmate use to increase access to educational and other resources that promote appropriate behavior and reduce recidivism and regulates the use of tablets as necessary to maintain safety and security.

II. APPLICABILITY

All secure facilities.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The Department issues inmate computer tablets and chargers through an approved vendor to all inmates in secure facilities.
 - a. Inmate computer tablets and chargers are not inmate or state property.
 - b. Neither the Department nor an inmate are allowed to physically alter or modify tablets.
2. Inmate computer tablets provide inmates access to approved communication with loved ones, receiving mail, legal and privileged mail, telehealth, educational courses, religious services, and various entertainment opportunities.
3. Rates and fees for services are provided in the *Inmate Tablet Programming Guide*.
4. Designated staff will train inmates on tablet functionality and tablet handling and care before issuance of tablets.
5. The Department routinely monitors inmate tablet usage for investigative and security purposes.
6. The Inmate Communications Committee will consider any new content for tablets that is intended to be used department wide.
 - a. The committee may form a temporary work group with subject matter experts from each area to review new content requests and report back to the committee.
7. Access to computer tablets is a privilege; the Department may restrict certain functions of tablets for disciplinary reasons, and for the safety and security of a facility.
8. Tablets do not have unrestricted access to the internet.
9. Facility administrators will:
 - a. assign duties and permission levels to staff, including the duty to process reports of damaged or malfunctioning tablets and permissions to reset passwords, monitor use activity, send notifications, and restrict or "power off" content; and
 - b. ensure that staff with assigned duties and permission levels have received appropriate training.

10. The person designated by the administrator to process reports of damaged or malfunctioning tablets will work with the vendor to take the tablet out of service and request replacement.

B. Programming

1. Each tablet is preprogrammed with a platform of content provided by the vendor and approved by the Inmate Communications Committee.
2. The Inmate Communications Committee will decide whether certificates will be provided as part of the platform to inmates for successful completion of coursework and will establish any necessary relevant protocols.
3. Movies that contain material that violates any Department policy will not be made available to inmates.
 - a. The Inmate Communication Committee may initiate removal of any movies or other content detrimental to the security, safety, health, good order, or discipline of the facility, or detrimental to the inmate rehabilitation process.
4. The administrator will designate one or more persons who may create new content for tablets (creator), and one or more different persons who may approve new content (approver).
 - a. The administrator may not designate the same person or persons to perform both the creation and approval functions.
5. Before creating content, the creator may consult with the facility administrator or the Inmate Communication Committee to gather initial input.
6. Once content is created, the creator will submit it to the approver.
 - a. The approver may approve, send back for adjustment, or reject any site-specific content such as unit rules, grievance forms, and facility procedures.
 - 1) If approved, the approver will add the content using the vendor's protocols.
 - 2) If the content is intended to be used Department-wide or is educational or therapeutic content that requires a determination of whether it must be evidence-based, the approver will submit the content to the Inmate Communications Committee.
 - a) The committee may approve, send back for adjustment, or reject the content.
 - (1) If approved, the committee will direct the approver for each pertinent facility to add the content using the vendor's protocols.
7. Types of content that may be added are listed in the *Inmate Tablet Programming Guide* maintained by the Inmate Communications Committee.

C. Inmate Use

1. Each inmate will answer self-chosen security questions and establish an individual password to allow for custom access.
 - a. All information and course progress are connected to an inmate's assigned tablet.
2. When an inmate signs in, the inmate must acknowledge the tablet is in good working condition. If the tablet is damaged or malfunctioning, the inmate must notify the staff assigned to process such reports.
3. Inmates will ensure tablets are plugged in and charged when in not in use for system updates to occur.
4. Inmates who encounter problems with a tablet may access the help and issue reporting features in the inmate personal account section. Inmates will communicate all issues or connectivity problems through the issue reporting feature.
5. If an inmate damages a computer tablet due to improper use or negligence, the inmate may be liable and charged restitution.

V. CLOSING

Questions about this policy should be directed to the Public Safety Chief.

VI. FORM

Inmate Tablet Programming Guide



POLICY DIRECTIVE

Policy:	DOC 3.3.15 AMERICANS WITH DISABILITIES ACT (ADA) OFFENDER ACCOMMODATIONS	
Effective Date:	03/11/2015	Page 1 of 7 with attachments
Revision Date(s):	12/12/2016; 08/5/2021; 08/29/2024	
Signature/Title:	/s/ Brian Gootkin, Director	

I. POLICY

The Department of Corrections will make reasonable accommodations to the known physical or mental limitations of an offender with a disability unless to do so would result in an undue financial or administrative burden, constitute a direct threat, endanger the health or safety of any person, or fundamentally alter the inherent nature of the Department's business.

II. APPLICABILITY

All divisions, facilities, and programs, Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Continuous Accommodations – Accommodations that are constant, on a permanent or semi-permanent basis. Certain examples of accommodations are listed in *DOC 3.3.15 Attachment A: Accommodation Categories*.

Disability – A physical or mental impairment that substantially limits one or more of a person's major life activities, a person who has a record of such an impairment, or a person who is regarded as having such an impairment. See *Americans with Disabilities Act of 1990, 42 USC 12010*, as amended.

Major Life Activities – Functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

Offender Americans with Disabilities Act (ADA) Coordinator – The individual assigned to facilitate ADA compliance for offenders.

OMIS – Acronym for the Department's Offender Management Information System.

Qualified Health Care Professional (QHCP): Physicians, physician assistants, nurses, nurse practitioners, dentists, mental health professionals, and others who, by virtue of their education, credentials, training, and experience are permitted by law to evaluate and care for patients, including Department staff and contracted or fee-for-service professionals.

Situational Accommodations – Accommodations that are temporarily needed based on circumstances. Certain examples of accommodations are listed in *DOC 3.3.15 Attachment A: Accommodation Categories*.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. The Department and contracted facilities or programs will provide offenders access to required or approved activities, services, and programs.

B. Responsibility

1. The offender Americans with Disabilities Act (ADA) Coordinator will assist facility and program administrators' compliance with the ADA and Montana Human Rights Act (MHRA). The offender ADA Coordinator will respond to requests for reasonable accommodations and complaints, train staff on the ADA, and grant accommodations to help ensure offenders with disabilities have access to all Department programs, services and activities that is consistent with the ADA.
2. The offender ADA Coordinator will have training in:
 - a. the Americans with Disabilities Act, Title II, which requires equal access to state programs and facilities by individuals with disabilities; and
 - b. the challenges faced by offenders with physical and/or mental impairments, programs designed to educate and assist disabled offenders, and all legal requirements for the protection of offenders with disabilities.
3. The offender ADA Coordinator, in coordination with the facility or program administrator, may designate a staff member at each facility or program to assist with the implementation of this policy.
4. All Department employees must recognize and take seriously all requests for disability accommodation, and any complaints or grievances involving disability discrimination or accessibility.
5. Through the screening, assessment, and intake process, if an offender appears to need an accommodation, Department employees will notify the ADA Coordinator.

C. Requests for Reasonable Accommodations

1. A request for accommodation is the first step in an interactive process between the offender ADA Coordinator, or designee, and the offender to clarify the offender's request and to identify any appropriate reasonable accommodation.
2. An offender may request information or an accommodation by contacting the offender ADA Coordinator verbally or in writing.
3. Offenders may submit requests for accommodation to any staff member who will forward the request to the offender ADA Coordinator. Offenders may also directly route any written request for accommodation by using an Offender/Staff Request (OSR) form to the locally designated facility or program ADA staff member or the offender ADA Coordinator.
4. When the disability is not obvious, the offender ADA Coordinator, or designee, may request reasonable documentation of the disability. Reasonable documentation is information necessary to establish that an offender has a qualified disability. This includes external documentation and internal testing and screening conducted by the Department. The offender may be asked to sign a release of information allowing the medical caregiver to respond to the Department.
5. Upon a determination the offender has a qualified disability, the offender and the offender ADA Coordinator, or designee, will determine what accommodation(s) would be most effective and reasonable. The list in *DOC 3.3.15 Attachment A: Accommodation Categories* may be used to assist this process, as may the Job Accommodation Network (<https://askjan.org/>). The Department will make the final determination of the reasonableness of an accommodation.
6. Offenders provided accommodations may be re-evaluated annually to ensure the accommodation is adequate and appropriate, the need for accommodation is ongoing, and no

additional accommodations are needed. No accommodations shall be taken away from an offender unless there has been a change to a program, a new accommodation has become available, a documented change in the offender's disability status has occurred, or facility staff determine it is necessary to remove the accommodation based on factors reasonably related to legitimate penological interests.

D. Accommodation Function in Offender Management System

1. All offender ADA accommodations will be documented in the offender management system. Staff who may use this function in the offender management system will be trained on its use.
2. Department staff will check the offender management system for documented ADA accommodations when an offender is new to a facility or program, needs services, or experiences other major events. Facilities and programs will define applicable major events in operational procedures.
3. Department staff will document in the offender management system when a situational or continuous accommodation is provided. Situational accommodations will be documented every time one is provided. Continuous accommodations will only be documented when one is first issued.
4. Staff should always consult the offender management system, if they have questions as to whether an offender is entitled to an accommodation.

E. Site-Specific Accommodations

1. Facilities and programs will make reasonable, site-specific accommodations for offenders with a verified disability.
2. Facilities and programs will adapt language in operational procedures to provide for accommodations to include, but not be limited to, count, body searches, and offender orientation.
3. The Department will operate each service, program, or activity so that the service, program, or activity, when viewed in its entirety, is readily accessible to and usable by individuals with disabilities. Specifically:
 - a. No individual with a disability will be housed in a cell that is physically inaccessible to them.
 - b. The determination whether an individual with a disability needs an accessible cell will be made by a Qualified Health Care Professional during the screening process referred to in IV.B.5 or pursuant to a request for reasonable accommodation under IV.C.
 - c. If a facility has fewer accessible cells than necessary to house individuals with disabilities who need such cells, priority will be given to individuals who are unable to ambulate into their cell without using a wheelchair. If a facility has fewer accessible cells than necessary to house individuals who are unable to ambulate into their cell without using a wheelchair, such individuals will be transferred to a facility that can house them consistent with this policy at their current security level or lower.

F. Complaints of Disability Discrimination

1. If an offender believes they have been subject to disability discrimination, the offender must report the allegation to the Department for prompt investigation and any appropriate actions.
 - a. Offenders who are unsatisfied with a final decision on a request for an accommodation by the offender ADA Coordinator or who are filing a complaint of disability discrimination may file a formal grievance in accordance with *DOC 3.3.3 Inmate Grievance Program*, and their facility or program's offender grievance procedure. In the case of a complaint of disability discrimination, the offender must file an informal resolution as required; however, the formal grievance will be processed regardless of whether the time limits set for filing the informal resolution were met.

- b. All requests, complaints, or grievances involving a disability issue should include specific facts, such as person or persons involved, structure or barrier involved, the date, time, and place of the occurrence, what was done or said, and the names of any witnesses present.

G. Response to Requests, Complaints, or Grievances

1. Employees and designated personnel at contracted facilities and programs will immediately inform the offender ADA Coordinator of any offender requests, complaints, or grievances involving a disability-related accommodation or discrimination. If the request, complaint, or grievance is unclear, staff shall meet with the offender for clarification.
2. The Department will act promptly to investigate and resolve all offender ADA requests, complaints, and grievances. Investigations shall be completed within 30 days, unless there are documented extenuating circumstances that make it impossible to complete the investigation. In those instances, the investigation shall be completed as promptly as possible.
3. A request may be denied if the accommodation is unreasonable or unnecessary, would result in undue financial or administrative burdens, constitute a direct threat, endanger the health or safety of any person, or fundamentally alter the inherent nature of the Department's business. After considering all resources, if a request is denied for these reasons, there must be a written statement outlining the reasons for the denial.

H. Record-Keeping Requirements

1. The offender ADA Coordinator will retain all documentation, including *DOC 3.3.15 Attachment B: Inmate ADA Request Routing*, when necessary, pertaining to the request, complaint, or grievance and the ensuing investigation in a separate investigative file.
2. The Department will maintain the confidentiality of all medical information, unless otherwise provided by law. The Department will only disclose information about the request internally on a need-to-know basis to personnel involved in making or assisting in the implementation of the reasonable accommodation or resolution of the request, complaint, or grievance.
3. The offender ADA Coordinator will maintain statistical data regarding requests, complaints, or grievances made pursuant to this policy, and the number of accommodations granted and will prepare an annual report on offender ADA activities to the Chief Legal Counsel and Department Director that includes successes, challenges, and recommendations.
4. The Department may conduct annual internal audits to ensure compliance with ADA offender requirements to include interviews with offenders, interviews with staff, and review of documentation.

V. CLOSING

Questions about this policy should be directed to the Department's offender ADA Coordinator. Copies may be posted in offender law libraries.

VI. REFERENCES

- A. 49-3-205, MCA; 49-3-209, MCA; 53-1-203, MCA
- B. *Americans with Disabilities Act of 1990*
- C. *DOC 3.3.3 Inmate Grievance Program*; *DOC 4.1.1 Offender Admission Process*; *DOC 4.1.2 Offender Reception and Orientation*

VII. ATTACHMENTS

DOC 3.3.15 Attachment A: Accommodation Categories
DOC 3.3.15 Attachment B: Inmate ADA Request Routing



ATTACHMENT A: ACCOMMODATION CATEGORIES

The following categories and accommodations are examples only. Other accommodations not listed here may be appropriate. If you have questions about disabilities or accommodations, please contact the Department ADA Coordinator.

Accommodation Category	Description
Speech Impairment	Communication Book or Board
Speech Impairment	Qualified Interpreter
Speech Impairment	Speech Synthesizer
Speech Impairment	Staff Assistance
Speech Impairment	TDD Machine
Mobility Impairment	Accessibility
Mobility Impairment	Cane
Mobility Impairment	Wheelchair
Mobility Impairment	Pusher
Mobility Impairment	Staff Assistance
Mental Impairment/Developmental Disability	Advocate
Mental Impairment/Developmental Disability	Staff Assistance
Visual Aid	Audiocassette
Visual Aid	Braille
Visual Aid	Large Print Material
Visual Aid	Magnifying Device
Visual Aid	Materials on Audiotape
Visual Aid	Personal Glasses
Visual Aid	Qualified Reader
Visual Aid	Reading Glasses
Visual Aid	Staff Assistance
Learning Disability	Audio-Taped Material
Learning Disability	Highlighter Pen and Marker
Learning Disability	Qualified Reader
Learning Disability	Reading Window, Ruler, or Angled Book
Learning Disability	Advocate
Learning Disability	Staff Assistance
Hearing Aid/Device	Assistive Hearing Device
Hearing Aid/Device	Closed Caption
Hearing Aid/Device	Communication Book
Hearing Aid/Device	Interpreter
Hearing Aid/Device	Note Taker
Hearing Aid/Device	Open and Closed Captioning
Hearing Aid/Device	Staff Assistance
Hearing Aid/Device	Typewriter
Hearing Aid/Device	Telecommunications Device
Hearing Aid/Device	Telephone Handset Amplifier
Hearing Aid/Device	Written Material
Other	



ATTACHMENT B: INMATE ADA REQUEST ROUTING

Offender Name: _____ Offender Number: _____

Facility: _____ Unit: _____

Date Request Received by Inmate ADA Coordinator: _____

Type of Request: _____

Please follow steps in numbered order.

1. Inmate ADA Coordinator

Is the request and/or concern an ADA issue?

- ☐ Yes (*develop proposed plan and proceed with step number 2*)
☐ No (*inform offender that their request is not an ADA issue*)

What disciplines does the request affect during the course of investigation?

- ☐ Medical
☐ Security
☐ Warden
☐ Legal
☐ Other: _____

Proposed Plan:

Date submitted to Health Services Bureau Chief: _____

Signature: _____ Date: _____
(Inmate ADA Coordinator)

2. Health Services Bureau Chief

- ☐ Proceed with Proposed Plan
☐ Proceed with Alternative Plan
☐ Do Not Proceed
☐ Comments:

Signature: _____ Date: _____
(Health Services Bureau Chief)

3. Inmate ADA Coordinator

(If applicable, revise proposed plan to align with Health Services Bureau Chief comments)

Revised Plan:

Signature: _____ Date: _____
(Inmate ADA Coordinator)

4. Review from Applicable Disciplines

**If request needs to be presented to the Warden Management Team, the Health Services Bureau Chief or designee will present the proposal.*

☐ Medical: _____
Initials: _____ Date: _____ Comments: _____

☐ Security: _____
Initials: _____ Date: _____ Comments: _____

☐ Warden: _____
Initials: _____ Date: _____ Comments: _____

☐ Legal: _____
Initials: _____ Date: _____ Comments: _____

☐ Other: _____
Initials: _____ Date: _____ Comments: _____

5. Health Services Bureau Chief

- ☐ Approved
- ☐ Not Approved
- ☐ Comments:

Signature: _____ Date: _____
(Health Services Bureau Chief)

6. Inmate ADA Coordinator

- ☐ Proposal has been approved by Health Services Bureau Chief and/or other disciplines (if applicable); proceed with resolution.
** In addition to this form, save the response letter, original request form, and all other pertinent documentation for record keeping.*
- ☐ Proposal has not been approved by Health Services Bureau Chief and/or other disciplines (if applicable); do not proceed.

Signature: _____ Date: _____
(Inmate ADA Coordinator)



POLICY DIRECTIVE

Policy:	DOC 3.3.20 OFFENDER NONDISCRIMINATION	
Effective Date:	03/20/2020	Page 1 of 2
Revision Date(s):	04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department does not tolerate employees committing any forms of discrimination, harassment, or retaliation against offenders based on the offender's race, color, religion, creed, political ideas, sex, age, marital status, physical or mental disability, or national origin, or in retaliation against an offender because the offender has opposed any discriminatory practices or because the offender has filed a complaint, testified, assisted, or participated in any manner in a discrimination investigation or proceeding. The Department is committed to resolving discrimination and harassment complaints in a fair and timely manner.

II. APPLICABILITY

All Department divisions, facilities, and programs.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. All administrators, supervisors, and Department employees must make every reasonable effort to ensure that offenders are not subject to discrimination, harassment, or retaliation within the context of the delivery of Department services or programs.
2. Any form of discrimination, harassment, or retaliation must not be tolerated.

B. Reporting and Investigation

1. An offender who believes the offender has been subjected to discrimination, harassment, or retaliation must report the allegation to the Department for prompt investigation and any appropriate actions.
2. Complaints may be made orally to appropriate Department staff or in writing; however, offenders are encouraged to put their complaint in writing.
3. Incarcerated offenders reporting a complaint of discrimination, harassment, or retaliation may file a formal grievance in accordance with *DOC 3.3.3 Offender Grievance Program*.
4. If a complaint of sexual harassment involves an incarcerated offender, the complaint will be handled in accordance with *DOC 1.1.17 Prison Rape Elimination Act of 2003 (PREA)*, and applicable facility or program procedures.
5. Offenders who are not incarcerated may report a complaint of discrimination, harassment, or retaliation by filing an *Offender Complaint Form* in accordance with *PPD 6.3.405 Offender Complaints*.

6. Any employee who believes an offender has been subjected to discrimination, harassment, or retaliation must report the incident(s) or action(s) to an administrator, supervisor, or HR as soon as possible after the alleged discrimination occurs.
7. Any administrator or supervisor who receives a complaint or becomes aware of offender discrimination, harassment, or retaliation will promptly relay the complaint to HR staff.
8. In accordance with ARM 2.21.4020, the Department will commence investigations regarding the circumstances and sufficiency of the complaint upon receiving the notice of allegations.
9. Upon receipt of a report alleging discrimination, harassment, or retaliation, the Department will take all appropriate steps to prevent the alleged conduct from continuing, pending completion of the investigation.
 - a. The Department will determine the steps to be taken by balancing the rights of the alleged victim, including the severity of the alleged conduct, and the rights of the alleged perpetrator.
10. Neither Department administrators nor any employee will retaliate against any offender for filing a discrimination complaint or for participating in any way in the discrimination or harassment complaint process.
11. Upon receipt of the investigator's report, the appropriate manager will disclose, in writing, the results of the investigation to the offender, the accused, immediate supervisors, and the facility or program EEO officer or ADA coordinator.
 - a. The specifics of disciplinary action taken against any Department employee will not be included in the report unless Department legal counsel advises to do so.
12. In the case of a cause finding, the appropriate agency manager will:
 - a. initiate the appropriate disciplinary actions in accordance with ARM Title 2, Chapter 21, Subchapter 65, Discipline Policy;
 - b. inform the offender in writing that corrective action has been taken;
 - c. reemphasize to the involved parties that retaliation is illegal; and
 - d. contact the offender within 30 days to ensure the behavior has stopped and no retaliation has occurred.
13. In the case of a no-cause finding, the supervisor or manager will contact the offender within 30 days to ensure the offender has not experienced retaliation.
14. Nothing in this policy prohibits an offender from filing a complaint of unlawful discrimination or retaliation with the Montana Human Rights Commission concurrently.

V. CLOSING

Questions about this policy should be directed to Human Resources.

VI. REFERENCES

- A. §§ 49-3-205; 49-3-209, MCA
- B. ARM 2.21.4001, *et seq.*; ARM 2.21.6505, *et seq.*
- C. DOC 1.3.12 *Staff Association and Conduct with Offenders*; DOC 1.1.17 *Prison Rape Elimination Act of 2003*; DOC 3.3.3 *Offender Grievance Program*
- D. PPD 6.3.405 *Offender Complaints*



POLICY DIRECTIVE

Policy:	DOC 3.3.21 OFFENDER VIDEO VISITATION	
Effective Date:	10/16/2020	Page 1 of 3
Revision Date(s):	04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department provides video visiting privileges for offenders consistent with facility security requirements and encourages family ties and the supportive relationships important to the stability of offenders while incarcerated and upon release.

II. APPLICABILITY

All Department secure facilities.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The chief of security will oversee a facility's video visiting program.
2. Offender video visiting arrangements will permit a degree of informality including the opportunity for visual and audio interaction with friends and/or family.
3. The facility administrator may permit and restrict video visits as deemed necessary to maintain facility security requirements or in the best interest of offender rehabilitation.
4. Facility employees will ensure written information governing video visits is available to offenders within 24 hours of arrival at the facility.
5. Facility video visiting requirements will:
 - a. categorize which video visitation violations are major violations and which are minor violations; and
 - b. specify an appropriate process for notifying visitors and offenders of restrictions, revocations, or suspensions the facility imposes for violations of the visiting requirements.
6. Facility video visiting requirements will define:
 - a. schedules that clearly define video visiting hours and offender availability;
 - b. methods for notifying and disseminating video visiting rules to prospective visitors;
 - c. methods of retaining official video visiting records or logs;
 - d. accommodations for special or official video visits and for persons with disabilities; and
 - e. video visiting as a privilege that may be suspended as a disciplinary sanction.

B. Video Visitation

1. The following conduct is prohibited during video visits:
 - a. any display of nudity;
 - b. behavior or actions that are sexual in nature;
 - c. use or display of any weapons, illegal substances, and related paraphernalia;
 - d. activity or display or graphics or paraphernalia associated with gangs; and
 - e. unlawful activity or depiction of unlawful activity.

2. Depending on the severity of the conduct violation, an offender's video visitation privilege may be suspended or revoked, as determined by the facility administrator.
3. Facilities will make reasonable accommodations to facilitate communication for offenders:
 - a. with hearing and/or speech disabilities; and
 - b. for offenders who wish to communicate with individuals who have such disabilities.
4. Facilities must include a plan to appropriately monitor offender video visitation in procedures or other written requirements.

C. Information for Video Visitors

1. Facility staff will ensure offenders are provided the following to communicate to visitors:
 - a. the process for establishing and scheduling video visits;
 - b. visiting schedule and number of video visitors permitted;
 - c. grounds on which video visits may be denied or terminated; and
 - d. reasons for special or extended video visits.
2. A visitor may be suspended or banned from participating in video visitations with offenders for conduct violations, as determined by the facility administrator.

D. Approval of Video Visitors

1. Children under the age of 18 may not participate in a video visit without a supervising adult present.
2. For juvenile video visits, a visitor must be on an approved visitors list.
3. Persons on probation, parole, or other forms of conditional release may not have video visit with offenders unless approved by the administrator.
 - a. Facility requirements may identify specific criteria for exclusion based on relationship to the offender or non-satisfactory adjustment to the community.
 - b. The applicable Probation and Parole Officer must contact the facility administrator prior to approval.
4. The chief of security may exclude a person from being a video visitor based on a reasonable suspicion that the video visitor may have a detrimental effect on the offender or may constitute a threat to facility safety or security.

E. Video Visiting Suspensions or Permanent Revocations

1. For a violation of visiting requirements, the facility may, at its discretion, suspend or permanently revoke an offender's video visiting privilege with a video visitor.
 - a. A video visitor whose privileges are being suspended or revoked, whether proposed or decided, will be notified in writing and informed of the right to appeal.
2. Suspension or revocation of privileges from one facility or program automatically applies to any Department-owned or contracted facility or program.
3. An offender's loss of visiting privileges through disciplinary action will not necessarily result in loss of video visiting privileges for the offender's visitor when the visitor is not involved in the rule infraction.
4. Offenders may appeal video visitation suspensions or revocations in accordance with *DOC 3.3.3 Inmate Grievance Program*.

F. Current and Former Employee Visiting

1. Current Department employees, or former Department employees who left employment in good standing, may have video visiting privileges with offenders who are immediate family members if the offender was an immediate family member before becoming incarcerated or committed to the Department.
 - a. Current or former employees who are granted video visiting privileges must comply with this policy and applicable facility procedures.
2. Department employees without immediate family ties to an offender prior to incarceration or community supervision may not have video visiting privileges.
3. Former employees who were not immediate family members of an offender prior to incarceration or community supervision may not have video visiting privileges unless approved by the facility administrator.
4. Any employee terminated from employment for cause, who resigned in lieu of termination due to inappropriate activities with an offender, or who engaged in inappropriate activities with offenders discovered after employment discontinued may be restricted from all types of offender visitation.

G. Sex Offender Visiting

1. On a case-by-case basis, a facility may restrict video visiting between minors and offenders convicted of current or prior sexual offenses against a minor or offenses causing bodily injury to a minor.
 - a. This restriction may be imposed if it is in the interest of visitor safety, the security of the institution, or the offender's rehabilitation.
 - b. If contact or no contact visits are disallowed, the facility may allow video visitation at the discretion of the facility administrator and the child's legal guardian and/or caregiver.

H. Monitoring of Video Visitation

1. An adult facility must audio-video record all video visits and ensure it has the technological ability for authorized staff to intermittently monitor the audio-video recording.
2. Inappropriate conduct resulting in an incident report or termination of the video visit will require staff to provide reasons for termination in writing to the offender and/or the video visitor.
3. Notices informing video visitors of monitoring and surveillance will be provided to persons who accept video visitation requests from offenders.
4. Staff must ensure video visitors do not have a line of sight to sensitive areas or materials that could jeopardize the safety and security of the facility.

V. CLOSING

Questions about this policy should be directed to chief of security or facility administrator.

VI. REFERENCES

- A. §§ 37-61-418; 45-7-307, MCA
- B. *Deserly v. Department of Corrections*, 2000 MT 42
- C. DOC 3.1.5 Secure Facility Entry and Exit; DOC 3.1.17 Searches and Contraband Control; DOC 3.3.3 Offender Grievance Program
- D. 4-4498, 4-4499, 4-4499-1, 4-4500 through 4-4504; ACA Standards for Adult Correctional Institutions, 4th Edition
- E. 3-JTS-2E-03; ACA Standards for Juvenile Correctional Facilities, 2003



POLICY DIRECTIVE

Policy:	DOC 3.4.1 INMATE DISCIPLINARY SYSTEM
Effective Date:	01/04/1996 Page 1 of 4
Revision Date(s):	09/09/2016; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

The Department maintains inmate rules of conduct, sanctions, and procedures for dealing with violations that are defined in writing and communicated to all inmate and staff. Disciplinary procedures are intended to hold inmate accountable for misconduct while incarcerated, to be acted on promptly, and carried out with respect for due process.

II. APPLICABILITY

All Department-owned and contracted secure facilities, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. inmate disciplinary procedures will incorporate American Correctional Association (ACA) standards in accordance with the provisions of this policy.
2. Administrators will ensure that penalties imposed on inmates are fair, reasonable, and consistent with the severity of the violation.
3. Confidential information will be restricted throughout the disciplinary process in accordance with *DOC 1.5.5 Inmate Records Management, Access, and Release*.
4. Any violation that is also a violation of criminal law may result in referral of the case to the appropriate court or law enforcement agency for consideration for prosecution of the case.
5. Staff assistance:
 - a. will be provided when a charged inmate is:
 - 1) illiterate,
 - 2) does not understand English, or
 - 3) where the complexity of the issue makes it unlikely that the inmate will be able to collect and present evidence; and
 - b. is assigned only to help inmates understand the charges against them, the disciplinary hearings process, the process for presenting their version of the charges, and the process to appeal.

B. Rules of Conduct

1. Facility requirements provide that:
 - a. written inmate conduct rules specify prohibited acts within the facility, the range of penalties that may be imposed for various degrees of violation, and disciplinary procedures governing inmate rule violations;
 - b. rules, penalties, and disciplinary procedures are reviewed annually and updated if necessary;

- c. inmates are provided written material that contains facility rules, penalties, and disciplinary procedures, signed acknowledgement of written material (receipt), and any necessary interpretative assistance in accordance with *DOC 4.1.2 Inmate Reception and Orientation*; and
 - d. all correctional staff who work directly with inmates receive initial and refresher training on current inmate conduct rules, rationale for rules, and available sanctions.
2. The general categories of inmate behaviors prohibited in facilities are outlined in *DOC 3.4.2 Prohibited Acts*.

C. Resolution of Minor Infractions

1. Procedures specify that written guidelines exist for resolving minor inmate infractions including a written statement of the violation and a hearing decision within 7 days, excluding weekends and holidays, and that inmates may waive their appearance at the hearing.

D. Disciplinary Reports

1. Procedures provide that when rule violations require a formal resolution, staff members must prepare a disciplinary report and forward it to the designated supervisor.
2. Disciplinary reports prepared by staff members include, but are not limited to, the following information:
 - a. specific rule(s) violated;
 - b. a formal statement of the charge;
 - c. any unusual inmate behavior;
 - d. any staff witnesses;
 - e. any physical evidence and its disposition;
 - f. any immediate action taken, including the use of force; and
 - g. the reporting staff member's signature, and report date and time.

E. Pre-Hearing Action

1. Procedures specify that when an alleged rule violation is reported, an appropriate investigation will begin within 24 hours of the time the violation is reported and is completed without unreasonable delay, unless there are exceptional circumstances for delaying the investigation.
2. Procedures for adult secure facilities include:
 - a. a provision for pre-hearing confinement of inmates who are charged with a rule violation;
 - b. documentation of the reason for the confinement; and
 - c. review of the pre-hearing status by the facility administrator or designee within 72 hours, including weekends and holidays.
3. Juvenile facilities will develop procedures for pre-hearing confinement in accordance with *DOC 3.5.1 Restrictive Housing*.
4. Pre-hearing confinement will not be punitive and will be used only when necessary to ensure the inmate's safety or facility security; no inmate will remain in pre-hearing confinement longer than necessary.
5. Procedures provide that an inmate charged with a rule violation:
 - a. receives a written statement of the charge(s) including the incident description and specific rules violated;
 - b. is given the statement when the disciplinary report is filed but no less than 24 hours prior to the hearing; and
 - c. may have a hearing within 24 hours with the inmate's written consent.
6. Procedures provide that the inmate may waive the right to a hearing if the waiver is documented and reviewed by the appropriate staff member.

F. Disciplinary Hearing – Scheduling

1. Procedures provide that inmates charged with rule violations are scheduled for hearings as soon as practicable but no later than 7 days, excluding weekends and holidays, after the alleged violation. Inmates are notified of the time and place at least 24 hours in advance of the hearing.
2. Procedures provide for disciplinary hearing postponement or continuance for a reasonable period and good cause, for example, defense preparation, investigation of related factual matters, and inmate illness or unacceptable behavior during the hearing process.
 - a. Reasons for all delays will be documented.

G. Conduct of Hearing

1. Procedures provide that rule violation disciplinary hearings are conducted by an impartial person or panel of persons.
 - a. Proceeding records are made and maintained for at least 6 months.
2. Procedures provide that inmates charged with rule violations are present at their hearings unless:
 - a. they waive that right in writing or through their behavior; or
 - b. inmates may be excluded during the testimony of any inmate whose testimony must be given in confidence; the reasons for the inmate's absence or exclusion will be documented.
3. Procedures provide that inmates have an opportunity to make a statement and present documentary evidence at the hearing and may request witnesses on their behalf.
 - a. The reasons for denying such a request are stated in writing.
4. Procedures provide that a staff member or agency representative may assist inmates at disciplinary hearings if requested.
 - a. A representative is appointed when it is apparent that an inmate is not capable of collecting and presenting evidence effectively on the inmate's own behalf.

H. Hearing Decisions – Basis for Decision

1. Procedures provide that the disciplinary decision is based solely on information obtained in the hearing process, including:
 - a. staff reports;
 - b. the statements of the inmate charged; and
 - c. evidence derived from witnesses and documents.

I. Hearing Record

1. Procedures provide that a written record is made of the decision and the supporting reasons and that a copy is given to the inmate.
 - a. The hearing record and supporting documents are kept in the inmate's file and in the disciplinary hearing records.
2. Procedures provide that if an inmate is found not guilty of an alleged rule violation, the disciplinary report is removed from the inmate's file, if reasonably possible.
 - a. Otherwise, the file must clearly indicate that the inmate was found not guilty of the alleged infraction.

J. Administrative Review

1. Procedures provide for review of all disciplinary hearings and dispositions by the facility administrator to assure conformity with policy and standards.

K. Appeal

1. Procedures grant inmates the right to appeal disciplinary decisions to the facility administrator.
 - a. Inmates have up to 15 days of receipt of the decision to submit an appeal.
 - b. The appeal is decided within 30 days of its receipt, and the inmate is promptly notified in writing of the results.
2. The appeal process will consider at least 3 factors:
 - a. whether there was substantial compliance with Department policy and procedures in handling inmate discipline;
 - b. whether the disciplinary decision was based on evidence; and
 - c. whether, under the circumstances, the sanction imposed was appropriate to the violation.

V. CLOSING

Questions about this policy should be directed to the facility administrator.

VI. REFERENCES

- A. *DOC 1.5.5 Offender Records Management, Access, and Release; DOC 3.4.2 Prohibited Acts; DOC 3.5.1 Restrictive Housing; DOC 4.1.2 Inmate Reception and Orientation*



POLICY DIRECTIVE

Policy:	DOC 3.4.2 PROHIBITED ACTS
Effective Date:	01/04/1996 Page 1 of 2
Revision Date(s):	05/06/2015; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

The Department requires its facilities to maintain and distribute a listing of the general categories of prohibited offender acts consistent with the provisions of this policy.

II. APPLICABILITY

All facilities Department owned and contracted, as specified in contract.

III. REQUIREMENTS

A. Prohibited Acts

1. In order to establish a firm foundation for offender conduct and the facility disciplinary process, the Department prohibits specific acts in its facilities.
2. Department Legal Services will review the Department's prohibited acts policy and corresponding facility operational procedures annually to ensure compliance with current statutory and case law requirements.
3. Specific Prohibitions
 - a. Although it is impossible to define every possible prohibited act or violation, the following acts are prohibited in all Department facilities:
 - 1) homicide
 - 2) assaulting any person
 - 3) threatening bodily harm or death to any person
 - 4) escape, attempting to escape, planning to escape, or leaving the facility without permission
 - 5) rioting or encouraging others to riot or cause an incident
 - 6) possessing or introducing ammunition, explosives, guns, or other weapons
 - 7) taking hostages
 - 8) setting a fire
 - 9) fighting with another person(s)
 - 10) engaging in sexual acts, making sexual proposals or threats; indecent exposure
 - 11) possessing, introducing, or using any narcotic, narcotic paraphernalia, drugs or intoxicant not prescribed for the offender by medical staff
 - 12) possessing contraband
 - 13) extortion, blackmail, protection; i.e., demanding or receiving anything of value in return for protection against others to avoid bodily harm or under threat of informing
 - 14) interfering with a staff member performing duties
 - 15) conduct that disrupts or interferes with the security or orderly operation of the facility, housing unit, or workplace
 - 16) destroying, altering, or damaging facility property or the property of another person
 - 17) theft or possessing stolen property
 - 18) counterfeiting, forging, possession, or unauthorized reproduction of any signature, document, article of identification, money, security or official papers

- 19) violating a condition of furlough, pass, or any other conditional or temporary release
- 20) refusing to work, report to work, or accept a program assignment
- 21) loaning or possessing property belonging to another person or the government, or loaning property or anything of value for profit or increased return
- 22) gambling or other illegal activity for gain
- 23) being in an unauthorized area
- 24) failing to abide by the conditions of a disciplinary disposition
- 25) failing to obey a staff member's order
- 26) interfering with due process
- 27) misusing authorized medication
- 28) encouraging, facilitating, attempting to commit any prohibited act, or being an accomplice or a conspirator in committing such acts
- 29) lying or providing a false statement to a staff member
- 30) inappropriate conduct with a visitor
- 31) failing to follow safety or sanitation regulations; being unsanitary or failing to keep oneself or one's quarters according to facility standards
- 32) unauthorized communication
- 33) insolent or disrespectful behavior toward a staff member
- 34) smoking or using tobacco products or paraphernalia
- 35) conducting unauthorized business
- 36) fraudulent claims for medical care or malingering or feigning an illness
- 37) refusing to provide a urine or breath sample for testing purposes
- 38) failing to report as directed
- 39) giving or offering any official or staff member a bribe or anything of value
- 40) violating any municipal, county, state, or federal law
- 41) failing to comply with, being late for, or interfering with offender count
- 42) using abusive language toward any person
- 43) participating in an unauthorized meeting or gathering
- 44) violating established facility rules

B. Categories of Offenses

1. Facilities may list prohibited acts into major and minor offense categories.
2. Acts categorized as major offenses are considered perilous and must be resolved formally.
3. At the discretion of staff, any other prohibited acts may be referred for formal disciplinary proceedings.

C. Offender Advisement

1. Facilities will ensure that the list of prohibited acts is:
 - a. written in a language spoken by the majority of the offender population;
 - b. posted in each facility housing area; and
 - c. readily available to all offenders and facility staff.
2. Offenders will sign a form acknowledging they have received and understand the prohibited acts information in accordance with *DOC 4.1.2 Offender Reception and Orientation*.

IV. CLOSING

Questions about this policy should be directed to the facility administrator or the Department Legal Services.

V. REFERENCES

- A. 2-15-112, MCA
- B. *DOC 3.4.1 Offender Disciplinary System; DOC 4.1.2 Offender Reception and Orientation*



POLICY DIRECTIVE

Policy:	DOC 3.4.3 TOBACCO USE REGULATIONS	
Effective Date:	01/01/1998	Page 1 of 2
Revision Date(s):	03/01/2016; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department will provide a smoke-free work and living environment for employees, visitors, and offenders in accordance with the Montana Clean Indoor Air Act and will outline tobacco use provisions appropriate to the functions of the Department.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Smoking Regulations

1. In compliance with the Montana Clean Indoor Air Act, smoking is prohibited in enclosed areas and buildings in order to:
 - a. protect the public health and welfare in public places and places of employment;
 - b. recognize the right of nonsmokers to breathe smoke-free air; and
 - c. recognize that the need to breathe smoke-free air has priority over the desire to smoke.
2. Administrators may establish designated outdoor smoking areas:
 - a. away from building entrances; and
 - b. in locations where smoke does not enter through entrances, windows, or ventilation systems that may affect nonsmoking areas on Department property that does not house offenders.
3. Tobacco use is prohibited in all State-owned and leased vehicles in accordance with the Montana Department of Transportation (Motor Pool) and Department of Corrections lease agreement.

B. General Tobacco Regulations

1. Administrators will ensure signs prohibiting smoking within Department buildings and offices are prominently displayed at the appropriate entrances.
2. For consistency, the recommended language for entrance signs will include:
 - a. Attention: All Employees and Visitors to DOC Properties
The Department prohibits smoking in Department buildings and offices in accordance with *DOC 3.4.3 Tobacco Use Regulations*.
3. Vacancy announcements for Department positions will contain tobacco use restrictions and newly hired employees will review the provisions of this policy upon employment.

C. Facilities Not Housing Offenders

1. Department employees, offenders, and visitors within Department buildings and offices that do not house offenders may possess tobacco products for personal use.
2. Smokeless tobacco products may be used inside Department buildings and offices that do not house offenders.
 - a. Employees must use professional judgment and discretion when using smokeless tobacco products while on duty.

D. Facilities Housing Offenders

1. Administrators will:
 - a. prohibit employees and visitors from possessing, using, or transferring tobacco products in facilities housing Department offenders;
 - b. may ban the use of tobacco products on all facility property; and
 - c. ensure signs prohibiting the possession, use, or transfer of tobacco products in facilities are prominently displayed at appropriate entrances.
2. Department employees who work in or who are visiting Department buildings and offices will secure tobacco products for personal use in locations that comply with facility operational procedures.

E. Regulations for Offenders

1. Offenders are prohibited from using, possessing, and transferring tobacco products while housed in Department facilities or programs.
 - a. Tobacco products are considered contraband or illegal in adult and youth secure facilities and will be confiscated.
2. Administrators may approve exceptions to tobacco use restrictions for legitimate offender spiritual practices in accordance with *DOC 5.6.1 Religious Programming* and the American Indian Religious Freedom Act of 1978.
3. Offenders under community supervision will comply with Department policies and procedures regarding tobacco use while on Department property.
4. Administrators of contracted facilities or programs housing Department offenders will prohibit the use, possession, and transfer of tobacco products in accordance with the provisions of this policy.

V. CLOSING

Questions about this policy should be directed to the appropriate administrator.

VI. REFERENCES

- A. §§ 2-15-112; 45-7-307; 53-1-203; 53-30-101(3)(c); Title 50, Chapter 40, MCA
- B. *State of Montana Motor Pool Lease Agreement*
- C. *American Indian Religious Freedom Act of 1978*
- D. *DOC 5.6.1 Religious Programming*



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy:	DOC 3.5.1 RESTRICTIVE HOUSING
Chapter 3:	FACILITY/PROGRAM OPERATIONS
Section 5:	Special Management
Effective Date:	May 1, 1997 Page 1 of 8
Revised:	January 31, 2022
Signature:	/s/ Brian Gootkin, Director

I. POLICY

The Department of Corrections maintains safe, secure housing for offenders who require separation from the general offender population for detention or for safety and security reasons.

II. APPLICABILITY

This policy is applicable to all Department secure care adult and youth facilities.

III. DEFINITIONS

Administrator – The official, regardless of local title (administrator, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Administrative Segregation – A non-punitive housing status for offenders whose continued presence in the general population may pose a serious threat to life, property, self, staff, other offenders, or to the facility's security or orderly operation, e.g., an offender may be housed in administrative segregation during an investigation of alleged violations.

Disability – see *DOC 3.3.15 Americans With Disabilities Act (ADA) Offender Accommodations*, for the definition and explanation of disability.

Disciplinary Detention – A form of separation from the general population in which inmates committing serious violations of conduct regulations are confined by the disciplinary committee or other authorized group for short periods of time to individual cells separated from the general population. Placement in detention only may occur after a finding of a rule violation at an impartial hearing and when there is not an adequate alternative disposition to regulate the inmate's behavior.

Mental Disorder - Means exhibiting impaired emotional, cognitive, or behavioral functioning that interferes seriously with an individual's ability to function adequately except with supportive treatment or services. The individual also must:

- (a) currently have or have had within the past year a diagnosed mental disorder; and
- (b) currently exhibit significant signs and symptoms of a mental disorder.

Post-Partum – The first six weeks following delivery.

Pre-hearing/Temporary Confinement – A short-term, non-punitive housing status that is used to safely and securely control high-risk or at-risk offenders.

Protective Custody – A form of separation from the general population for inmates requesting or requiring protection from other inmates for reasons of health or safety. The inmate's status is reviewed periodically by the classification committee or other designated group.

Restrictive Housing – A placement that requires an inmate to be confined to a cell at least 22 hours per day for the safe and secure operation of the facility. The term includes administrative segregation, protective custody, and disciplinary detention. The term Restrictive Housing does not include Pre-hearing confinement as defined above.

Qualified Mental Health Professional – Includes psychiatrists, psychologists, psychiatric social workers, licensed professional counselors, psychiatric nurses, or others who, by virtue of their education, credentials, and experience, are permitted by law to evaluate and care for the mental health needs of patients.

Severe Mental Illness – a substantial organic or psychiatric disorder of thought, mood, perception, orientation, or memory that significantly impairs judgment, behavior or the ability to cope with the basic demands of life. Intellectual disability, epilepsy, other developmental disabilities, alcohol or substance abuse, or brief periods of intoxication or criminal behavior do not alone constitute severe mental illness.

Step-down Program – A program that includes a system of review and establishes criteria to prepare an inmate for transition to general population or the community. Individualized programs involve a coordinated, multidisciplinary team approach that includes mental health, case management, and security practitioners. Medical personnel must be part of the multidisciplinary team when inmates who have chronic care or other significant medical accommodation needs participate in this program.

IV. DEPARTMENT DIRECTIVES

A. General Policy

1. Operational procedures that govern restrictive housing and protective custody will incorporate American Correctional Association (ACA) standards in accordance with the provisions of this policy.
2. An offender's placement in restrictive housing may not exceed 22 hours in a 24-hour period and is limited to circumstances that pose a direct threat to the safety of persons or a clear threat to the safe and secure operations of the facility. Placement may only be made after considering:
 - a. the relationship between the threat the offender poses, and behaviors articulated in the policy;
 - b. the impact that restrictive housing may have on medical and mental health conditions exhibited by the offender and possible alternatives that may be available to compensate for such conditions; and
 - c. a description of alternatives that may be available to safely address the threat posed by the inmate other than restrictive housing.
3. Youth will not be placed in restrictive housing, meaning they will not be kept in a room or cell for more than 22 hours per day. A youth may be placed in protective custody for temporary confinement when necessary to protect the youth or others, subject to the

provisions in IV.F of this policy and applicable facility procedures.

4. Female inmates determined to be pregnant or Post-Partum, will not be housed in restrictive housing unless it is determined exigent circumstances exist. When exigent circumstances exist, females who are pregnant or Post-Partum may be placed in restrictive housing for up to 24 hours. Any extension for exigent circumstances beyond 24 hours must be approved by the facility administrator or designee.
5. Written operational procedures will govern restrictive housing and protective custody units for the supervision of offenders under administrative segregation, disciplinary detention, pre-hearing status, and protective custody.
6. For secure care adult facilities, the administrator or shift supervisor may order immediate segregation or placement in a restrictive housing unit when it is necessary to protect the offender or others. The action must be reviewed within 24 hours by the appropriate supervisor.
7. Secure care adult facilities will maintain a sanctioning schedule for facility rule violations. The administrator, or designee, must review and approve adult offender confinement that continues beyond 30 days. Continuous confinement for more than 30 days requires the review and approval of the administrator or designee.

B. Admission and Review of Status

1. Adult facility operational procedures will include the following requirements:
 - a. there will be a documented process to admit an offender to a restrictive housing unit. Offenders may only be admitted for protective custody when there is documentation that this status is warranted, and no reasonable alternatives were available;
 - b. the classification committee or other authorized staff group will conduct a status review of offenders in administrative segregation and protective custody every seven (7) days for the first 60 days and at least every 30 days thereafter;
 - c. in non-emergent circumstances, no offender will be disciplined, placed on a behavior management plan, classified, or reclassified to a restrictive housing unit based upon his/her disability, or upon behavior that is a product of his/her disability unless the placement is after a prompt and appropriate evaluation by a qualified mental health professional;
 - d. there will be a documented review process to release an offender from administrative segregation or protective custody status;
 - e. no offender will be placed in pre-hearing confinement or placed in restrictive housing based solely upon his/her disability or upon behavior that is a product of his/her disability unless, after a prompt and appropriate evaluation by a qualified mental health professional, such staff determines that the offender presents such an immediate and serious danger that there is no reasonable alternative. In such a case, the offender will be promptly re-evaluated within 48 hours and regularly re-evaluated every 14 days, with the goal of securing appropriate treatment and reintegrating the offender into general population;
 - f. a hearing by the disciplinary committee or hearings officer must be completed before placing an offender in disciplinary detention for a rule violation; and
 - g. offenders held in disciplinary detention for periods exceeding 60 days will be

provided the same program services and privileges as offenders in administrative segregation or protective custody. The administrator, or designee will review and approve of the services and privileges to be allowed in such circumstances.

2. A new adult offender placed directly into restrictive housing will receive written orientation materials and/or translations in their own language. When a literacy problem exists, a staff member assists the offender in understanding the material. Completion of orientation is documented by a statement signed and dated by the offender.

C. Mental Health Status Reviews

1. When housing or management units exist for adult or youth offenders with mental disorders procedures provide for placements, assessments, specialized treatments, program services, and scheduled case reviews by qualified mental health professionals in accordance with *DOC 4.5.21, Restrictive Housing Offender Health Assessment and Services* and *DOC 4.5.27, Offender Mental Health Services*.
2. Upon notification that an inmate has been placed in restrictive housing, a qualified health care professional will review the offender's health record. If an existing medical, mental health or dental need(s) requires accommodation, custody staff will be notified. When reviewing health records of offenders with mental disorders who has been placed in restrictive housing, a qualified health care professional shall notify mental health staff. This review and notification must be documented in the health record.
3. Procedures will provide that offenders entering restrictive housing will be seen and assessed by a qualified mental health professional or health care professional, in accordance with the National Commission on Correctional Health Care (NCCHC) standard *P-G-02*. Each contact will be documented in the individual offender's record, and contain, at a minimum, a status report and the date and time of the contact. Individual documentation will be filed in the offender's medical and mental health records.
4. A qualified mental health professional will complete a mental health appraisal within the period set by American Correctional Association standards after an offender's placement in restrictive housing. This may include a mental health review that has been completed by health care personnel at the time the offender is placed in restrictive housing. If confinement continues beyond 30 days, a qualified mental health professional must complete an updated mental health appraisal with the frequency set by American Correctional Association standards for offenders with a diagnosed mental disorder and more frequently if clinically indicated. For offenders without a mental disorder, the appraisal is completed with the frequency set by American Correctional Association standards and more frequently if clinically indicated. The mental health appraisal will be conducted in a manner that ensures confidentiality. Dissemination of any information obtained in the mental health appraisal must be for the limited purpose of institutional safety and security.
5. An offender diagnosed with a severe mental illness will not be placed in restrictive housing for an extended period (more than 14 days), unless the multidisciplinary service team determines there is an immediate and present danger to others or the safety of the institution. There must be an active individualized treatment plan that includes weekly monitoring by mental health staff, treatment as necessary, and steps to facilitate the

transition of the offender back into general population.

D. Supervisory Oversight

1. Procedures will provide that adult offenders in restrictive housing or protective custody receive daily visits from the shift supervisor or supervisor in charge, daily visits from a qualified health care professional unless more frequent visits are indicated, and visits from members of the program staff upon request.
2. Procedures require that all restrictive housing adult offenders are personally observed by a correctional officer at least every 30 to 60 minutes on an irregular schedule. Adult offenders who are violent or mentally disordered or who demonstrate unusual or bizarre behavior will receive more frequent observation; suicidal offenders will be under continuing observation.
3. Procedures will govern the selection criteria, supervision, and rotation of staff who work directly with offenders in restrictive housing units on a regular and daily basis.

E. Logs and Record-Keeping

1. All restrictive housing units will comply with the general record-keeping requirements provided in *DOC Policy 3.1.3, Logs and Record-Keeping Systems*.
2. Facilities will adopt procedures providing that staff operating restricted housing units maintain permanent logs and records that adequately document the activities, programs, and visitation patterns of the unit and of individual offenders. Staff will maintain records that include the following:
 - a. all admissions and releases including date of action, time of action, reason for admission or release, and authorizing official or committee;
 - b. a record of visitors, including all official visits by staff members, e.g., medical staff visits, and the time, date, and signature of the visitor;
 - c. notations of unusual behavior by individual offenders or the unit as a whole; and
 - d. information from and observations by staff members, which are forwarded for staff action and observation to future shifts.

F. Conditions of Confinement

1. Offenders in restrictive housing units are provided:
 - a. prescribed medication and other medically necessary treatment as prescribed by a qualified health care professional;
 - b. clothing that is not degrading or specialized clothing when reasons for its use are documented;
 - c. access to basic personal items for use in their cells unless there is imminent danger that an offender or any other offender(s) will destroy an item or induce self-injury;
 - d. the opportunity to shower and shave at least three times per week;
 - e. laundry, barbering, and hair care services; and
 - f. the opportunity to exchange clothing, bedding, and linen on the same basis as offenders in the general population.

Exceptions may be permitted if found necessary by the supervisor, recorded in the offender's log and justified in writing.

2. The facility may provide alternative meal service to an offender who uses food or food service equipment in a manner that is hazardous to self, staff, or other offenders. Service will be provided on an individual basis, based only on health or safety considerations, meet basic nutritional requirements, and occur with the written approval of the administrator or chief health care authority. The food substitution period will not exceed seven (7) days.
3. Procedures provide that whenever an adult or youth offender is deprived of any usually authorized item or activity, a report of the action is filed in the offender's case record and forwarded to the facility's chief of security.

G. Programs, Services, and Access to Legal and Reading Materials

1. Offenders in restrictive housing units must be allowed:
 - a. to write and receive letters on the same basis as offenders in the general population;
 - b. have opportunities for visitation unless there are substantial reasons for withholding such privileges, as approved by the facility administrator;
 - c. have access to personal legal materials and available legal reference materials; and
 - d. have access to reading materials from the facility library.
2. Offenders in administrative segregation and protective custody have access to programs and services that include, but are not limited to, the following:
 - a. educational services;
 - b. commissary services;
 - c. library services;
 - d. social services;
 - e. counseling services;
 - f. religious guidance; and
 - g. recreational programs.
3. The programs and services described above may not be identical to those provided to the general population; however, there will be no major differences for reasons other than danger to life, health, or safety. This standard also applies to adult offenders held in disciplinary detention for more than 60 days.
4. No offender with a disability may be denied a reasonable accommodation simply because the offender is in restrictive housing, or similar condition, unless safety or security concerns render the accommodation unreasonable.
5. Offenders who use wheelchairs (who cannot stand independently) will not be housed in the isolation cells located in restrictive housing. Offenders who use wheelchairs who are not able to transfer into a shower stall will not be housed in restrictive housing.

H. Exercise Outside of Cell

1. Adult offenders in restrictive housing or protective custody will receive a minimum of one hour of exercise per day outside their cells, five days per week, unless security or safety considerations dictate otherwise.
2. Youth in protective custody will be allowed one hour of large muscle activity every 24

hours.

I. Telephone Privileges

1. Adult offenders in restrictive housing for administrative segregation and protective custody and youth in protective custody are allowed telephone privileges.
2. Offenders in restrictive housing are allowed at minimum telephone privileges to access the judicial process, to call an attorney of record and family emergencies as determined by the facility administrator or designee unless security or safety considerations dictate otherwise.
3. Unless phone restrictions have been invoked by the administrator or designee, an adult offender in disciplinary detention is allowed limited telephone privileges. Restrictions would not apply to calls related specifically to access to the attorney of record.

J. Additional Youth Facility Requirements

1. Youth facilities will not use restrictive housing as a sanction to manage youth behavior.
2. The administrator, shift supervisor, or designee may order a youth be placed in protective custody for temporary confinement, not to exceed 24 hours, when it is necessary to protect the youth or others. The action must be reviewed within four (4) hours regardless of weekends or holidays or the next morning if the youth is placed in protective custody after 2100 hours.
3. Procedures will provide special management for youth offenders with serious behavior problems and for youth requiring protective care.
 - a. Youth facilities will develop individual program plans and provide appropriate services that may require youth offenders to be separated from the general population.
 - b. Youth in protective custody will be allowed out of cell for more than two (2) hours per day.
4. Youth in protective custody will be observed by staff at least every 15 minutes.
5. Youth in protective custody will be visited at least once each day by staff from administrative, clinical, social work, religious, or medical units.

K. Stepdown Programs

1. Facilities will establish stepdown programs and offer them to offenders who have been in restrictive housing for longer than 30 days to facilitate reintegration of the offender into general populations or the community. Stepdown programs will include, at a minimum, the following:
 - a. a pre-screening evaluation;
 - b. monthly evaluations using a multidisciplinary approach to determine the offender's compliance with program requirements;
 - c. subject to monthly evaluations, gradually increasing out-of-cell time to gradually increasing group interaction to gradually increasing education and programming opportunities to gradually increasing privileges;
 - d. a stepdown transition compliance review; and

- e. post-screening evaluation.
- 2. Facilities will attempt to ensure that offenders are not released directly into the community from an extended period (more than 30 days) of restrictive housing.
 - a. In the event that the release of an offender directly from restrictive housing into the community is imminent, the facility will document the justification and, unless the justification is an immediate court-ordered release, will obtain approval from the Department Director or designee.
 - b. In addition to general release protocols, when an offender is released directly to the community from an extended period (more than 30 days) of restrictive housing, the following steps must be taken at a minimum:
 - 1) Development of a release plan tailored to specific needs of the offender (except in cases of immediate court-ordered release);
 - 2) Notification of the release to state and local law enforcement;
 - 3) Notification to the offender of applicable community resources; and
 - 4) Victim notification if applicable.

V. CLOSING

Questions concerning this policy should be directed to the facility administrator.

VI. REFERENCES

- A. *Mont. Code Ann. § 53-30-101; 53-30-701, et seq.*
- B. *4-4249 through 4-4273; ACA Standards for Adult Correctional Institutions, 4th Edition*
- C. *3-JTS-3E-01 through -3E-05; ACA Standards for Juvenile Correctional Facilities, 2003*
- D. *ACA Guidelines for Development of a Security Program, 3rd Edition, 2007*
- E. *National Commission on Correctional Health Care Standards, 2014*
- F. *DOC Policies 3.1.3, Logs and Record-keeping Systems; 3.5.5, Behavior Management Plans; 4.5.21, Restrictive Housing Offender Health Assessment and Services; 4.5.27, Offender Mental Health Services*

VII. ATTACHMENTS

None



POLICY DIRECTIVE

Policy:	DOC 3.5.5 BEHAVIOR MANAGEMENT PLANS	
Effective Date:	10/16/2003	Page 1 of 4
Revision Date(s):	06/15/2009; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

The Department maintains a comprehensive strategy to manage and end an inmate's repeated dangerous and/or assaultive conduct. Behavior management plans address chronic, serious behavior problems not associated with serious mental illness.

II. APPLICABILITY

Department and contracted secure facilities that house and manage adult inmates.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Comments

1. Dangerous and/or assaultive inmate behaviors may:
 - a. threaten the safe and orderly operation of the facility and the physical safety of staff, inmates, and facility visitors; and
 - b. impede efforts toward inmate rehabilitation.
2. Behavior management plans are not punishment but are used as the last recourse for controlling an inmate's dangerous and/or assaultive behaviors so that serious consequences to the inmate and others may be averted.
3. Behavior management strategies may include a period of time in which facility staff withhold an inmate's personal items and/or privileges and return them when an inmate demonstrates the inmate meets the objectives of the plan and is free of dangerous and/or assaultive behaviors.

B. Behavior Management Plan (BMP) Elements

1. The standardized BMP includes the following essential elements:
 - a. documentation of the inmate's specific dangerous and/or assaultive conduct that necessitated the plan;
 - b. examples of appropriate conduct that the plan is designed to achieve;
 - c. the actions facility staff will take to attempt to modify the dangerous and/or assaultive conduct (for example, turn off the cell water supply, initiate steps #1 through #3);
 - d. the date on which the plan will become effective;
 - e. the date on which the plan will end; and
 - f. the signatures of the unit management and mental health staff members who helped prepare the plan.
2. The unit manager may provide the inmate with a copy of the BMP and review the following with the inmate:
 - a. the inappropriate conduct in which the inmate has engaged;
 - b. the appropriate conduct the unit expects;

- c. the steps of the plan and what the inmate may expect in each step;
- d. that if the inmate engages in the specified inappropriate conduct, facility staff will place the inmate on step #1 of the plan;
- e. that if the inmate begins step #1, the inmate must successfully complete all steps of the plan before the inmate is returned to pre-plan status; and
- f. that the plan is not intended as punishment, but as a plan to gain the inmate's compliance with appropriate conduct.

C. BMP Initiation

1. When an inmate exhibits repeated dangerous and/or assaultive behavior, facility staff must thoroughly document the behavior:
 - a. based on the documentation, unit staff may place the inmate on cell confinement for a period of 24 hours and immediately refer the case to mental health staff for an initial assessment to determine if the inmate's behavior is the result of a serious mental illness.
 - 1) If mental health staff determine the inmate's behavior is unrelated to serious mental illness, the inmate will remain on cell confinement and may be placed on Step #1 of the standardized BMP.
2. Before an inmate may be formally reviewed for a BMP, a mental health professional must:
 - a. complete a thorough psychological assessment that concurs with each of the following:
 - 1) the dangerous and/or assaultive behavior is not the direct result of an Axis I serious mental illness;
 - 2) the inmate is knowingly, willingly, and purposely engaging in the dangerous and/or assaultive behaviors;
 - 3) a higher level of mental health care or observation is not indicated; and
 - 4) the inmate's mental status is not presently deteriorated or deteriorating.
3. The mental health professional will ensure that the inmate's name is added to the BMP clearance list so the inmate's behavior may be monitored and managed by unit management staff in accordance with the BMP.

D. BMP Activation

1. The inmate's name will be maintained on the BMP clearance list for 6 months.
2. Shift supervisors will ensure that housing unit officers provide the written incident reports of the inmate's behavior necessary to activate the BMP and promptly notify and consult with unit management staff.
3. With appropriate documentation, the unit manager will:
 - a. activate the BMP any time during the 6 months if the inmate violates its specific provisions;
 - b. notify mental health staff when and why a BMP is activated;
 - c. sign and date the plan and, if the inmate's behavior is under control, ask the inmate to sign the plan.
4. The plan will be placed in the inmate's unit and mental health files.
 - a. If the inmate refuses to sign the plan, the unit manager must document the refusal.

E. BMP Requirements

1. Facilities that manage an inmate referred to the BMP clearance list will use the standardized BMP that includes the specific requirements of steps #1, #2, and #3.
2. When the inmate is on any of the 3 steps of the BMP, housing unit security staff must complete written incident reports every 24 hours documenting the inmate's compliance or

noncompliance with the BMP and forward the documentation to the unit manager, mental health staff, and designated supervisory office.

3. An inmate on an activated BMP:
 - a. will maintain basic hygiene and keep the inmate's cell clean; showers will be offered every two days;
 - b. will not be offered out-of-cell recreation while on the plan; and
 - c. will be relegated to an earlier step in accordance with the plan and supporting documentation if and when the inmate engages in prohibited conduct.
4. Housing unit staff may enact a new plan by requesting a 6-month extension of the BMP and referring the inmate to mental health staff for a BMP clearance.

F. BMP Activation – Mental Health Issues

1. Unit staff must immediately notify the facility control center, a mental health clinician, and facility health care staff if an inmate exhibits any of the following symptoms:
 - a. makes statements or exhibits conduct that indicates imminent danger of self-harm or suicide;
 - b. exhibits ongoing signs of severe depression, such as lack of sleep, decreased energy or motivation, or hopelessness; or
 - c. exhibits signs of confusion that may include, but are not limited to:
 - 1) seems unaware of where the inmate is and what is occurring around the inmate;
 - 2) seems to have severe memory impairment;
 - 3) seems unable to comprehend other people's speech and actions;
 - 4) appears to be responding to internal stimuli, such as auditory hallucinations;
 - 5) appears to be overly suspicious of others or their intent; or
 - 6) exhibits extremely bizarre beliefs or thoughts that other people cannot understand (for example, "I have a radio transmitter attached to my brain").
 - d. the inmate exhibits bizarre or ritualistic conduct.
2. The mental health staff will, as soon as possible, assess the inmate's mental health condition if facility staff notify them of any symptoms listed under 1 immediately above.
3. The mental health staff will terminate the BMP if, in the opinion of mental health staff, the inmate:
 - a. presents behavior that is the direct result of an Axis I serious mental illness; or
 - b. is not knowingly, willingly, and purposely engaging in dangerous and/or assaultive behaviors;
 - c. needs a higher level of mental health care or observation; or
 - d. exhibits a mental status that is presently deteriorated or deteriorating.
4. Mental health staff will determine an appropriate placement based on the results of an evaluation.

G. BMP Committee Reviews

1. The BMP Review Committee will review the plan and the inmate's compliance or noncompliance with it:
 - a. if an inmate is on step #1 of an active plan for 7 consecutive days; or
 - b. weekly if the inmate is on the activated plan longer than a week.
2. The facility BMP Review Committee will consist of:
 - a. the facility administrator;
 - b. a facility mental health professional;
 - c. the unit management team; and
 - d. an appropriately constituted facility committee.

3. When assessing active BMP reviews, the designated committee members may change plan details as appropriate but must inform the inmate in writing of plan changes.
4. Applicable facilities will maintain data on the number of inmates referred to a BMP, including a brief narrative of outcomes, and submit the report to the facility administrator and Department Director on an annual basis.

V. CLOSING

Questions about this policy should be directed to the facility administrator or facility mental health staff.

VI. REFERENCES

- A. 4-4249, 4-4262; *ACA Standards for Adult Correctional Institutions, 4th Edition*
- B. MH-G-06, *Behavioral Consultation; Mental Health NCCHC Standards (2008)*



POLICY DIRECTIVE

Policy:	DOC 3.6.1 EXECUTIONS
Effective Date:	01/01/1998 Page 1 of 3
Revision Date(s):	07/16/2012; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

The Department will ensure that offender death sentences are carried out in the manner prescribed by law.

II. APPLICABILITY

Department adult secure facilities.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Death Warrant

1. When an execution date is set by the court for a condemned offender, the sentencing county must deliver a certified copy of the death warrant to the Department Director pursuant to 46-19-103, MCA.
2. The death warrant must indicate the following elements:
 - a. conviction;
 - b. judgment;
 - c. date of execution; and
 - d. duration of warrant.

B. Procedure Manual

1. The execution procedure manual must address the specific details of the execution process including, at minimum, the following:
 - a. pre-execution procedures;
 - b. execution procedures;
 - c. post-execution procedures;
 - d. stays, commutations, and other delays;
 - e. witnesses;
 - f. communications;
 - g. news media;
 - h. security zones/crowd control;
 - i. searches;
 - j. security pass list;
 - k. training and briefing; and
 - l. post orders.

C. Place and Time of Execution

1. The Montana State Prison Warden will provide a location in which executions will be carried out for either male or female offenders sentenced to death.

2. The execution area will be enclosed from public view, within the secure perimeter of the Montana State Prison, and have all the necessary items available for the execution.
3. The execution will take place after midnight at a time identified by the Warden on the date set by the court.

D. Method of Execution

1. The punishment of death must be administered pursuant to 46-19-103 (3), MCA.

E. Executioner

1. The execution must be performed by a person selected by the Warden and trained to administer a lethal injection.
2. The person administering the injection need not be a physician, registered nurse, or licensed practical nurse.
3. The Warden may select an alternate executioner(s).
4. The executioner's identity will remain confidential.
5. The Warden or Warden's designee will supervise the execution.

F. Witness to the Execution

1. The Warden will ensure that the execution is observed by no more than 12 witnesses. The witnesses, to the extent possible, will include:
 - a. three persons designated by the person to be executed;
 - b. three persons designated by the family of the victim of the crime;
 - c. three persons chosen by the Department; and
 - d. three persons from the news media.
2. The Department may reject a potential witness if the individual:
 - a. poses a risk to the safety or security of Department personnel, other witnesses, or any other person; or
 - b. may be perceived as likely to disrupt proceedings due to the individual's emotional or mental state.
3. No persons under age 18 or persons under the care or custody of the Department will be permitted to observe the execution.
4. Department staff or other approved persons necessary to carry out the execution may not be counted as witnesses.

G. Postponement

1. A dedicated communications line will be established between the place of execution, Warden's office, Department Emergency Operations Center (EOC), and the Governor's Office.
2. A second dedicated communications line will be established between the place of execution, Warden's office, Department Emergency Operations Center (EOC), and the State Attorney General's Office.
3. The dedicated lines will remain open until the offender is pronounced dead or until a postponement is granted by one of the following circumstances:
 - a. a stay is granted by a court of competent jurisdiction that will be communicated directly to the Warden by the Attorney General's Office; or

- b. a respite is granted by the Governor that will be communicated directly to the Warden by the Governor or the Governor's counsel.

V. CLOSING

Questions about this policy should be directed to the Department Director or the appropriate Warden.

VI. REFERENCES

- A. §§ 46-19-103, MCA; 46-23-315, MCA



POLICY DIRECTIVE

Policy:	DOC 4.1.1 INMATE ADMISSION PROCESS
Effective Date:	07/01/1998 Page 1 of 2
Revision Date(s):	12/14/2016; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

Department-owned and contracted secure facilities will provide an admission process and written information for all incoming inmates in accordance with this policy.

II. APPLICABILITY

All Department-owned and contracted secure facilities, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Admission Notifications

1. Facility processes will include instructions for sending jurisdictions on admitting inmates to the facility.
2. Processes will include requirements for admissions in emergency circumstances.
3. Transporting officers must comply with facility entry requirements including securing weapons and chemical agents outside the intake area.

B. General Requirements

1. Facility requirements will govern the admission of inmates new to the system; requirements will include, at minimum, that facility staff do the following:
 - a. confirm the inmate is legally committed to the facility;
 - b. provide an inmate admission receipt to the transporting officer;
 - c. perform a thorough search of the inmate and the inmate's possessions in accordance with facility requirements and *DOC 3.1.17 Searches and Contraband Control*;
 - d. maintain and dispose of inmate personal property in accordance with facility requirements and *DOC 4.1.3 Inmate Personal Property*;
 - e. require the inmate to complete the *Inmate Financial Disclosure* form in accordance with *DOC 1.2.6 Inmate Financial Transactions*;
 - f. provide the inmate access to toilet facilities, showering, and hair care, if necessary;
 - g. issue the inmate clean, laundered clothing in accordance with facility requirements and *DOC 4.4.1 Inmate Hygiene, Clothing, and Linen Supplies*;
 - h. photograph and fingerprint the inmate and note identifying marks or other physical characteristics in accordance with National Crime Information Center (NCIC) standards;
 - i. forward security threat group-related information to the facility intelligence coordinator in accordance with *DOC 3.1.24 Security Threat Group Management*;
 - j. assign an identification number to the inmate if not already assigned;
 - k. complete an NCIC entry and check for each new adult commitment;
 - l. perform medical, dental, and mental health screenings;
 - m. collect a DNA biological sample in accordance with *DOC 1.5.13 DNA Samples* if a sample is required;

- n. record basic personal data and information used for mail and visiting lists;
 - o. explain mail and visiting requirements applicable to the facility in accordance with *DOC 3.3.6 Inmate Mail in Secure Facilities* and *DOC 3.3.8 Inmate Visiting*;
 - p. assist the inmate to notify the inmate's next of kin and family of admission to the facility;
 - q. require the inmate to complete the *Escorted Leave Eligibility Form* as a prerequisite for escorted leave in case of family member serious illness or death in accordance with *DOC 3.1.30 Offender Escorted Leave*;
 - r. give written orientation materials to the inmate in accordance with facility requirements and *DOC 4.1.2 Inmate Reception and Orientation*;
 - s. document in the inmate's file each of the admission procedures that have been completed;
 - t. assign the inmate to a housing unit; and
 - u. when necessary, review the above requirements with inmates transferred from within the system.
2. Facility staff will enter the inmate's admission information into facility records and the Department's electronic information system.

C. Admission Documents

1. Facility requirements will address the documents or summaries required for new admissions to include, at minimum, the following information:
- a. a summary of the charge(s), conviction(s), and facts of the crime for the current admission;
 - b. a summary of criminal history, if any;
 - c. religious background and interests;
 - d. family and community support;
 - e. occupational experience and interests;
 - f. educational status and interests;
 - g. recommended vocational programming;
 - h. treatment recommendations;
 - i. pre-admission assessment information;
 - j. recommendations of areas that need follow-up; and
 - k. any reasonable disability-related accommodations necessary for the inmate to access areas of the facility, participate in programs, or otherwise avoid discrimination on the basis of disability in accordance with *DOC 3.3.15 Americans with Disabilities Act (ADA) Offender Accommodations*.
2. Staff will document screening and assessment results and treatment recommendations in facility records.
3. The classification committee and other staff may use the summary admissions report for risk and needs assessment, classification, and development of the inmate's program.

V. CLOSING

Questions about this policy should be directed to the facility administrator.

VI. REFERENCES

- A. §§ 44-6-103; 52-5-108; 53-1-201; 53-1-203
- B. *DOC 1.2.6 Inmate Financial Transactions*; *DOC 1.5.13 DNA Samples*; *DOC 3.1.17 Searches and Contraband Control*; *DOC 3.1.24 Security Threat Group Management*; *DOC 3.1.30 Offender Escorted Leave*; *DOC 3.3.6 Inmate Mail in Secure Facilities*; *DOC 3.3.8 Inmate Visiting*; *DOC 3.3.15 Americans with Disabilities Act (ADA) Offender Accommodations*; *DOC 4.1.2 Inmate Reception and Orientation*; *DOC 4.1.3 Inmate Personal Property*; *DOC 4.4.1 Inmate Hygiene, Clothing, and Linen Supplies*



POLICY DIRECTIVE

Policy:	DOC 4.1.2 INMATE RECEPTION AND ORIENTATION	
Effective Date:	01/01/1998	Page 1 of 2
Revision Date(s):	06/26/2015; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

Department owned and contracted facilities will provide a comprehensive reception and orientation program for all incarcerated inmates and may offer an abbreviated program for recommitted inmates.

II. APPLICABILITY

All secure facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Each facility administrator will ensure that facility staff involved with reception and orientation processes recognize that an inmate's initial impression may be vital to facility adjustment and that attitudes formed within the first few weeks may influence behavior during incarceration.
2. An effective program will meet the following requirements:
 - a. provide continuous case management;
 - b. familiarize an inmate to the facility and to the inmate's assigned unit;
 - c. provide instruction and ensure understanding of facility procedures, regulations, and programming opportunities;
 - d. ensure that each inmate is familiarized with the inmate's rights and responsibilities; and
 - e. provide staff an opportunity to identify and assist inmates who may experience emotional stress.
3. Reception staff will involve inmates in a program of interviews, screenings, and other admission-related activities in accordance with *DOC 4.1.1 Inmate Admissions Process* and will complete the initial reception and orientation within 30 calendar days of admission.
4. Facility administrators, or designees, are responsible for ensuring that inmates receive the following within 24 hours of arrival at the facility:
 - a. a screening for potential vulnerabilities, tendencies of acting out with sexually aggressive behavior, or other special needs;
 - b. verbal and written instruction on how to access facility health care services and process complaints regarding health care;
 - c. written information governing visitation in accordance with facility procedures and Department policy; and
 - d. written materials that include disciplinary procedures, facility rules, prohibited acts, and penalties in accordance with *DOC 3.4.1 Inmate Disciplinary System* and *DOC 3.4.2 Prohibited Acts* unless applicable information was previously provided at an initial reception center.
5. During orientation, staff will fulfill the following responsibilities:

- a. provide inmates with information about sexual assault and sexual harassment including reporting methods in accordance with *DOC 1.3.12, Staff Association and Conduct with Offenders* and *DOC 1.1.17, Prison Rape Elimination Act (PREA)*;
 - b. thoroughly orient inmates to the grievance process in accordance with facility procedures and *DOC 3.3.3 Inmate Grievance Program*;
 - c. review *DOC 3.3.15 Americans with Disabilities Act (ADA) Offender Accommodations*;
 - d. identify inmates who may be involved in security threat group related activities as soon as possible in order to effect management decisions in accordance with *DOC 3.1.24 Security Threat Group Management*;
 - e. provide written orientation materials and/or translations of all required information in the inmate's own language (if a literacy barrier exists, an individual will be designated to assist the inmate in understanding the material); and
 - f. provide an opportunity for inmates to discuss orientation material and provide, when possible, answers to questions and ensure that written orientation materials and informational audio or video supplements do not replace personal interaction.
6. At the completion of the orientation program, each inmate must date and sign a statement that the inmate has received and understood the required information.

V. CLOSING

Questions about this policy should be directed to the appropriate facility administrator.

VI. REFERENCES

- A. 53-1-203, MCA
- B. *DOC 1.3.12 Staff Association and Conduct with Offenders*; *DOC 1.1.17 Prison Rape Elimination Act (PREA)*; *DOC 3.1.24 Security Threat Group (STG) Management*; *DOC 3.3.3 Inmate Grievance Program*; *DOC 3.3.8 Offender Visiting*; *DOC 3.3.15 Americans with Disabilities Act (ADA) Offender Accommodations*; *DOC 3.4.1 Inmate Disciplinary System*; *DOC 3.4.2 Prohibited Acts*; *DOC 4.1.1 Inmate Admission Process*; *DOC 4.2.2 Special Needs Offenders*



POLICY DIRECTIVE

Policy:	DOC 4.1.3 INMATE PERSONAL PROPERTY	
Effective Date:	05/01/1997	Page 1 of 9
Revision Date(s):	06/19/2011; 01/15/2026	
Signature/Title:	/s/ John Schaffer, Public Safety Chief	

I. PURPOSE

To establish personal property possession limits for inmates at all Department secure facilities and contracted facilities. The intent is to permit inmates to possess only those items that do not disrupt the safe and orderly operation of the facility or endanger the safety and security of the public, staff, or other inmates.

II. DEFINITIONS (see Glossary)

III. REQUIREMENTS

A. General Requirements

1. It is prohibited for inmates to borrow, lend, give, trade, or sell their property items to, or receive property items from, other inmates.
2. Inmates may only possess or obtain personal property items through facility services or approved vendors/senders. All items must be in new and unused condition; used items and items from other sources are prohibited.
3. It is the inmate's responsibility to manage their property inventory; any excess items shall be disposed of properly.
4. Offender state or government issued documentation, IDs, driver's license, vital statistic documents, etc., are to be maintained by the Department Records Bureau while an offender is in custody.
5. Documentation of the final disposition of any inmate personal property item must be forwarded to the designated property officer who will adjust the inmate's property records.
6. Staff shall always handle inmate property with care to avoid damage. If staff damage inmate property in any way, it must be reported immediately, and an incident report shall be completed. If the property can be cost-effectively repaired, the Department will incur such costs. Otherwise, the Department will replace the property.
7. Limitations on an inmate's personal property will be consistent with the property list and the inmate's housing unit.
8. Authorization of an item does not imply that the item may not be prohibited at a later time or that the inmate may retain the item if placed in another housing unit or facility.
9. Property limits may be imposed on inmates as requirements of an incentive-based program. Property is required to be sent out or confiscated and disposed of if an inmate is readmitted within 12 months (365 days) of discharging the Step-Down Program. Inmate will be responsible for shipping costs.
10. Property may be limited or restricted as a sanction or due to classification.

11. Property may be restricted or allowed for medical or psychiatric reasons as authorized by a Qualified Health Care Professional and approved by the facility administrator or designee.
12. Allowable property will be held for temporary Administrative Segregation Custody or during the appeal process to a classification override. Once the appeal process is complete, the property staff will take the appropriate processing steps depending on the outcome of the appeal.
13. Protective Custody inmates are allowed general population property limits unless such limits are deemed a security risk in writing by the Warden or designee.
14. Staff shall process contraband in accordance with policy.
15. Staff shall process the following items in accordance with *DOC 3.1.28 Crime Scene and Physical Evidence Preservation*:
 - a. contraband items such as weapons, narcotics, and alcohol;
 - b. property of deceased inmates whose death was unattended; and
 - c. property of escaped inmates. This includes the following:
 - 1) The facility administrator or designee will decide whether to turn over the evidence to local law enforcement authorities for further investigation.
 - 2) When contraband and the property items of an escaped inmate are no longer needed as evidence, investigative staff will dispose of them as contraband as outlined in *DOC 3.1.17 Contraband Control*.
 - d. When the property items of deceased inmates are no longer needed as evidence, investigative staff will forward them to the designated property officer. The property officer will store them pending notification of the next of kin and their final disposition, but in no case longer than 60 days. After 60 days the property officer will dispose of the items as contraband.
16. Unless it is directly related to privileged communication with their attorney, inmates may not possess personal information regarding another offender's criminal or correctional history whether this information is public record or not; examples include, but are not limited to:
 - a. specifics about a crime;
 - b. tattoos/STG identification; and
 - c. DOC Identification numbers.

B. Authorized Property/Inventory List

1. The Department will draft a master property list that includes all allowable items and the amount of each item allowed. Each facility will submit requested modification to the allowable items list at the annual property meeting.
2. The appropriate staff as assigned by the Warden or designee will establish standards for property storage container design, appearance, purpose, and quantity.
3. The Warden or designee may make changes to the list on an emergency basis.
4. The amount of inmate personal property, including legal papers, will not exceed the amount of property that can be stored in the facility's two approved inmate personal property containers (state issued items such as parkas, shoes, medical items, spare clothing, etc. are not part of this limit):
 - a. the primary container can be no larger than four cubic feet. Inmates will be required to utilize this container for storing all their personal property, unless they purchase a secondary container;
 - b. the secondary container may be no larger than two cubic feet: 51 quarts: 23" x 16" x 12";
 - c. hobby property must be stored in a container not to exceed 6" x 12" x 2"; hobby property limits can be found in respective inventory lists; and

- d. publications (books, magazines, and similar material) are subject to screening and review and may not contain any of the following:
- 1) prohibited images or writings;
 - 2) contents focusing on weapons or explosives;
 - 3) instructions for the manufacturing of drugs or drug paraphernalia;
 - 4) metal bindings or metal fasteners; bindings must be glued;
 - 5) materials in used or refurbished condition;
 - 6) code(s);
 - 7) material that violates any Department policy or facility-specific operational procedure;
 - 8) content that, as a whole, lacks literary, artistic, political, scientific, or educational value;
 - 9) material larger than 9" wide, by 12" tall, and 2" thick;
 - 10) hard covers/bindings (books must be soft cover) will not be allowed, except as follows:
 - a) legal, religious, or educational books that exceed these parameters may be reviewed for authorization on a case-by-case basis;
 - b) existing personal property that has been purchased by the inmate that has been authorized and stamped by the property office will be allowed for the purchaser's retention (these items will be counted toward the inmate's book limit, including completed journals that are from canteen);
 - c) state-owned library books (not marked for library use only) are allowed in housing units based on the inmate following the appropriate library book check out process; on a limited, case by case basis, some library books may be marked for library use only;
 - d) new books that are not available in soft cover may be allowed in hard cover unless the inmate is in a restrictive/secure housing unit; and
 - e) other publications on a case-by-case basis with consideration of the inmate's custody level;
 - 11) materials, drawings, photographs or pictures primarily intended to promote sexual arousal or activity, or without any literary value involved are prohibited (for example, information sent from vendors to inmates for purchase of pictures of partially clad females wearing thongs, or pinup type pictures will not be allowed and will be returned to sender and any material received as a result of such purchases will not be allowed);
 - 12) language or material that advocates for, or encourages the following:
 - a) violence or activities that may disrupt the safety or security of the facility;
 - b) racial, religious, or national supremacy or hatred;
 - c) behavior that is detrimental to security or rehabilitation, such as gambling, illegal sexual activities, or the commission of a crime; and
 - d) publications that present history, historical perspective, critique or information related to race, religion, or other items may be allowed based on content review;
 - 13) publications in a language other than English may be allowed and are subject to a review and approval process that includes up to 20 days for magazines and newspapers and up to 30 days for books;
 - 14) pictures or other items that are removed from, or torn out of, books, newspapers, or magazines will be considered contraband;
 - 15) an inmate or a person on the inmate's approved visiting list may order new publications if such items are sent directly by an approved vendor, and comply with the following:
 - a) invoice or enclosed paperwork indicates the name of the sender; the inmate will be issued a *Notice of Undeliverable Mail* form for publications received without this information;
 - b) paperwork indicates the inmate's last name, identification number, and the name and address of the facility when it arrives; anything received without this information will be returned to the sender or disposed of;
 - c) does not contain items prohibited under this or any other section of this procedure;
 - d) is not the result of a contract purchase, such as music or book clubs;
 - e) does not contain a credit card or credit card application; and

- f) all book orders and books from vendors will be forwarded to the Property Officer who will screen them for proper authorization and content;
- 16) if the item meets requirements, the Property Officer will process it in accordance with this policy, including inventory and documentation and approval stamp;
- 17) if the Property Officer determines an ordered item received for an inmate is not permitted due to its content, the item will be forwarded for a final decision to the publication review committee designated by the facility administrator or designee; and
- 18) publications that have scholarly, literary, religious, or artistic value may be allowed. If an item is not permitted due to its content, the inmate and the publisher will be sent a written notice outlining the specific reason(s) the item is being rejected by the publication review committee or property office. Appropriate documentation about the contents of the item will be retained until final resolution of any grievance the inmate may file.

C. Packages

1. For mailed packages, *DOC 3.3.6 Inmate Mail in Secure Facilities* will be followed.
2. If an inmate does not have anyone on their approved visiting list, they may write to the Associate Warden or designee for permission to ship a package(s) to another person.
3. Visitors may pick up outgoing packages with prior written approval of the Associate Warden or designee.
4. Most of the items on the list will be available through facility canteen operations.
 - a. Inmates are authorized to purchase a specified amount of canteen per week based on their classification excluding major purchase electronics, for example, televisions, MP3 player, electric razors, radios, alarm clock radios, and game devices, hobby items, and shoes. This includes the following:
 - 1) TVs and MP3 players that are sold through the canteen. The inmate may purchase a replacement from the canteen if:
 - a) the inmate submits a damaged major purchase electronic item to the designated property officer; or
 - b) the property officer receives documentation from staff that the inmate's major purchase electronic item has been confiscated and disposed of, or there is substantial proof the item was stolen and could not be located; and
 - b. The only allowed vendors are suppliers of magazines and books; all other items shall be purchased through canteen.

D. Inmate Intake

1. Upon arrival at a facility, all personal property items the inmate was transported with will be handed over to admissions staff.
2. The following are the only items of personal property authorized into a secure facility through the initial intake process:
 - a. money (goes to Accounting and is credited to inmate's account);
 - b. inmate account statement received from Accounting, including receipts for money placed on the inmate's account (retained by inmate);
 - c. legal papers (retained by inmate);
 - d. prescription eyeglasses - as allowed by medical (retained by inmate);
 - e. address book – small (retained by inmate);
 - f. ring - 1 - wedding - only if declared marital status is "married" and verified by legal documentation, value is declared as less than \$75.00 (retained by inmate), no stones, only plain solid band allowed;
 - g. Social Security card (goes to Records file);
 - h. photo ID card (goes to Records file);

- i. birth certificate (goes to Records file); and
 - j. personal photos - 24 (retained by inmate).
3. Admissions staff must record on an inventory form all items of personal property accompanying the inmate. The inmate must be present and must sign the form in conjunction with the staff member inventorying the personal property. Copies of the signed form will be distributed as noted at the bottom of the form and to the facility's Property Officer.
 4. Admissions staff will ask the inmate if the inmate wants to mail the unallowable items to someone on the approved list or have them disposed of. If the inmate chooses to mail said items out, items will be mailed out at cost to the facility.
 5. Interstate Compact Transfers will have the opportunity to review with the Interstate Compact Coordinator or designee any items that are similar to above.
 6. Any clothing and accessories such as wallets will be sent out or destroyed.

E. Property Inventory Form

1. Whenever an inmate's property is taken by staff for storage or shipment, staff shall make an inventory of all items on an *Authorized Property/Inmate Personal Property Inventory* form.
2. A copy of each completed inventory form shall be provided to the inmate, placed in the inmate's property file, and included with the stored or shipped property.
3. All applicable information on the form must be completed.
4. Electronic items must be checked for proper operation with the inmate present when possible. If the inmate is not present (due to their placement in pre-hearing confinement, infirmary, etc.), another staff member must be present and will sign as a witness to the item's operational condition; this must be noted on the appropriate form.

F. Property Liability

1. Once an inmate has inspected, signed for, and taken possession of their property items they may not make a liability claim for them.
2. If a determination is made through the grievance process, including the informal resolution process, that a staff member is responsible for the loss, destruction, or damage of an inmate's property, the facility shall reimburse the inmate for the replacement value of the item, with a maximum amount not to exceed a total of \$500 for all items. If it is necessary for staff to process an inmate's property, the facility is only responsible for those items checked off on the *Authorized Property/Inmate Personal Property Inventory* form prepared by staff.

G. Processing Property for Moves Within the Facility

1. The property officer will disburse the appropriate property to the inmate as the inmate's level increases.
2. If an inmate is moved to restrictive housing and placed in a step-down program, the property officer will ensure that only authorized property is stored in the property office. A notice will be sent to the inmate requiring a decision to either send out or destroy their property upon their approval for readmittance into the step-down program if the placement has occurred within 365 days of the inmate's last discharge from the program. This notice shall take effect when the referral to the step-down program is received; the inmate will then have 14 days from their approval back into the step-down program to adjust their property accordingly. The inmate is responsible for shipping costs; if the inmate has insufficient funds or if the inmate fails to make a decision in the allotted time, the property will be destroyed.
 - a. current legal papers may be kept;

- b. physical photographs within defined limits may be kept while excess items will be mailed out at the inmate's expense; photographs may be scanned to be added to digital media; and
 - c. approved religious items may be retained.
3. When an inmate is admitted to the infirmary, placed in pre-hearing confinement, leaves the facility On Leave To Custody (OLTC), or is hospitalized, the sending unit staff must process the inmate's property for storage.
- a. if possible, two staff will process the property and prepare an *Authorized Property/Inmate Personal Property Inventory* form. Unit Sergeants and staff assigned to the inmate's housing unit will be responsible to secure and inventory the inmate's property before the end of their shift;
 - b. staff is required to remove any cellmate(s) from the cell until the property can be secured; staff may question the cellmate(s) about which items are/are not theirs when taking an inventory of the inmate's property;
 - c. staff is only required to obtain the inmate's property from the area approved to place property, such as inside the cell; staff is not responsible to recover the inmate's property from other areas;
 - d. under no circumstances shall the cellmate(s), or any inmate be involved in the packaging or inventorying of property;
 - e. contraband items will be removed and processed in accordance with *DOC 3.1.17 Searches and Contraband Control*;
 - f. open food containers will be thrown away; the items will be checked off on the form and their disposal noted;
 - g. the remaining property must be inventoried and moved to the property office; and
 - h. if the inmate is placed in Pre-Hearing Confinement Classification Decision or Pre-Hearing Classification Disciplinary Decision, staff will proceed as follows:
 - 1) unit staff must ensure the inmate receives the following facility issue items before the end of shift:
 - a) hairbrush (1);
 - b) toothbrush (1);
 - c) soap (one ½ oz. bar);
 - d) toothpaste (1);
 - e) flex pen or pencil (1);
 - f) stationery (per unit rules); and
 - g) all Keep-On-Person (KOP) medications; and
 - 2) if an inmate in pre-hearing confinement requests a religious text, the property office will provide a religious text associated with their religious preference for use while in pre-hearing confinement. The inmate will return the religious text to the unit staff, who will ensure it is returned to the property office;
 - i. once the inventory is complete, sending unit staff must bring the property, with a copy of the completed *Authorized Property/Inmate Personal Property Inventory* form attached to the property office for storage;
 - j. if it is necessary for staff to process an inmate's property, the facility is only responsible for those items checked off on the *Authorized Property/Inmate Personal Property Inventory* form prepared by staff; the inmate must receive a copy of the form;
 - k. when an inmate returns from OLTC, unit staff or the inmate (using an Offender Staff Request (OSR) form) will notify the property officer, so the officer can make arrangements for the inmate to receive the stored property items; and
 - l. if the Director of Nursing determines an inmate who is admitted long term to the infirmary or a hospital needs an item or items from the inmate's stored property, the Director of Nursing will consult with the Shift Commander and make arrangements with the property officer to get the authorized item(s) out of storage and to the inmate. The property officer will adjust the inventory form to show which items were taken from storage and delivered to the inmate.

4. When an inmate is receiving the inmate's property items from storage, the property officer will offer the inmate the opportunity to check them and sign a *Waiver of Liability*. The inmate must do one of the following:
 - a. sign that the inmate has received, checked, and accepted all property items; if the inmate checks this option, they will be given their property to take to their living quarters.
 - b. sign claiming certain items are damaged or missing; and
 - 1) If the inmate checks this option, they will be instructed to start the grievance process. The designated property officer will check the inmate's claims against what is present and what is checked off on the Authorized Property/Inmate Personal Property Inventory form. The facility is only responsible for those items checked off on the form. This includes:
 - a) if the property officer confirms the inmate's claims, they will initiate corrective action:
 - (1) the inmate may take any undisputed items that are present to their living quarters; and
 - (2) damaged items will remain in the property office until corrective measures are completed, after which they will be disposed of; or
 - b) if the property officer's findings don't substantiate the inmate's claims:
 - (1) the property officer will inform the inmate that they may file a grievance to resolve the issue; and
 - (2) items in dispute will be retained at the property office until the grievance is resolved; the incident report detailing the findings will be retained as evidence for the impending grievance.
 - c. if the inmate refuses to mark one of the options on the form, the designated property officer will inform the inmate that the items will be considered abandoned and disposed of if an option is not selected.
 - 1) If the inmate still refuses to sign, the designated property officer will document the refusal at the bottom of the form and send the abandoned items to the Disciplinary Hearing Investigator or designee to dispose of as outlined in *DOC 3.1.17 Searches and Contraband Control*.

H. Transfers Between Facilities

1. When an inmate transfers from one facility to another:
 - a. sending facility staff will:
 - 1) remove all contraband items and process them as outlined;
 - 2) check off the property items on an *Authorized Property/Inventory Inmate Personal Property Inventory* form;
 - 3) observe and note any damage present on the property as each item is packed in a shipping container;
 - 4) pack the items according to the shipping agent standards and seal the container(s);
 - 5) send the container(s) of allowable items to the receiving facility; if the container(s) are not sent on the transport vehicle(s) through prior arrangement, they will be shipped (by UPS, Fed Ex, USPS, etc.) at the expense of the Department; and
 - 6) maintain the container(s) in a secure storage area pending placement.
 - b. receiving facility staff will:
 - 1) take custody of all incoming property containers and maintain the container(s) in a secure storage area pending placement; at no time will inmates be allowed to directly accept transferred property;
 - 2) inspect and check the item in the container(s) against what is listed on the shipping inventory in the inmate's presence; if staff find discrepancies (missing items, or items that aren't in the condition listed, etc.) they must prepare a detailed report describing and documenting any missing/unlisted, damaged, or additional property; and
 - 3) the inmate should confirm that all items are present and in good condition;

- a) an inmate who verifies that everything is present and in good condition will sign a receipt and take possession of the property;
- b) if an inmate reports missing or damaged property, staff must document the claim in detail, specifying the items involved and whether the staff's findings support or refute the inmate's claim. This includes the following:
 - (1) if staff substantiates the inmate's claims, they will initiate corrective measures: the inmate will be allowed to take undamaged property items to the inmate's living quarters and damaged items will be retained by staff until the corrective measures are implemented, at which time the damaged item will be disposed of; and
 - (2) if staff is unable to substantiate the inmate's claims, they will inform the inmate that they may file a grievance to resolve the issue: the inmate will be allowed to take the undamaged property items that are listed and present to their living quarters, items in dispute will be retained by staff until the grievance is resolved, and the incident report detailing the findings will be retained as evidence for the impending grievance.
- 4) if a determination is made through the grievance process that facility staff are responsible for the claimed loss or damage, the facility must reimburse the inmate in an amount determined by the grievance process; and
- 5) an inmate may not file a grievance liability claim once they have inspected, signed for, and taken possession of their property.

I. Storage

1. Facility staff will:
 - a. maintain all stored inmate property in a secure restricted access storage area pending placement; the storage area must be designed to protect stored items from damage due to weather, unauthorized access, tampering and theft;
 - b. develop processes to track and audit all inmate property that is placed in storage according to the inmate's name and DOC ID number;
 - c. assure that any inmate involved in the inventory and storage of property is under direct staff supervision at all times; and
 - d. ensure that all electronics are tested.

J. Daily Monitoring of Property

1. Staff must monitor the property of all inmates on a regular, recurring basis. This includes the following:
 - a. staff will utilize an *Authorized Property/Inmate Personal Property Inventory* form as directed by their supervisor, whenever they are searching an inmate's property for compliance;
 - b. it is the inmate's responsibility to dispose of any items in excess of limits or unauthorized; staff will process excess and unauthorized items as contraband as outlined in *DOC 3.1.17 Searches and Contraband Control*;
 - c. excess property will be seized by staff and processed accordingly;
 - d. staff is only required to obtain the inmate's property from the area approved to place property, such as inside the cell; staff is not responsible to track down the inmate's property from other areas;
 - e. if an inmate is not present when staff are searching the inmate's cell and property for contraband or gathering his property for storage, staff must place the allowable items in the storage container(s) in the following order:
 - 1) legal papers;
 - 2) hobby items;
 - 3) religious items;
 - 4) television;
 - 5) stereo;

- 6) electric razor;
- 7) eyewear (glasses or sunglasses);
- 8) shoes and boots;
- 9) shorts;
- 10) t-shirts;
- 11) socks;
- 12) personal mail;
- 13) photos;
- 14) other items that cannot be consumed; and
- 15) all unopened items that can be consumed;
- f. items stored within the container(s) are not to exceed 50 lbs. of total combined weight; and
- g. items that are left over after the storage container(s) are full will be considered contraband, seized by staff, and processed as outlined in *DOC 3.1.17 Searches and Contraband Control*.

K. Undeliverable Items

1. When an item an inmate has ordered from a vendor is received and does not meet requirements, the designated property officer will send or deliver an undeliverable notice to the inmate with 3 options:
 - a. return to sender (inmate must enclose a completed Special Mailing Request with this response);
 - b. send item to an individual on the inmate's approved visitor list (inmate must enclose a completed Special Mailing Request with this response); or
 - c. dispose of the item.
2. The inmate must complete the appropriate sections on the notice and send the notice back to the designated property officer within 10 working days. If the completed form is not returned, or is received without one of the options selected, the designated property officer will return the item(s) to the vendor at the inmate's expense. If there are insufficient funds, the item will be disposed.

L. Release From Facility Custody

1. After an inmate death, any personal property will be returned to the individual designated on the inmate's *Emergency Contact and Beneficiary Designation Change* form.
2. When an inmate is released from facility custody to parole, discharge, pre-release, or out of state transfer, staff from the sending unit will search the inmate's living quarters and property for contraband and facility issued items. Any facility items found will be removed.
3. The facility items will be given to the appropriate department.
4. Contraband and any personal property items left behind by the inmate will be disposed of accordingly.

IV. CLOSING

Questions about this policy should be directed to the facility administrator at the respective facility.

V. REFERENCES

- A. *DOC 3.1.17b Contraband Control*;
- B. *DOC 3.1.28 Crime Scene and Physical Evidence Preservation*



POLICY DIRECTIVE

Policy:	DOC 4.1.4 INDIGENT INMATE STATUS
Effective Date:	11/29/1999 Page 1 of 2
Revision Date(s):	10/18/2005; 01/18/2006; 12/15/2008; 04/24/2026
Signature/Title:	/s/ Eric Strauss, Director

I. POLICY

Department adult secure facilities will assist inmates who are unable to provide for their personal hygiene or legal materials.

II. APPLICABILITY

Department and contracted adult secure facilities.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Method of Applying for Indigent Status

1. To request an indigent package, the inmate must:
 - a. use the *Indigent Status Request* form to request an indigent package;
 - b. submit the request to the facility resident account representative by the second day of the month; and
 - c. apply only once per calendar month.
2. Accounting will verify the inmate's financial status and:
 - a. approve the inmate's request for an indigent package; or
 - b. deny the inmate's request if the inmate:
 - 1) has received or spent \$15 or more in the previous month; or
 - 2) had \$15 or more on account at the end of the previous month; or
 - 3) has \$15 on account at the time of verification.
3. Upon being approved for indigent status, an inmate will receive an indigent package.
4. To continue to receive assistance, the indigent inmate must reapply each month.

B. Processing the Request

1. The facility resident account representative must ensure that all inmate requests for indigent status are expediently forwarded to accounting for verification of inmate account activity.
2. The accounting supervisor will review requests for approval or denial.
3. A list with inmate name and number will be provided to "Inmate Accounts" and to the housing unit staff each month of all inmates on indigent status.
4. Housing unit staff will distribute the indigent packages. Package contents may vary depending on security custody levels and each facility's requirements.

C. Reception Inmates

1. Reception personnel will provide indigent reception inmates with basic hygiene materials.
2. Upon leaving the reception unit, inmates may apply for indigent status according to IV.A above.

V. CLOSING

Questions about this policy should be directed to the facility administrator.

VI. REFERENCES

- A. 4-4342; *ACA Standards for Adult Correctional Institutions, 4th Edition*
- B. *DOC 4.4.1 Inmate Hygiene, Clothing, and Linen; DOC 3.3.6 Inmate Mail in Secure Facilities*

VII. FORM

Indigent Status Request



POLICY DIRECTIVE

Policy:	DOC 4.1.5 OFFENDER NAME CHANGE	
Effective Date:	05/12/2022	Page 1 of 2
Revision Date(s):	04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

Individuals committed to or under the supervision of the Department or incarcerated in a Department secure facility may apply to a court of competent jurisdiction to change their name in accordance with 27-31-101 through 103, MCA. The Department has established this policy for managing legal name changes granted by the court.

II. APPLICABILITY

All persons committed to or under the supervision of the Department or a Department secure facility.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Individuals committed to or under the supervision of the Department or Department secure facility who petition a court for a legal name change will provide a copy of the petition to their Case Manager or supervising officer.
2. Individuals shall serve any petition for name change on the Department, as provided by law and court procedure.
3. Any court order changing an individual's legal name must include the Court Clerk stamp indicating the date the order was filed.
4. If an employee becomes aware that an offender is attempting to seek a legal name change, the employee must notify Department Legal Services immediately.
5. Any individual who obtains an order changing the individual's name will provide a certified copy of the order to the Department within 5 days of the order being entered.
6. Upon receipt of a certified order changing an individual's name, records staff will enter the order in the offender management system.
7. If an individual obtains a valid court order in violation of this policy or state law, Department staff will consult with Legal Services regarding whether to process the name change and whether to initiate any necessary legal proceedings.
8. Any amended or corrected court order will be processed like any other name change order and replaces any prior orders granting a change of name.

B. Expectations

1. When the Department is properly notified of a legal name change, the new name becomes the offender's primary name.
2. Offenders who obtain an order changing their name will use the name for:

- a. all written or verbal communication with employees, contract staff, and volunteers;
 - b. all matters relating to their incarceration or community supervision; and
 - c. use of United States mail.
3. The name that the offender was committed under will be listed as an “Also Known As” (AKA) designation in the offender management system.
4. AKA names will not be printed on identification cards or used in daily correspondence (for example, callouts, mail, electronic messaging).
5. Department files (for example, central file, medical/unit files) will be labeled with the new legal name within 14 calendar days of notification.
6. Victims will be properly notified of an offender name change in accordance with *DOC 1.8.1 Victim Services*.
7. Employees, contract staff, and volunteers will communicate with individuals using their new legal name.

V. CLOSING

Questions about this policy should be directed to the appropriate administrator.

VI. REFERENCES

- A. *27-31-101 through 103, MCA*
- B. *DOC 1.8.1 Victim Services*



POLICY DIRECTIVE

Policy:	DOC 4.2.1	OFFENDER CLASSIFICATION SYSTEM
Effective Date:	05/01/1997	Page 1 of 5
Revision Date(s):	12/20/2023; 05/20/2024	
Signature/Title:	Brian Gootkin, Director	

I. POLICY

The Department of Corrections will ensure that an objective classification system is used on admission and upon status review to manage offenders at the appropriate custody, security, and supervision levels.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Classification System – A method that uses an objective scoring system to appropriately recommend offender custody levels based on verifiable case information, facility security levels, degree of required supervision, and available program resources.

Disability – See *DOC 3.3.15, Americans with Disabilities Act (ADA) Offender Accommodations*, for the definition and an explanation of disability.

Facility/Program – Refers to any division, prison, secure care correctional facility, correctional or training program, or community-based program under Department jurisdiction or contract. This term includes the facility building or residence, including property and land owned or leased and operated by the Department.

Offender Americans with Disabilities Coordinator – The individual assigned to facilitate ADA compliance with offenders.

Override – A management decision to place an offender at a different custody level than what is indicated by the objective classification system.

Qualified Health Care Professional (QHCP) – Physicians, physician assistants, nurse practitioners, nurses, dentists, mental health professionals, and others who by virtue of their education, credentials, training, and experience are permitted by law to evaluate and care for patients, including Department staff and contracted or fee-for-service professionals.

Qualified Mental Health Professional (QMHP) – Psychiatrists, psychologists, psychiatric social workers, psychiatric nurse practitioners, psychiatric nurses, licensed professional counselors, licensed clinical social workers, and others who, by virtue of their education, credentials, and experience, are permitted by law to evaluate and care for mental health needs of patients, including Department staff and contracted or fee-for-service professionals. This definition excludes Mental Health Technicians.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. Each facility/program will:

- a. provide a written offender classification plan that specifies the plan's objectives and methods to achieve them;
 - b. classify offenders based on an assessment of risks and needs;
 - c. classify offenders at the lowest custody level consistent with individual and facility safety and security;
 - d. ensure that custody assignments are imposed consistently, and never as a form of punishment;
 - e. ensure that no offender will be classified or reclassified to a higher level of security based upon a disability, or upon behavior that is a product of a disability unless, after a prompt and appropriate evaluation by a Qualified Mental Health Professional, such staff determines that the offender presents such an immediate and serious danger that there is no reasonable alternative. In such an event, the offender will be promptly and regularly re-evaluated with the goal of securing appropriate treatment and reintegrating into the general population. Physical and communication disabilities shall never be grounds for classification or reclassification to a higher custody level;
 - f. design a system to provide an incentive to offenders to achieve personal, court-ordered, and recommended program goals;
 - g. involve facility program representatives and offenders in classification reviews;
 - h. establish a method for initially assessing and periodically revising offenders' security categories that are established in parallel with the security features of the system's facilities;
 - i. provide a method with sufficient latitude for staff to override system-generated classifications, based on specific, well-documented rationale;
 - j. provide a process for an ongoing review and validation of the system that ensures its reliability and objectivity; and
 - k. review offender classification plans at least annually and update as needed.
2. Classification plans for youth will consider:
 - a. the level of risk presented;
 - b. the type of housing required;
 - c. participation in facility/community programs;
 - d. developmental and special needs, for example, physical, mental, social, emotional stability, educational maturity, escape history, assaultive behavior, medical status, age, enemies of record; and
 - e. adequate program space to allow individual and group-oriented interactions and activities to meet physical, social, and emotional needs.
3. Classification plans will specify that prior to a parole hearing, staff will issue an offender progress report to the paroling authority to include a current and complete history of the offender's activities during incarceration and a proposed parole plan.
4. Except as may be required for the security and orderly operation of a facility, no offender will be denied access to any program or service, or assigned or not assigned to a job, housing unit, classification status, or program solely on the basis of race, national origin, gender, religion, creed, sexual orientation, physical or mental disability, or political belief.
5. Exceptions may apply to cases in which age, gender, medical condition, physical or mental disability may preclude participation in a particular correctional facility or program.

B. Initial Classification

1. At intake, the classification system will use, at a minimum, the following criteria as part of the risk-assessment instrument:
 - a. severity of current offense;
 - b. length of sentence;
 - c. type of prior commitments;
 - d. history of escapes and attempts;
 - e. history of violence;

- f. victim impact; and
 - g. type of detainer.
2. To make detailed individual assessments, staff will solicit information from courts, social service agencies, pre-sentence investigation reports, and other resources to ensure the broadest possible range of information is available on which to make classification decisions.
 3. Facility staff will develop treatment plans and housing assignments consistent with the assessment criteria and placement recommendations for adult and youth offenders.
 4. Initial classification procedures will ensure that both adult and youth offenders are screened within 24 hours of arrival at the facility for potential vulnerabilities or tendencies of acting out with sexually aggressive behavior and that housing assignments are made accordingly, in accordance with *DOC 4.2.2 Special Needs Offenders*.
 5. Prior to completion of any risk assessment, all offenders will be screened by a QHCP to identify disabilities and disability-related accommodations, including an assessment for effective communication needs.
 6. Every offender or youth with a disability will receive the reasonable accommodation necessary for the offender or youth to understand and meaningfully participate in the intake and classification process. Staff shall check the offender management system and other available information and confer with health care staff for provisions of accommodations and may call the Offender ADA Coordinator if they have questions.
 7. Staff will complete initial classification of youth offenders, except in unusual circumstances, within two weeks of admission from court and within one week after transfer from another facility.
 8. Receiving staff will assign each offender to a staff member or unit management team to provide personal contact with at least one employee for advice and assistance during the intake and classification process.
 9. Because no classification system can correctly or unfailingly predict all needs and risks, each facility must include override capabilities that allow staff to exercise professional judgment in classification decisions. Because no judgment is infallible, staff must monitor these capabilities to prevent any abuse of overrides.

C. Special Needs Management

1. Classification procedures will include provisions to identify offenders who may be management problems or have special needs in accordance with *DOC 4.2.2 Special Needs Offenders*. These may include the following categories:
 - a. potentially dangerous offenders, for example, those with a history of assault or predatory behavior;
 - b. those who require protection and separation because they may be in danger from other offenders;
 - c. those who, by reason of their offense, criminal record, or institutional behavior, require particularly close supervision;
 - d. those who received unusual publicity because of the nature of their crime, arrest, or trial, or who are involved in criminal activity of a sophisticated nature, such as organized crime;
 - e. gang members; staff will identify these offenders at the earliest possible stage, to inform basic management decisions. Training and knowledge of gang behavior and symbolism is critical for staff supervision in accordance with *DOC 3.1.24 Security Threat Group Management*;
 - f. those with special needs, including those defined by age, infirmity, mental illness, developmental disabilities, addictive disorders, and medical problems;

- g. criminally-convicted youth offenders who may require a specialized unit and case management plan; and
 - h. where appropriate, differences in management and security needs between female and male offenders.
2. Classification procedures will ensure that every offender with a disability will receive the reasonable accommodations necessary for the offender to understand and meaningfully participate in any proceeding addressed by the procedure.

D. Offender Custody Levels

1. Facility procedures will establish appropriate staff supervision for each custody classification, including but not limited to:
- a. *community custody*: managing offenders in the community at the lowest level of risk and supervision;
 - b. *minimum custody*: managing offenders at a relatively low degree of risk under indirect supervision;
 - c. *medium custody*: managing offenders with a moderate degree of supervision and control, including frequent, direct observation;
 - d. *close custody*: managing offenders with a moderately high degree of supervision, including direct observation and restricting movement; and
 - e. *administrative segregation custody*: managing offenders with a high degree of supervision and control, under escorted movement, and using full restraints outside the facility.

E. Classification Status Review

1. Facilities will establish an offender status review or reclassification system that periodically reevaluates an offender's security needs, sentence progress, and other factors to include the following:
- a. percentage of time served;
 - b. type and frequency of disciplinary reports incurred;
 - c. involvement with drugs, alcohol, or other contraband;
 - d. mental and psychological stability;
 - e. staff assessment of level of personal responsibility;
 - f. family or community ties;
 - g. program participation; and
 - h. job and housing conduct.
2. The classification plan will specify criteria and procedures for determining and changing an offender's program status; the plan must include at least one level of appeal.
3. Unless precluded for security or other substantial reasons, all offenders will appear at their classification hearings and be given notice 48 hours prior to the hearing; such notice may be waived by the offender in writing.
4. Facility procedures will specify the conditions under which an offender can initiate a review of progress and program status.

F. Facility Security Levels

1. Each facility will establish security levels that include, at a minimum, a review of the following factors:
- a. type of perimeter security;
 - b. existence and operation of towers;
 - c. use of external mobile patrols;
 - d. use of detection devices;
 - e. type of housing arrangements; and

- f. nature of internal architectural features, for example, reinforced concrete construction, security glazing, corridor grilles, control centers, and electronically controlled steel cell doors.
2. Facility classification procedures will include descriptions and criteria for categorizing facility security levels, such as minimum, medium, close, and maximum custody facility requirements and specifications.

G. Classification Appeals

1. Each facility must establish a system by which offenders may appeal final classification decisions.

H. Classification Records

1. Staff will document all classification decisions on the appropriate forms and records for placement in the offender's case file.

I. CLOSING

Questions about this policy should be directed to the facility or program Classification Manager.

V. REFERENCES

- A. 4-4295 through 4-4304; 4-4309 & 4-4310; *ACA Standards for Adult Correctional Institutions, 4th Edition*
- B. 4-4281-2; *ACA Standards Supplement, 2008*
- C. 3-JTS-5B-01 through 3-JTS-5B-09; *ACA Standards for Juvenile Correctional Facilities, 2003*
- D. *ACA Guidelines for the Development of a Security Program, 2nd Edition*
- E. DOC 3.1.24 *Security Threat Group Management* and 4.2.2 *Special Needs Offenders*



POLICY DIRECTIVE

Policy:	DOC 4.2.2 SPECIAL NEEDS OFFENDERS	
Effective Date:	01/01/1998	Page 1 of 2
Revision Date(s):	02/22/2012; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

Department facilities and programs will identify, assess, and manage offenders with special needs, including those who are potentially vulnerable and potentially dangerous, to provide safe housing, adequate protection, and programmatic resources to meet their needs.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS

IV. REQUIREMENTS

A. Identification and Management

1. The facility or program administrator will follow applicable procedures and:
 - a. identify special needs offenders in accordance with the provisions of this policy and *DOC 4.2.1 Offender Classification System*;
 - b. comply with classification recommendations or separation needs directives when making housing, program, and work assignments;
 - c. address the safety and case management needs of youth offenders who may be committed to adult facilities;
 - d. investigate offender requests for status change or protection;
 - e. reassess classification status, placements, and assignments, as needed;
 - f. monitor offender adjustment and behavior to ensure the most appropriate management options are implemented;
 - g. activate the disciplinary process when required; and
 - h. document all information pertaining to offender special needs management.

B. Vulnerable and Predatory Offenders

1. The facility or program administrator will follow applicable procedures and:
 - a. require that offenders are screened within 24 hours of arrival at the facility to identify potential vulnerabilities or tendencies of acting out with sexually aggressive behavior;
 - b. ensure that offenders identified as high risk with a history of sexually assaultive behavior are assessed by a mental health or other qualified professional;
 - c. require that offenders with a history of sexually assaultive behavior are monitored and counseled by a qualified professional;
 - d. ensure that offenders identified as at risk for sexual victimization are assessed by a mental health or other qualified professional; and
 - e. require that offenders at risk for sexual victimization are monitored and counseled by a qualified professional.

C. Offender Orientation

1. The facility or program administrator will follow applicable procedures and provide:
 - a. offender orientation in accordance with *DOC 4.1.2 Offender Reception and Orientation*;
 - b. instructions by which offenders may communicate with staff in accordance with *DOC 3.3.5 Offender and Staff Communication Methods*;
 - c. information on the rights, programs, and services available to all offenders with special needs (for example, physically or developmentally disabled offenders) and where and how to access those services; and
 - d. information on the prevention, intervention, and confidential reporting of sexual abuse or assault toward any offender under Department jurisdiction or contract.

V. CLOSING

Questions about this policy should be directed to the facility administrator or program classification manager.

VI. REFERENCES

- A. 53-1-203, MCA
- B. *DOC 3.3.5 Offender and Staff Communication Methods*; *DOC 4.1.2 Inmate Reception and Orientation*; *DOC 4.2.1 Offender Classification System*



POLICY DIRECTIVE

Policy:	DOC 4.2.3	UNIT MANAGEMENT
Effective Date:	07/01/1998	Page 1 of 3
Revision Date(s):	03/22/2012; 04/24/2026	
Signature/Title:	/s/ Eric Strauss, Director	

I. POLICY

It is the policy of the Department to utilize, where practical, a unit management system in its facilities in order to decentralize authority, more effectively deliver programs and services to offenders, and oversee the operation of housing areas.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Unit Management

1. To the extent that resources permit, each facility or program will be organized under a unit management system that increases contact between staff and offenders, fosters increased interpersonal relationships, and leads to more knowledgeable decision making as a direct result of staff working with a smaller, more long-term group.

B. Unit Team

1. Each unit will be staffed by a unit team consisting of Department employees and service providers working in the unit directly responsible for the residing offenders.
2. Staff offices will be located in the unit, so employees and offenders are accessible to each other.
3. Unit team may include:
 - a. a unit manager;
 - b. shift sergeants;
 - c. case managers;
 - d. counselors;
 - e. service providers;
 - f. correctional officers; and
 - g. representatives from other facilities or programs serving as ad hoc team members.
4. Offenders are assigned to a unit team upon receiving housing assignments.
5. Unique needs of the offender population may dictate that more or fewer staff be assigned to a particular unit based on security, program, and treatment.
6. When possible, a minimum of 1 unit team member should be scheduled when offenders are not working or in programs.

C. Responsibilities

1. Responsibilities of the unit team include:
 - a. program planning;
 - b. responding to classification questions;
 - c. parole matters;
 - d. release planning;
 - e. assisting with personal and family issues; and
 - f. counseling.
2. The unit manager (or similar position) responsibilities include:
 - a. oversight of all unit programs and activities;
 - b. maintaining a close working relationship with facility or program personnel;
 - c. chairing the unit team and reviewing team decisions; and
 - d. oversight of sanitation and other on-unit programs.
3. The shift supervisor responsibilities include:
 - a. supervising activities of staff and offenders in daily operations of the unit; and
 - b. overall security, safety, and orderly operation of the unit during shift.
4. The case manager (or similar position) serves as the primary contact point between the offender, administration, and community; typical responsibilities include:
 - a. casework and many social services functions;
 - b. preparation of classification and parole reports;
 - c. assisting offenders with release plans; and
 - d. processing offender-related correspondence and other materials relating to the offender's commitment.
5. The unit counselor (or similar position) is a trained staff member who may:
 - a. provide services such as counseling and guidance for offenders in regard to institutional conduct, personal difficulties, and planning for the future;
 - b. visit offender work and program assignments regularly;
 - c. be the first resource for offenders in resolving daily problems; and
 - d. provide crisis counseling.
6. Service providers may perform clerical and administrative duties.
7. Correctional officers and service providers responsible for direct supervision or care are encouraged to establish professional relationships; they shall:
 - a. provide daily supervision of offenders;
 - b. enforce rules and regulations; and
 - c. oversee safety, security, and sanitation in the unit.
8. A casework supervisor position may be established as a specialty position to provide supervision of case managers and may serve in an advisory and consultant role to unit staff.

D. Communication

1. The primary communication in the unit management system is personal contact between staff and offenders.
 - a. Unit staff may maintain bulletin boards with written information that may be of interest to offenders.
 - b. Unit Managers may utilize group and individual meetings, at their discretion, to improve communications in the unit.

E. Offender Case Reviews by Unit Team

1. Case reviews may be held:
 - a. For initial classification of offenders after orientation and testing are complete,
 - b. to adjust programs or work assignments;
 - c. review transfer or custody reduction requests; and
 - d. to gather the information necessary for reports to the paroling authority.
2. Offenders will be provided with a written advisement of each team action resulting from a case review.

F. Appeals

1. Applicable facility or program policies and/or procedures will establish the process by which offenders may appeal unit team actions.

V. CLOSING

Questions about this policy shall be directed to facility unit managers.

VI. REFERENCES

- A. 53-1-203, MCA
- B. *ACA Standards for Adult Correctional Institutions, Fourth Edition, 2009*



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 4.3.1	Subject: GENERAL FOOD SERVICE OPERATIONS
Chapter 4: FACILITY/PROGRAM SERVICES	Page 1 of 3
Section 3: Food Service	Effective Date: May 1, 1997
Signature: /s/ Mike Ferriter, Director	Revised: 07/24/12

I. POLICY

The Department of Corrections will provide to the offenders confined in its facilities, nutritious, attractively presented meals, prepared in a sanitary manner.

II. APPLICABILITY

Facilities with full-scale food service operations Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Facility/Program – Refers to any division, prison, secure care correctional facility, correctional or training program, or community-based program under Department jurisdiction or contract. This term includes the facility building or residence, including property and land owned or leased and operated by the Department.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. The facility administrator, or designee, may provide exceptions to this policy for offender special programs when food preparation quality and nutritional standards are maintained.
2. The facility administrator, or designee, is responsible for the following:
 - a. establish an adequate food staffing pattern that is appropriate to the size and needs of the facility in regard to offender population, physical plant, and equipment;
 - b. contract in-house or off-site food services, when appropriate, and require contracted food service operations to provide an on-site food services administrator;
 - c. establish operational procedures; and
 - d. assign a full-time staff member to supervise the facility food service operation with the following qualifications prior to assignment:
 - 1) specific job-related training;
 - 2) a minimum of three years experience in food service management; and
 - 3) the resources, authority, and responsibility to provide a complete facility food service program.

B. Food Service Regulations

1. Food service areas will include the following:
 - a. food preparation space based on population size, type of food preparation, and methods of meal service;

Policy No. DOC 4.3.1	Chapter 4: Facility/Program Services	Page 2 of 3
Subject: GENERAL FOOD SERVICE OPERATIONS		

- b. adequate fire exits; and
 - c. clean and sanitary loading and storage areas.
- 3. Ovens, grills, and similar equipment must have sprinkler and extinguisher coverage as required by fire safety regulations.
- 4. Dining space will be clean and sufficiently equipped to serve all offenders while offering adequate time for each offender to complete each meal.
- 5. Food service will provide sanitary garbage collection and disposal.
- 6. Cafeteria facilities are preferable to offender waiter services.

C. Facility Procedures

- 1. The facility administrator, or designee, will implement and maintain operational procedures that meet the following food service standards:
 - a. outline offender assignments in food service;
 - b. provide direct meal supervision by staff members;
 - c. when possible, there will be no more than 14 hours between evening meal and breakfast unless the facility is operating under emergent conditions or is in a lockdown status;
 - d. offenders receive an interim meal of appropriate nutritional value when they are held more than four hours awaiting commitment, release, or transfer;
 - e. outline whether food may be taken from the dining area to housing units or kept in an offender's cell or unit;
 - f. ensure timely removal and disposal of all garbage;
 - g. a dining area with normal group eating arrangements that allows space for group dining and allow for conversation during dining hours unless security or safety consideration justify otherwise;
 - h. prohibition against serving meals in cells unless locked housing unit rules apply or it is necessary for safety or security, in which case a table or shelf and seating for meal periods will be provided unless safety and security issues prevail;
 - i. appropriate utensils for all general population offenders including at least a fork and spoon or "spork," which may include the use of plastic cutlery;
 - j. provision for meals in accordance with [DOC 4.3.2, Menu Planning](#) when offenders are not routinely absent from the facility for work or other purposes; and
 - k. ensure meals are served under conditions that minimize regimentation.
- 2. The facility administrator, or designee, will implement and maintain operational procedures that specify that food service budgeting, purchasing, accounting, and record keeping practices include, but are not limited to:
 - a. purchase supplies at wholesale or favorable prices and conditions and, when possible, products raised or produced in the system;
 - b. a uniform system to accurately record the number, cost, and type of meals served to offenders, employees, guests, and visitors;
 - c. food expenditure cost accounting designed to determine cost per meal per offender;
 - d. published menus and waste information;
 - e. determination of and responsiveness to offender eating preferences; and

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- f. safety standards in accordance with [DOC 4.3.3, Food Service Safety and Sanitation](#).
- 3. The facility administrator, or designee, will implement and maintain operational procedures that specify security practices including, but not limited to the following:
 - a. search all delivery traffic and incoming supplies as well as garbage removal services and require individuals bringing in prepared foods to comply with facility search requirements;
 - b. adequate key and tool control, including inventory procedures for knives, other sharp implements, and keys, as well as poppy seed, nutmeg, cayenne pepper, and fermentable items such as yeast and uncooked bread dough, in accordance with *DOC Policies* [3.1.13, Key Control](#) and [3.1.14, Tool Control](#); and
 - c. secure all food.

V. CLOSING

Questions concerning this policy should be directed to the food service director.

VI. REFERENCES

- A. [2-15-112](#), MCA
- B. 4-4313, -4314, -4315, -4326, -4327, -4328; *ACA Standards for Adult Correctional Institutions*, 4th Edition;
- C. 3-JTS-4A-01, -4A-02, -4A-03, -4A-13, -4A-14; *ACA Standards for Juvenile Correctional Facilities*, 2003
- D. *DOC Policies* [3.1.13, Key Control](#); [3.1.14, Tool Control](#); [4.3.2, Menu Planning](#); and [4.3.3, Food Service Safety and Sanitation](#)

VII. ATTACHMENTS

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 4.3.2	Subject: MENU PLANNING
Chapter 4: FACILITY/PROGRAM SERVICES	Page 1 of 3
Section 3: Food Service	Effective Date: May 1, 1997
Signature: /s/ Mike Batista, Director	Revised: 05/10/2016

I. POLICY

The Department of Corrections will establish menu planning systems that ensure a variety of nutritionally adequate meals are available to offenders.

II. APPLICABILITY

Facilities with full-scale food service operations Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

DGAs - Dietary Guidelines for Americans, as established by the U.S. Departments of Agriculture and Health & Human Services.

DRIs - Dietary Reference Intakes, as established by the Food and Nutrition Board, Institute of Medicine, National Academies of Sciences.

Facility/Program – Refers to any division, prison, secure care correctional facility, correctional or training program, or community-based program under Department jurisdiction or contract. This term includes the facility building or residence, including property and land owned or leased and operated by the Department.

Food Service Director (FSD) – The employee, regardless of local title, (food service manager, food service supervisor), responsible to manage the facility food service or food product operations.

Qualified Nutritionist - A registered dietitian or a person eligible for registration by the American Dietetic Association.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. The facility administrator, or designee, will establish a daily food allowance which satisfies basic nutrition standards and ensure the facility provides offenders three daily meals, except for special weekend and holiday brunch meals or other food service options authorized by the administrator to provide variety or to accommodate other activities.

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Subject: MENU PLANNING		

2. The facility administrator, or designee, will implement and maintain operational procedures that ensure the following:
 - a. designated staff plan menus in advance considering food appearance, palatability, texture, temperature, portioning, and appropriate food nutrient content and staff follow menu plans whenever possible;
 - b. designated staff make available for review all recipes and menus, including special diets, at least one week in advance and document that any substitutions in the meals served will be of equal nutritional value;
 - c. special therapeutic and religious diet needs are met and conform as closely as possible to the food served to other offenders;
 - d. a therapeutic diet manual is maintained and available in the health care and food service areas for reference and information.
3. A qualified nutritionist must document at least annually that each facility satisfies basic nutrition standards as provided by [Daily Guidelines for Americans \(DGAs\)](#) and [Dietary Reference Intakes \(DRIs\)](#).
4. Youth correctional facilities must have menus and provide meals through onsite kitchens or through a vendor, which meet the National School Lunch Program standards.

B. Special Diets

1. A registered dietitian must approve and document special diets.
2. Appropriate medical personnel will prescribe therapeutic diets in response to a real and documented medical need in accordance with the following:
 - a. a therapeutic diet will consist of a complete meal service and will not be used as a reward or to provide a choice between meals; and
 - b. therapeutic diet prescriptions must be specific and complete, furnished in writing to the food service director (FSD), and reviewed at least every 90 days, except in the case of chronic diagnoses such as diabetes.
3. Religious diets are provided to offenders whose religious beliefs require close adherence to religious dietary laws and will be approved by a religious activities director on a case-by-case basis. The religious activities director must provide requests monthly and in writing with specific and complete details to the FSD.
4. An offender observed violating the special diet terms will be reported to the appropriate authority and may be removed from a therapeutic diet by a medical authority or removed from a religious diet by an administrator in consultation with Legal Services Bureau staff.
5. An offender who wishes to be removed from a special diet may submit a request in writing to the FSD.

C. Special Management Menus

1. Staff may not withhold food or vary the standard menu as a disciplinary sanction for an offender.

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Subject: MENU PLANNING		

2. When an offender uses food or utensils in a disruptive manner or as a weapon against self or others, designated staff will provide nutritionally adequate, specially prepared, or packaged meals to minimize the potential for such actions.
3. Staff may use a special management menu when authorized within the offender's written management plan.

V. CLOSING

Questions concerning this policy should be directed to the food service director.

VI. REFERENCES

- A. 2-15-112; 20-10-206; MCA
- B. 4-4316, -4317, -4318, -4319, -4320; *ACA Standards for Adult Correctional Institutions, 4th Edition*;
- C. 3-JTS-4A-04, -4A-05, -4A-07, -4A-08, -4A-09; *ACA Standards for Juvenile Correctional Facilities, 2003*

VII. ATTACHMENTS

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 4.3.3	Subject: FOOD SERVICE SAFETY AND SANITATION
Chapter 4: FACILITY/PROGRAM SERVICES	Page 1 of 3 and Attachment
Section 3: Food Service	Effective Date: May 1, 1997
Signature: /s/ Mike Ferriter, Director	Revised: 08/24/12

I. POLICY

The Department of Corrections will ensure that food and dairy product preparation is completed in a clean, sanitary, and safe manner.

II. APPLICABILITY

Facilities with full-scale food service operations Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Administrator - The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Designee – The person designated to act on behalf of the person responsible for specific decisions or actions.

Facility/Program – Refers to any division, prison, secure care correctional facility, correctional or training program, or community-based program under Department jurisdiction or contract. This term includes the facility building or residence, including property and land owned or leased and operated by the Department.

Food Product – Food produced by the Department of Corrections.

Food Service – Food and dairy facilities and equipment related to food product preparation including, but not limited to, the dairy milking parlor, dairy processing personnel, and dining and food preparation areas.

Food Service Director (FSD) – The employee, regardless of local title (e.g., food service manager, food service supervisor), responsible to manage the facility food service or food product operations.

IV. DEPARTMENT DIRECTIVES

A. Responsibility Requirements

1. The facility administrator, or designee, will establish operational procedures to ensure the following:
 - a. compliance with all applicable rules, policies, and regulations is maintained and documented;
 - b. employees and offenders utilize the highest possible level of safety and sanitary practices in food service and food product programs;

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Subject: FOOD SERVICE SAFETY AND SANITATION		

- c. ensure the completion of employee and offender pre-assignment medical examinations, as necessary, in accordance with this policy;
 - d. when an outside source is utilized to provide facility food services, written verification of the provider's compliance with state and local regulations is obtained;
 - e. food service personnel meet regularly to discuss accident prevention;
 - f. supervised and scheduled cleaning for all food handling areas;
 - g. weekly sanitation inspections of all food and dairy areas and equipment by appropriate personnel with training in food service operations;
 - h. monthly comprehensive and thorough safety and sanitation inspections by a facility staff member trained in the application of jurisdictional codes and regulations; and
 - i. temperature-controlled food storage with the following temperature ranges:
 - 1) between 45-80° F for dry shelf storage;
 - 2) between 35-40° F for refrigerated areas; and
 - 3) 0° F or below for frozen food areas.
2. The food service director (FSD), or designee, is responsible for the following tasks:
- a. document and maintain pre-assignment written confirmation from employees and offenders understanding and agreement to report contraction of, or exposure to, a disease in a communicable form that can be transmitted by food or through food;
 - b. inspect assigned offenders at the start of the work period and provide notification to appropriate health care providers when an offender may require medical reexamination for handling food;
 - c. monitor employees and offenders for compliance with personal hygiene requirements;
 - d. ensure that an employee or offender diagnosed with any of the following does not prepare or handle food products and, in accordance with [37.114.203, ARM](#) and [37.114.204, ARM](#), report to the county, city-county, or district health officer when an employee is diagnosed with a reportable disease or condition including, but not limited to:
 - 1) Campylobacter enteritis;
 - 2) Cryptosporidiosis;
 - 3) Escherichia coli 0157:H7 enteritis;
 - 4) Giardiasis;
 - 5) Hepatitis A;
 - 6) Salmonellosis; or
 - 7) Shigellosis.
 - e. in accordance with [37.110.210, ARM](#), ensure that an employee or offender suffering from any of the following symptoms does not prepare or handle food products:
 - 1) diarrhea, fever, or vomiting;
 - 2) jaundice;
 - 3) sneezing, coughing, sore throat, or discharge from the eyes, nose, or mouth; or
 - 4) lesion(s) containing pus such as a boil or infected wound.

B. Health and Disease

- 1. Medical staff may conduct the employee and offender examinations to determine the absence of disease in a communicable form that can be transmitted by food or through food.

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2. Employees must sign the [Food Handler Health Requirements](#) form to indicate understanding of personal disclosure requirements regarding disease in a communicable form that can be transmitted by food or through food and submit the signed form to the food service director (FSD), or designee.
3. Offenders who are absent from work for an extended length of time due to a disease in a communicable form that can be transmitted by food or communicable food, including diarrhea, will be referred to the facility health care services for a determination of fitness for duty prior to resuming work.

C. Regulations and Inspections

1. Food and dairy products will be stored properly for no longer than the specified storage period and will be served at appropriate temperatures and as soon as possible after final preparation.
2. Local, state, and/or federal sanitation officials or other qualified persons from outside the program or facility will inspect all food service operations at least annually.

V. CLOSING

Questions concerning this policy should be directed to the food service director.

VI. REFERENCES

- A. [2-15-112, MCA](#)
- B. [37.110.210, ARM](#); [37.114.203, ARM](#); [37.114.204, ARM](#)
- C. 4-4321, -4322, -4323, -4324, -4325; *ACA Standards for Adult Correctional Institutions*, 4th Edition;
- D. 3-JTS-4A-10, -4A-11, -4A-12, -4A-15; *ACA Standards for Juvenile Correctional Facilities*, 2003
- E. [DOC Policy 4.5.11, Infection Control Program](#)

VII. ATTACHMENT

[Food Handler Health Requirements](#) [PDF](#)



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 4.3.4	Subject: FOOD SERVICE IN SPECIAL HOUSING UNITS
Chapter 4: FACILITY/PROGRAM SERVICES	Page 1 of 2
Section 3: Food Service	Effective Date: May 1, 1997
Signature: /s/ Mike Ferriter, Director	Revised: 04/20/05; 02/22/11

I. POLICY

The Department of Corrections will ensure that offenders in special housing units are provided the same general diet as offenders in general population housing.

II. APPLICABILITY

Facilities with full-scale food service operations that include the Montana State Prison, Montana Women's Prison, Pine Hills Youth Correctional Facility, and the private and regional facilities contracted to the Department of Corrections.

III. DEFINITIONS

Facility/Program – Refers to any division, prison, secure care correctional facility, correctional or training program, or community-based program under Department jurisdiction or contract. This term includes the facility building or residence, including property and land owned or leased and operated by the Department.

IV. DEPARTMENT DIRECTIVES

A. General Operations

1. Authorized staff will:
 - a. maintain food preparation, distribution, and storage areas for special housing units in accordance with all applicable safety and sanitation requirements, including those detailed in [DOC Policy 4.3.3., Food Service Safety and Sanitation](#);
 - b. supervise the preparation of all special unit meals;
 - c. ensure that the food is attractively presented and within the intended temperature range at the time of delivery;
 - d. carefully search all food carts and containers moving in and out of the unit;
 - e. adequately search each individual meal tray before distribution; and
 - f. monitor the consumption of all meals.
2. When retrieving offender meal trays, staff will ensure that all utensils and other distributed meal items are returned.
3. For safety or security purposes, authorized staff may alter the preparation and packaging of meals for special housing unit offenders in accordance with [DOC 4.3.2, Menu Planning](#).
4. Facility staff will prohibit offenders from serving meals in locked housing units.

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Subject: FOOD SERVICE IN SPECIAL HOUSING UNITS		

V. CLOSING

Questions concerning this policy should be directed to the food service director.

VI. REFERENCES

- A. [2-15-112, MCA](#)
- B. 4-4327; *ACA Standards for Adult Correctional Institutions*, 4th Edition
- C. DOC Policies [4.3.2, Menu Planning](#); [4.3.3, Food Service Safety and Sanitation](#)

VII. ATTACHMENTS

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 4.4.1	Subject: OFFENDER HYGIENE, CLOTHING, AND LINEN SUPPLIES
Chapter 4: Facility/Program Services	Page 1 of 4
Section 4: Sanitation and Hygiene	Effective Date: Oct. 1, 1997
Signature: /s/ Mike Batista, Director	Revised: 8/20/2013

I. POLICY

The Department of Corrections will provide offenders with the resources and facilities to maintain personal cleanliness and a supply of clothing, bedding, and linens sufficient to provide comfortable, sanitary, and environmentally suitable conditions during confinement.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. Each facility will establish offender hygiene and personal care procedures in accordance with the provisions of this policy.
2. Facilities will allow offenders freedom in personal grooming as long as their appearance does not conflict with the facility's safety, security, identification, and hygiene regulations. Grooming requirements may be more restrictive in specific training programs.
3. Procedures will address the re-issue of new identification photographs whenever an offender's personal appearance substantially varies from a current photograph.
4. Facilities must ensure that no civilian clothing or staff uniforms are stored in a manner that allows offender access to them.
5. The facility's supply of clothing, bedding, and linen will exceed the amount required for the offender population to prevent any delay in replacing items.
6. The facility will provide secure storage for offender clothing, bedding, and linen and establish accountability procedures for their issue and use; offenders are responsible for all issued or permitted items.

B. Hygiene Items

Policy No. DOC 4.4.1	Chapter 4: Facility/Program Services	Page 2 of 4
Subject: OFFENDER HYGIENE, CLOTHING, AND LINEN SUPPLIES		

1. Each facility will:
 - a. provide newly admitted offenders with an initial supply of personal hygiene items that may be replenished by offenders through the facility canteen or through indigent requests in accordance with *DOC Policy 4.1.4, Indigent Status*;
 - b. provide youth offenders at a youth facility with personal hygiene products for the duration of the youth's stay;
 - c. supply the following basic items to offenders upon admission:
 - 1) toothbrush;
 - 2) toothpaste or powder;
 - 3) soap and shampoo;
 - 4) comb;
 - 5) shaving implements; and
 - 6) feminine hygiene items, when applicable.
 - d. ensure that the type and amount of personal hygiene items complies with established procedures for offender personal property; and
 - e. when necessary, restrict personal hygiene items due to security concerns in mental health, segregation, and intensive management units.

C. Personal Hygiene

1. Each facility will:
 - a. require offenders to trim and maintain head and facial hair in a clean and neat manner and not endanger safety or security, especially during offender searches;
 - b. ensure hair length meets safety, health, and OSHA guidelines related to specific job assignments, e.g., industries and food services;
 - c. ensure fingernails are kept at a length that does not present safety or security concerns; and
 - d. provide hair care services that:
 - 1) comply with applicable health requirements;
 - 2) employ an individual skilled in haircutting;
 - 3) ensure observation by staff; and
 - 4) require that haircutting equipment is securely stored when not in use.
2. Facility staff may require an offender to unbraid, untie, or cut the hair in order to complete an adequate security search.
3. The facility administrator may restrict individual hair length and styles if they are deemed to present a security risk.

D. Showers

1. Each facility will:
 - a. require offenders to shower upon admission to the facility;
 - b. afford the opportunity for offenders to shower at least three times per week;
 - c. recommend that offenders with specific job assignments, e.g., food, medical, or industrial services, adhere to a daily showering schedule; and
 - d. document when offender access to showers is curtailed for any reason.

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Subject: OFFENDER HYGIENE, CLOTHING, AND LINEN SUPPLIES		

2. The facility administrator, or designee, may require an offender to adhere to a showering schedule.

E. Clothing

1. The facility will issue appropriate clothing to newly admitted offenders.
2. Facility procedures will address the disposition of offender clothing that may not be retained at the facility and provide the resources for a thorough cleaning, disinfecting, and storage of personal clothing if needed.
3. Offenders' personal clothing limits will be consistent with *DOC Policy [4.1.3, Offender Personal Property](#)*, and facility authorized property lists.
4. Each facility will provide offenders with information regarding clothing issue, exchange, and repairs, including the opportunity to obtain three complete sets of clean clothing per week.
5. Offenders will wear clothing appropriate for the season and in the manner for which it was designed.
6. The facility will provide offenders with suitable protective clothing as required for specific job assignments and work details.
7. If the facility allows relatives, attorneys, or friends to provide civilian clothing for an offender's court appearance, staff must use appropriate search and receipt procedures.
8. Unauthorized clothing will be considered contraband and an offender's possession of unauthorized clothing may subject the offender to a disciplinary violation for possession of contraband.

F. Bedding

1. Standard issue bedding will include one mattress, one pillow, one pillowcase, two sheets, and two blankets with allowance for seasonal variations.
2. Facilities will provide bedding and linen exchange no less than once a week.
3. Mattresses and pillows will remain in the housing units and sanitized when assigned to another offender.
4. The facility administrator may restrict bedding supplies for individual offenders where there is evidence of a security risk.
5. Medical services may approve other bedding for medical reasons.

G. Laundry

1. Facility procedures will include a laundry exchange schedule that ensures all offenders have the means to obtain clean clothing and linens; procedures will address a schedule for offenders in locked housing units.
2. Facilities will ensure blankets and pillows are cleaned every three months.

Policy No. DOC 4.4.1	Chapter 4: Facility/Program Services	Page 4 of 4
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3. Facility procedures will address the replacement of worn out, lost, or stolen items. Offenders may be required to reimburse the facility for issued items that are lost, stolen, or damaged.

V. CLOSING

Questions concerning this policy should be directed to the facility administrator.

VI. REFERENCES

- A. 4-4283; 4-4334 through 4-4343; *ACA Standards for Adult Correctional Institutions, 4th Edition*
- B. 4-4336, 4-4340; *ACA 2008 Standards Supplement*
- C. 3-JTS-3D-08, 3-JTS-4B-07 through 3-JTS-4B-15; *Standards for Juvenile Correctional Facilities, 2003*
- D. *DOC Policies 4.1.3, Offender Personal Property; 4.1.4, Indigent Status; 4.4.2, Facility Sanitation and Pest Control*

VII. ATTACHMENTS

None.



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 4.4.2	Subject: FACILITY SANITATION AND PEST CONTROL
Chapter 4: FACILITY/PROGRAM SERVICES	Page 1 of 4
Section 4: Sanitation and Hygiene	Effective Date: October 1, 1997
Signature: /s/ Mike Ferriter, Director	Revised: 04/18/11

I. POLICY

The Department of Corrections will provide offenders and staff with resources to maintain a clean and sanitary living and working environment free of vermin and consistent with applicable codes, standards, and sound correctional practices.

II. APPLICABILITY

Facilities and programs under the supervision of, and contracted to, the Department of Corrections.

III. DEFINITIONS

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Facility/Program – Refers to any division, prison, secure care correctional facility, correctional or training program, or community-based program under Department jurisdiction or contract. This term includes the facility building or residence, including property and land owned or leased and operated by the Department.

Pests –Destructive insects, rodents, or vermin that causes annoyance, discomfort, or disease.

Waste –Garbage, rubbish, and other decomposable and non-decomposable liquid and solid waste that accumulates from facility buildings, residences, and grounds.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. Each facility will establish a sanitation inspection program in accordance with this policy.
2. Each facility will establish a written housekeeping plan for the physical plant including regularly scheduled maintenance and specific duties and responsibilities assigned to staff and offenders.
3. The facility potable water source and supply, whether owned and operated by the public domain or the facility, will be certified by an independent outside source and in compliance with jurisdictional laws and regulations.

B. Sanitation Inspections

1. Facilities will undergo annual inspections completed by an independent outside source, will comply with the governing jurisdiction's applicable health codes and regulations and document corrections of past deficiencies.

Policy No. DOC 4.4.2	Chapter 4: Facility/Program Services	Page 2 of 4
Subject: FACILITY SANITATION AND PEST CONTROL		

2. Designated staff will forward copies of inspections to the facility administrator and the appropriate health authority.
3. Facilities will ensure completion of the following:
 - a. weekly sanitation inspections of facility areas by a qualified staff member;
 - b. thorough monthly inspections by a safety or sanitation specialist, who may be a staff member trained in the application of jurisdictional codes and regulations; and
 - c. at minimum, annual inspections by federal, state, and/or local sanitation and health officials or other qualified person(s).

C. Sanitation Requirements

1. Each offender will:
 - a. maintain the cleanliness of his/her cell, room, or living area, including walls, floors, sink, toilet, windows, and property within the assigned area;
 - b. properly use and care for issued cleaning materials and equipment;
 - c. clear, sweep, and mop the floor of the assigned area and deposit trash in the appropriate container before leaving for work assignment or program activities; and
 - d. comply with facility housekeeping procedures, including limitations on hanging or storing items that may create fire hazards or supervision obstacles.
2. Facility staff will:
 - a. issue cleaning items according to the unit cleaning schedule;
 - b. inspect cleaning equipment for safety, cleanliness, and damage before and after issue;
 - c. document and report needed repairs or replacements; and
 - d. store cleaning implements to provide security, proper ventilation, and drying.
3. Locked Unit Sanitation:
 - a. offenders in locked housing units will clean their cells including the bed, toilet, and mop the floor at least every other day and prior to transfer or release;
 - b. assigned offenders may clean the locked unit common areas under staff supervision; and
 - c. after a staff member inspects a vacated, unclean cell, an offender may be assigned to clean the unoccupied cell.
4. Common Area Sanitation:
 - a. staff will assign offenders to clean the corridors and facility common areas;
 - b. offenders will clean and wax corridor and facility floors as directed;
 - c. supervisory staff will ensure that floors are clean, dry, and free of potentially hazardous obstacles; and
 - d. supervisory staff will inspect common areas for compliance with sanitation standards.

D. Facility Maintenance

1. The facility will establish a system for reporting necessary repairs, assigning labor, and accounting for materials related to facility repairs.
2. The facility maintenance department will respond to major repairs regarding toilets, washbasins, sinks, and other facility equipment.

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Subject: FACILITY SANITATION AND PEST CONTROL		

3. Facility staff and offenders will respond to minor repairs and maintenance as appropriate.

E. Waste Disposal

1. The facility will provide a waste disposal system in accordance with a plan approved by the appropriate regulatory agency.
2. The facility may provide waste disposal services, contract with a city or county sanitation department, or hire a private contractor.
3. Waste disposal must meet the following requirements:
 - a. housing unit staff will deliver all trash, refuse, and garbage to a collection point or compactor on an established schedule;
 - b. food service and industrial and shop staff will deliver to a collection area or compactor on an established schedule no less than three times per week; and
 - c. the facility or refuse contractor will empty waste containers on a pre-agreed schedule to prevent odors and excess accumulation of trash.
4. The facility will manage effluent and sewage in compliance with applicable state agency regulations for water pollution control and requirements of the Federal Environmental Protection Agency.
5. The facility will collect, store, and dispose of liquid and solid wastes in a manner that avoids nuisance and hazards and protects the health and safety of offenders and staff in accordance with the policy and *DOC Policy [3.2.12](#), Control and Use of Hazardous Materials*.

F. Trash Burning

1. Facility procedures will prohibit open burning of trash or garbage on facility property unless expressly authorized by the facility administrator and performed according to local or state ordinances.
2. When trash burning is approved the facility administrator, or designee, will arrange for the appropriate staff notifications and implement safeguards against the spread of fire.
3. The facility, or contractor responsible for trash removal, will handle all combustible materials as normal trash on the established schedule.

G. Pest Control

1. The facility will contract with or purchase services from a licensed pest control firm or individual to:
 - a. provide vermin and pest control services;
 - b. conduct monthly inspections to eradicate any insects, rodents, or vermin; and
 - c. submit inspection reports to the facility administrator.
2. Designated facility staff may provide minor pest control measures, e.g., spraying, as needed.

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3. Staff will immediately report conditions conducive to harboring or breeding pests, or observation of any insects, rodents, or vermin to the appropriate supervisor who shall implement a corrective action plan.

V. CLOSING

Questions concerning this policy should be directed to the facility administrator.

VI. REFERENCES

- A. 4-4329 through 4-4333; *ACA Standards for Adult Correctional Institutions, 4th Edition*
- B. 3-JTS-4B-01 through 3-JTS-4B-06; *ACA Standards for Juvenile Correctional Facilities, 2003*
- C. DOC Policies [2.1.1](#), *Facility Maintenance*; [3.2.12](#), *Control and Use of Hazardous Materials*; [4.4.1](#), *Offender Hygiene, Clothing, and Linen Supplies*

VII. ATTACHMENTS

None.



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 4.5.2	Subject: RESPONSIBLE HEALTH AUTHORITY
Chapter 4: FACILITY/PROGRAM SERVICES	Page 1 of 3
Section 5: Clinical Services	Effective Date: Oct. 1, 1997
Department Director Signature: /s/ Brian Gootkin	Revised: 4/19/2021
Medical Director Signature: /s/ Dr. Paul Rees	
Clinical Services Division Administrator Signature: /s/ Connie Winner	

I. POLICY

The Department of Corrections will provide constitutionally mandated, quality health care to offenders in Department and contracted secure care facilities.

II. APPLICABILITY

All secure facilities Department of Corrections owned and contracted, as specified in the contract.

III. DEFINITIONS

Clinical Policy Team – A team which may consist of the Department Clinical Services Division administrator, bureau chief, medical director, dental director, managed care RN, facility or program designated health authority, mental health or psychiatric representative, and facility or program administrator.

Clinical Services – All necessary services including medical, mental health, dental and vision care.

Clinical Services Division (CSD) – The division that oversees all medical, mental health, dental and vision services for all offenders in the custody of the Department in secure and contracted facilities.

Clinical Services Division Administrator – The administrator responsible for overseeing the Clinical Services Division and is the designated Responsible Health Authority for the Department.

Designated Dental Authority – The dental clinician (DMD or DDS) designated by the Clinical Services Division Administrator to oversee dental services.

Designated Health Authority – Regardless of local title, the individual at the facility or program level who is responsible for health services, as designated by the Responsible Health Authority.

Designated Mental Health Authority – Regardless of local title, the individual at the facility or program level who is responsible for mental health services, as designated by the Responsible Mental Health Authority.

Drug Formulary – A written list of prescription and nonprescription medications that are ordinarily available to authorized prescribers, including consultants, working for the facility.

Health Care – The sum of all actions, preventive and therapeutic, taken for the physical and mental

Policy No. DOC 4.5.2	Chapter 4: Facility/Program Services	Page 2 of 3
Subject: RESPONSIBLE HEALTH AUTHORITY		

well-being of a population. Health care includes medical, dental, mental health, nutrition, and other ancillary services, as well as maintaining clean and safe environment conditions.

Health Care Staff – Includes qualified health care professionals and non-licensed health care staff (e.g., medical records staff, health care aides) responsible for offender health care administration and treatment.

Medical Director – The physician(s) designated by the Clinical Services Division administrator to oversee clinical practice decisions requiring medical judgments for offenders under Department jurisdiction.

Qualified Health Care Professionals – Physicians, physician assistants, nurses, nurse practitioners, dentists, mental health professionals and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for offenders, including contracted or fee-for-service professionals.

Responsible Health Authority –The Clinical Services Division administrator who oversees all levels of health care and assures quality, accessible and timely clinical services for offenders. The individual is appointed by the Department director.

IV. DEPARTMENT DIRECTIVES

A. Clinical Policy Team

1. The Department clinical policy team will:
 - a. develop, revise, and monitor the implementation of Department clinical services policies, procedures, protocols, and managed care policies;
 - b. review and approve each facility or program's clinical service procedures, and protocols;
 - c. oversee the drug formulary;
 - d. make medical, dental, vision, and mental health administrative judgments based on policies and protocols;
 - e. provide policy guidance and oversight to offender health care professionals;
 - f. monitor the level and quality of facility and program clinical services to ensure compliance with all applicable standards;
 - g. oversee the Department's health care-related, continuous quality improvement program;
 - h. provide professional direction and leadership; and
 - i. guide the Department's compliance with adult and youth health-related legal standards.

B. Health Authority Requirements

1. Written job descriptions or contracts will govern the responsible health authority and medical director responsibilities.
2. Written job descriptions or contracts will govern the medical and mental health bureau chiefs' responsibilities.

Policy No. DOC 4.5.2	Chapter 4: Facility/Program Services	Page 3 of 3
Subject: RESPONSIBLE HEALTH AUTHORITY		

3. The responsible health authority, medical and mental health bureau chiefs, and medical director will coordinate with each other and health care staff to ensure adequate, quality, accessible, and timely clinical services for offenders.
4. The medical and mental health bureau chiefs will:
 - a. serve as a liaison between the CSD and the designated health and mental health authorities at facilities to ensure health care services are rendered in accordance with Department policy and national standards;
 - b. evaluate facility health care needs;
 - c. regularly report facility-specific health care information to the CSD administrator; and
 - d. participate in strategic planning and program development as requested by the CSD administrator.
5. The medical director will:
 - a. render the final medical judgments for offenders under Department jurisdiction; and
 - b. review community health care provider treatment recommendations.
6. The designated health and mental health authorities on-site at the facility will:
 - a. assume the responsibility to direct the medical or mental health care of inmates in collaboration with the medical director and/or other qualified health care professionals;
 - b. function within the guidelines of their respective scopes of practice; and
 - c. not place restrictions on a physician's routine practice of medicine.
7. Department qualified health care professionals will:
 - a. function within the guidelines of their respective scopes of practice; and
 - b. will not place any restrictions on a physician's routine practice of medicine.

V. CLOSING

Questions concerning this policy should be directed to the Clinical Services Division administrator or designee.

VI. REFERENCES

- A. *ACA Standards for Juvenile Correctional Facilities, 4th edition*
- B. *P-A-02; National Commission on Correctional Health Care Standards for Health Services in Prisons, 2018*
- C. *MH-A-01, MH-A-02; National Commission on Correctional Health Care Standards for Mental Health Services in Correctional Facilities, 2015*
- D. *Y-A-02; National Commission on Correctional Health Care Standards for Health Services in Juvenile Detention and Confinement Facilities, 2015*

VII. ATTACHMENTS

None



POLICY DIRECTIVE

Policy:	DOC 4.5.03 HEALTH CARE AUTONOMY	
Effective Date:	08/01/1997	Page 1 of 3
Revision Date(s):	04/19/2021, 06/01/2024; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will ensure clinical decisions and actions regarding the health care provided to offenders to meet their serious medical, dental, and mental health needs are solely the responsibility of the Qualified Health Care Professional.

II. APPLICABILITY

All secure facilities Department owned and contracted, as specified in the contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The facility health care unit will be the sole provider of on-site offender health care services and may consist of Department employees as well as contracted professional staff.
2. Each Qualified Health Care Professional will render services in accordance with Department policy and operate with the guidance and, when appropriate, the direction of the clinical policy team.
3. The Department will not place restrictions on any physician, dentist, or psychiatrist with respect to the practice of their medical specialties.
4. The Department will ensure that all clinical decisions and their implementations are completed in an effective and safe manner.
5. Security regulations that apply to all Department staff members will apply to all health care staff.
6. The Department Medical Director and/or designated managed care nurses must approve off-site consultations and procedures in advance of services rendered in accordance with *DOC 4.5.10 Level of Therapeutic Care*.

7. Department managed care nurses will collaborate with internal and external designated health care staff to facilitate an offender's return to a Department facility following a hospitalization.
8. Prior to an offender's return, custody staff must receive notification from the facility health care staff that the offender has been approved to return to the Department facility.
9. Managed care policies developed by the clinical policy team will be binding upon each Qualified Health Care Professional.

B. Health Care Delivery

1. The Medical and Mental Health Services Managers will ensure that appropriately credentialed health care professionals deliver services within their respective scopes of practice.
2. The designated health and mental health authorities on-site at the facility will ensure access to, and monitoring of, offender health care services.
3. The responsible health authority, or designee, will ensure the necessary resources are provided for the delivery of offender health care.

C. Relationship Between Health Care and Security Responsibilities

1. Each Qualified Health Care Professional will have complete responsibility and authority for offender health care and treatment.
2. Custody staff will not be involved in providing direct health care or analyzing and evaluating the efficiency of health care treatment or the validity of health care requests.
3. Custody and health care staff will work together, recognizing that facility and offender interests are best served when all relevant health care delivery standards are implemented.
4. All staff trained in CPR and First Aid will provide emergency care within the scope of their training.
5. The designated Medical and Mental Health Services Managers are responsible to ensure proper coordination between the health care unit and the security or transportation staff assigned to move offenders to and from treatment areas.
6. Health staff do not write disciplinary reports.

D. Conflict Resolution

1. Health care providers will make every effort to comply with the security requirements inherent in correctional facility operations while meeting the legitimate health care needs of the offender population.
2. If any conflicts arise, the responsible health or mental health clinician will attempt to resolve them in consultation with health care staff and other affected facility staff; if the responsible health or mental health clinician cannot resolve a conflict, the issue may be addressed by the Department responsible health authority and the Medical and Mental Health Services Managers.
3. Conflicts between facility operational procedures and direct medical orders will be immediately referred for resolution by the responsible health authority or designee and, if needed, the clinical policy team.
4. If a physician's medical order, which may be life sustaining, is in direct conflict with a security directive, the medical order will be implemented and followed by an immediate review by the Department's responsible health authority, the Medical and Mental Health Services Managers, the Managed Care RN, and the facility administrator.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *ACA Standards for Juvenile Correctional Facilities, 4th Edition*
- B. *P-A-01, P-A-03; National Commission on Correctional Health Care Standards for Health Services in Prisons, 2018*
- C. *MH-A-03; National Commission on Correctional Health Care Standards for Mental Health Services in Correctional Facilities, 2015*
- D. *Y-A-03; National Commission on Correctional Health Care Standards for Health Services in Juvenile Detention and Confinement Facilities, 2022*
- E. *Montana Nurse Practice Act*
- F. *DOC 4.5.10 Level of Therapeutic Care*



POLICY DIRECTIVE

Policy:	DOC 4.5.04 HEALTH CARE CREDENTIALING	
Effective Date:	08/01/1997	Page 1 of 2
Revision Date(s):	06/01/2024; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will ensure that each Qualified Health Care Professional is legally eligible to perform their clinical duties. All Department and contracted facility offender health care services are provided by a licensed and Qualified Health Care Professional.

II. APPLICABILITY

All secure facilities Department owned and contracted, as specified in the contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Requirements

1. Each Department and contracted Qualified Health Care Professional and qualified mental health professional providing onsite or telehealth services will:
 - a. submit a copy of current license or appropriate credentials to the facility administrator and designated health and mental health authorities upon hire;
 - b. maintain current license or credentials and provide verification of renewal to the facility administrator and designated health and mental health authorities; and
 - c. immediately report any changes to their credentials to the designated mental health authority.
2. The designated health and mental health authorities will:
 - a. provide verification of current licenses and credentials through the appropriate licensing board, including sanctions or disciplinary actions;
 - b. provide verification for prescribers through the National Practitioner Data Bank (NPDB);
 - c. ensure qualified health and mental health professionals do not perform tasks beyond the scope of their credentials;
 - d. ensure licenses limiting practice to correctional health care only will not be permitted;
 - e. maintain verifications in individual personnel files; and
 - f. provide copies of verifications to the Department's contract monitor in contracted facilities.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-C-01; National Commission on Correctional Health Care Standards for Health Services in Prisons, 2018*
- B. *MH-C-01; National Commission on Correctional Health Care Standards for Mental Health Services in Correctional Facilities, 2015*
- C. *Y-C-01; National Commission on Correctional Health Care Standards for Health Services in Juvenile Detention and Confinement Facilities, 2022*
- D. *Montana Department of Labor and Industry Business Standards Division*
- E. *Montana Nurse Practice Act*
- F. *American Medical Association of Montana*
- G. *Board of Medical Examiners*



POLICY DIRECTIVE

Policy:	DOC 4.5.05 HEALTH SERVICES POLICIES AND PROCEDURES	
Effective Date:	10/01/1997	Page 1 of 2
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

Department facility health care units will ensure a health care manual and current Department health services policies and facility clinical services procedures, either hard copy or digital, are maintained and readily available within their units.

II. APPLICABILITY

All secure facilities Department owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Health Care Manual Contents

1. Each facility health care manual will contain, at a minimum, the following:
 - a. Department policies and procedures that address applicable National Commission on Correctional Health Care Standards; and
 - b. other relevant Department policies and/or facility procedures.

B. Health Care Manual Access

1. The manual, either hard copy or digital, will be retained in all health care unit administrative areas.
2. All health care staff will have access to the manual.

C. Health Care Manual Training

1. The designated health authority, in cooperation with the facility administrator, will familiarize all new health care staff with the manual.
2. The designated health authority will retain documentation verifying that each health care provider has read the manual.

D. Responsibilities

1. All health care staff will:
 - a. read the manual and sign a document to verify that fact;
 - b. follow established policies and procedures as instructed;
 - c. identify and inform supervisory staff of policies and procedures that may be inconsistent or inappropriate; and
 - d. review policies and procedures upon new implementations or revisions.
2. Qualified Health Care Professionals will assume full responsibility for their own clinical judgment while providing care within their scope of practice.
3. The designated health authority or designee will:
 - a. ensure that each health care staff is familiar with the clinical section of the manual;
 - b. provide for in-service training programs to address new or revised policy and procedures;
 - c. review health care policies and procedures at least annually with the responsible physician;
 - 1) documentation of this review will include signatures and the date of the review;
 - d. ensure other policies do not conflict with the health care policies; and
 - e. maintain documentation of all in-service training programs.
4. The designated mental health authority will;
 - a. review mental health policies and procedures at least annually;
 - 1) review will be documented with the mental health authority signature, and if necessary, the mental health clinician signature, and the date of the review; and
 - b. ensure other policies do not conflict with the mental health policies.

V. CLOSING

Questions about this policy should be directed to the Department Medical Director or Health Services Bureau Chief.

VI. REFERENCES

- A. *ACA Standards for Juvenile Correctional Facilities, 5th Edition*
- B. *4-4415; ACA Standards for Adult Correctional Institutions, 5th Edition*
- C. *P-A-05; National Commission on Correctional Health Care Standards for Health Services in Prisons, 2018*
- D. *Y-A-05; National Commission on Correctional Health Care Standards for Health Services in Juvenile Detention and Confinement Facilities, 2022*
- E. *MH-A-05; National Commission on Correctional Health Care Standards for Mental Health Services in Correctional Facilities, 2015*



POLICY DIRECTIVE

Policy:	DOC 4.5.06 ADMINISTRATIVE MEETINGS AND REPORTS	
Effective Date:	06/01/1998	Page 1 of 2
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

Department facilities will hold administrative meetings and generate reports to coordinate health care and mental health services delivery system through joint monitoring, planning, and problem resolution.

II. APPLICABILITY

All secure facilities Department owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Reviews

1. The designated health authority will conduct annual health care program reviews at the request of the responsible health authority and/or Medical Director. Results will be forwarded to the facility administrator, responsible health authority, and the Medical Director.
2. The review will include, at minimum, the following information:
 - a. the number of offenders receiving health services by category of care;
 - b. referrals to specialists;
 - c. deaths;
 - d. infectious disease monitoring (for example, HIV, STDs, TB);
 - e. emergency services provided to patients;
 - f. dental procedures performed;
 - g. any staffing, space, or equipment issues or needs;
 - h. access, timeliness or health services, and follow-up; and
 - i. missed appointments.

B. Health Policy Team Meetings

1. The health services policy team meetings will:
 - a. be chaired by a designated member of the health services policy team;
 - b. be documented;

- c. convene at least semiannually;
- d. focus on monitoring, planning, and problem resolution within the adult and youth health care delivery systems;
- e. provide agendas that include review of quarterly monitoring reports and sentinel events and discussion of interdepartmental problems and health care system effectiveness; and
- f. include the following personnel:
 - 1) the health services manager;
 - 2) the designated health authority for each facility;
 - 3) facility administrators;
 - 4) the Department managed care nurses;
 - 5) physician(s);
 - 6) pharmacists/pharmacy consultants;
 - 7) psychiatrist(s);
 - 8) mid-level practitioners; and
 - 9) the Department Dental Director.

C. Facility Health Care and Mental Health Services Staff Meetings

1. The designated health authority will meet at least quarterly with health care staff to review administrative and procedural issues.
2. The meetings will be documented, and notes will include:
 - a. an account of health care system effectiveness;
 - b. a description of any environmental health factors that need improvement;
 - c. policy and procedure issues;
 - d. changes applied since the last report; and
 - e. recommended corrective action
3. Meeting notes will be retained for reference, and copies will be reviewed and made available to all health staff.
4. On-site health staff meetings will take place at least monthly to address pertinent health care issues.
 - a. minutes or meeting summaries will be made and retained for reference, and
 - b. copies of minutes or meeting summaries will be made available and reviewed by all staff.

D. Reports

1. Statistical reports of all health and mental health services will be created and will be forwarded to the facility administrator, responsible health authority, and Medical Director to monitor trends in the delivery of services.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-A-04; National Commission on Correctional Health Care Standards for Health Services in Prisons, 2018*
- B. *MH-A-04 National Commission on Correctional Health Care Standards for Mental Health Services in Correctional Facilities, 2015*
- C. *Y-A-04 National Commission on Correctional Health Care Standards for Health Services in Juvenile Detention and Confinement Facilities, 2022*



POLICY DIRECTIVE

Policy:	DOC 4.5.07 OFFENDER WORKERS IN HEALTH CARE UNITS	
Effective Date:	08/01/1997	Page 1 of 2
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department limits the use of offenders as health care workers in Department and contracted facility health care and mental health care units to assignments for which they are appropriately trained and supervised.

II. APPLICABILITY

All secure facilities Department owned and contracted, as specified in the contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Offender Assignments

1. Adult offenders, if appropriately trained and supervised, may be permitted to:
 - a. provide maintenance duties in the facility health care unit;
 - b. handle biohazardous wastes (for example, dirty linens or utensils);
 - c. participate in peer health-related programs or reentry health care training programs;
 - d. assist patients in activities of daily living (except for infirmary level care); and
 - e. participate in hospice programs after documented training.
2. Adult offenders will not be permitted to:
 - a. make treatment decisions or provide patient care;
 - b. distribute or collect sick call slips;
 - c. schedule appointments;
 - d. transport or view health records;
 - e. handle or administer medications;
 - f. handle surgical instruments; or
 - g. substitute for health care staff.
3. Adult offenders in peer-health related programs are permitted to:
 - a. assist offenders in activities of daily living (except for infirmary-level care offenders);
 - b. participate in a buddy system for nonacute suicidal offenders after documented training;and

- c. participate in palliative care programs after documented training.
- 4. The designated health authority, classification staff, and chief of security, or designees, will conduct periodic reviews of adult offender worker placements in health care units.
- 5. Youth offenders are prohibited from performing health care duties in youth facilities in accordance with *ACA Performance-based Standard 4-JCF-4C-57* and the National Commission on Correctional Health Care Standards for Health Services in Juvenile Detention and Confinement Facilities.

B. Security Precautions

- 1. Each facility will develop security processes to ensure that offenders do not have access to:
 - a. needles;
 - b. syringes;
 - c. sharps;
 - d. surgical instruments;
 - e. medications;
 - f. offender health care records or files; and
 - g. other prohibited items.
- 2. Security precautions will include:
 - a. appropriate inventory procedures; and
 - b. required supervision and routine searches of all adult offenders working in the health care unit.
- 3. Offenders have the right to refuse care delivered by offenders who are in reentry health care training programs.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. 4-4393; *ACA Standards for Adult Correctional Institutions, 5th Edition*
- B. 4-JCF-4C-57; *ACA Performance-based Standards for Juvenile Correctional Facilities, 5th Edition*
- C. P-C-06; *National Commission on Correctional Health Care Standards for Health Services in Prisons, 2018*
- D. MH-C-06; *National Commission on Correctional Mental Health Services in Correctional Facilities, 2015*
- E. Y-C-06; *National Commission on Correctional Health Standards for Health Services in Juvenile Detention and Correctional Facilities, 2022*
- F. *Montana Nurse Practice Act*



POLICY DIRECTIVE

Policy:	DOC 4.5.09 CONTINUOUS QUALITY IMPROVEMENT PROGRAM	
Effective Date:	05/01/1998	Page 1 of 4
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will monitor and improve health and mental health care delivery through Continuous Quality Improvement (CQI) activities that include monthly monitoring, sentinel events, and data review.

II. APPLICABILITY

All secure facilities Department owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Quality Improvement Committee

1. The responsible health authority will establish a multi-disciplinary quality improvement committee to identify health care aspects to be monitored, implement and monitor corrective action when necessary, and study the effectiveness of corrective action plans.
2. The quality improvement committee will include representatives from the following disciplines:
 - a. physician;
 - b. nursing staff;
 - c. mental health staff;
 - d. correctional staff;
 - e. facility administration; and
 - f. Health Services Bureau.
3. Committee membership is fluid based on identified problems.
4. The quality improvement committee meets at least quarterly to:
 - a. identify health care and mental health care aspects to be monitored and establish thresholds;
 - b. complete health record reviews to ensure that appropriate care is ordered, implemented, and coordinated by the appropriate staff;
 - c. design quality improvement monitoring activities;
 - d. analyze factors that may have contributed to less than threshold performance;

- e. design and implement improvement strategies to correct the identified health care or mental health care problem; and
 - f. monitor performance after implementation of the improvement strategies.
5. When the committee identifies a health care or mental health care problem from its monitoring, the committee will examine the effectiveness of the health care delivery process and examine whether the expected outcomes of patient care were achieved by performing:
- a. a process quality improvement study that includes:
 - 1) identification of a facility problem;
 - 2) conducting a baseline study;
 - 3) developing and implementing a corrective action plan; and
 - 4) restudying the problem to assess the effectiveness of the corrective action plan; or
 - b. an outcome quality improvement study that includes:
 - 1) identification of a patient clinical care problem;
 - 2) conducting a baseline study;
 - 3) developing and implementing a corrective action plan; and
 - 4) restudying the problem to assess the effectiveness of the corrective action plan.
6. Meeting minutes:
- a. will contain detailed information identifying:
 - 1) problems;
 - 2) agreed upon solutions;
 - 3) person responsible for carrying out the corrective action plan; and
 - 4) time frame for the corrective action plan; and
 - b. will be retained for reference and copies will be made available for and reviewed by all appropriate personnel.
7. Data from the process and outcome quality improvement studies will be maintained by the committee.
8. The responsible physician and Medical and Mental Health Service Managers will actively participate in the CQI program and committee.
9. CQI will include an annual review of deaths and serious incidents involving offenders with mental illness to identify trends and corrective action.
10. The CQI program will be evaluated annually by the quality improvement committee including review of:
- a. CQI studies;
 - b. minutes of quality improvement committee meetings;
 - c. minutes of administrative and/or staff meetings related to health care; and
 - d. other pertinent written materials.

B. Service Areas

1. The CQI program will evaluate each of the following service areas annually:
- a. intake processing;
 - b. acute care (sick call for both general population and restrictive housing);
 - c. medication services;
 - d. chronic care services;
 - e. intra-system transfer services;
 - f. scheduled off-site services (consultations and procedures);
 - g. unscheduled on-site and off-site services (urgent/emergent care);
 - h. mental health services;
 - i. dental services;
 - j. ancillary services (lab and x-ray);
 - k. dietary services; and
 - l. infirmary services.

C. Performance Measures

1. Each service area reviewed will include one or more of the following performance measures:
 - a. accessibility (unimpeded access to health care services);
 - b. appropriateness of clinical decision making by:
 - 1) record of current license and credentials status;
 - 2) documentation of continuous education training;
 - 3) documentation of required certifications;
 - 4) regular review of clinician performance that includes feedback to increase the probability of clinically appropriate decision making;
 - c. continuity:
 - 1) pre-existing conditions are identified and addressed during the intake process;
 - 2) follow-up of on-site and off-site services, scheduled and unscheduled:
 - a) evaluate time between complaint, referral, and response;
 - b) timeliness of the follow-up encounter with designated health care professional;
 - c) timeliness of receipt of applicable service reports;
 - 3) consistent receipt of services without breaks in service;
 - d. timeliness:
 - 1) time between health service requests being retrieved and the face-to-face encounter with the Qualified Health Care Professional;
 - 2) time between initial diagnosis of chronic illness and the first chronic care visit;
 - 3) time between the ordering of a critical medicine and its receipt by the patient;
 - 4) time between contact with emergency services regarding a patient emergency and the arrival at the emergency room or infirmary;
 - e. effectiveness:
 - 1) clinical outcome measures for certain common chronic diseases (for example, A 1c levels due to diabetes, Hep C viral load, etc.);
 - 2) clinical outcome measures for certain mental illnesses (for example, schizophrenia, Bipolar, etc.);
 - f. efficiency:
 - 1) utilization of available resources;
 - 2) cost of care;
 - 3) continuity of care;
 - g. quality of clinical-patient interaction:
 - 1) patient satisfaction surveys;
 - 2) number and type of health care grievances;
 - h. safety:
 - 1) physical environment:
 - a) incident reports;
 - b) evidence of inspection;
 - c) self-harm; and
 - d) suicide;
 - i. adherence to custody safety and security requirements; and
 - j. investigating and performing root cause analysis for all offender deaths as well as other adverse events.

D. Clinical Performance Enhancement

1. The responsible health authority or designee will ensure that health care staff meet clinical performance thresholds on an annual basis.
2. Documentation of clinical performance enhancement will be confidentially maintained for each health care employee and will contain the following elements:
 - a. name and credentials of the individual being reviewed;
 - b. date of the review;

- c. name and credentials of the reviewer;
 - d. summary of the findings and corrective action, if any; and
 - e. confirmation that the review was shared with the individual being reviewed.
3. Health staff responsible for guiding the CQI program should be given training opportunities to enhance their skills and the program's effectiveness.
 4. Clinical performance enhancement reviews are conducted on all full-time, part-time, and per diem providers, RNs, LPNs, psychologists, Licensed Clinical Social Workers, and dentists.
 5. A system is maintained that lists the names of individuals reviewed and dates of their reviews and is made available to the appropriate staff.

E. Reports

1. Quarterly CQI reports will be developed and presented at each quarterly quality improvement committee meeting with copies to the responsible health authority or designee and facility administrator.
2. Annual CQI reports will be developed and presented at the annual CQI program review meeting with copies sent to the responsible health authority or designee and facility administrator.

F. Release of Information

1. Information including CQI data, analysis, findings, recommendations, conclusions, and actions developed by or for health care staff, health services, or other individual committees performing CQI assessments or similar functions will not be available to unauthorized persons or organizations or used for other than intended purposes as allowed for under state and federal law.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-A-06, P-C-02; National Commission on Correctional Health Care Standards for Health Services in Prisons, 2018*
- B. *MH-A-06, MH-C-02; National Commission on Correctional Health Care Standards for Mental Health Services in Correctional Facilities, 2015*
- C. *Y-A-06, Y-C-02; National Commission on Correctional Health Care Standards for Health Services in Juvenile Detention and Confinement Facilities, 2022*



POLICY DIRECTIVE

Policy:	DOC 4.5.10 LEVEL OF THERAPEUTIC CARE	
Effective Date:	05/01/1998	Page 1 of 3
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will provide the appropriate level of offender health care services consistent with national correctional health care standards and ensure that clinically appropriate procedures are performed by qualified health care providers.

II. APPLICABILITY

All secure facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The Department Medical Director must review recommended elective medical or surgical procedures or therapies.
 - a. Exception: If a delay in treatment would cause irreparable harm, significant risk, or fail to comply with sound medical principles, the review may be conducted after treatment has been initiated and the Medical Director should be notified as soon as possible.
2. Medical care and treatment are prioritized by levels, each with specific authorizations.
3. The levels of care are general guidelines for providing diagnostic evaluation, therapies, and processes including levels of authorization.
4. Offender access to care as well as diagnosis and appropriate treatment by a Qualified Health Care Professional (QHCP) is an essential right not abridged by this policy.
5. Any provider or offender may request review of a denial by the Medical Director through the Medical Review Panel (MRP).
6. The responsible health authority, or designee, after consultation with appropriate medical and legal personnel, will be the final authority in all review appeals.

B. Medical Care and Treatment Levels

1. Level 1, Medically Mandatory Care:
 - a. is routinely provided to all offenders;
 - b. includes care essential to life and health without which rapid deterioration may be an expected outcome and where medical or surgical intervention makes a significant difference in outcome;
 - c. includes, but is not limited to: acute problems, potentially fatal, where treatment prevents death and/or significant morbidity and may allow full recovery (for example, appendectomy for appendicitis, arterial and venous lacerations, myocarditis, myocardial infarction, major head injury, eclampsia, etc.);
 - d. may be authorized by any licensed health services practitioner in an emergency situation; and
 - e. is usually urgent or emergency care, initiated by medical personnel at the time of intervention, and is routinely authorized, provided, and paid for by the Department.
2. Level 2, Presently Medically Necessary Care:
 - a. may be provided by any prescribing practitioner;
 - b. subject to periodic utilization review by the Medical Director;
 - c. includes care without which the offender may have significant risk of progression of serious deterioration of the condition, significant reduction in the chance of possible repair after release, or significant pain or discomfort;
 - d. examples include, but are not limited to:
 - 1) chronic conditions, usually progressing to death, or where treatment improves life span and/or quality of life (for example, medical management of insulin dependent diabetes mellitus, surgical treatment for treatable cancer, medical management of asthma, moderate to severe hypertension, surgical treatment of significant degenerative orthopedic disease, or cardiac pacing);
 - 2) supportive care such as pain management and hospice-type care for the end stages of diseases such as cancer or AIDS; and
 - 3) acute, non-fatal conditions where treatment may allow a return to a previous state of health including, but not limited to, medical treatment of various infectious disorders, surgical repair of an incarcerated hernia, acute gallbladder disease, relocation of dislocated joints, or repair of a corneal laceration;
 - e. surgeries and major durable medical equipment may be authorized by the Medical Director and managed care RN; and
 - f. when not an emergency, authorization should undergo review by the Medical Director and managed care RN for approval and, in general, will be provided and paid for by the Department.
3. Level 3, Medically Acceptable but Not Medically Necessary Care:
 - a. will be authorized on an individual, case-by-case basis;
 - b. includes care for non-fatal conditions when treatment may improve the quality of life for the patient including, but not limited to: routine non-incarcerated offender hernia repair and treatment of noncancerous skin lesions;
 - c. involves acute/on-site medical and surgical procedures and therapies that can be appropriately completed on premises in a routine clinic setting, are within the skills of the health care provider, and may be authorized by the Medical Director;
 - d. chronic diseases indicated by the Medical Director, or designee, that require off-site procedures, treatments, and/or therapies may be authorized by the MRP following submission and review of the *Health Services Preauthorization Request* and *Medical Review Panel Disposition*; and
 - e. the final authority in all Level 3 reviews will be the Medical Director, or designee.

4. Level 4, Limited Medical Value:
 - a. is usually not provided by the Department;
 - b. includes care that may be appropriate for certain individuals but may have limited benefit or is not likely to produce substantial long-term gain such as treatment of minor conditions to decrease recovery time that provides little improvement in quality of life, and/or offers minimal palliation of symptoms, and/or is primarily for the convenience of the individual; and
 - c. examples include, but are not limited to, elective procedures (for example, tattoo removal, nasal septoplasty, circumcision) or minor conditions (for example, common cold, aphthous ulcers, etc.)

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *ACA Standards for Juvenile Correctional Facilities*
- B. *P-A-02, P-F-01, P-F-02 National Commission on Correctional Health Services in Prisons*
- C. *National Commission on Correctional Mental Health Services in Correctional Facilities*
- D. *National Commission on Correctional Health Services in Juvenile Detention and Confinement Facilities*



POLICY DIRECTIVE

Policy:	DOC 4.5.11 INFECTIOUS DISEASE PREVENTION AND CONTROL	
Effective Date:	05/01/1998	Page 1 of 5
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will ensure that the health care services in each facility provide an infection control program that assists in maintaining a safe and healthy environment for offenders and staff which includes surveillance, prevention, and control of communicable diseases in accordance with state and federal guidelines.

II. APPLICABILITY

All secure facilities Department owned and contracted, as specified in the contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Facility health care units must have a written exposure control plan that is approved by the responsible physician. The plan is reviewed and updated annually, if needed.
2. The Department will provide prompt care and treatment to offenders afflicted with infectious or communicable diseases.
3. Each health care unit will implement a program to minimize the incidence of infectious and communicable diseases (for example, tuberculosis (TB), skin infections, lice, scabies) among inmates. Inmates receive health care in a clean, safe, and healthy environment. infectious and communicable diseases in an effort to minimize their occurrence in accordance with state and federal guidelines.
4. Health care providers will:
 - a. use standard precautions when providing offender health care;
 - b. use personal protective equipment that must be readily available for routine and emergency care;
 - c. have procedures in place to account for equipment; and
 - d. provide annual in-service training on its use.

5. Mental health staff that have contact with offenders will be trained on standard precautions and utilize them to minimize risk of exposure to blood and body fluids of infected offenders.
6. The responsible mental health authority ensures compliance with the approved written exposure control plan.
7. All sanitation workers must be trained in appropriate methods for handling and disposing of biohazardous materials and spills.

B. Infectious Disease Screening

1. Each facility will screen offenders on admission for tuberculosis and acute infectious diseases according to guidelines established by the medical director in accordance with Centers for Disease Control (CDC) and NCCHC guidelines.
2. Each youth facility health care unit will ensure that a current immunization history for measles, mumps, rubella and tetanus is obtained and recorded on the offender's medical history form.

C. Immunizations

1. Each facility health care unit will make immunizations available to individuals without adequate immunizations or whose medical conditions would be severely compromised if they are infected with vaccine preventable diseases.

D. Flu Vaccine

1. Each fall, facility health care units will offer an influenza vaccine program to individuals identified at risk for complications of influenza.

E. HIV

1. Each facility health care unit will offer HIV counseling, education, and testing to all offenders.

F. Hepatitis C

1. Each facility health care unit will offer Hepatitis C counseling, education and screening to all offenders.
2. Facility health care staff will follow *DOC 4.5.11A Hepatitis C Treatment* for screening, diagnosis and treatment of Hepatitis C.

G. Tuberculosis

1. Each facility health care unit will follow a Tuberculosis control plan that is consistent with current guidelines from the CDC and Montana Public Health Tuberculosis Prevention to screen offenders for tuberculosis annually
2. The Department requires that all employees who work in residential facilities or programs be screened for tuberculosis upon employment and annually thereafter.

H. Hepatitis B

1. Each facility health care unit will offer a Hepatitis B vaccine program to offenders diagnosed with Hepatitis C virus (HCV) as recommended by the CDC.

I. Hepatitis A

1. Each facility health care unit will offer Hepatitis A post-exposure prophylaxis in the form of Hepatitis A vaccine to offenders determined to be susceptible contacts to an index case of Hepatitis A (have been exposed to HAV, and who have not been vaccinated previously nor had a history of Hepatitis A nor had a history of a positive total anti-HAV test) as recommended by the CDC.

J. Ectoparasites

1. Each facility will screen offenders for ectoparasites (lice and scabies) at intake and anytime an outbreak occurs among offenders who share living and bathroom facilities with an infected inmate.
2. If offenders are infected, effective ectoparasite control procedures are used to treat them by ensuring that:
 - a. infected offenders, bedding, and clothing are disinfected;
 - b. prescribed treatments consider all conditions (for example, pregnancy, open sores, rashes) and is treated by provider; and
 - c. when treatment is required, CDC and NCCHC standards are used.

K. Inspection

1. An environment inspection of health services is conducted monthly to verify that:
 - a. equipment is inspected and maintained;
 - b. the unit is clean and sanitary; and
 - c. measures are taken to ensure the unit is occupationally and environmentally safe.

L. Treating Offenders

1. Health care providers will treat offenders presenting with acute or chronic infectious or communicable diseases in accordance with the CDC and NCCHC guidelines and must provide information about disease transmission and methods to prevent future infection of self or others.

M. Isolating Offenders

1. When medical staff orders an offender to be isolated for an infectious disease, health care providers will follow the CDC's current guidelines for prevention and control of infections.
2. When juvenile offenders are placed in isolation for an infectious disease, on site health care providers will monitor them frequently for changes in physical and mental status, and are accommodated in a separate room with the following:
 - a. hand-washing station;
 - b. soap dispenser;
 - c. single-service towels; and
 - d. separate toilet.

N. Prevention

1. An integral component of the infection control program is prevention of the occurrence and spread of infectious and communicable diseases.
2. Health care providers will:
 - a. offer education on communicable disease prevention to offenders as part of the health education program;
 - b. maintain essential ongoing communication with the respective County Health Department and the Montana Department of Public Health and Human Services;
 - c. instruct correctional employees on measures to prevent disease transmission, including additional precautions that may be necessary during transport, hospital supervision, or while in an infirmary; and
 - d. assure that continuity of care is established with appropriate documented community resources referrals, as medically indicated, prior to releasing offenders who are diagnosed with communicable or infectious disease.

O. Reporting

1. Each facility health care unit must report infectious and communicable diseases to the Montana Department of Public Health and Human Services and the Department's Health Services Bureau Chief.

P. Blood Borne Pathogens

1. Facilities will handle and treat bodily fluid exposure incidents, and ensure employees use standard precautions when providing offender care, in accordance with *DOC 1.3.35 Bloodborne Pathogens Exposure Control Plan*.

Q. Infection Control Committee

1. Facilities must have an Infection Control Committee to oversee infection control practices within the facility.
2. The committee will:
 - a. meet at least quarterly;
 - b. require committee meetings notes to be kept and maintained on file;
 - c. provide a quarterly report to the facility administrator; and
 - d. ensure committee functions include, but are not limited to:
 - 1) Tracking infectious and communicable diseases through health care units and safety and sanitation reports;
 - 2) Analyzing epidemiological data and trends;
 - 3) Making recommendations to decrease the incidence of disease; and
 - 4) Monitoring the facility's application of standard precautions, cleaning and disinfectant techniques, and the disposal of medical and biohazardous waste.
3. Facility Infection Control Committees must have representation from the facility's administration, the responsible physician or designee, nursing and dental services, other appropriate personnel involved in sanitation or disease control, and, if appropriate, the individual responsible for facility livestock or other on-site animal training or programming use.

R. Medical Sharps and Biohazardous Waste

1. Facility health care units will dispose of medical sharps and biohazardous waste using methods and materials that are in compliance with Environmental Protection Agency standards.
2. Facility health care units will provide sharps with engineered sharps injury protections to prevent occupational exposure incidents.
3. The facility will arrange for proper waste disposal based on resources available in their respective communities.

S. Decontamination

1. The facility will ensure that contaminated non-disposable medical, dental and laboratory equipment is appropriately cleaned, decontaminated, and sterilized per applicable recommendations and/or regulations.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *DOC 1.3.35 Bloodborne Pathogens Exposure Control Plan; DOC 4.5.11A Hepatitis C Treatment*
- B. *P-B-02, P-B-031; National Commission on Correctional Health Care Standards for Health Services in Prisons, 2018*
- C. *MH-B-01; National Commission on Correctional Mental Health Services in Correctional Facilities, 2015*
- D. *Y-B-0201; National Commission on Correctional Health Care Standards for Health Services in Juvenile Detention and Confinement Facilities, 2022*
- E. *OSHA and Environmental Protection Agency Standards*
- F. *Centers for Disease Control and Prevention*



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
OPERATIONAL PROCEDURE**

Procedure No. DOC 4.5.11A	Subject: HEPATITIS C VIRUS (HCV) TREATMENT	
Chapter 4: FACILITY/PROGRAM SERVICES		Page 1 of 8 and Attachments
Section 5: Clinical Services		Effective Date: 12/23/2016
Medical Director Signature: /s/ Dr. Paul Rees		Revised: 02/11/2022
Clinical Services Division Administrator Signature: /s/ Connie Winner		

I. PURPOSE

The Department's Clinical Services Division, using evidence-based clinical guidance, will provide appropriate monitoring for all Hepatitis C Virus Antibody positive (HCVAB+) / Hepatitis C Viruspositive (HCV+) offenders, and will provide HCV antiviral drug treatment when determined by clinical indication and/or treatment criteria to reduce all-cause mortality and liver-related health adverse consequences, including end-stage liver disease and hepatocellular carcinoma, by the achievement of virologic cure as evidenced by a sustained virologic response.

APPLICABILITY

All secure care facilities Department owned and contracted, as specified in contract.

II. DEFINITIONS

Directly Observed Therapy (DOT)– Medication or other treatment provided directly by clinical services staff that is not appropriate for self-administration.

Direct Acting Antiviral (DAA)- Medications inhibitors of the NS3/4A protease, the NS5A protein, and the NS5B polymerase. NS3/4A protease inhibitors are inhibitors of the NS3/4A serine protease, an enzyme involved in post-translational processing and replication of HCV.

Qualified Health Care Professionals (QHCP) – Physicians, physician assistants, nurses, nurse practitioners, dentists, mental health professionals and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for offenders, including contracted or fee-for-service professionals.

Medical Review Panel (MRP) – A panel of qualified health care professionals that is comprised of the Clinical Services Division administrator, Medical Director, at least two additional health care QHCPs (one of whom must be a physician), and the Department managed care RNs, all of whom are designated to review complex health care cases and health care topics relevant to the patient population under the care and custody of the Department of Corrections.

Electronic Health Record (EHR)- digital version of a patient's medical chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users.

Mountain Pacific Quality Health (MPQH) – A federally designated Quality Innovation Network-Quality Improvement Organization (QIN-QIO) providing drug utilization review services to the Clinical Services Division of the Department of Corrections.

Subject: **HEPATITIS C VIRUS (HCV) TREATMENT****III. HVC Treatment Steps**

1. **STEP 1. Test for HCV infection with HCV Ab test.**
 - diagnostic evaluation of other conditions;
 - all inmates screened at least once;
 - prenatal testing for each pregnancy;
 - periodic risk-based testing related to potential HCV exposure; and
 - upon inmate request
2. **STEP 2. Evaluate inmates who are HCV Ab positive.**
 - a. problem-focused history and physical exam:
 - 1) lab tests—CBC, PT/INR, liver panel, serum creatinine and eGFR, hepatitis A&B serology (HBsAg, anti-HBs, anti-HBc total), HIV serology, quantitative HCV RNA viral load.
 - 2) HCV genotype testing is not routinely required in treatment-naïve cases with no decompensated cirrhosis, hepatocellular carcinoma, liver or other solid organ transplant, chronic hepatitis B virus infection (HBV), or HIV infection.
 - b. assess for hepatic cirrhosis/compensation—Calculate APRI score if no obvious cirrhosis; Calculate Child-Turcotte-Pugh (CTP) score if cirrhosis is known or suspected.
 - c. if HCV RNA is detectable, determine eligibility for treatment, provide patient education and preventive health care for patients with HCV infection and with cirrhosis.
3. **STEP 3. Treat eligible patients with an approved direct-acting antiviral (DAA) regimen.**
 - a. pre-treatment interventions:
 - 1) obtain a pregnancy test prior to starting treatment; and
 - 2) repeat CBC, PT/INR, liver panel, serum creatinine and eGFR if previous results were obtained more than 6 months ago.
 - b. determine the most appropriate DAA regimen, including an assessment for drug-drug interactions:
 - 1) with the availability of pangenotypic regimens, a simplified approach takes many of the medication selection factors into consideration to get to a treatment decision quickly in certain patients.
 - 2) following the AASLD/IDSA simplified algorithm, treatment-naïve inmates with HCV infection may be approved for treatment with an 8-week course of glecaprevir/pibrentasvir if there are no drug-drug interactions, and the patient does not have any of the following conditions – decompensated cirrhosis, hepatocellular carcinoma, liver or other solid organ transplant, end-stage renal disease with compensated cirrhosis, or co-infection with HBV and/or HIV.
 - c. submit Hepatitis C Treatment Algorithm/Nonformulary Request

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Worksheet to Managed Care RN for review. If approved, submit for specific DAA medication to MPQH; and

- d. begin treatment and appropriate monitoring.

IV. Pre-Authorization Form for HCV/DAA Treatment

1. Once the QHCP determines offender is an appropriate candidate for DAA medication, the QHCP initiates the Hepatitis C Treatment Algorithm/Nonformulary Request Worksheet filling out the appropriate portions of the form such as the Diagnosis, clinical requirements, eligibility criteria and treatment recommendation.
2. A Qualified Health Care Professional (QHCP) will gather additional information from correctional and other staff to determine offender readiness criteria. The QHCP consults with the managed care nurse at CorMedical@mt.gov.
3. The managed care nurse reviews the case, in consultation with the medical director as appropriate, to ensure the case establishes the need for DAA medication treatment. If necessary, the managed care nurse poses questions to the chronic care nurse and documents additional information in the EHR.
4. Once final review is complete and treatment is approved, the managed care nurse will forward the information to MPQH for final treatment recommendations.
5. If treatment is denied as a result of not meeting pre-treatment and readiness criteria, an appeal may be presented to MRP. It is the primary care QHCPs responsibility to request the MRP review.

V. MPQH Review

1. MPQH reviews the information submitted and recommends:
 - a. drug regimen approval as submitted;
 - b. drug regimen approval subject to additional evidence-based clinical requirements; or
 - c. alternative treatment recommendations; and
 - d. denial with supporting clinical rationale based on current Department of Corrections policy and community standards of care.
2. The managed care nurse communicates the MPQH recommendation to designated facility nursing staff. If MPQH has recommended a drug regimen, the managed care nurse forwards those recommendations to the prescribing QHCP.
3. The prescribing QHCP orders recommended medication.

VI. Testing Criteria and Method

1. Testing for HCV infection is recommended:
 - a. as a screening test for all inmates;

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- b. as part of a diagnostic evaluation of inmates with certain clinical conditions (e.g., elevated liverenzymes of uncertain etiology);
 - c. prenatal testing for each pregnancy; and
 - d. periodic risk-based testing related to potential HCV exposure for all inmates who request testing.
2. The preferred screening test for HCV infection is an immunoassay that measures the presence of antibodies to HCV antigens, referred to as HCV Ab (“anti-HCV” in the AASLD Guidance). The presence of these antibodies only indicates a history of exposure to the HCV virus, but does not distinguish between active and resolved infection.
 - a. initial testing with an HCV RNA test is recommended for cases with a known prior positive HCV Ab if they are at risk for reinfection or suspected of reinfection, and if they previously cleared the HCV spontaneously or achieved a sustained virologic response (SVR) with treatment.
3. An “opt-out” strategy of voluntary testing for HCV infection is recommended for all inmates, regardless of sentencing status, including new intakes and those already in population who have not been previously tested.
4. An “opt-out” approach involves an informed refusal of testing, rather than informed consent (or “opt in”) for testing. After informing a patient of the indications and plan for testing, the particular test is ordered and performed—unless the patient declines it.
5. Testing is considered voluntary and is good clinical practice but is not required by policy or law. Testing is recommended as soon as practical upon intake as well as for inmates already in population who have not been tested previously.

VII. Risk Factors for HCV Infection

1. The AASLD, CDC, and USPSTF recommend risk factor-based and birth cohort screening for HCV infection. The incarcerated population is reported to have higher prevalence rates of HCV than the general population and is considered as a risk factor for which screening is recommended.

Other well-described risk factors, either for acquiring a new infection or already having HCV infection, which should be considered when recommending HCV testing to inmates, include:

- has ever injected illegal drugs or shared equipment, including intranasal use of illicit drugs;
- received tattoos or body piercings while in jail or prison, or from any unregulated source;
- high-risk sexual activity, especially HIV-infected men who have sex with men;
- HIV or chronic hepatitis B virus (HBV) infection;

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- received a blood transfusion or an organ transplant before 1992, received clotting factor transfusion prior to 1987, or received blood from a donor who later tested positive for HCV infection;
- history of percutaneous exposure to blood;
- has ever received hemodialysis [*Order alanine aminotransferase (ALT) monthly and HCV Ab semiannually for inmates on chronic hemodialysis*];
- born to a mother who had HCV infection at the time of delivery;
- born between 1945 and 1965; and
- current pregnancy

VIII. Clinical Conditions for Testing

1. HCV testing is recommended for all inmates with the following clinical conditions:

- a reported history of HCV infection without prior medical records to confirm the diagnosis;
- cirrhosis;
- elevated liver enzyme alanine aminotransferase test (ALT) levels of unknown etiology; and
- evidence of extrahepatic manifestations of HCV – mixed cryoglobulinemia, membranoproliferative glomerulonephritis, porphyria cutanea tarda, vasculitis.

IX. Refusal of Testing

1. It is recommended that inmates who decline testing at the baseline visit, should be counseled about and offered HCV testing during periodic preventive health visits.- Documentation of treatment refusal will be permanently captured in the offender's health record.

X. Evaluation of Inmates Testing Positive for HCV Ab

1. Initial evaluation of HCV Ab positive inmates includes: (a) a baseline history and physical examination and (b) baseline lab tests. The inmate should also (c) be assessed regarding the need for preventive health interventions such as vaccines and screenings for other conditions, as well as (d) counseled with information on HCV infection.

Ideally, this evaluation is performed in a timely manner after a positive HCV Ab test result is reported and combines the baseline/initial evaluation and the pre-treatment evaluation into one step.

2. A simplified approach is recommended, especially for HCV treatment-naïve cases. These cases may then proceed directly to treatment with an 8-week course of glecaprevir/pibrentasvir if there are no drug-drug interactions, and the patient does not have decompensated cirrhosis, hepatocellular carcinoma, liver or other solid organ transplant, or HBV

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and/or HIV coinfection.

3. If cirrhosis is present, *Assess for Hepatic Cirrhosis and Decompensation*, to determine whether the liver disease is compensated or decompensated.

XI. Baseline Evaluation

1. A baseline clinician evaluation should be conducted for all inmates who are HCV Ab positive. At minimum, this evaluation should include the following elements in the problem-focused history and physical exam:
 - evaluate for signs and symptoms of liver disease, as well as for evidence of HCV sequelae (e.g. cryoglobulinemia, vasculitis);
 - obtain a past medical history to include co-occurring medical / mental health conditions and current medications, as well as other pertinent aspects of the patient's medical history;
 - quantify prior alcohol consumption, and determine risk behaviors for acquiring HCV infection (See the section on risk factors under Screening Criteria (above). Attempt to estimate the earliest possible date of infection, including when risk factors for exposures started and stopped, e.g., the time period in which the inmate engaged in injection drug use;
 - referral for evaluation and treatment of substance use disorder is recommended for inmates with evidence for ongoing high-risk behaviors related to drug and alcohol use, e.g., incident reports and sanctions related to drug use during their incarceration; and
 - require about prior treatment for HCV infection, specific medications used, dosages and duration of treatment and outcomes, if known.
2. Offenders receiving treatment prior to and upon entry to a secure facility or community corrections facility will not have the treatment interrupted unless the physician believes that continuing treatment is not in the offender's best interest. If there is reason to suspect the offender has not been compliant with medication immediately prior to entry (e.g., discontinued while in jail), or if the offender engaged in high-risk activities prior to entry, the continuation should be discussed with the offender's community physician and Department medical director.

XII. Laboratory Tests

1. Complete blood count (CBC); prothrombin time (PT) with International Normalization Ratio (INR); comprehensive metabolic panel (CMP).
 - a. CMP includes liver panel (albumin, total and direct bilirubin, serum alanine aminotransferase (ALT) and aspartate aminotransferase (AST), and alkaline phosphatase); serum creatinine and calculated glomerular filtration

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rate (GFR); and

- b. unexplained abnormalities should prompt additional diagnostic evaluations, as clinically indicated, to determine the underlying cause, e.g., low hemoglobin/platelet count or GFR.
2. Serology for hepatitis A (anti-HAV total), hepatitis B (HBsAg, anti-HBs, and anti-HBc total), and HIV (anti-HIV).
 - a. refer to the relevant DOC Clinical Guidance for management of a positive HBsAg or HIV test. These tests may need to be repeated prior to starting HCV treatment if risk factors for transmission have occurred since their last test.
3. Quantitative HCV RNA viral load testing, sensitive to ≤ 25 IU/ml, to determine if the inmate has active HCV infection.
 - a. undetectable levels of HCV RNA indicate resolved infection or a false positive HCV Ab test. Such cases **do not** require ongoing follow-up or monitoring in a chronic care clinic.
4. HCV genotype testing is no longer routinely recommended for HCV treatment-naïve cases because many of them will be eligible for a pangenotypic regimen.
 - a. a genotype does need to be obtained when considering SOF/VEL in a patient with cirrhosis as well as in situations where a non-pangenotypic regimen may be required, including: prior HCV treatment failures, decompensated cirrhosis, hepatocellular carcinoma, liver or other solid organ transplant, HBV and/or HIV coinfection, or drug-drug interactions.
5. Consider other possible causes of liver disease, especially alcoholism, nonalcoholic steatohepatitis (NASH), iron overload, and autoimmune hepatitis, as clinically indicated. Unless otherwise clinically indicated, testing for other causes of liver disease—e.g., antinuclear antibody (ANA), ferritin, iron saturation, ceruloplasmin—are not routinely ordered in the evaluation of a positive HCV Ab test.
 - a. a urine drug screen is recommended only if ongoing substance use is suspected or if it is otherwise clinically indicated.

XIII. Preventive Health Measures

1. All inmates who are HCV Ab positive should be evaluated to assess the need for the preventive health interventions. Patients with liver disease should receive standard immunizations that are applicable to an otherwise healthy population, including the following:
 - hepatitis B vaccine: Indicated for susceptible inmates with chronic HCV infection. For foreign-born inmates, consider prescreening for hepatitis B immunity prior to vaccination. (Inmates with evidence of liver disease should be priority candidates for hepatitis B vaccination.);
 - hepatitis A vaccine: Indicated for susceptible inmates with chronic HCV; and
 - influenza vaccine: Offer to all HCV-infected inmates annually.

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(Inmates with cirrhosis are highpriority for influenza vaccine.)

2. Pneumococcal vaccine: Recommended by the CDC’s Advisory Committee on Immunization Practices (ACIP) for use in adults with chronic liver disease, including cirrhosis, regardless of age. Evidence for its use in chronic HCV infection without cirrhosis is limited.

XIV. Patient Education

1. Inmates diagnosed with chronic HCV infection should be counseled by a Qualified Health Care Professional regarding the natural history of the infection, potential treatment options, and specific measures to prevent transmitting HCV infection to others, both during incarceration and on release.

XV. Assessing for Advanced Hepatic Fibrosis and Cirrhosis

1. Assessment is recommended for all inmates with HCV infection in order to select the most appropriate treatment regimen, prioritize inmates for treatment of HCV, and determine the need for additional health care interventions. Cirrhosis may be diagnosed in several ways:
2. Symptoms and signs that support the diagnosis of cirrhosis may include: Low albumin or platelets, elevated bilirubin or INR, ascites, esophageal varices, and hepatic encephalopathy. However, isolated lab abnormalities may require additional diagnostic evaluation to determine the etiology.
3. The AST-Platelet Ratio Index (APRI) is the DOC-preferred method for non-invasive assessment of hepatic fibrosis and cirrhosis.
 - a. the APRI score, a calculation based on results from two blood tests—the AST (aspartate aminotransferase) and the platelet count—is a less invasive and less expensive means of assessing fibrosis than a liver biopsy.
 - b. the formula for calculating the APRI score is:

$$[(\text{AST}/\text{AST ULN}) \times 100] / \text{platelet count (10}^9\text{/L)}$$

*A calculator is available at: <http://www.hepatitisc.uw.edu/page/clinical-calculators/apri>
 - c. **APRI score ≥ 2.0 may be used to predict the presence of cirrhosis.** At this cutoff, the APRI score has a sensitivity of 48%, but a specificity of 94%, for predicting cirrhosis. Inmates with an APRI score ≥ 2.0 should have an abdominal ultrasound performed to identify other findings consistent with cirrhosis (see *abdominal imaging studies* bullet below in this list).
 - d. lower APRI scores have different sensitivities and specificities for cirrhosis. For example, an
 APRI score ≥ 1 has a sensitivity of 77% and a specificity of 75% for predicting cirrhosis.
 - e. the APRI may also be used to predict the presence of significant fibrosis (stages 2 to 4, out of 4). Using a cutoff of ≥ 0.7 , the sensitivity is 77% and

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specificity is 72% for significant fibrosis.

- f. the APRI score may be invalidated in cases of splenectomy. An alternative non-invasive test(e.g., Fibrosure) may be appropriate. If a person is known to have cirrhosis, the APRI is irrelevant and unnecessary.
4. Liver biopsy is not required unless otherwise clinically indicated or if there is uncertainty about the stage of fibrosis, based on results from non-invasive testing or other clinical indicators. However, the presence of cirrhosis on a prior liver biopsy may be used to meet the DOC criteria for HCV treatment.
5. Abdominal ultrasound is routinely performed in cases of known or suspected cirrhosis, and as clinically indicated on a case-by-case basis. Abdominal imaging studies such as ultrasound or CT scan may identify findings consistent with or suggestive of the following:
 - a. cirrhosis (nodular contour of the liver),
 - b. portal hypertension (ascites, splenomegaly, varices), or
 - c. hepatocellular carcinoma

XVI. Assessing Hepatic Compensation

1. Assessing hepatic compensation is important for determining the most appropriate HCV treatment regimen to be used. The recommended HCV treatment regimen may differ depending on whether the cirrhosis is compensated or decompensated.
 - a. the CTP score is a useful tool to help determine the severity of cirrhosis and in distinguishing between compensated and decompensated liver disease in patients with known or suspected cirrhosis. However, if the CTP score indicates compensated cirrhosis but the overall clinical picture is suggestive of decompensated cirrhosis, it may be more appropriate to choose a DAA regimen for decompensated cirrhosis; and

→ CTP calculators are readily available on the Internet and are not reproduced in this document.

See <http://www.hepatitisc.uw.edu/page/clinical-calculators/ctp>.
 - b. the CTP score includes five parameters (albumin, bilirubin, INR, ascites, and hepatic encephalopathy), each of which is given a score of 1, 2, or 3. The sum of the five scores is the CTP score, which is classified as shown in the following Table 1:

TABLE 1. USING CTP SCORES TO ASSESS HEPATIC COMPENSATION

CTP SCORE	CTP CLASS	HEPATIC COMPENSATION
5–6	Class A	Compensated cirrhosis
7–9	Class B	Decompensated cirrhosis
≥ 10	Class C	

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- ▶ Warfarin anticoagulation will invalidate CTP calculations if the INR is 1.7 or higher.
- ▶ It is recommended that cases of decompensated cirrhosis be managed in consultation with a clinician experienced in the treatment of this condition.
- ▶ Inmates with CTP Class C decompensated cirrhosis may have a reduced life expectancy and should be considered for Reduction in Sentence/Compassionate Release in accordance with current policy and procedures.

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XVII. Additional Interventions for Inmates with Cirrhosis

1. The following recommendations apply to all inmates with cirrhosis, whether they have ongoing or resolved HCV infection;
 - a. pneumococcal vaccine: Offer to all inmates with cirrhosis.
 - b. hepatocellular carcinoma screening: Liver ultrasound is recommended every 6 months for patients with cirrhosis.
 - c. esophageal varices screening: Screening for esophageal and gastric varices with esophagogastroduodenoscopy (EGD) is recommended for patients diagnosed with cirrhosis.
2. Other healthcare interventions recommended for patients with cirrhosis may include:
 - a. nonselective beta blockers for prevention of variceal bleeding in patients with esophageal varices;
 - b. antibiotic prophylaxis if risk factors are present for spontaneous bacterial peritonitis;
 - c. optimized diuretic therapy for ascites; and
 - d. lactulose and rifaximin therapy for encephalopathy
3. In general, NSAIDs should be avoided in advanced liver disease/cirrhosis, and metformin should be avoided in decompensated cirrhosis.

XVIII. Treatment Criteria and Pretreatment Interventions

1. Sustained virologic response (SVR) rates of 90% or higher can be achieved with DAA medication regimens. Eradication of HCV is associated with a number of improved outcomes, including a reduction in the following: liver inflammation and fibrosis, severity of advanced liver disease and its complications, risk of liver cancer and liver-related mortality, need for liver transplantation, and transmission of HCV infection.

XIX. DOC Eligibility Criteria for HCV Treatment

1. All sentenced inmates with HCV infection (detectable HCV RNA) are eligible for consideration of treatment. The AASLD/IDSA guidance now recommends treatment for acute HCV infection, rather than monitoring for spontaneous resolution over 6–12 months.
Inmates being considered for treatment of HCV infection should:
 - a. have no contraindications to, or significant drug interactions with, any component of the treatment regimen.
 - b. not be pregnant, especially for any regimen that would require ribavirin.
 - c. pregnant inmates may be considered for treatment on a case-by-case basis using a shared decision-making model considering the lack of data on DAA safety during pregnancy and the risk of transmitting HCV to the baby.

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- d. have sufficient time remaining on their sentence in the DOC to complete a course of treatment.
 - e. if the inmate cannot complete the course of treatment prior to discharge, the health care staff responsible for discharge planning will educate the inmate on obtaining continuing resources in the community. If possible continuity of care will be coordinated with those community resources prior to release.
 - f. inmates with a more urgent need for treatment but insufficient time remaining in DOC custody, may be considered for treatment if they will have access to medications and healthcare QHCPs for continuity of care at the time of release.
 - g. have a life expectancy greater than 18 months. Consultation with the Department Medical Director is recommended in cases where life expectancy is uncertain.
 - h. inmates must demonstrate a willingness and an ability to adhere to a rigorous treatment regimen by showing compliance to previous prescribed treatments as well as an understanding of need to comply with DAA regimen.
 - i. inmates with evidence for ongoing behaviors associated with high risk of HCV transmission (e.g., injection drug use) are not automatically excluded from consideration for HCV treatment.
 - j. ideally, such decisions are individualized and made in the context of an integrated model of care in which there is assessment and treatment for substance use disorder, or other disorders intersecting with HCV infection.
 - k. consultation with Mountain Pacific Quality Health, Regional Medical Director, or Central Office Managed Care Registered Nurse is recommended for making treatment decisions about inmates who become reinfectd as a result of ongoing high-risk behavior.
2. Certain conditions are at **higher risk for complications or disease** progression and may require more urgent consideration for treatment, as follows:
- a. advanced hepatic fibrosis;
 - 1) APRI ≥ 2.0 ; or
 - 2) Metavir or Batts/Ludwig stage 3 or 4 on liver biopsy;
 - b. known or suspected cirrhosis;
 - c. liver transplant recipients;
 - d. hepatocellular carcinoma;
 - e. comorbid medical conditions associated with HCV, including:
 - 1) cryoglobulinemia with renal disease or vasculitis;
 - 2) certain types of lymphomas or hematologic malignancies; and

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3) porphyria cutanea tarda

f. immunosuppressant medication for a comorbid medical condition:

- 1) some immunosuppressant medications (e.g., certain chemotherapy agents and tumor necrosis factor inhibitors) may be needed to treat a comorbid medical condition but are not recommended for use when infection is present. Although data are insufficient and current guidelines are inconsistent regarding treatment of HCV infection in this setting, such cases will be considered for prioritized treatment of HCV on an individual basis.

3. Evidence for progressive fibrosis:
 - a. stage 2 fibrosis on liver biopsy, if treatment clinically indicated.
4. Comorbid medical conditions associated with more rapid progression of fibrosis:
 - a. coinfection with HBV or HIV
 - b. comorbid liver diseases [e.g., autoimmune hepatitis, hemochromatosis, fatty infiltration of the liver, steatohepatitis (fatty liver disease)]
 - c. diabetes mellitus
5. Chronic kidney disease (CKD) with $\text{GFR} \leq 59 \text{ mL/min per } 1.73 \text{ m}^2$.
6. Birth cohort 1945–1965.
7. Continuity of care for those already started on treatment, including inmates who are newly incarcerated in the DOC.

XX. Pre-Treatment Assessment and Interventions

1. A simplified approach combining Steps 2 and 3 (See [*Steps*](#)) into a seamless process is recommended for treatment naïve patients without current or prior history of decompensated cirrhosis, hepatocellular carcinoma, liver transplantation, end-stage renal disease ($\text{GFR} < 30$), HIV or HBV coinfection, or pregnancy.
 - a. pretreatment assessment is recommended within 6 months of the projected start of treatment if there is no cirrhosis or within 3 months, if there is compensated cirrhosis; and
 - b. many aspects of the pretreatment assessment also are part of the initial evaluation and do not need to be repeated if consideration for treatment is performed within these time frames. This is an efficient way to accomplish the test-evaluate-treat approach and is recommended whenever feasible.
2. Pretreatment assessment and interventions include the following:
 - a. laboratory tests including CBC, PT/INR, liver panel, serum creatinine, calculated GFR:
 - 1) labs do not need to be repeated if obtained within 6 months in patients without cirrhosis or within 3 months in patients with

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- compensated cirrhosis;
 - 2) consider retesting for HBV and HIV if ongoing risk factors since last test result; and
 - 3) a urine drug screen is not required as part of the pretreatment evaluation and is recommended only if ongoing substance use is suspected or if it is otherwise clinically indicated.
 - b. assessment for hepatic cirrhosis and decompensation:
 - 1) calculation of the APRI score using results from the pretreatment labs. (An APRI score is not needed if there is confirmed cirrhosis.);
 - 2) calculation of current CTP score for inmates with known or suspected cirrhosis; and
 - 3) an abdominal US is recommended within 6 months of starting treatment for patients with cirrhosis.
 - c. pregnancy testing and education covering the potential risks of DAAs during pregnancy prior to initiating treatment in all women with childbearing potential
 - 1) ribavirin is contraindicated in pregnancy and in both male and female partners attempting to become pregnant.
 - d. assessment for significant drug-drug interactions:
 - 1) resources for assessing drug interactions with DAA regimens include the AASLD HCV guidance, DHHS antiretroviral guidelines, University of Liverpool HEP Drug Interactions and manufacturers' prescribing information for specific drug interactions.
3. Assessment for current/prior medication adherence:
- a. review of incident report history for high-risk behaviors (alcohol/drug possession/use; tattooing);
 - b. for ribavirin containing regimens:
 - 1) pretreatment ECG is recommended for inmates with preexisting coronary heart disease.
 - 2) if anemia is present and host not been previously evaluated, a diagnostic evaluation is recommended prior to starting treatment;
4. Testing for NS5A resistance-associated substitutions (RASs) is not routinely indicated, but is recommended prior to treatment with the following regimens or situations:
- a. elbasvir/grazoprevir for HCV genotype 1a and GFR ≥ 30 . If RASs are present at position 28, 30, 31, or 93, a regimen other than EBR/GZR should be used;
 - b. sofosbuvir/velpatasvir for treatment-naïve HCV genotype 3 with cirrhosis being considered for 12 weeks of treatment. If the Y93H RAS

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- is present, RBV is added to a 12-week regimen of SOF/VEL;
 - c. sofosbuvir/velpatasvir for treatment-experienced HCV genotype 3 and no cirrhosis;
 - d. NS5A resistance testing may be considered when ledipasvir/sofosbuvir is an option for treatment-experienced HCV genotype 1a with no cirrhosis or compensated cirrhosis; and
 - e. NS3/4A resistance testing is no longer routinely recommended.
5. Patient education—including, but not limited to: how to take the medication, the importance of adherence, monitoring and follow up, and potential medication side effects. When ribavirin is used, specific counseling about the risks and recommendations related to pregnancy should be provided and captured in the patient’s medical record.

XXI. Direct Acting Antiviral (DAAs) Treatment Regimens

1. Recommendations for **DAA treatment** regimens continue to evolve, but still depend on several factors:
 - a. HCV genotype, except for pangenotypic regimens;
 - b. prior HCV treatment history;
 - c. compensated vs. decompensated liver disease;
 - d. co-occurring medical conditions (HBV or HIV coinfection, hepatocellular carcinoma, chronic kidney disease, solid organ transplant);
 - e. resistance-associated substitutions (certain clinical scenarios); and
 - f. drug-drug interactions
2. Special considerations: Certain conditions require special consideration when selecting an HCV treatment regimen, including decompensated cirrhosis, hepatocellular carcinoma, chronic kidney disease and compensated cirrhosis, solid organ transplant recipients, HBV or HIV coinfection, HCV infection with multiple genotypes, and pregnancy. These special considerations are addressed in [Section 8](#).
 - a. cost: The cost of DAA regimens can vary widely. When more than one regimen is appropriate for an individual case, the most cost-effective regimen is recommended, taking into consideration all the factors listed above.
 - b. currently, there are three classes of HCV DAAs: NS5A replication complex inhibitors (-asvir), NS5B polymerase inhibitors (-buvir), and NS3/4a HCV protease inhibitors (-previr). These antiviral medications for HCV infection act directly on some part of the virus, usually the replication mechanism.
 - c. DAAs cannot be used as monotherapy. They must be used in combination with at least one other DAA with or without ribavirin, depending on the clinical scenario.
 - d. the most commonly recommended regimens are described briefly on the

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next three pages.

Regimens not recommended

- **Monotherapy** with peginterferon, ribavirin, or any of the DAAs.
- **Dual therapy** with peginterferon and ribavirin.
- **NS3/4 HCV protease inhibitors** (boceprevir, simeprevir, or telaprevir)
- **HCV protease inhibitors for genotypes 2, 3, 5, or 6** (paritaprevir, simeprevir)

XXII. Preferred Treatment Regimen

1. For eligible treatment-naïve cases, an 8-week course of glecaprevir/pibrentasvir is recommended, regardless of HCV genotype. Cases not eligible for this short-course, pangenotypic regimen, will need to have a genotype test if not previously performed and selection of one of the other AASLD/IDSA preferred treatment regimens.
2. Alternative treatment regimens: The AASLD/IDSA guidance includes recommendations for some regimens that are not specifically FDA-approved and also describe alternative treatment regimens for situations in which a preferred regimen is not an option. These alternative regimens are not included in this DOC guidance but can be considered on a case-by-case basis.
3. Submit a Hepatitis C Treatment Algorithm/Nonformulary Request with the necessary supporting documentation. If approved, submit non-formulary requests for the specific DAA medications.

→ *More detailed information about the regimens and the individual medications—including indications and drug interactions—may be found in the AASLD guidance (<https://www.aasld.org/publications/practice-guidelines>), manufacturer's prescribing information, Facts and Comparisons (available in the Bureau of Electronic Medical Records System (BEMR)), University of Liverpool HEP Drug Interactions website (<https://www.hep-druginteractions.org/checker>), and other validated resources.*

XXIII. Potential drug interactions

1. In addition to the genotype, prior HCV treatment history, and status of hepatic compensation, as noted above, it is essential to review each treatment candidate for potential drug interactions prior to selecting the most appropriate regimen for HCV treatment. Adjustments of the inmate's current medications may be needed prior to starting treatment for HCV. Since information on drug-drug interactions are updated as new information becomes available, medical literature and drug interaction websites should be checked routinely. Useful resources for potential drug interactions include the AASLD/IDSA guidance, the individual manufacturers' prescribing information, University of Liverpool HEP Drug Interactions website, and the DHHS Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents.

XXIV. On-treatment monitoring

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- For regimens containing ribavirin:
 - a. a CBC should be drawn 2 weeks after starting therapy, then at 4 weeks, then monthly; more frequently as clinically indicated. Ribavirin dosage adjustments may be required.
 - b. pregnancy testing is required periodically during and after treatment—usually monthly during treatment and for 6 months after completion of treatment when women with childbearing potential are treated with ribavirin-containing regimens.
- For regimens containing elbasvir/grazoprevir, more frequent monitoring of ALT is necessary:
 - a. for 12-week regimens, a liver panel including ALT should be drawn at 8 weeks, and as clinically indicated. For 16-week regimens, a liver panel including ALT should be drawn at 8 weeks and again at 12 weeks.
 - b. ALT increases of less than tenfold should be monitored approximately every 2 weeks and consideration given to discontinuation of treatment if the ALT elevations persist. Early discontinuation of HCV treatment is also recommended if ALT increases by tenfold—or if less than tenfold, but accompanied by symptoms such as weakness, anorexia, nausea, vomiting, or change in stool color, or *signs* including elevations in conjugated bilirubin, alkaline phosphatase, and INR, related to hepatic dysfunction.
- For patients with evidence of chronic HBV infection (i.e., HBsAg positive) who do not meet established criteria for antiviral HBV therapy, either monitoring of HBV DNA levels or prophylactic HBV antiviral medication may be considered.
 - a. monitoring with quantitative HBV DNA levels is done prior to starting HCV DAA treatment, periodically during DAA treatment (usually every four weeks), and immediately after DAA treatment. Initiate antiviral HBV treatment if the HBV DNA level increases more than 10-fold from baseline or above 1,000 IU/ml if it was previously undetectable.
 - b. prophylactic HBV antiviral medication may be initiated prior to or at the same time HCV DAA treatment is started, and continued for 12 weeks after DAA treatment completion.

XXV. Post-treatment monitoring

- A quantitative HCV RNA viral load assessment is recommended at 12 weeks after completion of treatment; if HCV is undetectable, it defines a sustained viral response (SVR).
- If the HCV viral load is undetectable at 12 weeks after completion of

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treatment, the inmate may be removed from the chronic care clinic for this condition, if he or she has no cirrhosis, complications, or related comorbidities, and the HCV infection has been changed to “resolved” in the problem list.

- Recurrent viremia following an SVR may be due to relapse *or* reinfection. To help distinguish between relapse and reinfection in such cases, an HCV genotype, along with subtyping for genotype 1, should be obtained. If the post-SVR genotype is the same as the pre-treatment genotype, it is not possible to distinguish relapse from reinfection. In addition, ask about and educate on HCV risk factors, assess readiness for retreatment, and consider referring for drug education programming and treatment if there is evidence for ongoing substance use.

XXVI. Ongoing monitoring

- Periodic monitoring is recommended for all those with active infection, including HCV treatment failures, relapse of HCV infection or reinfection, and those with chronic HCV infection who are not yet treated.
- For cases without advanced fibrosis, cirrhosis, or complications, annual evaluation is appropriate. This evaluation should include a focused review of systems and patient education relevant to HCV, vital signs and a focused physical examination, and lab monitoring (CBC, PT/INR, liver panel, serum creatinine, calculated GFR, and calculation of the APRI score).
- For patients with cirrhosis or significant comorbidities, even in those who achieve SVR after treatment, evaluation is recommended at least every 6 months, and more frequently when clinically indicated.

XXVII. Special Considerations

- HCV Infection with more than one genotype
 - a. very little data are available to guide the selection of a DAA regimen when more than one HCV genotype are present at the same time. In such cases, selection of either a pangenotypic regimen or a regimen that is effective against both of the existing genotypes is appropriate, in consultation with the Department Medical Director and MPQH.
- HBV/HCV Coinfection
 - a. in patients coinfecting with HBV and HCV, HBV reactivation may occur during or after treatment with HCV DAAs. Testing for HBV infection—including HBsAg, anti-HBs, and anti-HBc total, as well as HBV DNA levels in those with a reactive HBsAg—is recommended for all patients being considered for treatment of HCV infection.
 - b. if criteria for treatment of HBV are met, it is recommended that

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HBV treatment be started prior to or at the same time as HCV treatment, and monitored according to HBV treatment guidance.

- c. for patients with evidence of chronic HBV infection (i.e., HBsAg positive) who do not meet established criteria for antiviral HBV therapy, either monitoring of HBV DNA levels or prophylactic HBV antiviral medication may be considered.
 - d. monitoring with quantitative HBV DNA levels is done prior to starting HCV DAA treatment, periodically during DAA treatment (usually every four weeks), and immediately after DAA treatment. Initiate antiviral HBV treatment if the HBV DNA level increases more than 10-fold from baseline or above 1,000 IU/ml if it was previously undetectable.
 - e. prophylactic HBV antiviral medication may be initiated prior to or at the same time HCV DAA treatment is started, and continued for 12 weeks after DAA treatment completion.
 - f. for isolated anti-HBc total positive cases with negative HBsAg and anti-HBs, monitor ALT at baseline, at the completion of HCV treatment, and again during post-treatment follow-up.
- HIV Coinfection:
 - a. currently recommended HCV regimens are equally effective for HCV mono-infection and coinfection with HIV. However, an alternative HCV regimen or an alternative antiretroviral medication regimen may be necessary due to potential drug interactions between the HCV DAAs and certain antiretrovirals.

→ The following are links to tables showing drug interactions between the HIV antiretrovirals and the HCV Direct Acting Antivirals (DAAs):

See <https://aidsinfo.nih.gov/guidelines/htmltables/1/7363>

See <https://www.hcvguidelines.org/unique-populations/hiv-hcv>

- Decompensated Cirrhosis
 - a. treatment of HCV patients with decompensated cirrhosis should be managed in consultation with an experienced clinician/specialist, with treatment requests considered on a case-by-case basis. The regimens and other considerations listed below are for those with a current or prior history of decompensated cirrhosis. Inmates with decompensated cirrhosis and a CTP score ≥ 10 (Class C) may meet reduction in sentence criteria.

→ See Table 2. HCV Treatment Recommendation for Decompensated Cirrhosis. Attachment 2

- Hepatocellular carcinoma
 - a. the presence of HCC may impact both the timing of HCV treatment

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and the choice of DAA treatment regimen. The timing of treatment for HCV relative to the treatment of HCC is an important consideration that is impacted by the choice of treatment for HCC and the patient's life expectancy, and is recommended to be done in collaboration with the treating oncologist.

- 1) in the context of HCV infection, HCC usually occurs in the presence of cirrhosis. Whether cirrhosis is compensated or decompensated affects the choice of DAA medication; and
 - 2) the SVR rates are lower for patients with HCC than those who don't have HCC. Therefore, these cases are not eligible for the shorter 8-week treatment regimens. Additional data is needed to determine whether a longer duration of treatment will achieve a higher SVR rate.
- Transplant Recipients:
 - a. consultation with a transplant specialist is recommended before and in conjunction with treatment of HCV in liver, kidney or other solid organ transplant candidates or recipients. AASLD-recommended HCV DAA regimens for liver or kidney transplant recipients, as well as potential DAA drug interactions with anti-rejection medications, may be found at <https://www.hcvguidelines.org/unique-populations>
 - Chronic kidney disease (CKD):
 - a. HCV is independently associated with the development of chronic kidney disease (CKD). Published studies indicate that HCV is associated with 1) a higher risk of developing proteinuria and CKD; 2) a higher risk for progression to end-stage-liver-disease (ESLD); and 3) an increased risk of mortality for dialysis patients.
 - b. patients with CKD, HCV and no cirrhosis may be considered for the simplified approach to treatment. Those with cirrhosis are not eligible for the simplified approach.
 - c. no dosage or duration adjustment is required for any degree of renal impairment when using any of the currently recommended DAAs including elbasvir/grazoprevir (genotypes 1 or 4), glecaprevir/pibrentasvir (genotypes 1-6), ledipasvir/sofosbuvir (genotypes 1, 4, 5, or 6), or sofosbuvir/velpatasvir (genotypes 1-6).
 - d. ribavirin doses must be decreased with GFRs ≤ 50 . For GFRs 30–50, ribavirin is dosed 200 mg alternating every other day with 400 mg. For GFR < 30, including hemodialysis, the ribavirin dose is 200 mg daily. Consultation with a transplant specialist is recommended prior to and in conjunction with treatment of HCV in kidney transplant candidates or recipients.

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- Pregnancy Considerations
 - a. the current AASLD/IDSA guidance recommends consideration of treatment of HCV during pregnancy or breastfeeding on an individual basis only if the benefits outweigh the potential or unknown risks.
 - 1) Testing for HCV infection is recommended as part of prenatal care for each pregnancy.
 - 2) Treatment of HCV infection is recommended before becoming pregnant to decrease the risk of maternal-infant transmission.
 - b. ribavirin is contraindicated during pregnancy:
 - 1) women with childbearing potential who are being considered for an HCV regimen that includes ribavirin should be counseled on the adverse fetal effects of ribavirin. They should be advised not to become pregnant during treatment with ribavirin—and for 6 months after the treatment has ended. They should also be advised that the same risks apply if a male sex partner is being treated with ribavirin. A negative pregnancy test should be documented before starting treatment with ribavirin, then monthly during treatment and monthly for 6 months after treatment.
 - 2) men being treated with ribavirin should also be counseled on the adverse fetal effects of ribavirin. They should be advised not to cause pregnancy in their female sex partners during treatment with ribavirin—and for 6 months after the treatment has ended.
 - c. HCV RNA testing is recommended prior to initiating treatment in the postpartum period to determine if spontaneous resolution of HCV infection occurred during the pregnancy.

XXVIII. References

1. AASLD/IDSA. *Recommendations for testing, managing, and treating hepatitis C*. AASLD/IDSA website. <http://www.hcvguidelines.org>.
2. American Association for the Study of Liver Diseases and Infectious Disease Society of America. *Hepatitis C Guidance*
3. *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents*. AIDS info website. <https://aidsinfo.nih.gov/guidelines>. Updated October 17, 2017.
4. Federal Bureau of Prisons, *Clinical Guidance, Evaluation and Management of Chronic HCV Infection* <http://www.bop.gov/resources/healthcaremgmt.jsp>
5. Centers for Disease Control and Prevention National Center for Infectious Diseases—Hepatitis Branch
<http://www.cdc.gov/ncidod/diseases/hepatitis/>
6. MELD Score Calculator
<http://optn.transplant.hrsa.gov/converge/resources/MeldPeldCalculator.asp?index=98>

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7. *National Institutes of Health
National Institute of Diabetes and Digestive and Kidney Diseases <http://www.niddk.nih.gov>*
8. *National Clinicians' Post-Exposure Prophylaxis PEP line: (888) 448-4911
<http://www.nccc.ucsf.edu/>*
9. *U.S. Department of Veterans Affairs National Hepatitis C Program
<http://www.hepatitis.va.gov/>*

Subject: **HEPATITIS C VIRUS (HCV) TREATMENT****Glossary of Abbreviations**

MEDICATIONS	
DAA	direct acting antiviral medication
DCV	daclatasvir
DSV	dasabuvir
EBR	elbasvir*
GLE	glecaprevir*
GZR	grazoprevir*
LDV	ledipasvir*
OBV	ombitasvir
PTV	paritaprevir
PEG-IFN	pegylated interferon, peginterferon
PI	protease inhibitor
PIB	pibrentasvir*
PrO	paritaprevir/ritonavir/ombitasvir
PrOD	paritaprevir/ritonavir/ombitasvir/dasabuvir
RBV	ribavirin
RBV-LD	ribavirin, low initial dose
SOF	sofosbuvir*
SMV	simeprevir
VEL	velpatasvir*
VOX	voxilaprevir*
* Medications marked with an asterisk (*) are direct acting antiviral medications (DAAs).	
OTHER TERMS	
AASLD	American Association for the Study of Liver Diseases
ALT	alanine aminotransferase
ANA	antinuclear antibody
APRI	AST to Platelet Ratio Index
AST	aspartate aminotransferase
CBC	complete blood count
CTP score	Child-Turcotte-Pugh score
EGD	esophagogastroduodenoscopy
GFR	glomerular filtration rate
HBV	hepatitis B virus
HBsAg	hepatitis B surface antigen
HCC	hepatocellular carcinoma

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HCV	hepatitis C virus	

Hepatitis C Treatment Algorithm/Nonformulary Request Worksheet

Montana Department of Corrections

Inmate Name:	AO#:	Date Submitted:
Parole Eligibility Date:	Weight (lb.): (within 90 days of request)	
Prison Discharge Date:		
APRI Score: APRI Date:	HCV Genotype: 1a 1b 2 3 4 5 6	
CTP Score (if cirrhotic): Date: POINTS (circle): <u>1</u> <u>2</u> <u>3</u> Albumin(g/dL): >3.5 2.8-3.5 <2.8 Bilirubin(mg/dL): <2 2-3 >3 INR: <1.7 1.7-2.3 >2.3 Encephalopathy: ☐ none ☐ grade 1-2 ☐ grade 3-4 Ascites: ☐ none ☐ diuretic ☐ responsive ☐ refractory Liver Biopsy Result (amount of fibrosis): Date Performed: ☐ Not Performed ☐ Portal ☐ Periportal ☐ Bridging ☐ Cirrhosis ☐ None Note: For regimens with elbasvir/grazoprevir in the treatment of HCV genotype 1a, an HCV NSSA virologic resistance test is required.		
Prior Antiviral Treatment for HCV: ☐ No ☐ Yes If yes, answer the following:		
Drug Names and Dosages: Start Date: Stop Date: Reason stopped: Prior Treatment Response ☐ SVR ☐ Relapse ☐ Partial Responder ☐ Null Responder		
Requested Treatment Regimen (check all that apply): ☐ Ledipasvir/sofosbuvir (Harvoni) ☐ Elbasvir/grazoprevir (Zepatier) ☐ Glecaprevir/pibrentasvir (Mavyret) ☐ Sofosbuvir/velpatasvir (Epclusa) ☐ Sofosbuvir/velpatasvir/voxilaprevir (Vosevi) ☐ Ribavirin ☐ Other _____		
Eligibility Criteria: ☐ Inmate has sufficient time remaining on sentence to complete a course of treatment prior to Pre-release, probation, discharge of sentence, and life expectancy >18 mo. ☐ Inmate is willing and able to adhere to a rigorous treatment regimen (no documented non-adherence to prior therapy, failure to complete pretreatment evaluation process, or unwillingness to commit to consent to HCV treatment). ☐ No contraindications or drug interactions with requested treatment regimen verified through MPQH ☐ No uncontrolled or unstable medical or mental health conditions. ☐ No current pregnancy		
Health Services Staff Name / Signature / Date / Institution		
Documentation – include copies of the following with the non-formulary request: ☐ CBC, serum creatinine and eGFR, liver panel, INR (dated within 180 days of request) ☐ HCV RNA viral load (reported as IU/ml) (any time prior to treatment) ☐ HCV genotype (any time prior to treatment) if not treatment naïve or a candidate for simplified treatment. ☐ HIV Ab – if positive, include CD4 and HIV viral load (dated within 180 days of request) and current antiretroviral medication regimen ☐ Hepatitis B serology (sAb, sAg, and cAb)- if HBsAg reactive, include eAg, eAb, and HBV DNA viral load ☐ Liver biopsy report (if performed, but not required unless clinically indicated) ☐ If cirrhosis or APRI ≥ 2 (defined by pathology or clinical findings), include abdominal US or CT ☐ Pregnancy test if woman with child-bearing potential (dated within 90 days of request)		
PROCEDURE FOR SUBMITTING HCV TREATMENT REQUEST - Generate a non-formulary request for Hepatitis C Treatment. - Include all information and attach all required documentation from above. - May scan and attach Hepatitis C Treatment non-formulary request.		



POLICY DIRECTIVE

Policy:	DOC 4.5.12 MANAGED CARE AND COST CONTAINMENT	
Effective Date:	09/01/1998	Page 1 of 2
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

Department facilities will monitor and maintain offender health care services and costs to provide the recommended and necessary level of health care to offenders in Department custody.

II. APPLICABILITY

All secure care facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Each facility will establish processes to implement managed care and cost containment processes and recommendations provided by the Health Services Bureau Chief and the Medical Director (see managed care recommendations in IV.B below).
2. The Health Services Bureau Chief will explore potential funding sources for which the offender may be eligible. Each facility may be asked to assist with this process.
3. The Health Services Bureau Chief or designee will use information provided by the Department's medical staff to identify, review, and contract with agencies, facilities, or services to provide quality offender care in a timely and cost-efficient manner.
4. Administrative decisions, such as utilization review, are coordinated, if necessary, with clinical needs so that offender care is not jeopardized.

B. Managed Care Recommendations

1. The following is a list of administrative processes utilized by health care organizations to educate care providers and consumers in appropriate use of resources and services:
 - a. review and preauthorize care to assure it is appropriate and necessary;
 - b. monitor outcomes to establish cost/benefit relationships;
 - c. recognize and use providers who generate consistently good outcomes at the most reasonable cost;

- d. analyze financial and outcome data to identify trends and to identify offenders who generate the highest 10% of cost and/or the highest 10% of consumer's medical services;
- e. manage individuals identified as over-utilizer or medically unnecessary, for example, those individuals who tend to excessively access the health care system;
- f. conduct concurrent review of inpatient services and referral patterns, for example, review of hospital procedures and admissions while the offender is receiving these services;
- g. provide discharge planning, for example, examine alternatives to hospitalization and costly procedures and arrange for these services so there is a good outcome for the offender without generating excessive costs for the State of Montana;
- h. employ case management for complex or costly cases, for example, identify those procedures and/or diagnoses that are likely to generate excessive cost and evaluate all care on a basis of a cost/benefit ratio for the individual;
- i. prevent duplication of services by improved communication between health care service providers; and
- j. authorize and prioritize care with oversight from the medical review panel.

C. Cost Containment Recommendations

1. The following is a list of administrative processes to reduce the overall cost of health care while maintaining quality:
 - a. contract review and negotiations;
 - b. competitive bidding;
 - c. clinical review of utilization and quality of care provided;
 - d. regionalization and specialization;
 - e. continuous quality improvement review; and
 - f. retrospective review of bills to determine accuracy.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief or Department Medical Director.

VI. REFERENCES

- A. 53-1-203, MCA
- B. MH-A-03; *National Commission on Correctional Health Care Standards*, 2018
- C. Y-A-03; *National Commission on Correctional Health Services in Juvenile Detention and Confinement*, 2022



POLICY DIRECTIVE

Policy:	DOC 4.5.13 INTAKE AND RECEIVING HEALTH CARE SCREENING	
Effective Date:	07/15/1999	Page 1 of 5
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department health care staff or designated staff will perform a receiving screen on all offenders upon arrival at the facility to immediately identify and address emergent and urgent health care needs.

II. APPLICABILITY

All secure facilities Department owned and contracted, as specified in the contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Receiving screening must be conducted as soon as possible and without unnecessary delay.
2. Offenders should not be released from the intake/receiving screening area until the receiving screening is completed.
3. Receiving screening must be conducted using a form and language fully understood by the offender, who may not speak English or may have a physical (for example, speech, hearing, sight) or mental disability.
4. Receiving screening personnel must closely monitor and annotate the potential for suicide.
5. Signs of trauma or a reported history of trauma will be closely monitored and evaluated.

B. Receiving Screen

1. Reception personnel ensure that offenders who are unconscious, semiconscious, bleeding, mentally unstable, severely intoxicated, exhibiting symptoms of alcohol or drug withdrawal, suicidal, or otherwise urgently in need of medical attention are referred immediately for care and medical clearance into the facility, except for juvenile offenders, who should be immediately referred to an outside facility for medical clearance. The mental health portion of the receiving screening is conducted by mental health staff when available on-site.

2. All facilities will complete a receiving health care screen form and use the screen results to determine immediate placement needs and appropriate referrals.
3. The receiving health care screen form includes inquiries as to the offender's:
 - a. current and past illnesses (medical and mental), health and mental health conditions, or special health or mental health requirements (for example, hearing impairment, visual impairment, wheelchair, walker, sleep apnea machine);
 - b. past infectious disease;
 - c. recent communicable illness symptoms (for example, chronic cough, coughing up blood, lethargy);
 - d. weakness, weight loss, loss of appetite, fever, night sweats;
 - e. past or current mental illness, including hospitalizations and outpatient treatment;
 - f. history of or current suicidal ideation;
 - g. dental problems (decay, gum disease, abscess);
 - h. allergies;
 - i. dietary needs;
 - j. prescription medications (including type, amount, and time of last use);
 - k. current state or history of alcohol or legal and illegal drug use (including type, amount, and time of last use);
 - l. current or prior withdrawal symptoms;
 - m. possible, current, or recent pregnancy;
 - n. history of and current use of psychotropic medication(s), including the name of the prescriber and pharmacy;
 - o. history and details of any suicidal behavior, including history of suicide watch during incarceration during prior incarceration at the facility; and
 - p. other health/mental health problems as specified by the responsible physician or mental health clinician.
4. The receiving health care screen form records receiving personnel's observations of the offender's:
 - a. appearance (for example, sweating, tremors, anxious, disheveled);
 - b. behavior (for example, disorderly, appropriate, insensible, delusions, hallucinations, communication difficulties, speech, posture, disorganization, memory defects);
 - c. state of consciousness (for example, alert, responsive, lethargic);
 - d. ease of movement (for example, body deformities, gait);
 - e. breathing (for example, persistent cough, hyperventilation);
 - f. skin (for example, including lesions, jaundice, rashes, infestations, bruises, scars, tattoos, needle marks or other indications of drug use, and evidence of self-mutilation); and
 - g. any known indicators for suicidal potential.
5. For female juvenile offenders, the receiving screening includes these additional inquiries:
 - a. if there are children under her care;
 - b. type and time of most recent sexual encounter and use of contraception in order to screen for emergency contraception eligibility; and
 - c. victimization by recent sexual assault in order to screen for emergency contraception eligibility.
6. On the receiving screening form, the staff member will indicate the disposition of the offender (for example, immediate referral to an appropriate health care service, placement in the general population), the date and time completed, and printed name, signature, and title of the staff member completing the form.
7. Facility health care providers will draw an IGRA Blood Test (QuantiFeron TBGold test) from all offenders as recommended by the Centers for Disease Control and Prevention and current national standards. If the IGRA Blood Testing is not available, the facility health care providers will administer a two-step Tuberculin skin test to all offenders.

8. Potentially infectious offenders are isolated from the general offender population.
9. Prescribed medications will be reviewed and appropriately maintained within the scope of the approved formulary according to the offender's medication schedule before admission or alternate treatment will be initiated and documented.
10. If a female offender is pregnant, an opiate history is obtained.
11. If a female offender reports current opiate use, she is immediately offered a test for pregnancy to avoid opiate withdrawal risks to the fetus.
12. Emergency contraception is available to female offenders during intake.
13. A pregnancy test is offered to all juvenile offenders upon arrival and the juvenile offender is referred to health staff within 48 hours for testing.
14. Sexually transmitted diseases (chlamydia, gonorrhea, HIV, HCV, and syphilis where there is significant prevalence) testing is offered to all offenders upon arrival or within 24 to 48 hours, consistent with national guidelines.
15. Health care staff will regularly monitor receiving screens to determine the safety and effectiveness of this process.
16. When mental health staff are not on-site, mental health trained custody staff perform the mental health portion of the receiving screening, which is then reviewed by a Qualified Mental Health Professional on the next shift they are present so that the timeliness of referrals mitigates negative mental health consequences.
17. When offenders indicate they are under treatment for a medical, dental, mental health, or substance use problem, staff will initiate a request for a health summary from the community prescriber(s) after receiving a signed release from the offender.

C. Referrals

1. The facility will initiate referrals to address immediate health and mental health concerns in the following circumstances:
 - a. if offenders are unconscious, semiconscious, bleeding, or in need of urgent medical or mental health attention beyond the scope of what the facility can provide, referrals will be made to a community hospital for immediate treatment. Admission or return to the facility is predicated upon written medical clearance from the hospital and approval from the Health Services Bureau managed care RN;
 - b. if offenders have a chronic disease, chronic mental illness, symptoms of communicable disease or illness, or are on chronic care medications (for example, insulin), referrals will be made to a physician or advanced practice clinician;
 - c. when offenders arrive with medications, unless the offender has received a physical prior to admission, referrals will be made to a physician or advanced practice clinician for a medication review; offenders taking psychiatric medications will be referred to a psychiatrist for a psychiatric medication review;
 - d. if an offender reports suicidal ideation during the health care screen, a referral will be made for an urgent mental health evaluation by a Qualified Mental Health Professional, and suicide precautions should be considered; and
 - e. if the offender demonstrates difficulties on the mental status examination that are significant enough to cause immediate concern for the offender's well-being or ability to function, initiate an urgent referral to a Qualified Mental Health Professional.

D. Intake/Receiving Screen Form

1. Facilities will use the standardized *Intake/Receiving Screen Form* approved by the responsible health authority and ensure the form is filed in the offender's health record. The mental health portion of the form will be approved by the responsible health authority.
2. All facilities will establish routing procedures for the form.
3. The form includes the following offender inquiries into:
 - a. current and past illnesses, health conditions, or special health requirements;
 - b. past infectious disease;
 - c. recent communicable illness symptoms;
 - d. past or current mental illness, including hospitalizations;
 - e. history of or current suicidal ideation;
 - f. dental problems;
 - g. allergies;
 - h. dietary needs;
 - i. prescription medications;
 - j. legal or illegal drug use;
 - k. current or prior withdrawal symptoms;
 - l. possible, current, or recent pregnancy;
 - m. history of outpatient treatment;
 - n. history and current use of psychotropic medication(s);
 - o. history and details of suicidal behavior; and
 - p. current state or history of alcohol abuse.
4. The form is dated and timed immediately on completion and includes the name, signature, and title of the staff completing the form.
5. Youth immunization status will be completed on a separate form.

E. Training

1. Correction staff members may be trained to conduct an abbreviated intake interview to alert health care professionals to any urgent health care needs.
2. When health and mental health-trained correctional staff perform the receiving screen, they are trained by the responsible physician or designee in early recognition of medical or mental health conditions requiring clinical attention.
3. Training will be based on curriculum approved by the responsible physician and contain instructions on completing the *Intake/Receiving Screen Form* and when to contact Qualified Health Care Professionals to determine appropriate dispositions of offenders.
4. Receiving screening personnel will be trained to conduct an intake/receiving screening to identify potential emergency situations and to ensure offenders with known illnesses and those on medications are identified for further assessment and treatment.
5. Screening personnel are trained in aspects of mental health and chemical dependency to enable staff to intervene early to treat withdrawal and to prevent suicides.
6. Mental health staff are involved in training receiving/screening staff, since offenders with mental disorders are often unable to give complete or accurate information in response to *Intake/Receiving Screen Form* inquiries.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. 53-21-102(9)(a), MCA
- B. *ACA Standards for Juvenile Correctional Facilities, 2022*
- C. *P-B-06, P-E-02; National Commission on Correctional Health Care Standards for Health Services in Prisons, 2018*
- D. *MH-E-02; National Commission on Correctional Health Care Standards for Mental Health Services in Correctional Facilities, 2015*
- E. *Y-E-02, Y-G-08; National Commission on Correctional Health Care Standards for Health Services in Juvenile Detention and Confinement Facilities, 2022*



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 4.5.14	Subject: OFFENDER HEALTH CARE ASSESSMENTS (MEDICAL, BEHAVIORAL HEALTH AND DENTAL)	
Chapter 4: FACILITY/PROGRAM SERVICES		Page 1 of 5
Section 5: Clinical Services		Effective Date: Jan. 1, 1998
Department Director Signature: /s/ Brian Gootkin		Revised: 4/19/2021
Medical Director Signature: /s/ Dr. Paul Rees		
Clinical Services Division Administrator Signature: /s/ Connie Winner		

I. POLICY

The Department of Corrections facility health care units or designated staff will ensure that offenders receive initial and periodic health assessments to provide for their ongoing health care needs.

II. APPLICABILITY

All secure facilities Department of Corrections owned and contracted, as specified in contract.

III. DEFINITIONS

Active Problems – Current and active diagnosis relevant to the current care of the patient.

Acutely Suicidal (active) – Offenders who engage in self-injurious behavior or threaten suicide with a specific plan and are placed on constant observation to ensure safety.

Adverse Child Experiences – One or more of the following traumatic experiences in a person's life occurring before the age of 18: physical abuse, sexual abuse, emotional abuse, mental illness of a household member, problematic drinking or alcoholism of a household member, illegal street or prescription drug use by a household member, divorce or separation of a parent, domestic violence towards a parent, incarceration of a household member.

Health Assessment – The process whereby an individual's health status is evaluated, including questioning the patient about symptoms. The extent of the health assessment is defined by the responsible physician but should include at least the steps noted in NCCHC Standard P-E-04.

Health Care – The sum of all actions, preventive and therapeutic, taken for the physical and mental well-being of a population. Health care includes medical, dental, mental health, nutrition, and other ancillary services, as well as maintaining clean and safe environment conditions.

Level 1 Mental Health Assessment – A standardized mental health screening process utilizing evidence-based tools and an interview by mental health staff to promptly identify and refer offenders who have significant mental health needs.

Level 2 Mental Health Evaluation – An interview conducted by a qualified mental health professional to identify an individual's current mental health status and mental health treatment needs, as well as history of mental illness and psychosocial factors across multiple domains of life.

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Mental Health Staff – Qualified health care professionals who have received instruction and supervision in identifying and interacting with individuals in need of mental health services.

Physical Examination – An objective, hands-on medical evaluation of an individual to determine the presence or absence of physical signs of disease.

Problem List – A list detailing the physical, emotional, and behavioral problems relevant to the offender’s care and treatment. Problems on the list can change during the course of incarceration depending on the offender’s completion of treatment requirements related to the problem or the development of new problems during incarceration.

Psychosis – A serious mental illness (such as schizophrenia) characterized by defective or lost contact with reality often with hallucinations or delusions.

Qualified Health Care Professionals – Physicians, physician assistants, nurses, nurse practitioners, dentists, mental health professionals and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for offenders, including contracted or fee-for-service professionals.

Qualified Mental Health Professionals – Psychiatrists, psychologists, psychiatric social workers, psychiatric nurses and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of offenders.

Receiving Screening – A process of structured inquiry and observation intended to identify potential emergency situations among new arrivals and to ensure that offenders with known illnesses and those on medications are identified for further assessment and continued treatment.

Responsible Health Authority – The individual that arranges for all levels of health care and assures quality, accessible and timely health services for offenders. The individual is appointed by the Department director.

Responsible Physician – A designated person who holds a physician's license pursuant to 37-3-102 and 37-3-303, MCA who has the final authority at a given facility regarding clinical issues.

Treatment Plan – The offender’s individualized, specific written course of therapy based on an assessment of the offender’s needs and the roles of qualified mental health staff in carrying it out. The treatment plan includes short- and long-term goals, is sensitive to cultural and language differences, and includes the methods by which goals will be pursued.

Vital Signs – Signs of life, specifically, height, weight, pulse rate, blood pressure, and body temperature.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. The Responsible Health Authority (RHA) approves the health assessment form.
2. The responsible physician determines the components of an initial health assessment.

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Subject: OFFENDER HEALTH CARE ASSESSMENTS		

3. Facilities that operate diagnostic and intake programs will complete an initial health assessment on each offender within seven (7) days of arrival.
4. All offenders receive an initial mental health assessment within 14 days after admission to the correctional facility conducted by mental health staff or mental health professionals.
5. Mental health screening may be conducted by Qualified Mental Health Professionals or Qualified Health Care Professionals who have received documented training.

B. Health Assessment

1. The initial health assessment will include, but is not limited to, the following:
 - a. a qualified health care professional collecting additional data to complete the medical, dental, and mental health histories, including any follow up from positive findings obtained during the receiving screening and subsequent encounters;
 - b. a qualified health care professional recording of vital signs (i.e., height, weight, pulse, blood pressure, and temperature);
 - c. a physical examination (including breast, rectal, and genitourinary exams as indicated by the patient's gender, age and risk factors) performed by a physician, physician assistant, nurse practitioner, or RN in a private setting..
 - d. when clinically indicated, a pelvic exam, or referral for a pelvic exam, with or without pap smear;
 - e. laboratory and/or diagnostic tests as determined by the responsible physician in juvenile populations;
 - f. tuberculosis test unless there is documentation from the health department that the prevalence rate does not warrant it in juvenile populations;
 - g. review of immunization history and update of schedules as needed in juvenile populations;
 - h. initiation of therapy when appropriate in juvenile populations;
2. All abnormal findings (i.e., history and physical, screening, and laboratory) are reviewed by the provider..
3. Specific problems are integrated into an initial problem list..
4. Diagnostic and therapeutic plans for each problem are developed as clinically indicated. .
5. A health history is completed on juveniles, which includes information on their participation in risky behavior, including sexual activity, is collected by qualified health care professionals.
6. The hands on portion of the health assessment for the juvenile population is performed by a physician, physician's assistant, nurse practitioner, or RN (the health assessment may be performed by an RN only when the nurse completes appropriate training that is approved by or provided by the responsible physician).

C. Mental Health Screening and Evaluation

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1. The initial mental health screening (Level 1) includes a structured interview with inquiries into:
 - a. a history of:
 - 1) psychiatric hospitalization, psychotropic medication, and outpatient treatment;
 - 2) substance use hospitalization;
 - 3) withdrawal seizures;
 - 4) detoxification and outpatient treatment;
 - 5) suicidal behavior;
 - 6) violent behavior;
 - 7) victimization;
 - 8) special education placement;
 - 9) cerebral trauma or seizures;
 - 10) physical trauma or abuse;
 - 11) sex offenses;
 - 12) exposure to traumatic life events and losses for juvenile offenders; and
 - 13) recent stressors (conflict with family and others, breakup, unstable living conditions, death of a friend or family) for juvenile offenders.
 - b. the current status of:
 - 1) mental health symptoms and psychotropic medications;
 - 2) suicidal ideation;
 - 3) drug or alcohol use;
 - 4) drug or alcohol withdrawal or intoxication;
 - 5) orientation to person, place, and time;
 - c. the emotional response or adjustment to incarceration.
 - d. screening for intellectual functioning (i.e., mental retardation, developmental disability, learning disability).
2. The offender's health record contains results of the initial (Level 1) screening and documentation of referral or initiation of treatment when indicated.
3. offenders with screen positive Level 1 mental health problems are referred to a qualified mental health professional for further evaluation.
4. Mental health evaluations (Level 2) of offenders with positive screens should be completed within 30 days or sooner if clinically indicated.
5. Offenders who require acute mental health services beyond those available on-site are transferred to an appropriate facility.
6. Juvenile offenders who present with psychological distress are referred to qualified mental health professionals for further evaluation in a timely manner.
7. Offenders who require acute mental health services beyond those available on-site are transferred to an appropriate facility.
8. All offenders who screen positive for mental health problems on the initial (Level 1) screen are referred to a qualified mental health professional for further (Level 2) mental health evaluation.

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Subject: OFFENDER HEALTH CARE ASSESSMENTS		

9. Mental health evaluations (Level 2s) are completed by a qualified mental health professional or referred offenders within 30 days of arrival or sooner if clinically indicated.

D. Periodic Health Assessments

1. The designated health authority, in collaboration with qualified health care professionals, will determine the frequency and content of periodic health assessments based on:
 - a. the offender's current age, gender, and overall health-specific clinical practice guidelines; and
 - b. protocols promulgated by nationally-recognized professional medical organizations.

E. Records

1. Qualified health care professionals will enter the collected and reviewed data from the health assessment in the offender health record at the time of the assessment in accordance with *DOC Policy 4.5.37 Offender Health Record Format and Content*.

F. Restrictions

1. Qualified health care professionals will document any health or mental health-related accommodations on an offender's housing, work, or other activities, and communicate these accommodations to the appropriate facility staff.

G. Informing Offenders

1. Qualified health care professionals will:
 - a. inform the offender of test results and any recommendations for further evaluation, referral, or treatment; and
 - b. provide mental health and health education and disease prevention information to offenders during initial and periodic assessments.

V. CLOSING

Questions concerning this policy should be directed to the Clinical Services Division administrator.

VI. REFERENCES

- A. *ACA Standards for Juvenile Correctional Facilities*
- B. *P-A-07, P-E-04, P-E-05; National Commission on Correctional Health Care Standards for Health Services in Prisons, 2018*
- C. *Y-E-04; National Commission on Correctional Health Care Standards for Health Services in Juvenile Detention and Confinement Facilities, 2015*
- D. *MH-E-04; National Commission on Correctional Health Care Standards for Mental Health Services in Correctional Facilities, 2015*

VII. ATTACHMENTS

None



POLICY DIRECTIVE

Policy:	DOC 4.5.15 OFFENDER HEALTH CARE ACCESS	
Effective Date:	08/01/1998	Page 1 of 2
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

Department facilities will provide offenders with access to medical, dental, vision, and mental health services upon admission, and inform them how to obtain these services during incarceration.

II. APPLICABILITY

All secure care facilities Department owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Health Care Services Information

1. Upon admission, the facility will inform the offender verbally and in writing about:
 - a. availability of services;
 - b. how to access emergency and routine health and mental health services; and
 - c. the grievance process for health-related complaints.
2. Facilities must provide information on how to access health care services in formats accessible to all offenders, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to offenders who have limited reading skills.
3. Offenders will be offered information on how to obtain specific health care services at the following times:
 - a. at the time of the initial health screening;
 - b. when an offender is receiving a particular service for the first time; and
 - c. on any other occasion when an offender displays a lack of understanding about how services are obtained.
4. A sign explaining how to access health services is posted in intake/processing areas.
5. Mental health staff have had input about the information given to inmates about mental health services.

B. Change in Procedures

1. Facilities must publish, or post in each housing unit, any procedural changes on how to obtain health care services prior to implementation.
2. Where applicable, facilities must update offender handbooks as necessary.

C. Requests for Health Care

1. Correctional staff may not approve or deny offender requests for health care attention.
2. Facilities must establish processes to ensure that all offender health care requests are forwarded to the health care unit or designated health care staff in a confidential manner.

D. Unreasonable Barriers

1. The facility will avoid creating unreasonable barriers to offender health care access. Examples of these barriers may include, but are not limited to, the following:
 - a. punishing offenders for seeking care for health needs;
 - b. assessing excessive co-payments that prevent or deter offenders from seeking care for health needs or assessing a fee for treatments arising from sexual abuse;
 - c. deterring offenders from seeking care for health needs through unreasonable practices not related to legitimate facility needs, for example, holding sick call at 2:00 a.m.; and
 - d. having an understaffed, underfunded, or poorly organized system with the result that it is not able to deliver appropriate and timely care for offenders' serious needs.

E. Grievance Process for Health Care Complaints

1. The facility will have a grievance process that includes, at minimum:
 - a. a time frame to respond; and
 - b. a process for appeal.
2. Responses to inmate grievances must be:
 - a. timely;
 - b. based on principles of adequate medical and mental health care; and
 - c. documented.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *ACA Standards for Juvenile Correctional Facilities, 2023*
- B. *P-A-01, P-A-10, P-E-01; National Commission on Correctional Health Care Standards for Health Services in Prisons, 2018*
- C. *Y-A-01, Y-A-11, Y-E-01; National Commission on Correctional Health Care Standards for Health Services in Juvenile Detention and Confinement Facilities, 2022*
- D. *MH-A-01, MH-A-11, MH-E-01; National Commission on Correctional Health Care Standards for Mental Health Services in Correctional Facilities, 2015*



POLICY DIRECTIVE

Policy:	DOC 4.5.16 OFFENDER NON-EMERGENCY HEALTH REQUESTS AND SICK CALL	
Effective Date:	01/01/1998	Page 1 of 3
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

Department facility health care units will provide offenders with a system to request health care on a daily basis and be evaluated and treated in a timely manner for non-emergent illness, injury, and mental health needs.

II. APPLICABILITY

All secure care facilities Department owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Each facility will ensure that all offenders, regardless of housing, have the opportunity daily to request health care through oral, written or electronic requests.
2. Offenders must submit health care requests in accordance with facility procedures. Offenders may access care through:
 - a. a walk-in clinic;
 - b. written requests that are dropped into a locked box;
 - c. a staff-assisted telephone call to health care staff;
 - d. an electronic request from inmate authorized tablets; or
 - e. a sign-up sheet on which offenders may place their names.
3. Non-health care staff may not determine whether an offender has access to or receives health care services.
4. In all cases, care should be taken to protect the confidentiality of offender health concerns.

B. Health Care Requests

1. Health care requests must be received daily by health staff.

2. Health care requests are reviewed and prioritized daily by Qualified Health Care Professionals, or the health care liaison, if applicable.
3. A face-to-face encounter for a health care request is conducted by a Qualified Health Care Professional, or the health care liaison (if applicable), within 24 hours of receipt by health staff.
4. Patients must be evaluated in a private/clinical setting which affords patient confidentiality.
5. All aspects of the health care request process, from review and prioritization to subsequent encounter, are documented, dated, and timed.

C. Mental Health Requests

1. Oral, written, and electronic requests for mental health care are received daily by Qualified Health Care Professionals and triaged within 24 hours. When a request describes a clinical symptom, a face-to-face encounter between the offender and mental health staff or a Qualified Mental Health Professional occurs within 24 hours. When the encounter is provided by mental health staff, they schedule offenders to be seen by a Qualified Mental Health Professional based on the protocols approved by the responsible mental health clinician.
2. When mental health staff or Qualified Mental Health Professionals are not on duty within a 24-hour period, a mental health liaison, using facility protocols established by the correctional and mental health authorities, reviews and responds to offenders' mental health requests.
3. Mental health staff are trained to triage and respond to offenders with mental health requests by training approved by the Health Services Bureau Mental Health Section Supervisor.
4. During mental health appointments, Qualified Mental Health Professionals make timely assessments in a clinical setting. Provide treatment according to clinical priorities or, when indicated, schedule patients for the next available specialty provider's clinic.
5. All offenders, regardless of housing assignment, have access to regularly scheduled mental health appointments.
6. The frequency and duration of appointments is sufficient to meet the mental health needs of the offender population.

D. Juvenile Requests

1. Oral, written, and electronic requests for health care are received daily by Qualified Health Care Professionals and triaged within 24 hours. When a request describes a clinical symptom, a face-to-face encounter between the juvenile and Qualified Health Care Professional occurs within 48 hours (72 hours on weekends).
2. When responding to health services requests, Qualified Health Care Professionals make timely assessments in a clinical setting. Qualified Health Care Professionals provide treatment according to clinical priorities or, when indicated, schedule offenders as clinically appropriate.
3. All juveniles, regardless of housing assignment, have access to regularly scheduled times for nonemergency health services (sick call).
4. The frequency and duration of response to health services requests are sufficient to meet the health needs of the juvenile population.

E. Sick Call

1. All offenders, regardless of housing assignment, have access to regularly scheduled times for nonemergent health services (sick call). Sick call times and locations may vary among facilities to meet the needs of the offender population.
2. When a nursing assessment is required, the offender will be seen individually in a designated area to ensure privacy and confidentiality.
3. Qualified Health Care Professionals will provide the offender with a verbal explanation of the assessment findings, any further recommended treatment or evaluation, and any patient education relevant to the health complaint.
4. Qualified Health Care Professionals will make timely assessments in a clinical setting according to clinical priorities or, when indicated, schedule offenders as clinically appropriate when:
 - a. indicated by protocol;
 - b. referred by nursing or a mid-level practitioner; or
 - c. an offender reports to sick call more than twice with the same complaint and has not seen a physician.
5. When an offender request does not require a nursing assessment, health care staff must respond to the request in writing and document their signature and date of response.

F. Informing Offenders

1. Staff will inform all offenders of the process for requesting health care attention during the facility admission/orientation process.

G. Restrictive Housing Offenders

1. Qualified Health Care Professionals will conduct daily sick call for Restrictive Housing offenders in accordance with *DOC 4.5.21 Restrictive Housing Offender Health Assessment and Services*.

H. Records

1. Health care staff will document each offender request or complaint and disposition in the offender's health record.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *ACA Standards for Juvenile Correctional Facilities, 2023*
- B. *National Commission on Correctional Health Care Standards for Health Services in Prisons, 201*
- C. *MH-E-05; National Commission on Correctional Health Care Standards for Mental Health Services in Correctional Facilities, 2015*
- D. *National Commission on Correctional Health Care Standards for Health Services in Juvenile Detention and Confinement Facilities, 2022*



POLICY DIRECTIVE

Policy:	DOC 4.5.19 NURSING ASSESSMENT PROTOCOLS	
Effective Date:	01/01/1998	Page 1 of 2
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

Department facility health care unit nursing protocols will guide offender health assessments, initiate treatment of identified conditions, and ensure appropriate referral to a physician, dentist, or mid-level practitioner for further evaluation and treatment.

II. APPLICABILITY

All secure facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Facility health care units will establish nursing protocols that outline the steps for the assessment, treatment, and monitoring of specific offender health conditions that comply with the state practice act.
2. The designated health authority or designee in collaboration with the responsible physician will be responsible for the annual review and development of the nursing protocols that are consistent with national clinical practice guidelines.
3. Only a licensed clinician may initiate prescription medication treatment by a written or verbal order. Prescription medications used for life-threatening situations will require subsequent clinician verbal or written order.
4. The designated health authority in collaboration with the responsible physician may allow the use of standing orders but only for preventive medications (for example, immunizations), and for ailments that are typically treated with over-the-counter medications.
5. Approved assessment protocols pertaining to emergency life-threatening conditions (for example, chest pain, shortness of breath) may contain prescription medications and must include immediate communication with a provider.

6. The facility designated health authority will ensure that nurses are trained in protocol use and will document the following:
 - a. evidence that all new nursing staff is trained;
 - b. demonstration of knowledge and skills;
 - c. evidence of annual review of skills; and
 - d. evidence of retraining when new protocols are introduced, or existing protocols are revised.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *Title 37, Chapter 8, MCA*
- B. *P-E-08, National Commission on Correctional Health Care Standards for Health Services in Prisons, 2018*
- C. *Y-E-108; National Commission on Correctional Health Care Standards for Health Services in Juvenile Detention and Confinement Facilities, 2022*



POLICY DIRECTIVE

Policy:	DOC 4.5.20 EMERGENCY SERVICES AND RESPONSE PLAN	
Effective Date:	01/01/1998	Page 1 of 3
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

Department facility health care units will ensure that offender emergency medical, dental, and mental health services are available 24 hours each day, seven days per week.

II. APPLICABILITY

All secure facilities Department owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Emergency Services

1. Health care staff will have a written plan for accessing emergency services, approved by the responsible health authority and facility administrator, that includes the following:
 - a. responsibilities of health staff;
 - b. procedures for triage, including multiple casualties;
 - c. predetermination of the site for care;
 - d. emergency patient transport from the facility;
 - e. use of an emergency medical vehicle;
 - f. use of one or more designated hospital emergency departments or other appropriate facilities;
 - g. emergency on-call physician, mental health, and dental services when the emergency health care facility is not located nearby;
 - h. security processes for the immediate transfer of patients for emergency medical care; and
 - i. notification of the facility administrator and the responsible health authority or designee.
 - j. processes for evacuating patients, including in a mass disaster;
 - k. alternate back-ups for each of the plan's elements;
 - l. time frame for response; and
 - m. telephone numbers and processes for calling health staff and the community emergency response system (for example, hospitals and ambulances).

2. For mental health emergencies, facilities must have a written plan, approved by the mental health authority and facility administrator, to access need-to-know mental health information by designated staff if no mental health staff are on-site and the information is necessary to provide acute mental health care. The plan must outline:
 - a. definition of mental health emergency;
 - b. on-call mental health processes including the name, address, and telephone numbers of individuals to be notified and services to be contacted;
 - c. designated staff with permission to access need-to-know information;
 - d. what information these individuals are allowed to access; and
 - e. confidentiality of mental health information.
3. Health care staff will ensure that emergency drugs, supplies, and medical equipment are regularly maintained.
4. Health care staff will follow a written process for on-call emergency services.
5. Juveniles who have significant health problems should not be housed in facilities from which the trip to an emergency room would take longer than 15 minutes via ambulance.

B. Emergency Response

1. Staff will immediately respond to emergencies with appropriate equipment.
2. It is not necessary for non-health care staff to wait for health care staff to arrive before activating emergency response procedures or initiating emergency intervention.
3. The first person on the scene intervenes until facility health care staff or community emergency responders arrive.
4. In response to an emergency, trained personnel must assess the offender's health status and, when possible, stabilize the offender's condition.
5. Qualified Health Care Professionals must respond to medical emergencies in accordance with specified protocols.

C. Training

1. All health care staff will be trained in cardiopulmonary resuscitation (CPR) and emergency medical response procedures, including automated external defibrillator (AED).
2. All correctional staff will be trained in CPR, First Aid, AED, the recognition of medical emergencies, the location of first response emergency equipment, and procedures to obtain emergency assistance. First aid supplies will be available in each housing unit and replenished after use.
3. All staff in direct contact with offenders will receive training in emergency response and intervention.
4. All health care staff and correctional staff will be trained in recognizing and responding to a mental health emergency and obtaining emergency mental health support.
5. The names, addresses, and telephone numbers of individuals to be notified and services to be contacted will be readily accessible to all personnel.
6. Facilities, including satellites, must:
 - a. conduct a minimum of one mass disaster drill annually in the facility so that over a three-year period each shift has participated;
 - b. conduct a minimum of one health emergency man/juvenile down drill once a year on each shift where health care staff are regularly assigned; and

- c. critique the disaster and man/juvenile down drills, share the results with all staff, and ensure recommendations for health care staff are implemented.

D. Documentation

1. Health care staff will record the date and time of the emergency response in the offender's health record, include assessment and treatment information, and sign the document.

E. Transportation

1. When necessary to transport the offender to an off-site health care facility, the following guidelines will determine the appropriate mode of transportation:
 - a. an ambulance will be used if the emergency is life threatening or deemed necessary by attending staff; or
 - b. the facility will transport or arrange transportation for ambulatory offenders in non-emergent situations.

F. Written Information

1. Health care staff will provide, when possible, written or printed electronic information to emergency medical technicians that includes:
 - a. history of the emergency condition;
 - b. treatment given;
 - c. present status with most recent vital signs;
 - d. suspected diagnosis;
 - e. allergies; and
 - f. other pertinent information.

G. Resuscitation

1. If staff initiates resuscitation measures, they will continue to resuscitate until they transfer the offender's care to emergency personnel, or a physician or mid-level practitioner authorized by the State of Montana makes a finding of death.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-D-07; National Commission on Correctional Health Care Standards for Health Services in Prisons, 2018*
- B. *MH-A-07, MH-E-06; National Commission on Correctional Health Care Standards for Mental Health Services in Correctional Facilities, 2015*
- C. *Y-A-07, Y-E-08; National Commission on Correctional Health Care Standards for Health Services in Juvenile Detention and Confinement Facilities, 2022*
- D. *ACA Standards for Juvenile Correctional Facilities, 2023*



POLICY DIRECTIVE

Policy:	DOC 4.5.21 RESTRICTIVE HOUSING OFFENDER HEALTH ASSESSMENT AND SERVICES	
Effective Date:	01/01/1998	Page 1 of 3
Revision Date(s):	04/18/2006; 10/27/2009; 03/21/2016; 04/19/2021; 05/20/2024; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department's facility qualified health care professionals will manage each offender's physical and mental health conditions while the offender is in restrictive housing.

II. APPLICABILITY

All secure care facilities Department owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Notification

1. Facilities will develop procedures to ensure facility staff notify a QHCP as soon as possible but within 24 hours of an offender's admission to restrictive housing.
2. No inmate shall be placed in pre-hearing confinement or placed in restrictive housing based solely upon a disability or upon behavior that is a product of a disability unless, after a prompt and appropriate evaluation by a QMHP, such staff determines that the inmate presents such an immediate and serious danger that there is no reasonable alternative. In such case, the inmate will be promptly and regularly re-evaluated with the goal of securing appropriate treatment and reintegrating into general population.

B. Review and Referral

1. Upon notification that an offender is placed in restrictive housing, a QHCP will:
 - a. review the offender's health record to determine whether existing medical, dental, or mental health needs contraindicate the placement or require accommodation and will document such review in the offender's health record;
 - b. immediately communicate any contraindications or required accommodations identified for juveniles to the responsible health authority and custody leadership;
 - c. when health staff are not on duty, the on-call QHCP is notified for juveniles placed in segregated housing; and

- d. immediately refer an offender who is currently receiving mental health treatment to appropriate QMHPs for further evaluation; and document the referral in the offender's health record.
2. QMHPs must evaluate the offender and review the offender mental health file and any other relevant documents within 24 hours of the initial referral. QMHPs shall take appropriate measures to ensure confidentiality of all information communicated, including but not limited to out-of-cell interviews, and make appropriate housing recommendations. QMHPs provide mental health services according to established treatment plans.

C. Housing Alternatives

1. The QHCP will notify and consult with the facility administrator on offender housing alternatives if there are medical, dental, or mental health contraindications to placement in segregated housing.
2. The QMHP will notify the facility administrator of the latest scientific information concerning any health effects of segregated housing.

D. Contraindicating Conditions

1. Contraindicating conditions to placement in facility restrictive housing may include, but are not limited to:
 - a. diminished consciousness;
 - b. disorientation;
 - c. persistent vomiting;
 - d. significant contusions;
 - e. severe laceration or trauma;
 - f. respiratory distress;
 - g. current suicidal ideation or behavior;
 - h. unstable psychiatric illness;
 - i. inter-maxillary fixation;
 - j. uncontrolled seizure disorder; and
 - k. acute alcohol or drug withdrawal.

E. Monitoring

1. Offenders in restrictive housing have frequent, routine contact with qualified health care professionals, qualified mental health professionals, and/or correctional officers. Therefore, monitoring of a restrictive housing offender is based on the following degrees of isolation:
 - a. offenders in restrictive housing who have limited contact with staff or other offenders are monitored a minimum of three days a week by mental health staff and daily by medical staff;
 - b. offenders who are allowed periods of recreation or other routine social contact among themselves while in restrictive housing are checked weekly by medical or mental health staff; and
 - c. when qualified health care or qualified mental health professionals are on duty, juvenile offenders are monitored daily by performing health checks.
2. Health care staff will schedule the offender for an assessment when they identify medical needs or mental health concerns during monitoring rounds.
3. Correctional officers will make an appropriate referral to health care staff anytime they believe an offender is experiencing medical or mental health problems.
4. Qualified health care professionals will promptly identify and inform custody officials of offenders who are experiencing physical or mental health deterioration and those exhibiting other signs or symptoms of failing health.

5. Childcare workers or program staff will monitor juveniles in restrictive housing at least every 15 minutes.
6. On days when health staff are on-site, health-trained childcare workers or program staff alert health staff on call if a health problem is noted for juvenile offenders.
7. Use of restrictive housing for juveniles more than 2 to 5 hours is not used except under documented exceptional circumstances, where there is no safe alternative.
8. In the rare instance that a juvenile's out-of-control behavior lasts more than 24 hours in restrictive housing, qualified health care professionals will:
 - a. evaluate for a medical or psychiatric condition or contraindication to continued isolation that warrants further evaluation and treatment; and
 - b. generate a written plan for urgent mental health assessment by a qualified mental health professional and/or the use of alternatives to segregation (for example, return to living units under supervision, use of medications, transfer to a mental health facility).

F. Documentation

1. Qualified health care professionals will document restrictive housing rounds either on logs or cell cards or in the offender's health record.
2. Any significant health findings are documented in the inmate's health record.
3. All documentation must include the date and time of contact and the signature or initials of the qualified health care professional.
4. A note as to whether findings were documented in the health record for juvenile offenders.

G. Reporting

1. A monthly report on the use of restrictive housing is given to the responsible health authority and facility administrator. This report should include information about the number of juveniles in restrictive housing during the month, the number of days spent in restrictive housing, and the health status of juveniles in restrictive housing.

V. CLOSING

Questions about this policy should be directed to the Rehabilitative and Enterprise Division Chief or designee.

VI. REFERENCES

- A. *P-E-07; P-G-02, National Commission on Correctional Health Care Standards for Health Services in Prisons, 2018*
- B. *MH-E-07; National Commission on Correctional Health Care Standards for Mental Health Services in Correctional Facilities, 2015*
- C. *DOC Policy 3.5.1 Restrictive Housing*
- D. *Y-E-09; National Commission on Correctional Health Care Standards for Juveniles in Detention and Confinement Facilities, 2015*



POLICY DIRECTIVE

Policy:	DOC 4.5.22 INMATE HEALTH CARE CONTINUITY	
Effective Date:	01/01/1998	Page 1 of 3
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department facility health unit will facilitate offender health care continuity from admission to discharge, including referral to community practitioners when indicated.

II. APPLICABILITY

All secure facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Clinical Care

1. Offenders receive medical, dental, and mental health services from admission to discharge per prescribers' recommendations, orders, and evidence-based practices.
2. Prescriber orders are implemented in a timely manner.
3. If deviations from evidence-based practices are indicated, clinical justification for the alternative treatment plan while in custody is documented in the offender's health care record.
4. Diagnostic tests must be reviewed by a provider in a timely manner.
5. Treatment plans are modified as clinically indicated based on diagnostic test and treatment results as appropriate.
6. Treatment plans and test results must be shared and discussed with the offender.
7. For hospitalization, urgent care, emergency department, or specialty visits:
 - a. offenders are seen by a Qualified Health Care Professional or health care liaison (if appropriate) upon return;
 - b. recommendations are reviewed for appropriateness of use in the correctional environment; and
 - c. a provider is contacted in a timely manner to ensure proper implementation of any orders and to arrange appropriate follow up.

8. If a Qualified Mental Health Professional is not on-site upon an offender's return from a hospitalization, urgent care, or emergency department visit, health staff immediately review the discharge orders and contact a health professional for orders as needed.
9. Evaluations (for example, neurological, neuropsychological) and other specialty consultations (for example, laboratory work, imaging procedures) are completed in a timely manner, with evidence in the record of the ordering clinician's review results. The clinician reviews abnormal findings face to face with the offender in a timely manner.
10. The responsible physician determines the frequency and content of periodic health assessments based on protocols of nationally recognized professional organizations.
11. Health record reviews are completed to ensure that appropriate care is ordered and implemented and that care is coordinated by all health staff, including medical, dental, mental health, and nursing.

B. Health Records

1. Health care staff will:
 - a. obtain offender health records from previous providers when the information is clinically relevant to the treatment of recurrent, chronic, or exacerbated health conditions in accordance with health care information release requirements pursuant to *DOC 4.5.38 Offender Health Record Access, Release, and Retention*;
 - b. when possible, anticipate the need for prior health records and information so that delays or alterations in prescribed care and treatment are minimized;
 - c. consult previous providers by telephone regarding an offender's condition when prior health care and treatment records have not been obtained; and
 - d. handle health records for offenders transferring to other correctional facilities or community corrections programs in accordance with *DOC 4.5.36 Health Records Transfer*.

C. Release Plans

1. Health care staff will coordinate with case managers to assure follow-up arrangements or provide referrals to community providers for offenders who will be released from a Department facility with critical medical or mental health needs.
2. For planned releases to the community, arrangements are made to initiate contraception for female offenders, upon request.

D. Discharge Orders and Planning

1. Health care providers will provide written prescriptions for controlled medications, if deemed medically necessary, when offenders are released.
2. Offenders will receive a minimum 30-day supply of medication upon release for continuing treatment of chronic illness and continuity of care.
3. For offenders with serious medical, dental, or mental health needs, arrangement or referrals are made for follow-up services with community prescribers, including exchange of clinically relevant information.
4. The facility has a process to assist offenders with health insurance application prior to release from the facility.
5. All aspects of discharge planning are documented in the offender's health record in a timely manner.

- a. Provide the offender with a list of resources and support commensurate with the offender's level of functioning.

E. Acute Illness Medications

1. When offenders are on acute illness medications at the time of release, health care providers will encourage them to take their medication cards to complete the course of therapy consistent with accepted medical practice.

F. Juvenile Offenders

1. Females who are on a method of contraception in the community, either for birth control or medical indications, are able to continue that method after receiving screening.
2. The facility offers methods for initiating contraception while in custody, including medical indications.
3. For planned discharges, health staff will coordinate with case management to:
 - a. coordinate and document plans with the juveniles' legal guardian as appropriate;
 - b. arrange for a minimum 30-day supply of current medications; and
 - c. for juveniles with identified medical, dental, or mental health needs, make arrangement for referrals for follow-up services with community clinicians, including exchange of clinically relevant information, and document those arrangements.

G. Offender Transports

1. Health care staff will ensure written instructions accompany any offender needing medication or medical care during transport between Department facilities or programs.
2. When offenders are referred for outside care, written or verbal information about the offender and the specific problem to be addressed must accompany them.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-B-06, P-E-0912, P-F-01; National Commission on Correctional Health Care Standards for Health Services in Prisons, 2018*
- B. *MH-E-09, MH-E-10; National Commission on Correctional Mental Health Services in Correctional Facilities, 2015*
- C. *Y-E-12, Y-E-13, Y-G-08; National Commission on Correctional Health Services in Juvenile Detention and Confinement Facilities, 2022*
- D. *DOC 4.5.36 Health Records Transfer; DOC 4.5.38 Offender Health Record Access, Release, and Retention*



POLICY DIRECTIVE

Policy:	DOC 4.5.23 OFFENDER HEALTH CARE ESCORT AND TRANSPORT	
Effective Date:	01/01/1998	Page 1 of 2
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

Department facilities will ensure that offenders are escorted and transported safely and promptly to medical, mental health, and dental clinic appointments both inside and outside the facility.

II. APPLICABILITY

All secure facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Patient confidentiality is maintained by staff during all transports and escorts.
2. When an offender is transported, health care staff will alert transporting custody staff to accommodations needed during the transport process, including instructions for administration of necessary medications.
3. Staff involved in transportation of offenders will be provided information regarding times and frequency for offenders to self-administer ordered medications during transport.

B. In-House Movement/Escort

1. Facility administrators will ensure security staff is available to escort offenders from housing to clinic areas for scheduled health care appointments and emergency medical needs.
2. When possible, health care providers will see the offender in a clinical area within the housing unit.
3. If the offender's ability to walk to the health services unit is compromised, health care providers will be consulted beforehand to ensure the mode of transportation is appropriate to the nature of the medical problem.

C. Off-Site Referrals/Transportation

1. Facility health care providers and correctional staff will provide offender emergency health care or transport in accordance with *DOC 4.5.22 Offender Health Care Continuity* and *DOC 4.5.20 Emergency Medical Services*.
2. Each Qualified Health Care Professional (QHCP) will:
 - a. make all non-emergency off-site medical referrals according to protocols outlined by the Department Medical Director;
 - b. establish applicable off-site referral notification procedures;
 - c. provide security transport staff with only the amount of offender medical information necessary to ensure offender and staff protection and safety; and
 - d. if indicated, make special arrangements to ensure continuity of care by providing written instructions, medications, and supplies in accordance with *DOC 4.5.22 Offender Health Care Continuity*.

D. Appointments

1. Facility health staff will establish a system to track missed appointments.
2. The designated health authority will investigate missed appointments and take corrective action when needed.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-DE-106; National Commission on Correctional Health Care Standards for Health Services in Prisons, 2018*
- B. *MH-E-08; National Commission on Correctional Health Care Standards for Mental Health Services in Correctional Facilities, 2015*
- C. *Y-E-10; National Commission on Correctional Health Care Standards for Health Services in Juvenile Detention and Confinement Facilities, 2022*
- D. *DOC 4.5.20 Emergency Medical Services; 4.5.22 Offender Health Care Continuity*



POLICY DIRECTIVE

Policy:	DOC 4.5.24 INMATE HEALTH EDUCATION, PROMOTION, AND SELF-CARE
Effective Date:	01/01/1998 Page 1 of 4
Revision Date(s):	04/19/2021; 04/24/2026
Department Director Signature:	/s/ Eric Strauss, Director
Medical Director Signature:	/s/ Dr. Paul Rees, MD
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN

I. POLICY

The Department facility health care unit will provide education and information to inmates to promote a healthy lifestyle, self-care, disease prevention, early detection, treatment, and recovery.

II. APPLICABILITY

All secure facilities Department-owned and contracted, as specified in the contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Facility health care staff will provide inmate education and counseling throughout incarceration to promote a healthy lifestyle, prevention, and recovery.
 - a. Health staff document that inmates receive individual health education and instruction in self-care for their health conditions.
2. Health care education may be provided by health care staff, program staff, custody staff, a registered dietician nutritionist, or volunteers.
3. At the completion of the initial health and mental health assessments, health care staff will inform inmates of the recommended schedule for preventative health care exams in accordance with *DOC 4.5.14 Offender Health Assessments*.
4. Health care education must be age and gender appropriate for the facility population.
5. The offender's health record will contain documentation that the offender has received health care education.
6. Health education may be delivered individually or in a group setting and may include the following methods:
 - a. a wellness program;
 - b. chronic care system;
 - c. educational program;

- d. pamphlets; or
 - e. audio and video.
7. Health care information and educational materials on a variety of topics are made available to all offenders.
 8. Facilities provide a nutritionally adequate diet to the general population.
 9. A registered dietitian nutritionist (RDN), or other licensed qualified nutritional professional, as authorized by state scope of practice laws, documents a review of the regular diet for nutritional adequacy at least annually.
 10. The facility has a procedure in place to notify the RDN whenever the regular diet menu is changed.
 11. Juveniles are informed that they can contact their Probation and Parole Officer or their own physician for help in accessing care for any medical, mental health, or substance abuse needs.
 12. Counseling and social services regarding all aspects of sexuality are available to the juvenile population within a facility or by referral to appropriate community agencies.

B. Health Education

1. Health education should be designed to increase the offender's ability to monitor and manage individual needs.
2. Health education topics should include but are not limited to:
 - a. alcohol and other drugs;
 - b. medication assisted treatment (MAT)
 - c. chronic disease and disability;
 - d. comprehensive family planning, including services, contraceptive methods, and referrals;
 - e. counseling in preparation for release;
 - f. effects of smoking, use of tobacco products, and smoking cessation;
 - g. Hepatitis A, B, and C;
 - h. HIV infection and AIDS;
 - i. immunizations;
 - j. "keep-on-person" medications;
 - k. nutrition;
 - l. parenting skills;
 - m. perinatal care;
 - n. personal hygiene;
 - o. physical fitness;
 - p. prevention of sexual and other physical violence;
 - q. preventative oral health care;
 - r. sexually transmitted diseases;
 - s. stress management;
 - t. tuberculosis;
 - u. education; and
 - v. physical activity.

C. Mental Health Education

1. Mental health education should be designed to empower mentally ill offenders to manage their illness, gain better control over their lives, keep their symptoms under control, reduce stress, and increase self-esteem.
2. Offenders are encouraged to take an active partnership role in their treatment.

3. Mental health education topics should include but are not limited to:
 - a. reducing relapse;
 - b. using medications effectively;
 - c. medication side effects;
 - d. coping with stress;
 - e. coping with problems and symptoms;
 - f. building social support;
 - g. advocating for effective treatments;
 - h. personalized strategies for managing mental illness and achieving goals;
 - i. the process of mental illness;
 - j. mental health treatment alternatives;
 - k. crisis planning;
 - l. anger management;
 - m. conflict negotiation; and
 - n. coping with mental illness.

D. Juvenile Exercise

1. Exercise is provided to all custody classes of juveniles except those in transient status. Juveniles are provided with opportunities to exercise daily, at least 1 hour, 7 days a week within their unit.
2. Exercise takes place outside the juvenile's room in an area large enough to accommodate the activity.

B. Juvenile Personal Hygiene

1. Facilities will provide sufficient services and supplies so that juvenile personal hygiene needs are met.
2. All custody classes of juveniles have the opportunity to take showers daily.
3. In every area where juveniles are detained for at least 48 hours, there is a tub or a shower with hot and cold running water.
4. Juvenile personal items include, at minimum, the following:
 - a. soap;
 - b. comb;
 - c. soft round-bristle toothbrush;
 - d. toothpaste;
 - e. deodorant;
 - f. toilet paper; and
 - g. for female juveniles, sanitary napkins and tampons.
5. Haircuts and individual shaving instruments are available to the juvenile population.
6. Juveniles receive a change of outer clothing three times a week, a daily change of underwear, and a weekly bed linen and towel change.
7. Shower, bath, and laundry facilities are in good working order for the juvenile population.

C. Tobacco Use

Smoking and tobacco products are prohibited in all DOC facilities.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-BF-01, P-B-03, P-B-06, P-D-05, P-F-01; National Commission on Correctional Health Care Standards for Health Services in Prisons, 2018*
- B. *MH-F-01, MH-F-02; National Commission on Correctional Health Care Standards for Mental Health Services in Correctional Facilities, 2015*
- C. *Y-F-01, Y-F-02, Y-F-03, Y-F-04, Y-F-05, ; National Commission on Correctional Health Care Standards for Health Services in Juvenile Detention and Confinement Facilities, 2022*
- D. *ACA Standards for Juvenile Correctional Facilities, 2023*



POLICY DIRECTIVE

Policy:	DOC 4.5.25 PHARMACEUTICAL OPERATIONS	
Effective Date:	07/01/1998	Page 1 of 2
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

Department facility health care staff will ensure that all medications are prescribed, distributed, administered, procured, and disposed of in accordance with state and federal laws and regulations.

II. APPLICABILITY

All secure facilities Department owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Pharmaceutical Distribution

1. QHCPs will procure, dispense, and administer pharmaceuticals in accordance with all state and federal regulations.
2. An unlicensed person may observe an offender self-administer medications, give verbal prompts or reminders, or hand a prefilled labeled medication holder to the offender.

B. Pharmaceutical Procedures

1. Each facility will develop processes that comply with all state and federal regulations and that address:
 - a. prescribing;
 - b. procurement and distribution;
 - c. dispensing and administration in a timely and safe manner;
 - d. storage and disposal;
 - e. accountability and maximum security of Drug Enforcement Agency (DEA) controlled substances;
 - f. processes for offender self-administration; and
 - g. adequate supplies of antidotes and emergency medications.
2. The facility maintains records as necessary to ensure adequate control and accountability for all medications, except those that may be purchased over the counter.

3. Drug storage and medication areas are devoid of outdated, discontinued, or recalled medications, except in a designated area for disposal.
4. All medications are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security.
5. Antiseptics, other medications for external use, and disinfectants are stored separately from internal and injectable medications. Medications requiring special storage (for example, refrigeration) for stability are stored in special locations.
6. An adequate and proper supply of antidotes and other emergency medications (for example, Naloxone, Epinephrine) and related information are readily available to staff.
7. The poison control telephone number is posted in areas where overdoses or toxicologic emergencies are likely.
8. For locations with no staff pharmacists, consulting pharmacists are asked to provide consultation and documented inspections on a regular basis, but no less than quarterly.
 - a. Off-site satellite locations are included in inspection schedules.

C. Formulary Management

1. The Department Health Services Bureau Chief and Medical Director will:
 - a. develop the drug formulary with the assistance of the consulting pharmacist and the clinical team; and
 - b. define the approval process for using non-formulary medication.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-D-01, P-D-02; National Commission on Correctional Health Care Standards for Health Services in Prisons, 2018*
- B. *Y-D-01; National Commission on Correctional Health Care Standards for Health Services in Juvenile Detention and Confinement Facilities, 2022*
- C. *MH-D-01; National Commission on Correctional Health Care Standards for Mental Health Services in Correctional Facilities, 2015*
- D. *Statutes and Rules Relating to Physicians, Nursing, Nurse Practitioners and Physician Assistants as issued by the Montana Department of Professional Licensure*
- E. 37.8.202, MCA; 41.5.1802 MCA
- F. ARM 20.9.623; ARM 24.159.1604; ARM 24.174.1111



POLICY DIRECTIVE

Policy:	DOC 4.5.26 OFFENDER DENTAL SERVICES	
Effective Date:	07/01/1998	Page 1 of 2
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

Department facilities will provide offender dental services under the direction and supervision of a licensed dentist, including dental screenings upon admission and clinically indicated services during incarceration.

II. APPLICABILITY

All secure facilities Department owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Each facility will establish offender dental services to include the following:
 - a. oral screenings conducted as part of the intake process;
 - b. a timely comprehensive oral examination provided by a dentist to determine needed follow-up dental care;
 - c. diagnostic radiographs taken as needed to support the comprehensive examination and oral treatment plan;
 - d. instructions on oral hygiene provided by Qualified Health Care Professionals;
 - e. triaged oral treatment plans that identify existing dental needs and proposed oral treatment;
 - f. prioritizing clinically indicated treatment, including emergent, urgent, and routine dental health care needs;
 - g. oral treatment that may include routine restorative treatment, extractions and other oral surgery, endodontic treatment, dental cleanings and periodontal care, and partial and complete dentures. The triaged oral treatment provided will be subject to the amount of time the offender is under Department care;
 - h. preventive fluoride treatment available in a form approved by the Department;
 - i. offender oral care as part of a continuum of care unaffected by offender transfer from one facility to another;
 - j. a formal communication process by which offenders may access care; and
 - k. consultation and referral to dental specialists, including oral surgeons, when necessary.

2. To ensure the most urgent and important oral treatment is completed in a timely manner for all offenders, a treatment rotation program will be implemented at each facility. The highest priority dental care needs that can be addressed in a given dental appointment are resolved first. The offender is then placed on the oral treatment list for one appointment at a time until all other high priority dental care needs have been attended to.

B. Standards of Practice

1. Dental care providers will:
 - a. comply with American Dental Association (ADA) clinical standards of care;
 - b. account for all sharps and instruments; and
 - c. follow Centers for Disease Control and Prevention (CDC) and ADA recommended infection control practices including instrument sterilization, equipment and surface disinfection, and hazardous waste disposal.
2. Facility health care administrators will ensure continuous quality improvement as requested by the health services bureau chief by analyzing the timeliness and appropriateness of offender oral care and report such analysis to the facility administrator and Health Services Bureau Chief on a regular basis.
3. All facilities will follow *DOC 4.5.26A Dental Services* and other Department dental health care and security policies and cooperate with the Health Services Bureau concerning offender oral care.
4. Offender noncompliance with good oral hygiene practices, for example, plaque control, may not be used as a basis to deny needed oral care.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-E-06, P-F-01; National Commission on Correctional Health Care Standards for Health Services in Prisons, 2018*
- B. *DOC 4.5.26A Dental Services*
- C. *Y-E-06; National Commission on Correctional Health Care Standards in Juveniles Detention and Confinement Facilities, 2022*



**MONTANA DEPARTMENT OF CORRECTIONS
CLINICAL SERVICES DIVISION
PROCEDURE**

Procedure No.: CSD 4.5.26A	Subject: DENTAL SERVICES
Chapter 4: FACILITY/PROGRAM SERVICES	Page 1 of 22
Section 5: Clinical Services	Effective Date: 04/16/2018
Dental Director Signature: /s/ Daniel W. Hash, D.M.D	Revised: 4/19/2021
Clinical Services Division Administrator Signature: /s/ Connie Winner	

I. PURPOSE

The Clinical Services Division of the Department of Corrections will provide offender dental services under the direction and supervision of a licensed dentist, including dental screenings upon admission and clinically indicated services during incarceration.

II. APPLICABILITY

All secure care facilities Department owned and contracted, as specified in contract.

III. DEFINITIONS

Dental Services – Routine and emergency dental care provided to offenders under the direction and supervision of licensed dental providers.

Facility – Refers to any prison or secure care correctional facility under Department jurisdiction or contract.

Health Care – The sum of all actions, preventive and therapeutic, taken for the physical and mental well-being of a population. Health care includes medical, dental, mental health, nutrition, and other ancillary services, as well as maintaining clean and safe environment conditions.

Health Care Staff – Includes qualified health care professionals and non-licensed health care staff (e.g., medical records staff, health care aides) responsible for offender health care administration and treatment.

Oral Care – Instruction in oral hygiene, examination, and treatment of dental problems. Instruction in oral hygiene minimally includes information on plaque control and the proper brushing of teeth.

Oral Examination – Taking or reviewing the patient's oral history, an extraoral head and neck examination, charting of teeth, and examination of the hard and soft tissue of the oral cavity with a mouth mirror, explorer, adequate illumination and necessary radiographs by a dentist.

Oral Screening – Visual observation of the teeth and gums, and notation of any obvious or gross anomalies requiring immediate referral to a dentist.

Oral Treatment – The full range of services that in the supervising dentist's judgment are necessary for maintaining the offender's health.

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Qualified Health Care Professionals – Physicians, physician assistants, nurses, nurse practitioners, dentists, mental health professionals and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for offenders, including contracted or fee-for-service professionals.

IV. INITIAL DENTAL CARE PROCEDURES

A. Intake Oral Screening

1. All adult offenders arriving at a secure facility will receive an oral screening, as part of the Initial Health Intake Screening process or separately by a member of the dental staff, within 7 days of admission. This should occur even if the offender was a transfer from another Department secure facility.
2. The intake oral screening can be performed by a dentist, dental support staff or by another trained health care professional.
3. All dental support staff or other qualified health care professionals providing intake oral screenings must be appropriately trained. Such training must be done by a dentist and the standardized training program must consist of more than completion of a self-study program.
4. The oral screening is to include a visual observation of the teeth and surrounding soft tissue. Notations should be made of any obvious abnormalities, severe painful conditions, acute infection, or facial trauma requiring immediate referral to a dentist.

B. Comprehensive Oral Examination

1. All adult offenders arriving at a secure facility will receive a comprehensive oral examination within 30 days of admission, juvenile offenders within 60 days of admission. If the offender has transferred from another Department secure facility and has had a comprehensive oral exam within the last 10 months then the oral examination can instead be scheduled for an annual Re-care Examination one year after their last Oral Examination.
2. The comprehensive oral examination shall only be performed by a dentist currently licensed in the State of Montana.
3. All notations concerning the comprehensive oral examination will be made in a standardized Department dental chart. Guidelines set forth by the *Guidelines to the Dental Chart* will be utilized when documenting information resulting from the comprehensive oral examination.
4. Radiographs necessary for the comprehensive oral examination to appropriately develop a triaged dental treatment plan will be utilized.
5. The comprehensive oral examination should include an evaluation of the offender's medical history, the offender's oral history, current complaints, extraoral head and neck evaluation, oral hard and soft tissue evaluation, periodontal screening, examination and charting of teeth, as well as evaluation of current radiographs.

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6. If an offender is re-admitted to a secure facility within 10 months and there is a properly documented oral examination on record, a new comprehensive oral examination is not required. If an initial comprehensive examination is not done the offender should be placed on the annual Re-care Examination list appropriate to the date of his last oral examination.

C. Triaged Dental Treatment Plan

1. Through the comprehensive oral exam, a triaged dental treatment plan will be developed identifying existing dental and oral needs and proposed dental treatment.
2. To ensure the most urgent and important dental treatment is completed in a timely manner on all offenders, the proposed clinically-indicated dental treatment is prioritized.
3. The triaged dental treatment provided will be subject to the amount of time the offender is in a Department secure facility.
4. The offender's dental care is part of a continuum of care unaffected by the offender's transfer from one secure facility to another (not including Community Correction facilities).
5. Clinically-indicated dental treatment needs will be prioritized:
 - a. Phase 1(P1): Conditions requiring treatment for the elimination of severe pain, acute infections, and trauma. These conditions should be treated as high priority conditions and should be addressed within 24-48 hours once a dentist is available. Nursing Dental Condition Protocols may be followed prior to the offender being seen by the dentist.
 - b. Phase 2 (P2): Conditions which if left untreated, will in time likely become a phase 1 condition, or conditions that do not allow for the adequate mastication of food. Phase 2 conditions will be divided into 2 categories in order of priority.
 - 1) P2a: Conditions while currently not resulting in severe pain or acute infection will require expedited treatment. If in the estimation of the dentist, the tooth condition needs to be addressed within the next 12 months it should be classified as P2a.
 - 2) P2b: Conditions recognized as requiring treatment in the future, however, in the estimation of the dentist, will not likely result in acute infection, severe pain, pulpal exposure, or significant tooth structure loss even if left un-treated for 12-24 months. P2b restorative needs will, in most cases, not be treated. At the annual Re-care (Periodic) Examination dental treatment needs classified as P2b will be re-evaluated and if necessary re-classified.
 - c. Phase 3 (P3): Conditions which are not expected to deteriorate significantly if left untreated, areas to be re-evaluated at subsequent examination appointments (waits / watches) or conditions requiring treatment beyond the dental treatment normally provided by the Department. At the annual Periodic (Re-care) Examination P3 conditions will be re-evaluated.
6. Dental Care Scheduling.
 - a. The treatment goals at each appointment will be to take care of the most urgent treatment need(s). This will normally be treatment that can be accomplished in 60 – 90 minutes or less.
 - 1) P2a Operative treatment: Treatment generally limited to one or two teeth.

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- 2) P2a Extractions / oral surgery: Treatment for a single tooth or limited area for extractions (such as a posterior quadrant).
 - b. As needed, the offender is re-placed on the P2a treatment list for additional dental care. When the offender comes to the top of the treatment list again the offender's highest priority need(s) will be addressed. This cycle will continue until all the offender's priority dental care needs are resolved or the offender is released.
 - c. This will allow for the most urgent dental care needs of the largest possible number of offenders to be taken care of.
 - d. Denture / Partial Dentures. If the offender is at the top zone of the Denture list, then all necessary restorative treatment, for completion of the partial denture, will be expedited.
 - e. The dentist will still retain the ability to set additional appointments in select cases. The provider can request (through the NV notes) the offender be rescheduled as a priority if deemed necessary. This could occur if the provider feels that another appointment is needed with minimal delay. This should be the exception not the rule for rescheduling dental care.
 - f. Dental care that normally requires multiple appointments for a given procedure are scheduled by the provider through the NV notes in the timeline that is appropriate.
 - g. This should maximize the number of offenders seen for a given amount of clinic time. This will distribute dental services equitably. In addition, this guideline should ensure that the highest priority dental care needs are addressed first.
7. ART: Alternative Restorative Technique (ART) is a provisional restoration designed to remove the majority (but not all) of the decay on teeth with large or open areas of decay and restore them with a provisional glass ionomer restoration.
 - a. Generally, after the gross decay is removed, a layer of Dycal or other CaOH base may be placed over the remaining deep decay and the tooth is provisionally restored with a glass ionomer material.
 - b. Except for anterior teeth where esthetics is a consideration, a glass ionomer such as miracle mix or Fuji Triage should be considered as it would be obvious to another dentist that the tooth was provisionally restored.
 - c. During the Comprehensive Oral Exam, the tooth can be charted as a P2a ART with the second line treatment planned as a P2a in the priority section and the involved surfaces noted (see example below).
 - d. The goal is to resolve (temporarily) a significant dental condition and allow for potential secondary dentin formation. For this reason, the follow-up basic restoration may be delayed for 12-18 months. Often this can be the difference between having to perform endodontic treatment (with the likely commitment of a crown in the future) or an extraction and eventually being able to restore the tooth with a basic restoration.
 - e. This likely will not be successful with teeth exhibiting symptoms of nerve involvement such as constant or throbbing pain or where a clinically evident pulpal exposure exists. It often, however is successful with teeth that are asymptomatic, discomfort when eating, with food impaction, or with teeth with areas of exposed broken tooth structure or restorations.

D. Oral Hygiene Instruction

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1. Instruction in oral hygiene and preventive oral education will be given to adult offenders within 30 days of admission and within 14 days of admission for juvenile offenders.
2. Interactive education concerning health care risk with poor oral hygiene, proper brushing and flossing techniques, the need for regular dental cleanings and examinations and general information concern dental health care in a correctional environment will be provided.
3. The Oral Hygiene Instruction (OHI) label will be utilized, signed by the instructor and offender, and placed on the lower left portion of the Dental Chart cover. If during an annual examination or dental cleaning appointment there is no Oral Hygiene Instruction label on the cover, then presume the required OHI instruction has not been given.
4. For more information concerning Oral Hygiene Instruction consult the *Guidelines to the Dental Chart*.
5. Subsequent oral health education should be documented in the Daily Treatment Sheet or the Dental Hygiene Record in the dental chart. Additional oral health education should be provided whenever it is evident the offender's oral health would benefit from the additional instruction.
6. The offender should be offered a copy of the MT DOC Dental Health Care brochure and, if applicable, the MT DOC Denture Care handout.

E. Privacy Notification

1. Privacy Notification information should be presented to each offender. This will usually be done as part of the Comprehensive Oral Exam appointment.
2. The offender should be presented an opportunity to review and receive a copy of the MT DOC Privacy Practices Notification handout.
3. This information does not need to be repeated if the offender already has a completed Privacy Notification label on the Dental Chart.
4. A Privacy Practice Notification label should be placed in the lower right area of the dental chart and signed by the presenter. The offender should initial and sign the label once the information has been presented and any questions answered.

F. Tobacco Cessation

1. Offenders who have indicated in the Drug Use section of the Dental Chart a history of tobacco usage should be presented information concerning tobacco cessation.
2. The presentation should be tailored to whether the past tobacco usage was cigarettes, smokeless or both.
3. Since facilities are tobacco-free, the offenders should be encouraged to take advantage of this and avoid re-starting unhealthy habits.
4. The offender should be offered a copy of the MT DOC Tobacco Cessation brochure.

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V. EMERGENT DENTAL CARE PROCEDURES

A. Emergent Dental Treatment

1. Dental emergency evaluation and treatment will be determined and prioritized through the nursing dental protocols and/or emergency dental protocols during regular clinic hours.

B. Nursing Dental Protocols After Hours

1. Primary focus of treatment is alleviation of pain, control of acute infection and oral-facial trauma.
2. Nursing Dental protocols are to be utilized by medical staff after regular dental clinic hours.
3. Documentation of any treatment provided, concerning the dental emergency should be forwarded to the dental department in a timely manner.
4. Depending on the severity of the condition the request for emergency treatment and treatment provided can immediately forwarded to the dental department or the on-call dentist can be contacted.
5. Offenders with life threatening dental emergencies or combination of medical and dental issues will be directed to the medical department.

C. Emergent Dental Protocols

1. The request, once received by the dental department will be expedited and the offender should be scheduled for evaluation and treatment at the earliest available clinic appointment time.
2. Treatment may include, but not be limited to:
 - a. No treatment, if not deemed appropriate.
 - b. Medications for relief of pain or acute infection.
 - c. Sedative or permanent restoration.
 - d. Extractions or other oral surgical treatment.
 - e. Adjustment of tooth structure, restorations, or prosthetic appliances.
 - f. Treatment for acute periodontal conditions.
 - g. Pulpotomy or pulpectomy (first step endodontic treatment).
 - h. Referral to outside practitioners, the Infirmary, or the hospital emergency center.

D. Treatment Follow-Up

1. When appropriate, the offender should receive an appointment for follow-up dental treatment or post-op evaluation.
2. All offenders referred to outside practitioners or hospital emergency centers for emergency treatment should be set up for a post-op evaluation appointment.

VI. NON-EMERGENT DENTAL CARE PROCEDURES

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A. Restorative

1. Basic restorative dental treatment will be provided. Restorative materials utilized will be based on the dentist assessment as to which material will be best suited for the specific situation, the offender's age, general health, and the offender's oral hygiene. The offender will not be given the option of choosing the restorative materials to be utilized.

B. Oral Surgery

1. All basic needed oral surgery within the scope of ability of the dentist is authorized.
2. Assessment of current diagnostic radiographs, the offender's health history and pertinent medical information should be made.
3. A pre-operative consult with the offender, concerning the surgical risk factors should be signed and documented in the Surgery Data Sheet (lilac chart insert).
4. The offender should be informed of any complications that may arise and the expected prognosis. This should be documented and the offender should be placed on the follow-up treatment list. The medical staff may be notified if their involvement in follow-up care is likely.
5. Oral and written post-operative instructions should be provided to the offender.
6. Potential pathological conditions not immediately biopsied or referred should be re-evaluated in 10-14 days.
7. Any surgical conditions beyond the ability or comfort level of the dentist should be reviewed for referral.

C. Endodontic Treatment

1. Endodontic (Root Canal) treatment is authorized in select cases, where endodontic treatment would significantly enhance the offender's oral health, arch integrity or if a required abutment for a partial denture. Endodontic treatment is not recommended if:
 - a. The offender does not have the ability or desire to have a cast restoration (if needed) placed on the tooth once they are released from custody.
 - b. The overall poor condition of the offender's dentition would make a partial (or full) denture a recommended choice for the offender.
 - c. The offender would benefit significantly from a partial denture and the tooth is not an essential abutment tooth for the partial.
 - d. The long-term prognosis of the tooth is poor or guarded due to the overall poor condition or lack of long term restorability of the tooth, significant periodontal involvement, or lack of adequate bone support for the tooth.
2. The offender's desire to "keep the tooth" is not an over-riding factor in determining whether endodontic treatment is to be performed. If the offender is scheduled for release within a very short time period a first step endodontic procedure may be provided; however, the offender must be informed (and the dental chart well documented) that they,

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not the Department, will be responsible for completion of the endodontic treatment and subsequent restoration.

3. The pre-endodontic consult with the offender should be signed and documented in the RCT Data Sheet (salmon chart insert).

D. Surgical Periodontal Care

1. Surgical Periodontal treatment can be provided, in select cases, for offenders who have limited areas of periodontal disease where periodontal surgery can correct or reduce the periodontal defect. Offenders scheduled to receive a partial denture, who have correctable periodontal defects should have the periodontal surgery, if indicated, prior to construction of the partial denture.

E. Orthodontics

1. Orthodontic services are not normally provided. In special circumstances, orthodontic treatment can be considered with authorization of the Dental Services Review Committee.
2. Offenders entering the correctional facility with fixed or removable orthodontic appliances:
 - a. Consult with the offender's orthodontist to determine, based on the offender's projected incarceration time, whether to continue or terminate the orthodontic treatment.
 - b. In select cases the offender may be transported to the orthodontist office for evaluation or treatment.
 - c. If the orthodontic treatment is to be continued the offender should be set up for regular follow-up appointments with the facility dental staff. Periodontal care and personal oral hygiene with offenders with fixed orthodontic appliances is very important and should be closely monitored.
 - d. If the orthodontic appliances are to be removed, written informed consent from the offender should be obtained. In some cases, the orthodontic appliances can be inactivated by removing the wires and elastics but leaving the brackets and bands in place. This should not be done with offenders with long sentences. If the offender refuses to allow the recommended removal of the orthodontic appliance a documented Refusal of Treatment form should be completed.

F. Fixed Prosthodontics

1. Fixed Prosthodontics (cast crowns and bridges) are not normally provided. In special circumstances fixed prosthodontic treatment can be considered with authorization of the Dental Services Review Committee.
2. If the offender has a crown or bridge being fabricated, but not cemented, arrangements should be made to have the appliance delivered to the Dental Department to enable completion of the treatment.
3. The Department is not financially responsible for any cost related to prosthodontic treatment started prior to the offender entering the correctional system, but completed while the offender is under the care of the Department.

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G. Implants

1. Dental implant services are not normally provided. In special circumstances, dental implants can be considered with authorization of the Dental Services Review Committee. In cases where dental implants and associated restorative treatment have been initiated but not completed, a consultation with the originating dentist should be made. A determination should be made whether the treatment can be suspended until the offender's release, the restorative phase can be finished at the facility, or if the offender needs to be transported to the originating dentist office for continued treatment.

H. Re-Care (Periodic) Oral Examination

1. Offenders will be given an option be placed on the Re-care (Periodic) Oral examination treatment list.
2. Offenders are authorized to receive a re-care examination on an annual basis.
3. If medically necessary, and with prior approval from the Dental Services Director, an offender may be scheduled for more frequent oral examinations.
4. New bitewing radiographs may be taken during the re-care examination. New Panograph radiographs should be taken every 3 – 5 years.
5. The medical history update section should be completed during the re-care examination.

I. Medically Compromised Offenders

1. Consultation with the appropriate clinical medical staff concerning the offender's medical and dental care is encouraged for medically compromised offenders.
2. Medical tests can be ordered for the offender. Prior approval from the Dental Services Director should be obtained for all non-emergent, non-routine medical tests.

J. Documentation

1. All notations concerning the provision of non-emergent dental care will be made in a dental chart. Guidelines set forth by *Guidelines to the Dental Chart* will be utilized.

VII. PERIODONTAL CARE PROCEDURES

A. Comprehensive Oral Examination – Periodontal Care Treatment Planning

1. An assessment of the offender's overall periodontal condition should be made and a periodontal treatment plan determined.
2. As part of the offender's initial Comprehensive Oral Examination the dentist should complete and document:
 - a. A Periodontal Screening Record (PSR).
 - b. An evaluation of the offender's general periodontal condition, calculus, and plaque levels.
 - c. An assessment of the offender's personal oral hygiene.

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- d. A periodontal care treatment plan for the offender.
 - e. Discussions concerning significant periodontal conditions and recommendations.
3. Notations should be made in the Periodontics section at the bottom of page 1 of the Comprehensive Treatment Plan (goldenrod) dental chart insert.
 4. Instruction in oral hygiene and preventive oral education should be provided to each offender. The Oral Hygiene Instruction (OHI) label should be utilized and signed by the instructor and Offender. The label should be affixed to the lower left corner of the Dental Chart cover.

B. Periodontal Screening Record (PSR)

1. A PSR record will be determined on each offender. The PSR is the standardized periodontal screening developed by the American Dental Association and the American Periodontal Association. It is an efficient method to determine the offenders overall periodontal condition. The PSR record will determine the course of periodontal treatment the offender will receive.
2. **PSR Records of 2 or less** generally indicates minimal periodontal involvement. The Periodontal Care program for these offenders will consist of:
 - a. The offender receiving a periodontal cleaning appointment in conjunction with their first annual Re-care Examination appointment.
 - b. Thereafter they can receive annual re-care dental cleanings with their Annual Re-Care Examinations.
3. If the Offender has PSR readings of 2 or less yet has very heavy calculus present and / or very inflamed gingival tissues the offender may receive an Initial Debridement (ID-2) appointment prior to the first Re-care Examination appointment / Initial Debridement (ID-1) appointment.
4. **PSR Records of 3 or 4** indicates generalized periodontal disease or the existences of specific periodontal conditions or defects. The Periodontal Care program for offenders with PSR readings of 3 or 4 (2 sextants of code 3 or 1 sextant of code 4) will consist of:
 - a. An Initial Debridement (ID-2) appointment may be made for the offender to remove the bulk of the calculus and dental plaque prior to the first Re-care Examination appointment / Initial Debridement (ID-1) appointment.
 - b. The offender should then receive an Initial Debridement (ID-1) appointment in conjunction with the annual re-care examination appointment. At this ID-1 appointment a complete periodontal evaluation, including full mouth probing should be done.
 - c. Annual re-care dental cleanings and oral examinations thereafter.
5. **PSR records of *3 or *4.** If an offender has a 3 or 4 reading in only a specific area in a sextant, such as distal to # 18 only, a *3 or *4 will be recorded. Specific notes concerning this should be documented, which could include specific periodontal probe readings for the area. If more than one area is involved in the sextant the *3 or *4 coding should not be utilized. The Periodontal Care protocol for PSR Records of 2 or less should

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be followed with offenders with *3 or *4. However, the condition leading to the *3 or *4 should be documented and if appropriate, the offender's treatment plan should reflect the plan for resolving the condition.

C. Initial Debridement – 1(ID-1) Appointments

1. Offenders with 12 months or more time remaining on their incarceration should be given an option to be scheduled for an Initial Debridement appointment.
2. This appointment will be an abbreviated periodontal cleaning with the purpose of removing the majority of the offender's calculus and plaque build-up and to further educate the offender in personal oral health care.
3. The ID-1 appointment should consist of:
 - a. A dental cleaning utilizing ultrasonic and hand instrumentation.
 - b. A Periodontal Screening Record (PSR).
 - c. An assessment of the offender's personal oral hygiene.
4. Additional oral hygiene instruction should be provided, as needed, to improve and reinforce the offender's personal oral health care. Oral Hygiene Instruction will be given and recorded on the OHI label (placed on the front cover of the offender's dental chart) at this appointment if not done at a prior appointment.
5. Complete periodontal evaluations, including full mouth probing will not normally be done at this appointment.
6. Preventive fluoride treatment may be given, if deemed beneficial for dental caries management.
7. If the offender does not desire a dental cleaning appointment they will be instructed to send an OSR if they desire an appointment in the future.
8. Offenders will be given an option to have an annual Periodic (Re-care) Examination and dental cleaning (debridement or adult prophylaxis) appointments thereafter. At each of these appointments a new PSR reading should be determined.

D. Initial Debridement – 2 Appointment

1. Offenders with 2 or more sextants with a PSR code of 3 or one sextant (or more) of PSR code of 4 may receive an Initial debridement (ID-2) appointment prior to the to the first Re-care Examination appointment / Initial Debridement (ID-1) appointment.
2. The ID-2 appointment, like the ID-1 appointment, will be an abbreviated periodontal cleaning with the purpose of removing the majority of the offender's calculus and plaque build-up and to further educate the offender in personal oral health care.
3. Offenders with 2 or more sextants with a PSR code of 3 or one sextant (or more) of PSR code of 4, who receive an Initial Debridement 2 (ID-2) should receive a complete periodontal evaluation, including full mouth probing at the next dental cleaning (ID-1 or adult prophylaxis) appointment.

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4. An assessment of the offender's personal oral health care should be made. Additional OHI will be given to the offender as necessary.
5. If the offender is scheduled to receive a partial denture, a dentist should evaluate the offender's periodontal condition prior to placement of the partial denture.
6. If the offender still has not significantly improved their oral hygiene condition, the OHI should be repeated. The offender may be scheduled for re-evaluation of their oral hygiene condition.

E. Oral Hygiene Re-Evaluation

1. If after the Initial Debridement appointment, the offender presents with an apparent lack of desire or ability to properly maintain their oral health they may be placed in an Oral Hygiene Re-evaluation program.
2. The offender should again receive the complete OHI program. Including interactive instruction and instructive aids such as dental models, disclosing tablets and educational literature.
3. The offender's current oral health condition and details related to the OHI provided should be documented in the Daily Treatment Sheet or Periodontal Treatment Sheet.
4. Any member of the dental staff properly trained to provide OHI instruction can provide the instructions.
5. The offender should be scheduled for an oral hygiene re-evaluation in 3-4 weeks.
6. If the offender still has not improved their oral hygiene condition, the OHI should be repeated.
7. The offender should again be scheduled for re-evaluation of their oral hygiene condition. This process can be repeated as often as necessary and as long as the offender desires to improve their personal oral health care.
8. If after 3-4 sessions the offender seems to have the desire to improve their personal oral health care but is not making significant improvements the offender should be referred to a dentist to evaluate for possible medical or physical factors relating to their poor oral health care.

F. Pre-Prosthetic Periodontal Evaluations

1. Offenders scheduled to receive a partial denture should have a dentist evaluate the offender's periodontal health prior to starting construction of the partial denture.
2. Any periodontal compromised teeth should be evaluated to determine if the teeth should be removed or have periodontal surgery prior to placement of the partial. Teeth with poor long-term prognosis should not be maintained unless the loss of these teeth will not have an adverse effect on the partial denture.

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3. The dentist evaluating the offender's periodontal condition should date and initial the Pre-prosthetic Evaluation section at the bottom of page 3 of the Comprehensive Treatment Plan (goldenrod) dental chart inserts.
4. The Pre-Prosthodontic Evaluation can be completed intra-orally or by reviewing the Dental Chart records, including the documentations made in the Periodontal Treatment (blue) dental chart insert.
5. Unless the offender's PSR is class 2 or less, the offender should have completed his ID-1 and ID-2 appointment. If not, a full mouth periodontal probing record should be part of the Pre-prosthetic Evaluation.

G. Periodic (Re-Care) Dental Cleaning

1. The offenders should be set up for an annual Periodic (Re-care) Dental Cleaning and Oral Examination after the ID-1 (or ID-2 if applicable) appointment is completed.
2. Normally the offender will receive one periodic dental cleaning appointment per year after the ID-1 (or ID-2) appointment. In select cases, a staff dentist may request the change to the frequency of dental cleanings provided per year. In addition, in select cases a staff dentist can authorize 2 appointments to provide quadrant scaling and root planning (minimum of 2 quadrants per appointment).
3. When possible the Periodic (annual) Oral Examination will be provided at the same time as the Periodic Dental Cleaning appointment. If a dentist is not available then the offender should be scheduled for a Periodic Oral Examination.
4. Radiographs will be ordered at intervals requested by a staff dentist or as set forth by guidelines from the Dental Services Director.
5. The Offender's Medical History (pink chart insert) should be updated at each periodic examination.
6. The dentist needs to evaluate the periodontal condition of the offender by reviewing the latest (and current) Periodontal Treatment Record notations (blue dental chart insert). It may be useful to evaluate the progression of the offender's periodontal health, by evaluation of the series of periodontal treatment record notations.
7. Topical fluoride treatment may be provided at each periodic dental clinic as directed by a staff dentist or as set forth by guidelines from the Dental Services Director.

H. Emergent Periodontal Care

1. Emergent periodontal care is available to all offenders. The offender should be scheduled according to Emergency Dental protocols with the purpose of treating periodontal conditions causing severe pain, severely swollen gingival tissues and/ or excessive gingival bleeding. Treatment will generally consist of a localized or full mouth debridement.

I. Fluoride Treatment

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1. All offenders will be given the option to receive topical fluoride treatments.
2. The offender will be given an option to receive topical fluoride during the Initial Debridement appointments and subsequent Periodic (Re-care) Dental Cleaning appointments.
3. Additional applications of topical fluoride can be prescribed by a staff dentist on a case by case basis.
4. Daily topical fluoride gel can be prescribed, in select cases when medically indicated. A dental prescription label is placed on the fluoride gel container and a packet of cotton swabs to allow the offender to take the fluoride to their living quarters.

J. Oral Hygiene Instruction (OHI)

1. Each offender should have been provided Oral Health Instruction within 30 days of arrival at the facility. If any offender is lacking an Oral Hygiene Instruction (OHI) label on the front cover of his dental chart, the offender is to receive instructions on oral hygiene and personal oral care during their ID-1 or periodic (re-care) dental cleaning and examination appointment.
2. The OHI Label should be placed on the lower left corner of the Dental Chart cover. A check mark should be placed on each area of instruction given. The offender should initial, sign and date the OHI label.
3. The instructor should also sign and date the OHI label.
4. Additional OHI sessions can be recommended by the dental hygienist or dentist.

K. Chlorhexidine Mouth Rinses

1. In select cases the offender can be prescribed Chlorhexidine mouth rinse.
2. Alcohol containing Chlorhexidine mouth rinse is more effective, however it may not be provided to the offender in unit and must be utilized in the infirmary area.
3. "Alcohol free" Chlorhexidine mouth wash should be utilized if the offender has a history of alcohol addiction or is in a unit which prevents easy access the Infirmary.

L. Special Needs Care

1. Offenders with special periodontal care needs, where additional Oral Examinations are recommended or customized topical fluoride applications are advised, will have this therapy tracked on the Special Needs List.
2. Offenders with specific high risk situations concerning their oral health will be tracked on the Special Needs Watch List. This will include:
 - a. Offenders with HIV.
 - b. Offenders on Amitriptyline or other medications known to cause severe dry mouth.

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- c. Special Management Offenders (SMI). These offenders are tracked due to their high security status. Dental care for these offenders should be closely coordinated with the Command Post.
 - d. Select at risk offenders, referred from the Mental Health Department, as being potentially susceptible to having dental issues.
3. Any offenders on the Special Needs Watch List who require customized periodontal care or fluoride therapy should be transferred to the main Special Needs List.
 4. The Special Needs List will track the type of customized dental care recommended, frequency of the recommended care and the care provided will be documented.
 5. Offenders should be removed from the Special Needs List if their need for this customized dental care is no longer deemed necessary.

M. Dental Chart Documentation

1. All notations concerning periodontal care will be made on the dental chart. Guidelines set forth by the *Guidelines to the Dental Chart* will be utilized when documenting information in the dental chart.

VIII. PROSTHETIC DENTAL CARE PROCEDURES

A. Removeable Dentures and Partial Dentures

1. Offenders may receive an evaluation to receive a complete denture, partial denture, repair, or adjustment to an existing dental prosthetic devise or occlusal (night guard) splint through:
 - a. Comprehensive Oral Examination or Periodic Oral Examination appointments.
 - b. Request for Medical Services – Dental (kite). The offender can request to be evaluated concerning need for new dental prosthetic devices or reline, repair or adjustment to existing dental prosthetic devices.

B. Treatment – New Dental Prosthetic Devices

1. Offender will be evaluated for need and eligibility to receive a new dental prosthetic device. If eligible the offender will be placed on the appropriate dental treatment list.
2. The request will be prioritized depending on the number of functional teeth the offender has per dental arch and medical necessity.
3. The offender's dental prosthetic devices will be started when they are in the top range of the treatment list.
4. Offenders coming into the secure facility without a denture or partial denture (who would qualify for a partial denture), including continuous time served in another secure facility, would qualify for a complete or partial denture after 18 months of time served.
5. Offenders who have all required extractions completed will qualify for a complete or partial dentures after a 6-month healing period. This is the minimum time. In most

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cases, a longer time period will occur before the complete or partial dentures are constructed.

6. Offenders transferred to regional correctional facility or to Community Corrections facilities as Offender Workers will continue to be tracked on the treatment list. Once the offender comes to the top of the treatment list arrangements should be made to have the dental prosthetic devise constructed and delivered. This could be provided by a community based dental or denturist clinic, a contract provider or transportation to a capable Department facility for the construction and placement of the dental prosthetic devise. Once delivered and follow-up care is complete, the offender can be returned.
7. Once the dental prosthetic devises have been delivered, access to follow-up care must be provided.

C. Complete and Partial Dentures

1. Offenders with existing teeth, treatment planned to be removed, can be placed on the appropriate dental prosthetic list at the treatment planning session. However, the start of construction of the denture should not occur until after a minimum of six months healing period. Often, a longer time period will occur before the complete or partial dentures are constructed.
2. Partial denture patients should have a pre-prosthetic evaluation prior to commencing construction of the partial denture. This evaluation should include:
 - a. Evaluation of current radiographs.
 - b. Evaluation of planned restorative treatment.
 - c. A periodontal evaluation.
 - d. Overall evaluation of existing teeth to ensure the best long-term prognosis of the teeth and partial denture are considered.
3. The Pre-prosthetic Evaluation section located at the bottom of page 3 of the Treatment Plan (goldenrod) dental chart insert should be dated and signed by the evaluating dentist.
4. Minor surgery such as minor ridge bone re-contouring or small root removal may allow for a shortened healing period.
5. Construction of a complete denture may precede that of the offender's partial denture to accommodate completion of restorative or periodontal treatment or if the offender marginally meets the requirements for a partial denture.
6. The offender must be able to demonstrate an ability and desire to maintain their personal oral health. If a minimum oral hygiene standard is not met, the offender should be referred for periodontal care and oral hygiene re-evaluation. Once the offender has demonstrated an acceptable level of personal oral hygiene the partial denture construction should continue.
7. Repairs, adjustments and relines. The request for a repair, adjustment or reline to an existing denture should be evaluated for urgency and medical necessity.

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- a. If causing significant discomfort or resulting in an inability to utilize the dental prosthesis the repair, adjustment or reline request may be placed on a priority list or taken care of immediately.
- b. Normally request for relines will be placed on the same treatment list for new dentures.
- c. A temporary reline may be placed to aid in improving function or act as a tissue conditioner until the permanent reline or new denture can be made.
- d. Adjustments to new complete or partial dentures should be made in a timely manner.
- e. If necessary, an improperly fitting new denture can be re-made or relined.

D. Lost Dentures

1. If a denture is lost the offender may be placed on the appropriate treatment list. Only if it can be substantiated that the correctional facility is responsible for the lost dental prosthetic device will a prioritization of the replacement be made. If an offender has lost multiple dental prosthetic devices, additional delays in constructing the replacement may be warranted not to exceed 5 years.

E. Prosthetic Devices Outside Location

1. If an offender has a dental prosthetic device outside of the correctional facility, it may be mailed to the Dental Clinic, Dental Services utilizing signed receipt documentation to enable the dental prosthetic device to be delivered to the offender.

F. Occlusal Splints/Night Guards

1. Offenders may be provided occlusal splints (night guards) if medically necessary to minimize signs and symptoms of significant TMJ disorders.
2. All necessary restorative treatment of the dental arch in which the occlusal splint is to be placed should be completed prior to placement of the device.
3. In cases of severe TMJ disorders the construction of the occlusal splint can be prioritized.

G. Rehabilitation Considerations Prior to an Offender Release

1. The Department strives to provide offenders an opportunity for rehabilitation, and the Dental Services department may provide dental prosthetic devices prior to release. This effort could improve the offender's ability to secure employment and function within society.
2. The offender is required to have been in the secure facility for a minimum of 18 months beyond arriving at a Department secure facility and 6 months after extraction.
3. The offender must kite the Dental Department as soon as they have documented confirmation of impending release, parole, or transfer to a Community Corrections facility.
4. An effort will be made, as time allows, to provide the offender recommended complete dentures, partial dentures, or acrylic temporary partials prior to release.

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5. The emphasis for these cases is providing esthetics as well as function. An increase in the offender's confidence and ability to smile may be a contributing factor in the offender's ability to function in society, secure meaningful employment and may reduce recidivism rates for these offenders.
6. If necessary, with the offender's cooperation a Dental Hold may need to be placed on the offender to ensure the dental prosthetic devices are delivered prior to their release.
7. The Department will not be held responsible if it is not possible to deliver the dental prosthetic device prior to the offender's release.

IX. DENTAL REFERRAL SERVICES PROCEDURES

A. Request for Referral – Dental Conditions

1. For conditions involving primarily the oral, dental, or maxilla-facial region, dental staff submits a recommendation for a referral to an outside practitioner or specialist utilizing the Clinical Services Department Preauthorization Request Form.
2. The referral request is forwarded, along with documentation and radiographs to the Dental Services Director. The request may be forwarded to the Dental Services Review Committee if appropriate.
3. The Dental Services Director determines if the treatment, diagnostic consultation, or laboratory services are necessary, whether the services could be accomplished by a member of the dental staff, or approves the referral request to an outside practitioner or specialist.
4. A copy of the approved or denied referral request is forwarded to the Managed Care Nurse.
5. The Dental Services Director forwards the request to the medical staff member designated to schedule off-site appointments.
6. The offender is placed on the Offender Treatment Follow-up List. This allows for tracking of offenders scheduled for a consultation or treatment with an outside dentist or other health care provider. In addition, this ensures post-referral follow-up care is completed.
7. Notation is made in the Daily Treatment Sheet in the offender's dental charts concerning the referral.

B. Request for Referral – Dental/Medical Conditions

1. For conditions where there is an overlap of medical and dental concerns, head and neck conditions (other than dental conditions, above) or for complex conditions where involvement of dental and medical practitioners in the offender's care are anticipated.
2. Dental staff submits a recommendation for a referral to an outside practitioner or specialist utilizing the Clinical Services Department Preauthorization Request Form.

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3. The referral request is forwarded, along with documentation and radiographs to the Dental Services Director. The request is then forwarded to Medical Director through the Managed Care Nurse.
4. If approved, the offender is scheduled with an outside practitioner or specialist by the medical staff member designated to schedule off-site appointments.
5. The offender is placed on the Offender Treatment Follow-up List to allow for tracking of offenders scheduled for a consultation or treatment with an outside health care provider. In addition, this ensures post-referral follow-up care is completed.
6. In an emergent situation, referral or direct consultation with a medical provider should be considered.
7. Notation is made in the Daily Treatment Sheet in the offender's dental charts concerning the referral.

C. Results of Referral

1. Resulting documentation from the referral is forwarded to the Dental Clinic and if appropriate to the Medical Department.
2. Determination is made concerning the need for further follow-up or post treatment evaluation or consultation.
3. All documentation concerning the referral should be placed in the offender's dental chart. Notations are made in the dental chart concerning recommended follow-up appointments or routine dental care.
4. After all treatment, follow-up appointments or consultations are completed the offender is removed from the Offender Treatment Follow-up List. If additional follow-up care is recommended such as a 6-month radiograph or evaluation the offender is left on this treatment list.

D. Community Practitioners or Specialists Treating Offenders at a Department Facility

1. Security checks need to be completed on the practitioner or specialist and their staff members prior to entering the facility.
2. The *Authorization for Outside Guest* sheet must be completed and delivered to the Command Post a minimum of 48 hours prior to the initial background security check.
3. Subsequent visits need to be delivered to the Command Post for authorization at least 24 hours prior to the visit.
4. Scheduling should be made in consultation with the medical treatment coordinator to minimize scheduling conflicts, especially with offenders requiring escorting to the dental clinic.

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5. All referred dental consultations or treatment should be reviewed by the dentist prior to the planned treatment date, to ensure the referral is necessary and that the treatment cannot be accomplished by dental staff.
6. Scheduling of patients should be made to minimize non-productive time for the visiting practitioner.
7. Dental staff can assist the practitioner or specialist to a limited extent; however, they should provide their own support staff, if needed.
8. The practitioner or specialist must document all consultations and treatment in the offender's dental chart in accordance with the *Guidelines to the Dental Chart*. The practitioner or specialist will have future access to the offender's dental chart if needed for medical or legal requirements.
9. All dental charts seen by the practitioner or specialist should be reviewed by a dentist to ensure follow-up requirements are taken care of and dental chart documentation is complete.
10. All requests for laboratory or referral to outside practitioners or facilities made by the community provider or specialist should follow the standard referral process (above). In cases where it is deemed necessary for immediate referral, Dental Services Director approval can be made after the fact.

E. Outside Dental Referral Log

1. A log of dental referrals for consultation, treatment and/or laboratory services should be maintained to monitor whether:
 - a. Referrals have been made in a timely manner.
 - b. The scheduled appointments have been kept.
 - c. The report back from the referral were received and reviewed by dental staff.
 - d. Appropriate follow-up care was made by dental staff.
 - e. The offender was consulted concerning the referral or laboratory report.
 - f. Notations were properly made in the offender's dental chart.
2. A separate section of the Dental Referral Log should track treatment, for offenders seen at a facility, provided by community practitioners or specialist.

X. REQUEST FOR NON-STANDARDIZED DENTAL TREATMENT

A. Request for Non-Standard Dental Treatment

1. Dental staff may request a review of a dental treatment plan or specific proposed dental treatment not normally provided by the Dental Department. This review request can be for treatment proposed by themselves or by other dental staff members. This request should be in writing to the Dental Services Director.
2. Offenders may request special consideration for dental treatment not normally provided by the Dental Department. In addition, the offender may request a review of proposed specific dental treatment or the proposed dental treatment plan. This request may be

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through a Request for Medical Services – Dental (kite) or directly to a member of the Dental staff.

B. Review Process – Dental/Oral Care

1. The request will be forwarded to the Dental Services Director.
2. The Dental Services Director will compile information on the specific request and forward the data to the members of the Dental Services Review committee.
3. The requested non-standard dental treatment will be reviewed and a decision determined by the Dental Services Review committee.
4. The Health Services Bureau Chief should be consulted if the requested non-standard dental treatment expenditures would exceed \$2,500 for materials, laboratory fees or referral expenditures.
5. The requesting dental staff member or offender should be provided in writing with the decision made by the Dental Services Review committee.
6. The Dental Services Director retains ultimate responsibility for dental care provided by the Dental Department and can overrule decisions of the Dental Services Review committee.
7. Appeals may be made to the Health Services Bureau Chief.

C. Review Process – Maxilla-facial or Overlapping Medical and Dental Care

1. With cases involving extensive maxilla-facial treatment or complex overlapping medical and dental considerations, the request will be forwarded to the Dental Services Director.
2. The Dental Services Director will compile information on the specific request and complete the Medical Review Panel (MRP) Disposition document.
3. The Dental Services Director should review this with the Medical Director.
4. The MRP Disposition document is forwarded, with supporting information, to the Health Services Bureau Office. It will then be placed on the agenda for the next MRP meeting.
5. The Dental Services Director and/or assigned representative should present the case at the MPR meeting.
6. The MPR Committee will review the Level of Therapeutic Care and appropriateness of the proposed offender medical / dental care.
7. If approved, the treatment plan will be implemented with consultations with the medical staff when appropriate.
8. If the MRP Committee denies the request then the requesting dentist and offender should be notified in writing.
9. Appeals may be made to the Health Services Bureau Chief.

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D. Dental Treatment Requiring Authorization

1. The Dental Services Review committee must review all requests for:
 - a. Orthodontic treatment exceeding single tooth movement appliances.
 - b. Fixed prosthetic appliances. Cast dental crowns, veneers, bridges and implant restorations.
 - c. Dental implants and bone grafting for preparation of placement of dental implants.
 - d. Advanced periodontal treatment including comprehensive full mouth periodontal surgery, periodontal bone grafting and referrals to an outside dentist or periodontist.
 - e. Referrals to an outside dentist or endodontist for endodontic treatment or endodontic surgery.
 - f. Referrals for advanced elective oral surgery.
 - g. Request for outside dental laboratory or diagnostic services exceeding two thousand, five hundred dollars.
 - h. Request for completion of dental treatment started prior to offender arriving to the facility requiring laboratory or referral expenditures.
 - i. Extensive maxilla-facial treatment.
 - j. Complex cases involving complicated or overlapping medical and dental considerations.
 - k. Other dental services not normally provided by the Dental Department.

XI. CLOSING

Questions concerning this procedure should be directed to the Dental Services Director.

XII. REFERENCES

- A. 53-1-203, MCA
- B. DOC Policy 4.5.26 Dental Services
- C. Guidelines to the Dental Chart
- D. P-E-06, P-F-01; National Commission on Correction Health Care in Prisons, 2018
- E. Y-E-06; National Commission on Correctional Health Services in Juveniles Detention and Confinement Facilities, 2015

XIII. ATTACHMENTS

None



POLICY DIRECTIVE

Policy:	DOC 4.5.27 OFFENDER MENTAL HEALTH SERVICES
Effective Date:	09/01/1998 Page 1 of 2
Revision Date(s):	06/14/2001; 03/26/2002; 04/18/2006; 10/27/2009; 08/11/2017; 04/19/2021; 04/24/2026
Department Director Signature:	/s/ Eric Strauss, Director
Medical Director Signature:	/s/ Dr. Paul Rees, MD
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN

I. POLICY

Department facilities will provide access to mental health services at intake and as clinically indicated for offenders who require them.

II. APPLICABILITY

All secure facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Patients' mental health needs are addressed on-site or by referral to appropriate alternative facilities or community services.
2. Outpatient services include, at minimum:
 - a. identification and referral of inmates with mental health needs;
 - b. crisis intervention services;
 - c. psychotropic medication management, when indicated;
 - d. individual counseling;
 - e. group counseling and/or psychosocial/psychoeducational programs; and
 - f. treatment documentation and follow-up.
3. When commitment or transfer to an inpatient psychiatric setting is clinically indicated:
 - a. required processes are followed;
 - b. transfers occur in a timely manner; and
 - c. patient is safely housed and adequately monitored until the transfer occurs.
4. Offenders receiving outpatient mental health services are seen as clinically indicated but no less than every 90 days, and as prescribed in their individual treatment plans.

5. Mental health, medical, and substance abuse services are sufficiently coordinated so that patient management is appropriately integrated, medical and mental health needs are met, and the impact of these conditions on each other is adequately addressed.

B. Commitment or Transfer to Inpatient Psychiatric Setting

1. When commitment or transfer to an inpatient psychiatric setting is clinically indicated:
 - a. required processes are followed;
 - b. transfer occurs in a timely manner;
 - c. until transfer occurs and patient is safely housed, patient is adequately monitored and appropriately treated.

C. Patient Management

1. Mental health, medical, and substance use services are sufficiently coordinated such that patient management is appropriately integrated, medical and mental health needs are met, and the impact of these conditions on each other is adequately addressed.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-f-02 National Commission on Correctional Health Care Standards for Health Services in Prisons, 2026*
- B. *MH-f-02 National Commission on Correctional Health Care Standards for Mental Health Services in Correctional Facilities, 2026*
- C. *Y-f-03 National Commission on Correctional Health Care Standards for Health Services in Juvenile Detention and Confinement Facilities*
- D. *Performance-Based Standards and Expected Practices for Juvenile Correctional Facilities, Fifth Edition, 2025*



POLICY DIRECTIVE

Policy:	DOC 4.5.29 PRESCRIPTION MEDICATION FOR OFFENDERS WITH MENTAL ILLNESS	
Effective Date:	11/20/2007	Page 1 of 3
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department of Corrections (Department) and the Department of Public Health and Human Services (DPHHS) have established the Prescription Medication for Offenders with Mental Illness Project to provide a limited pharmacy benefit program to eligible offenders.

II. APPLICABILITY

Eligible offenders with mental illness who are being released from correctional institutions, the state hospital, or other secure custody placements.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Project Guidelines

1. The distribution of psychotropic medications for the mental health needs of youth and adults will comply with the following guidelines:
 - a. extend the time period for issuing psychotropic medications at release from secure custody to a minimum of 60 days to offenders who meet the eligibility requirements;
 - b. provide ongoing financial support of psychotropic medication costs on a fixed benefit/per diem basis to offenders under Department supervision who meet the eligibility requirements;
 - c. provide short-term support of psychotropic medication costs for offenders in mental health crisis; and
 - d. provide support of psychotropic medication costs for eligible offenders who have applied for publicly funded programs but have not yet been enrolled.

B. Offender Eligibility Requirements

1. In order to be eligible for Prescription Medication for Offenders with Mental Illness Project funds, an offender must be:
 - a. an adult diagnosed with a serious mental illness or a youth diagnosed with a serious emotional disturbance;

- b. within 3 months of release from secure custody, either by parole eligibility, conditional release or discharge, or currently in a community corrections program and have no pending legal proceedings; and
- c. ineligible for public benefit programs but still require medication support, and/or have submitted an application for benefits, but not yet enrolled.

C. Requests for Medication

1. Staff requesting medication for eligible offenders must submit a *Mental Illness Medication Request*, which includes the appropriate internal approvals, to the Contract Manager(s). Medication requests for eligible youth offenders will initially be submitted to the applicable administrator, who will process the request and forward it to the Contract Manager(s).
2. Regional or private prison staff requesting medications for eligible offenders must submit a *Mental Illness Medication Request* form to the Contract Manager(s) through the facility Case Specialist.
3. Staff will submit request forms electronically using a dedicated e-mail address, [cormed\(at\)mt.gov](mailto:cormed(at)mt.gov). Approvals will be electronically signed and returned to the requesting facility or staff member.

D. Data Collection

1. Staff must address the following details prior to approving an offender for medication benefits:
 - a. name, dosage, duration, and estimated cost of medication requested;
 - b. name of prescribing medical professional;
 - c. name, address, and phone number of the preferred pharmacy;
 - d. transition and/or treatment plan; and
 - e. short-term and long-term goals with services and/or medication.

E. Distribution of Funds

1. Upon receipt and approval of the *Request*, the Department will distribute funds to the appropriate staff member designated to directly supervise the offender. Funds will be made payable to the named pharmacy.

F. Progress Reports and Monitoring

1. The behavioral health program facilitator or designated staff will develop a monthly status report that includes the name, offender number, birth date, and current program or placement of the offender receiving medication, prescribed medications, dosages, actual cost and benefit paid by the Department, and the reason for release from the project.
2. Offenders participating in the Prescription Medication for Offenders with Mental Illness Project will report to regional case management providers and/or the supervising community corrections staff (for example, facility Case Specialist, community Probation and Parole officer, juvenile parole officer) for monitoring medications. This reporting must occur a minimum of once per month or more frequently if needed.
3. Staff will work with all offender service providers (for example, mental health practitioners, treatment courts, etc.) to monitor progress, assess compliance with supervision, and ensure that needs are being met.

G. Removal from Services

1. An offender is no longer eligible for this program when the offender:
 - a. discharges their complete sentence and is no longer under the supervision of the Department;
 - b. is enrolled in a public benefit program that provides payment for services funded under this program.

2. The staff member directly supervising the offender will review approved applications every 6 months for continuation of services. If the offender is no longer in need of services, the supervising staff member will submit a request to remove the offender from the program.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. 53-1-201, MCA; 53-1-202, MCA; 53-1-203, MCA
- B. *Section 1912(c) of the Public Health Service Act, as amended by Public Law 102-321*



POLICY DIRECTIVE

Policy:	DOC 4.5.31 INFORMED CONSENT AND RIGHT TO REFUSE CARE
Effective Date:	07/01/1998 Page 1 of 2
Revision Date(s):	04/19/2021; 04/24/2026
Department Director Signature:	/s/ Eric Strauss, Director
Medical Director Signature:	/s/ Dr. Paul Rees, MD
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN

I. POLICY

The Department will ensure that offenders have the right to make informed decisions regarding health care, including the right to refuse care.

II. APPLICABILITY

All secure facilities, Department owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. All examinations, treatments, and procedures are governed by informed consent practices applicable in the jurisdiction.
2. For processes and medications that in the community setting would require informed consent, written documentation of informed consent is required.
3. Any health evaluation and treatment refusal are documented in the offender's health record and must include the following:
 - a. description of the service being refused;
 - b. evidence that the offender has been informed of any adverse health consequences that may occur because of the refusal;
 - c. signature of the offender; and
 - d. signature of a health staff witness.
4. If the offender does not sign the refusal form, it is to be noted either on the form or in the patient's health record by a health or custody staff witness.

B. Mental Health

1. Risks and benefits of an intervention, as well as benefits to refusing an intervention, are explained to the offender.

2. For processes, testing, or any treatment where there is risk and benefit to the offender, such as the prescription of psychotropic medication, informed consent is documented on a written form containing the signatures of the offender and a mental health services staff witness.
3. Any health intervention refusal is documented and must include the following:
 - a. description of the nature of the service being refused;
 - b. evidence that the inmate has been made aware of any consequences to health or mental health that may occur as a result of the refusal;
 - c. signature of the offender; and
 - d. signature of the mental health staff witness.
4. If the offender does not sign the refusal form, it is to be noted either on the form or in the offender's health record by a health or custody staff witness.

C. Juvenile Offenders

1. Policy and procedures specify circumstances under which risks and benefits of an intervention are explained to the offender.
2. The informed consent of next of kin, guardian, or legal custodian applies when required by law.
3. For invasive procedures or any treatment where there is risk and benefit to the offender, informed consent is documented on a written form containing the signatures of the offender, legal guardian if required, and a health staff witness.
4. Any health evaluation and treatment refusal are documented and must include the following:
 - a. description of the nature of the service being refused;
 - b. evidence that the juvenile has been made aware of any adverse health consequences to health that may occur because of the refusal;
 - c. signature of the offender; and
 - d. signature of the health witness.
5. There is evidence of involvement of the legal guardian in cases of refusal when required by the laws of the jurisdiction.
6. In the event the offender does not sign the refusal form, it is to be noted on the form by a health staff witness.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. 53-1-203, MCA
- B. DOC 4.5.32 *Right to Refuse Medical Treatment*
- C. P-G-05; *National Commission on Correctional Health Services in Prisons, 2018*
- D. ACA Standards for Juvenile Correctional Facilities, 2003
- E. MH-1-04; *National Commission on Correctional Mental Health Services in a Correctional Facility, 2015*
- F. Y-1-04; *National Commission on Correctional Health Services in Juvenile Detention or Confinement Facilities, 2022*

VII. FORM

Informed Clinical Consent



POLICY DIRECTIVE

Policy:	DOC 4.5.33 OFFENDER MEDICAL EMERGENCY NOTIFICATIONS	
Effective Date:	01/01/1998	Page 1 of 2
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

Department facilities will establish reporting processes to provide notifications of an offender's serious or critical illness, injury, or death in accordance with the provisions of this policy.

II. APPLICABILITY

All secure facilities Department owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Notifications

1. QHCPs:
 - a. will encourage offenders to discuss their non-emergent medical problems, planned treatments, and surgeries with family members;
 - b. will notify the Designated Health Authority of a serious offender illness or injury requiring medical treatment; and
 - c. must notify the on-call physician if the facility has on-call physician coverage.
2. The designated health authority, or designee, will notify the facility administrator or designated custody staff when medical emergencies warrant notification to the next of kin.
3. The facility administrator, or designee, will notify the offender's next of kin by telephone or, when telephone contact is impossible, by written communication.

B. Special Visits

1. The facility administrator will review all requests for special family visits with a serious or critically ill or injured offender at a hospital or in the facility.
2. Approved family visits will be conducted in accordance with facility operating requirements.

C. Offender Death

1. The Designated Health Authority, or designee, will notify the Department Medical director of offender death and comply with procedures in accordance with *DOC 4.5.34 Offender Death*.

D. Release of Information

1. Facility health care staff will handle information about an offender's medical condition in accordance with *DOC 4.5.38, Offender Health Record Access, Release, and Retention* and *DOC 1.5.6 Offender Records Access and Release*.
2. Facility staff will refer all information requests to the Public Information Officer, facility administrator, or Department Communications Director.
3. In all cases, the facility administrator or designee must notify the offender's next of kin prior to the release of information to the public or media.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *DOC 1.5.6 Offender Records Access and Release; DOC 4.5.34 Offender Death; DOC 4.5.38 Offender Health Record Access, Release, and Retention*
- B. *Y-1-12; National Commission on Correctional Health Services in Juveniles Detention or Confinement Facilities, 2015*



POLICY DIRECTIVE

Policy:	DOC 4.5.34 OFFENDER DEATH	
Effective Date:	05/01/1998	Page 1 of 2
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will conduct a thorough review of all deaths in their custody to improve care and prevent future deaths.

II. APPLICABILITY

Secure facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Notifications

1. Within 8 hours of an offender death, the nurse or staff in charge must notify the designated health authority, or designee, the appropriate physician, and the facility administrator, or designee.
2. In the event of offender death, the facility administrator, or designee, must notify the Department Medical Director, the Investigations Bureau Chief, and appropriate law enforcement officials.
3. The facility administrator will immediately notify the Department Director by phone of offender deaths.

B. Documentation and Incident Reports

1. A log is maintained by health care staff and will be updated as soon as possible, but no later than the end of shift. The log will include, at minimum:
 - a. patient name or identification number;
 - b. age at time of death;
 - c. date of death;
 - d. date of clinical mortality review;
 - e. date of administrative review;
 - f. cause of death (for example, hanging, respiratory failure);
 - g. nature of death (for example, accident, natural, suicide or homicide);
 - h. date pertinent findings of review(s) shared with staff; and
 - i. date of psychological autopsy, if applicable.

2. All staff who witnessed the death will complete incident reports as soon as possible, but no later than the end of the shift.

C. Release of Information

1. Department employees must not release information about offender death to outside media; all information releases will comply with *DOC 1.1.8 Media Relations*.

D. Report of Offender Death and Health Record

1. Within 24 hours or the next business day, the facility designated health authority, or designee, will complete and forward the *Death in Custody: Inmate Death Report* to the warden, Department Director, the Health Services Bureau Chief, and the Investigations Bureau chief.
2. The facility designated health authority or designee will ensure that all health record entries are complete, and that the original offender health record is kept in a locked cabinet on-site.

E. Death Reviews

1. The Medical Director and/or the Health Services Bureau Chief or designee must conduct a clinical mortality review and will:
 - a. coordinate a multi-disciplinary *Mortality Case Review* within 30 working days of an adult or youth offender's death; and
 - a. notify all the necessary disciplines involved (for example, legal, medical, mental health, and custody staff) that the review will be conducted to determine the following:
 - 1) there was a pattern of symptoms that may have precipitated an earlier diagnosis and intervention;
 - 2) events immediately surrounding the death indicate if appropriate interventions occurred; and
 - 3) treating staff are informed of pertinent findings of the review.
2. An administrative review is conducted with custody staff and treating staff are informed of pertinent findings of the review.
3. Facility administrators or designees will consult with the Medical Director and decide whether to request a postmortem examination; if deemed necessary:
 - a. the postmortem examination is performed within 30 days; and
 - b. medical treating staff are informed of pertinent findings of the review.
4. Psychological Autopsies must be performed on all deaths by suicide within 30 days.

F. Review by Medical Examiner/Coroner

1. The Medical Examiner or Coroner will review all offender deaths and subsequent reports.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief

VI. REFERENCES

- A. 46-4-122, MCA; 50-22-101, MCA; 53-1-203, MCA
- B. P-A-09; *National Commission on Correctional Health Care Standards*, 2018
- C. MH-A-10; *National Commission on Correctional Mental Health Services in Correctional Facilities*, 2015
- D. Y-A-10; *National Commission on Correctional Health Services in Juvenile Detention and Confinement Facilities*, 2022



POLICY DIRECTIVE

Policy:	DOC 4.5.35 CHEMICAL TREATMENT OF SEX OFFENDERS	
Effective Date:	04/01/1999	Page 1 of 2
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department complies with Montana law that authorizes district courts to order certain offenders to undergo chemical treatment and permits certain offenders to undergo such treatment voluntarily.

II. APPLICABILITY

Adult sex offenders in Department and contracted secure care facilities and under community corrections supervision.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Court Ordered Treatment

1. Each administrator will establish written requirements to:
 - a. identify which offenders are ordered by a district court to undergo chemical treatment pursuant to 45-5-512, MCA; and
 - b. include the treatment order in the offender's main program file.
2. Appropriate staff will implement the necessary procedures during the offender's discharge process as follows:
 - a. arrange for the offender to undergo a complete medical examination prior to discharge and before undergoing chemical treatment;
 - b. fully inform the offender of the medical risks and benefits of chemical treatment prior to undergoing the treatment;
 - c. arrange for the appropriate staff to administer the initial treatment regimen at an appropriate time prior to the offender's discharge;
 - d. ensure that the discharge plan requires the offender to continue chemical treatment in the community;
 - e. make the necessary arrangements for the offender's treatment to continue in the community;
 - f. notify the county attorney of the sentencing county and the Board of Pardons and Parole if:
 - 1) an offender refuses to undergo chemical treatment ordered by the court; or
 - 2) medical staff determine the medication is inappropriate for the offender or a doctor will not prescribe it.

3. The administration of court ordered chemical treatment will be at the expense of the Department until the date of the offender's complete discharge of sentence, including discharge from community supervision.
4. The offender's probation or parole plan must include the name of the medical provider who will provide continued care. The Probation and Parole Officer must monitor compliance and notify the appropriate entities if the offender is noncompliant with treatment.

B. Voluntary Treatment

1. Each administrator must establish written requirements to accommodate sex offenders who want to voluntarily undergo chemical treatment.
2. Offenders who are eligible for voluntary treatment are offenders convicted of a first or subsequent offense under 45-5-502, -503 or -507, MCA.
 - a. Offenders who undergo treatment must be actively participating in a sex offender treatment program or be under the care of mental health services.
 - b. The written requirements will require that an offender must have a medical examination in preparation for the treatment.
 - c. The administrator must ensure that the offender is fully informed of the medical risks and benefits of undergoing the chemical treatment.
 - d. The Department Medical Director must approve the voluntary chemical treatment, the start date, and treatment plan.
 - e. The administration of voluntary chemical treatment will be at the expense of the Department until the date of the offender's complete discharge of sentence, including discharge from community supervision.

C. Qualified Health Care Professionals

1. Qualified Health Care Professionals employed by the Department may not be compelled against their wishes to administer chemical treatment to offenders.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. §§ 45-5-502; 45-5-503; 45-5-507; 45-5-512; 53-1-203, MCA



POLICY DIRECTIVE

Policy:	DOC 4.5.36 HEALTH RECORDS TRANSFER	
Effective Date:	10/29/1999	Page 1 of 2
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department facility health care unit will share relevant medical information with other correctional health care providers to ensure continuity of offender health care.

II. APPLICABILITY

All secure facilities Department owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Records Transfer

1. When an offender transfers to another facility, health care providers will:
 - a. complete a release summary document to include the following information:
 - 1) a problem list
 - 2) disabilities and special needs
 - 3) allergies
 - 4) chronic illness documentation
 - 5) current medications
 - 6) current treatments
 - 7) mental health issues
 - 8) TB screening results and date of last test
 - b. submit the release summary document to the unit in charge of the transfer for inclusion in the transfer packet.
2. When the offender transfers to another facility, health care staff will:
 - a. maintain the offender health record in accordance with guidelines developed by the health policy team and Department Medical Director; and
 - b. forward the offender medical records with the transferring offender.
3. When required to provide continuity of care, health care staff may forward copies of medical and mental health records to any treating physician, hospital, or health agency upon written authorization by the offender pursuant to *DOC 4.5.38 Offender Health Record Access, Release, and Retention*.

4. When a juvenile offender needs medical or mental health care immediately upon arrival, the record should be flagged in a manner that allows the receiving facility to recognize the need for immediate follow-up.

B. Transfer Without Medical Unit Notification

1. If the offender transfer occurs before the medical unit is notified, the health care staff will forward the release summary document and other relevant medical information to the receiving facility as soon as they are notified of the transfer.
2. If a delay in forwarding the offender medical record or transfer form may adversely affect offender health, a health care staff will telephone the receiving facility to convey any critical medical information.
3. The health care staff will document in the offender health record the time of the call and the name of the person contacted at the receiving facility.
4. Health care providers will maintain the confidentiality of the offender health record at all times by only sharing health care information pertinent to providing continuity of care.
5. When required to provide continuity of care, copies of the medical record may be forwarded to any treating physician, hospital, or health agency upon written authorization by the offender pursuant to *DOC 4.5.38 Offender Health Record Access, Release, and Retention*.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-A-08; National Commission on Correctional Health Services in Prisons, 2018*
- B. *ACA Standards for Juvenile Correctional Facilities, 2003*
- C. *DOC 4.5.38, Offender Health Record Access, Release, and Retention*
- D. *MH-H-03; National Commission on Correctional Mental Health Services in Correctional Facilities, 2015*
- E. *Y-H-03; National Commission on Correctional Health Services in Juveniles Detention and Confinement Facilities, 2015*



POLICY DIRECTIVE

Policy:	DOC 4.5.37 OFFENDER HEALTH RECORD FORMAT AND CONTENT	
Effective Date:	04/01/1998	Page 1 of 2
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department facility health care units will establish and maintain a complete and comprehensive offender health care record.

II. APPLICABILITY

All secure facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Initial Health Record

1. Upon admission, health care staff will compile an offender health care record to include all medical, dental, and mental health information.
2. The Department health policy team will establish guidelines for the organization of the health care record.

B. Health Care Record Content

1. The health care record will contain all offender health-related information to include:
 - a. identifying information (for example, name, DOC ID number, date of birth, gender);
 - b. a problem list containing medical and mental health diagnoses, treatments, and known allergies;
 - c. admission screening and health assessment forms;
 - d. progress notes of all significant findings, diagnoses, treatments, and dispositions;
 - e. provider orders for prescribed medications and medication administration records;
 - f. laboratory and x-ray reports and diagnostic studies;
 - g. flow sheets;
 - h. consent and refusal forms;
 - i. release of information forms;
 - j. reports of specialty consultations and off-site referrals;
 - k. hospital and inpatient treatment discharge summaries;
 - l. special needs treatment plans, if applicable;
 - m. immunization records, if applicable;
 - n. patient's condition (for example, poor, fair, good);

- o. patient status (for example, stable improving, deteriorating);
 - p. patient education provided;
 - q. type and frequency of diagnostic testing and therapeutic regimens;
 - r. clinical justification for any deviation from established protocol; and
 - s. criminal justice information that is pertinent to clinical decisions is available to Qualified Health Care Professionals.
2. Where mental health and dental records are separate from medical records, a process ensures that pertinent information is shared. At minimum, a listing of current problems and medications is common to all medical, dental, and mental health records of an offender.

C. Documentation

1. Health care providers will document in the health care record:
- a. all offender health encounters in accordance with guidelines established by the Department health policy team and facility health care unit procedures;
 - b. all off-site specialty care requests approved by the Department Medical Director; and
 - c. all consultants' reports, including diagnostic findings and recommendations; and
 - d. date, signature, and title for each health record entry.

D. Health Record Confidentiality

1. Health care staff will ensure that:
- a. offender health care records are maintained separately from other offender records;
 - b. health care record information is only released in accordance with *DOC 1.5.6 Offender Records Access and Release*, and *DOC 4.5.38 Offender Health Record Access, Release, and Retention*; and
 - c. documentation that health staff, non-health staff, and custody staff have received training in maintaining patient confidentiality.

E. Record Reactivation

1. Upon admission of re-incarcerated offenders, health care staff will reactivate the previous health care record, if available.

F. Electronic Health Record (EHR) downtime

1. In the event of a network or system outage, health staff will ensure a process to maintain health care and subsequent documentation by:
- a. providing access to health care services through paper HCRs;
 - b. maintaining essential paper versions of health care forms and templates (including receiving screening, provider notes, etc.);
 - c. maintaining copies of Medication Administration Records or requesting current MARs directly from the contracted pharmacy provider; and
 - d. ensuring all paper documents are entered into EHR when the system regains functionality.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *DOC 1.5.6 Offender Records Access and Release; DOC 4.5.38 Offender Health Record Access, Release, and Retention*
- B. *P-A-08, P-D-08, P-F-01, P-F-02; National Commission on Correctional Health Care Standards, 2018*
- C. *ACA Standards for Juvenile Correctional Facilities, 2003*
- D. *MH-H-01, MH-H-02, MH-H-03; National Commission on Correctional Mental Health Services in Correctional Facilities, 2015*
- E. *Y-H-01, Y-H-02, Y-H-03; National Commission on Correctional Health Services in Juveniles Detention and Confinement Facilities, 2015*



POLICY DIRECTIVE

Policy:	DOC 4.5.38 OFFENDER HEALTH RECORD ACCESS, RELEASE, AND RETENTION	
Effective Date:	05/01/1998	Page 1 of 3
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

Department facility health care units understand that health care information is protected by a right of privacy and will maintain health record confidentiality as well as retain and store offender health records in accordance with Montana statute and *DOC 1.5.5 Offender Records Management, Access, and Release*.

II. APPLICABILITY

All secure facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The chief facility health officer, in consultation with the Legal Services Bureau Chief, or designee, may approve staff requests for access to health care information on a need-to-know basis.
2. Demands for offender health records pursuant to a subpoena will be submitted to the Legal Services Bureau for review; an attorney in the Legal Services Bureau will advise health care staff concerning dissemination of the records identified in the subpoena.
3. A mental health practitioner may release mental health records in accordance with the following:
 - a. adult records may be released with the signed consent of the adult offender; and
 - b. youth records may be released with the signed consent of a parent or legal guardian.
4. Health care staff will not release health care information in accordance with the following:
 - a. information obtained from another health care provider or organization will not be released;
 - b. staff will not release information without written offender consent unless:
 - 1) medical records are necessary for the offender's medical care and treatment;
 - 2) staff receive evidence of child abuse;

- 3) there is a medical emergency;
 - 4) for the control of certain communicable diseases;
 - 5) a health care provider determines a situation presents a clear and immediate danger to others; or
 - 6) a request for information is received from the Montana Departments of Justice and/or Administration, Risk Management and Tort Defense Division in which a claim of constitutionally inadequate medical care, diagnosis, or treatment has been filed against the Department of Corrections.
5. An offender may:
 - a. authorize, in writing, release to the offender's attorney or other persons authorized by statute; and
 - a. review the offender's care records by submitting a written request to health care staff.
 6. When an offender authorizes release of health care information, staff will place a signed release form the offender's medical file. If the offender does not consent to the information release, health care staff will notify the inquiring party.
 7. When offender records are transported by non-health staff, the records are sealed.
 8. Qualified health care and mental health professionals have access to information in an offender's custody record when the responsible health or mental health authority determines that such information may be relevant to the offender's health, mental health, and course of treatment.

B. Health Care Staff Responsibilities

1. Health care staff will maintain offender health records in a secure location in the health care unit area and control access to offender health records including ensuring that records are inaccessible to offenders or non-health care staff.
2. A member of the health care staff who denies the release of health information must complete the following:
 - a. document a reason(s) for denial on the original release request form;
 - b. date and sign the form;
 - c. file the form in the offender health record; and
 - d. return a copy of the form to the requesting party.
3. Health care staff will protect the confidentiality of inactive health care records, prevent unauthorized health care information release, and allow for timely records access and reactivation if an offender returns to the facility.
4. Following a youth or adult offender death or discharge from the Department or in the event a youth offender reaches age of majority, health care staff will, in accordance with Montana Secretary of State standards, ensure offender health care records are retained according to the following:
 - a. in the facility medical unit for two years; and
 - b. at the records storage center for eight years.
5. Health care staff ensure that when the medical, dental, and mental health records are stored separately, a process is in place to ensure that all pertinent information is shared.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. 41-3-201, MCA; Title 50, Chapter 16, MCA
- B. DOC 1.5.5 Offender Records Management, Access, and Release
- C. P-A-08; National Commission on Correctional Health Services in Prisons, 2018

- D. *Performance-Based Standards and Expected Practices for Juvenile Correctional Facilities, 5th Edition, 2025*
- E. *MH-H-02, MH-H-03, MH-H-04; National Commission on Correctional Mental Health Services in Correctional Facilities, 2015*
- F. *Y-H-02, Y-H-03, Y-H-04; National Commission on Correctional Health Services in Juvenile Detention and Confinement Facilities, 2022*



POLICY DIRECTIVE

Policy:	DOC 4.5.39 OFFENDER PARTICIPATION IN RESEARCH PROJECTS	
Effective Date:	12/01/1996	Page 1 of 2
Revision Date(s):	04/19/2021; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will not allow offenders in its care or custody or under its supervision to participate in any medical, pharmaceutical, or cosmetic research project without the express permission of the Department Director; if approved, offenders will not be compensated, remunerated, or paid for participation.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. Project Requirements

1. Individuals or agencies that submit research proposals involving offenders will request, in writing, to the Department Director.
2. The Department Director will:
 - a. review all research proposals that require offender involvement;
 - b. provide written permission before such projects are implemented;
 - c. specify the limits and conditions under which any such project may be conducted; and
 - d. provide the steps to be taken to preserve the offender's rights.
3. When offenders are participants in community-based research protocols, they are admitted to the facility with processes for:
 - a. continuation of participation; and
 - b. consultation with community researchers so that withdrawal from the research protocol is done without harming the health or mental health of the offender.
4. Any research conducted on juvenile offenders should meet the standards for design and control, and the juvenile (or legal guardian where required by jurisdictional law) must have given informed consent.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. §§ 53-1-201; 53-1-206, MCA
- B. *P-G-06, National Commission on Correctional for Health Services in Prisons 2008*
- C. 45 CFR 46, Code of Federal Regulations
- D. *MH-I-05; National Commission on Correctional Mental Health Services in Correctional Facilities, 2015*
- E. *Y-I-05; National Commission on Correctional Health Services in Juvenile Detention and Confinement Facilities, 2022*



POLICY DIRECTIVE

Policy:	DOC 4.5.40 TRANSFER SCREENING	
Effective Date:	04/19/2021	Page 1 of 2
Revision Date(s):	04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department ensures offenders who are transferred within the same correctional system continue to receive appropriate health and mental health services.

II. APPLICABILITY

All Department secure care facilities.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Qualified health care professionals (QHCPs) review each transferred offender's health record or summary to ensure continuity of care.
 - a. If the offender's health summary indicates that the offender is under treatment for a medical, dental, mental health, or substance abuse problem and has been diagnosed with a chronic medical problem or is taking chronic care medications, additional health information may be requested from the sending facility.
 - b. Mental health staff review each transferred offender's mental health record or summary within 12 hours of arrival to ensure continuity of care; the review must be documented in the offender's record.
2. When transferred from an intake facility, offenders who do not have initial medical, dental, or mental health assessments are to be evaluated at the receiving facility in a timely manner.
3. When a seriously mentally ill offender is transferred, mental health staff at the sending facility will inform mental health staff at the receiving facility of any condition that requires special and immediate attention (for example, special medication and treatment needs).
4. Documentation in the health record will demonstrate continuity of health care.

B. Juvenile Transfer Screening

1. QHCPs review each incoming juvenile's health record or summary within 12 hours of arrival and:
 - a. continuity of care is initiated;
 - b. initial assessments (health, mental health, dental) are identified;
 - c. required assessments are completed in a timely manner; and
 - d. health information from the sending facility is captured in the juvenile's current health record.
2. The receiving screening for transfers takes place upon the juvenile's arrival at the facility.
3. When the health record or a health information transfer summary comes with the juvenile and is immediately available to the screening staff, a face-to-face transfer screening encounter focuses on observation of appearance and behavior and problems the juvenile recounts that occurred during the transfer process.
4. When the health record or a health information transfer summary is not available to the screening staff, a face-to-face health screening encounter at minimum includes:
 - a. identification of acute and chronic health conditions;
 - b. evaluation of suicidal risks;
 - c. review of any allergies;
 - d. observation of appearance and behavior; and
 - e. problems the juvenile recounts that occurred during the transfer process.
5. Documentation of the transfer screening is dated and timed immediately upon completion and includes the signature and title of the person completing the process.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-E-03; National Commission on Correctional Health Services, 2018*
- B. *MH-E-03; National Commission on Mental Health Services in Correctional Facilities, 2015*
- C. *Y-E-03; National Commission on Correctional Health Services in Juvenile Detention and Confinement Facilities, 2015*
- D. *DOC 4.5.22 Offender Health Care Continuity*



POLICY DIRECTIVE

Policy:	DOC 4.5.41 BEHAVIORAL CONSULTATION	
Effective Date:	01/04/2021	Page 1 of 1
Revision Date(s):	04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will ensure that mental health staff provide behavioral consultation when such services are needed.

II. APPLICABILITY

All secure care facilities Department-owned and contracted.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. On request, mental health staff will consult with custody staff on offender mental health needs.
2. Mental health staff may provide consultation at disciplinary proceedings.
3. When on-site mental health staff are not able to provide consultation, facilities will have procedures in place for accessing facility resources or community specialty resources or services.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *MH-G-06; National Commission on Mental Health Services in Correctional Facilities, 2015*



POLICY DIRECTIVE

Policy:	DOC 4.5.42 CARE FOR TERMINALLY ILL ADULT OFFENDERS
Effective Date:	01/04/2021 Page 1 of 1
Revision Date(s):	04/24/2026
Department Director Signature:	/s/ Eric Strauss, Director
Medical Director Signature:	/s/ Dr. Paul Rees, MD
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN

I. POLICY

The Department of Corrections will ensure the needs of terminally ill offenders are met, including protecting their rights regarding end-of-life decisions.

II. APPLICABILITY

All secure care facilities Department-owned and contracted.

III. DEFINITIONS

IV. REQUIREMENTS

A. General Requirements

1. Each facility must have a process to address the needs of terminally ill offenders that includes palliative care.
2. When the responsible physician determines that care in a community setting is medically preferable, a recommendation is made to the appropriate legal authority regarding the offender's transfer or medical parole.

B. Palliative Care

1. The on-site palliative care process shall include the following:
 - a. participation is an offender's informed choice;
 - b. qualified health care professionals providing palliative care have received training in palliative care techniques;
 - c. offender workers or volunteers providing services in the program are properly trained and supervised.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-F-07; National Commission on Correctional Health Services in Prisons, 2018*



POLICY DIRECTIVE

Policy:	DOC 4.5.43 CLINIC SPACE, EQUIPMENT, AND SUPPLIES	
Effective Date:	01/04/2020	Page 1 of 3
Revision Date(s):	04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will ensure sufficient and suitable space, supplies, and equipment are available for the facility's medical, dental, and mental health services.

II. APPLICABILITY

All secure care facilities Department-owned and contracted.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Examination and treatment rooms for medical, dental, and mental health care are available and large enough to accommodate the necessary equipment, supplies, and fixtures, and to permit privacy during clinical encounters to meet the needs of the offender population.
2. Pharmaceuticals, medical supplies, and mobile emergency equipment are available and checked in accordance with policy.
3. Facilities will ensure there is adequate office space with administrative files, secure storage of health records, and writing desks.
4. When laboratory, radiological, or other ancillary services are provided on-site, the designated area is adequate to hold equipment and supplies.
5. When patients are placed in a waiting area for more than a brief period, the waiting area has seats and access to drinking water and toilets.
6. At minimum, daily inventories are maintained on items subject to abuse (for example, syringes, needles, scissors, and other sharp instruments).

B. Medical Equipment, Supplies, and Materials

1. At minimum, facilities have the following equipment, supplies, and materials for the examination and treatment of patients:

- a. hand-washing facilities or alternate means of hand sanitations;
- b. examination table;
- c. light capable of providing direct illumination;
- d. scale;
- e. thermometer;
- f. blood pressure monitoring equipment;
- g. stethoscope;
- h. ophthalmoscope;
- i. otoscope;
- j. transportation equipment (for example, wheelchair, stretcher);
- k. trash containers for biohazardous materials and sharps;
- l. sterilizer for non-disposable medical or dental equipment;
- m. appropriate space, equipment, and supplies for pelvic examinations if the facility houses females;
- n. oxygen;
- o. automated external defibrillator;
- p. pulse oximeter; and
- q. personal protective equipment (for example, gloves, eye protection, gowns, masks).

C. Dental Equipment, Supplies, and Materials

1. Basic equipment required for on-site dental examinations includes, at minimum:
 - a. hand-washing facilities or alternate means of hand sanitations;
 - b. dental examination chair;
 - c. examination light;
 - d. instruments;
 - e. trash containers for biohazardous materials and sharps;
 - f. dentist's stool;
 - g. personal protective equipment; and
 - h. sterilizer.

D. Mental Health Equipment, Supplies, and Materials

1. Individual therapies and assessments as well as group therapies are provided in an area with private interview space, as well as desks, chairs, and lockable file space as necessary.
2. Relevant psychological testing materials, supplies, and reference resources are available to support the mental health evaluations completed on-site and are stored in a secure area.
3. When mental health staff give injections of psychotropic medication or manage medication reactions in the mental health area, at minimum the following equipment, supplies, and materials for the examination and treatment of offenders are necessary:
 - a. hand-washing facilities or appropriate alternative means of hand sanitation;
 - b. blood pressure monitoring equipment;
 - c. stethoscope; and
 - d. trash containers for biohazardous materials and sharps.
4. Any pharmaceuticals, medical supplies, and mobile emergency equipment kept in the mental health area are checked regularly. At minimum, weekly inventories are maintained on items subject to abuse (for example, syringes, needles, scissors, other sharp instruments, and testing supplies).

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-D-03; National Commission on Correctional Health Services in Prisons, 2018*
- B. *MH-D-03; National Commission on Correctional Mental Health Services in Correctional Facilities, 2015*
- C. *Y-D-03; National Commission on Correctional Health Services in Juvenile Detention and Confinement Facilities, 2022*



POLICY DIRECTIVE

Policy:	DOC 4.5.44 COMMUNICATION ON OFFENDER HEALTH NEEDS
Effective Date:	01/04/2021 Page 1 of 2
Revision Date(s):	04/24/2026
Department Director Signature:	/s/ Eric Strauss, Director
Medical Director Signature:	/s/ Dr. Paul Rees, MD
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN

I. POLICY

The Department will ensure communication occurs between facility administration and treating health staff regarding offender's significant health needs that must be considered in classification decisions in order to preserve the health and safety of that offender, other offenders, or staff.

II. APPLICABILITY

All secure facilities Department-owned and contracted.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Custody staff are advised of an offender's special health needs that may affect the following:
 - a. housing;
 - b. work assignments;
 - c. program assignments;
 - d. disciplinary measures;
 - e. transport to and from outside appointments;
 - f. admissions to and transfers from facilities;
 - g. clothing or appearance; and
 - h. activities of daily living.

B. Offender Special Needs Conditions

1. Health care staff and custody staff communicate about accommodations for conditions that may include but not limited to the following:
 - a. chronically ill (for example, diabetes)
 - b. on dialysis
 - c. have communicable diseases that require special housing or isolation
 - d. physically disabled
 - e. pregnant
 - f. age-related needs

- g. terminally ill
- h. mentally ill or suicidal
- i. Physical or sexual abuse
- j. physical or mental contraindications to restraint or seclusion
- k. intellectually disabled
- l. vulnerable to manipulation
- m. require protection from physical or sexual abuse
- n. hearing or vision impaired
- o. require limb prosthetics
- p. gender dysphoria, transgender
- q. adolescent insomnia
- r. require medical supplies

C. Mental Health Special Needs

1. Mental health staff and custody staff communicate about offenders with special mental health needs that may include, but are not limited to the following:
 - a. chronic mental illness;
 - b. suicidal ideation or behavior;
 - c. intellectual and developmental disability;
 - d. significant substance use histories;
 - e. suspected or known victims of physical or sexual abuse; and
 - f. other serious mental health problems.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-B-07; National Commission on Correctional Health Services in Prisons, 2018*
- B. *MH-A-08; National Commission on Correctional Mental Health Services in Correctional Facilities, 2015*
- C. *Y-B-07; National Commission on Correctional Health Services in Juvenile Detention and Confinement Facilities, 2022*



POLICY DIRECTIVE

Policy:	DOC 4.5.45 HEALTH CARE LIAISON	
Effective Date:	01/04/2021	Page 1 of 2
Revision Date(s):	04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will ensure health services continue to be coordinated when qualified health and mental health professionals are not available.

II. APPLICABILITY

All secure facilities Department-owned and contracted.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. A designated, trained health care liaison coordinates health services delivery in all Department secure facilities on days when no Qualified Health Care Professional is on-site for a continuous 24-hour period.
2. The health care liaison is instructed in the role and responsibilities by the responsible physician or designee.
3. The mental health liaison is instructed in the role and responsibilities by the responsible mental health clinician or designee.

B. Health Care Liaison

1. The responsible health authority works with the responsible physician to ensure the duties that can be assigned to a health care liaison are limited to providing access to care.
2. The health care liaison must have a plan that includes contact information for the on-call health staff, ambulance, and other emergency community contacts.
3. The health care liaison generally carries out the following duties at minimum:
 - a. reviews receiving screening forms for follow-up attention;
 - b. reviews nonemergency health care requests as instructed by the responsible physician;
 - c. helps to carry out prescriber orders regarding such matters as diet, housing and work assignments; and
 - d. maintains patient privacy.

C. Mental Health Liaison

1. The mental health liaison must have a plan that tells staff what to do when a mental health situation arises when mental health staff are not present.
2. The mental health liaison generally carries out the following duties at minimum:
 - a. reviews receiving screening forms for follow-up attention;
 - b. reviews nonemergency mental health care requests as instructed by the responsible mental health clinician;
 - c. helps to carry out clinician's orders regarding such matters as housing and work assignments; and
 - d. maintains patient privacy.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-C-08; National Commission on Correctional Health Services in Prisons, 2018*
- B. *MH-C-08; National Commission on Correctional Mental Health Services in Correctional Facilities, 2015*
- C. *Y-C-08; National Commission on Correctional Health Services in Juvenile Detention and Confinement Facilities, 2022*



POLICY DIRECTIVE

Policy:	DOC 4.5.46 ORIENTATION FOR HEALTH STAFF	
Effective Date:	01/04/2021	Page 1 of 2
Revision Date(s):	04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will ensure qualified health and mental health professionals are appropriately oriented to work in the correctional environment and understand their roles and responsibilities.

II. APPLICABILITY

All secure facilities, Department-owned and contracted.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The orientation program is approved by the responsible health authority and the facility administrator.
2. The orientation lesson plan is reviewed annually or more frequently, as needed.
3. All health staff receive basic orientation on or before the first day of on-site service and prior to offender contact.
4. Within 90 days of employment, all full-time, part-time, and frequently used temporary health staff complete an in-depth orientation.
5. Completion of the orientation program is documented and kept on file.
6. Health care and mental health staff remain subject to the same security regulations and mandatory training requirements as other facility employees.

B. Basic Orientation

1. Health care staff basic orientation covers, at minimum, the following:
 - a. relevant security and health services policies and procedures;
 - b. response to facility emergency situations;
 - c. the staff member's functional position description; and
 - d. offender-staff boundaries and relationships.

C. In-Depth Orientation

1. Health care staff in-depth orientation includes a full familiarization with the health services delivery system and focuses on the similarities and differences between providing health care in the community and in a correctional setting to include, at minimum, the following:
 - a. all health service policies and procedures not addressed in basic orientation;
 - b. health and age specific needs of the offender population;
 - c. infection control including use of standard precautions; and
 - d. confidentiality of records and health information.
2. The content may vary depending on the roles and responsibilities of the new staff members.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-C-09: National Commission on Correctional Health Care Services in Prisons, 2018*
- B. *MH-C-03; National Commission on Mental Health Care in Correctional Facilities, 2015*
- C. *Y-C-09; National Commission on Correctional Health Services in Juvenile Detention and Confinement Facilities, 2022*



POLICY DIRECTIVE

Policy:	DOC 4.5.47 HEALTH TRAINING FOR CUSTODY STAFF	
Effective Date:	01/04/2021	Page 1 of 2
Revision Date(s):	04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will provide health care and mental health training for custody staff to understand their part in early detection of illness and injury and to recognize the need to refer an offender to a qualified health care or mental health professional.

II. APPLICABILITY

All secure care facilities Department-owned and contracted.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The responsible health and mental health authorities in cooperation with the facility administrator will establish a health training program for correctional officers.
2. The responsible health authority will approve the health training program.
3. An outline of the approved training, including course content and length, must be kept on file.
4. Custody staff who work with offenders receive health-related training at least every two years.
5. A certificate or other evidence of attendance is kept on-site for each employee.

B. Health Training Program

1. The training program needs to include at minimum the following:
 - a. administration of first aid;
 - b. cardiopulmonary resuscitation including use of an automated external defibrillator;
 - c. acute manifestations of certain chronic illnesses (for example, asthma, seizures, diabetes);
 - d. intoxication and withdrawal;
 - e. adverse reactions to medications;
 - f. signs and symptoms of mental illness;

- g. dental emergencies;
 - h. processes for suicide preventions;
 - i. processes for appropriate referral of offenders with medical, dental, and mental health complaints;
 - j. precautions and processes for infectious and communicable diseases; and
 - k. maintaining patient confidentiality.
2. Custody staff for the juvenile population who are assigned to outside programs are current in CPR, first-aid training, and prevention of heat-related illnesses.

C. Mental Health Training Program

1. All custody staff will receive mental health training annually that includes, at minimum:
 - a. recognizing signs and symptoms of mental illness, substance abuse, and intellectual and developmental disabilities;
 - b. communicating with offenders who exhibit signs of mental illness, substance abuse, and intellectual and developmental disabilities;
 - c. processes for suicide prevention and intervention; and
 - d. processes for appropriate referral of offenders with mental health complaints or suicidal behaviors to mental health staff.
2. Custody staff assigned to intake screening and mental health services, including mental health programs, residential units, and restrictive housing areas, receive additional training from mental health staff in order to fulfill their specific roles.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-C-04; National Commission on Correctional Health Services in Prisons, 2018*
- B. *MH-C-04; National Commission on Correctional Mental Health Services in Correctional Facilities, 2015*
- C. *Y-C-04; National Commission on Correctional Health Services in Juvenile Detention and Confinement Facilities, 2022*



POLICY DIRECTIVE

Policy:	DOC 4.5.48 HOSPITAL AND SPECIALTY CARE	
Effective Date:	01/04/2021	Page 1 of 2
Revision Date(s):	04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will ensure hospitalization and specialty care are available to offenders who need these services.

II. APPLICABILITY

All secure facilities Department-owned and contracted.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The Health Services Bureau ensures there is appropriate and timely access to hospital (acute care and psychiatric) and specialist care when necessary.
2. When offenders are referred for outside care, written or verbal information about the offender and the specific problem to be addressed must be communicated to the outside entity.
3. For on-site specialty services used regularly for medical and mental health care, the Health Services Bureau ensures providers are appropriately licensed and/or certified.
4. Off-site facilities or health professionals provide a summary of the treatment given and any follow-up instructions, including specific instructions about the signs, symptoms, or conditions that require return to the hospital; this information accompanies the offender on return to the facility.
5. The offender health record contains results and recommendations from off-site visits or attempts by health staff to obtain these results.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-D-08; National Commission on Correctional Health Services in Prisons, 2018*
- B. *MH-D-05; National Commission on Correctional Mental Health Services in Correctional Facilities, 2015*
- C. *Y-D-08; National Commission on Correctional Health Services in Juvenile Detention and Confinement Facilities, 2015*



POLICY DIRECTIVE

Policy:	DOC 4.5.49 MEDICAL SURVEILLANCE OF OFFENDER WORKERS	
Effective Date:	01/04/2021	Page 1 of 2
Revision Date(s):	04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department ensures the health and safety of the offender worker population are protected.

II. APPLICABILITY

All secure facilities Department-owned and contracted.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The responsible physician and the responsible health authority develop and oversee a medical surveillance program to prevent illness and injury among the offender worker population.
2. The responsible physician reviews and approves the health aspects of the medical surveillance program.
3. The responsible physician will determine which regulations apply to offender workers and consult with local, state, or national authorities for technical assistance in determining exposure risk for offenders and approaches to risk reductions and elimination.
4. Each facility has a medical surveillance program.

B. Medical Screening

1. An initial medical screening of an offender for contraindications to a work program, based on job risk factors and offender condition, is conducted prior to enrollment into the program.
2. Ongoing medical screening of offenders in work programs is conducted in a way that affords the same health protections as medical screening of employee workers in equivalent jobs.

C. Medical Surveillance Committee

1. The medical surveillance committee will meet at least annually, or as needed, to discuss work-related health risks that are identified and create mitigation plans.

2. Offender illness or injury potentially related to occupational exposure or with occupational implications is identified and the information is provided to the committee for review.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-B-04; National Commission on Correctional Health Services, 2018*



POLICY DIRECTIVE

Policy:	DOC 4.5.50 MEDICATION ADMINISTRATION TRAINING	
Effective Date:	01/04/2021	Page 1 of 2
Revision Date(s):	04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will ensure that staff who administer or deliver prescription medication are appropriately trained and/or licensed.

II. APPLICABILITY

All secure facilities Department-owned and contracted.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Custody, health care, and mental health staff who administer or deliver prescription medication to offenders must be permitted by state law to do so.
2. Medication administration training is approved by the responsible physician or designee and facility administrator or designee.
3. Documentation of completed training and testing is kept on file for staff who administer or deliver medications.

B. Training

1. Staff who administer or deliver prescription medications are trained in matters of:
 - a. security;
 - b. accountability;
 - c. common side effects;
 - d. dispensing;
 - e. disposing;
 - f. distributing;
 - g. documentation of medicines; and
 - h. procuring.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-C-05; National Commission on Correctional Health Services, 2018*
- B. *MH-C-05; National Commission on Mental Health Services in Correctional Facilities, 2015*
- C. *Y-C-05; National Commission on Correctional Health Services in Juvenile Detention and Confinement Facilities, 2015*



POLICY DIRECTIVE

Policy:	DOC 4.5.51 CLINICAL STAFF PROFESSIONAL DEVELOPMENT	
Effective Date:	04/19/2021	Page 1 of 2
Revision Date(s):	04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will ensure that all qualified health care and mental health professionals maintain current clinical knowledge and skills and participate in continuing education appropriate for their positions.

II. APPLICABILITY

All Department of Corrections secure facilities.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The responsible health authority will maintain a list of the state's continuing education requirements for each category of licensure of all qualified health care and mental health professionals.
2. The responsible health authority must document compliance with continuing education requirements.
3. All Qualified Health Care Professionals who have patient contact must be current in cardiopulmonary resuscitation technique.

B. Continuing Education

1. Each Qualified Health Care Professional must obtain at least 12 hours of continuing education per year.
2. Each Qualified Mental Health Professional must obtain at least 12 hours of continuing professional education per year; part-time staff prorate their continuing education hours on full-time equivalency. Each Qualified Mental Health Professional must obtain the hours of continuing professional education required to maintain their applicable licenses per year.

3. Qualified health and mental health professionals must submit to the appropriate training records staff or Human Resources a list of completed courses, dates, and numbers of hours to be kept on file.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-C-03; National Commission on Correctional Health Services in Prisons, 2018*
- B. *MH-C-03; National Commission on Mental Health Services in Correctional Facilities, 2015*
- C. *Y-C-03; National Commission on Correctional Health Services in Juvenile Detention and Confinement Facilities, 2015*



POLICY DIRECTIVE

Policy:	DOC 4.5.52 MENTAL HEALTH MEDICATION SERVICES	
Effective Date:	04/19/2021	Page 1 of 2
Revision Date(s):	04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will ensure that mental health medications are clinically appropriate and provided in a timely, safe, and sufficient manner.

II. APPLICABILITY

All Department secure facilities.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The responsible mental health authority will monitor medication services to identify and resolve causes of delay and discontinuity.
2. The responsible mental health clinician will determine prescribing practices for psychotropic medications in the facility.
3. Medications are prescribed only when clinically indicated.

B. Psychotropic Medications

1. Psychotropic medications are administered or delivered to the patient only on the order of an individual legally authorized to prescribe according to the requirements of the jurisdiction, such as a prescribing clinician.
2. Psychotropic medications are delivered in a timely fashion. Facilities must identify the expected time frames from ordering to delivery and have contingencies in place if delivery time frames cannot be met.
3. Offenders entering the facility on verifiable (for example, a prescription from a community provider) prescription medication continue to receive the medication in a timely fashion as prescribed, or acceptable alternate medications are provided as clinically indicated.

4. Offenders entering the facility with a prescription that cannot be verified should be evaluated by facility health staff or a prescribing clinician for the appropriateness of the prescription medication.
5. The prescribing clinician is notified of the impending expiration of an order so that the clinician can determine whether the drug administration is to be continued or altered.
6. Psychotropic and behavior modifying medications are not used for disciplinary purposes.
7. Health and custody staff are trained on the potential negative side effects of medications, particularly psychotropics.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *MH-D-02; National Commission on Mental Health Services in Correctional Facilities, 2015*



POLICY DIRECTIVE

Policy:	DOC 4.5.53 MENTAL HEALTH PROGRAMS AND RESIDENTIAL UNITS	
Effective Date:	04/19/2021	Page 1 of 2
Revision Date(s):	04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will ensure that mental health programs meet the serious mental health needs of offenders.

II. APPLICABILITY

All Department secure facilities.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Mental health programs without a residential component, when provided on-site, are approved by the responsible mental health clinician and have, at minimum:
 - a. defined goals;
 - b. mental health staff of sufficient numbers and kind in keeping with program purposes;
 - c. individual treatment plans; and
 - d. protocols for offender follow-up at least every 60 days.

B. Acute Mental Health Residential Units

1. Acute mental health residential units, when provided on-site, are consistent with their defined scope of care to provide for offenders who are psychotic, clinically unstable, acutely suicidal, or at imminent risk of self-harm, and have, at minimum:
 - a. continuous (24 hours per day, 7 days per week) coverage by mental health staff assigned to the unit;
 - b. orientation and training for correctional officers assigned to the unit;
 - c. daily (7 days per week) offender evaluation by mental health staff;
 - d. programming or appropriate therapies, as indicated;
 - e. individual treatment plans; and
 - f. housing in a safe and therapeutic environment conducive to symptom stabilization and maintenance of good personal hygiene.

C. Nonacute Mental Health Residential Units

1. Nonacute mental health residential units, when provided on-site, have at minimum:
 - a. defined scope of care;
 - b. either programming or appropriate therapies (or both) to meet the mental health needs of the offenders in the unit;
 - c. mental health staff of sufficient numbers and kind in keeping with the purpose of the unit;
 - d. individual treatment plans;
 - e. orientation and training for correctional officers; and
 - f. a clean, safe, therapeutic environment and milieu, including facilities for maintaining good personal hygiene with guidance in the activities of daily living, if needed.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *MH-G-02; National Commission on Mental Health Services in Correctional Facilities, 2015*



POLICY DIRECTIVE

Policy:	DOC 4.5.54 MENTAL HEALTH TREATMENT PLANS	
Effective Date:	04/19/2021	Page 1 of 2
Revision Date(s):	04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will ensure that mental health services are provided according to individual treatment plans.

II. APPLICABILITY

All Department secure facilities.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. An individual treatment plan directs the mental health services needed for every offender on the mental health caseload and includes treatment goals and objectives.
2. The responsible mental health clinician completes periodic reviews of individual treatment plans.
3. Individual treatment planning is initiated when the offender enters treatment with a Qualified Mental Health Professional. Development of a treatment plan is undertaken in collaboration with the offender when feasible.
4. Although a specific form for the treatment plan is recommended, documentation may vary in format provided that the required content is addressed.

B. Treatment Plan

1. Mental health treatment plans include, at a minimum, the following:
 - a. frequency of follow-up for evaluation and adjustment of modalities;
 - b. adjustments of psychotropic medications, if indicated;
 - c. referrals for psychological testing, medical testing, and evaluation, including blood levels for medication monitoring as required;
 - d. when appropriate, instructions about diet, exercise, personal hygiene, and adaptation to the correctional environment; and

- e. documentation of treatment goals and objectives, interventions necessary to achieve those goals, and notation of clinical progress.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *MH-G-03; National Commission on Mental Health Services in Correctional Facilities, 2015*



POLICY DIRECTIVE

Policy:	DOC 4.5.55 OFFENDER NUTRITION AND MEDICAL DIETS
Effective Date:	04/19/2021 Page 1 of 1
Revision Date(s):	04/24/2026
Department Director Signature:	/s/ Eric Strauss, Director
Medical Director Signature:	/s/ Dr. Paul Rees, MD
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN

I. POLICY

The Department will ensure that nutrition and medical diets are provided that enhance offenders' health and are modified when necessary to meet specific requirements related to clinical conditions.

II. APPLICABILITY

All Department secure facilities.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Regular and medical diets are nutritionally adequate and appropriate for age and gender groups.
2. For juvenile populations, a registered dietitian, registered dietitian nutritionist, or licensed dietitian (as permitted by state scope of practice laws) reviews medical diets and menus for nutritional adequacy at least every 6 months and whenever a substantial change in the menus is made. Review may take place in a documented site visit or by written consultation.
3. Written documentation of menu reviews includes the date, signature, and title of the consulting dietitian.
4. Medical diets are provided per prescribed order and are documented in the health record.
5. Orders for medical diets are communicated electronically or in writing to dietary staff and include the type of diet, duration for which it is to be provided, and special instructions, if any.
6. Workers who prepare regular and medical diets are trained and supervised in preparing the diets, including appropriate substitutions and portions.
7. When offenders refuse prescribed diets, follow-up nutritional counseling is provided.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *DOC 4.3.2 Menu Planning*
- B. *P-D-05; National Commission on Correctional Health Services, 2018; Y-F-; National Commission on Correctional Health Services in Juvenile Detention and Confinement Facilities, 2015*



POLICY DIRECTIVE

Policy:	DOC 4.5.56 OFFENDERS WITH SUBSTANCE USE DISORDERS	
Effective Date:	04/19/2021; 04/24/2026	Page 1 of 1
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will ensure that offenders with Substance Use problems are assessed and properly managed by a physician or, where permitted by law, other qualified health and mental health professionals.

II. APPLICABILITY

All Department secure facilities.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Facilities have written clinical procedures for the management of Substance Use Disorder (SUD) offenders.
2. There is documentation in the offender's record of the communication and coordination between medical, mental health, and substance use staff regarding SUD care.
3. Disorders associated with SUD (for example, HIV and liver disease) are recognized and treated.
4. Custody staff are trained in recognizing SUD problems in offenders and discussing with them.
5. There is on-site medication-assisted therapy (MAT), individual counseling, group therapy, or self-help groups for offenders with SUDs.
6. Didactic approaches to drug education are available to offenders.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-F-04; National Commission on Correctional Health Care, 2018*
- B. *MH-G-05; National Commission on Mental Health Services in Correctional Facilities, 2015*
- C. *Y-G-06; National Commission on Correctional Health Services in Juvenile Detention and Confinement Facilities, 2022*



POLICY DIRECTIVE

Policy:	DOC 4.5.56A MEDICATION-ASSISTED TREATMENT (MAT) PROGRAM	
Effective Date:	01/05/2023	Page 1 of 6
Revision Date(s):	08/01/2025; 04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will provide access to Medication-Assisted Treatment (MAT) for patients who are identified as meeting criteria and have agreed to participate in the treatment for Opioid Use Disorder (OUD) and/or Alcohol Use Disorder (AUD).

II. APPLICABILITY

All secure facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS (see Glossary)

IV. RESPONSIBILITY

Department facilities providing MAT will have an authorized representative. The authorized representative is the assigned Qualified Health Care Professional or designee and will be responsible for monitoring, compliance, and maintaining records with any REMS certification and state and federal regulations.

V. REQUIREMENTS

A. Referral

1. Screening and evaluation
 - a. All patients will be screened upon entering the facility by a Qualified Health Care Professional for evidence of a Substance Use Disorder (SUD).
 - b. For those reporting a history of substance abuse, screening instruments and an American Society of Addiction Medicine (ASAM) evaluation will be utilized. In instances where post custody SUD placements will be pursued, ASAM criteria will be shared following proper guidelines.
 - c. During the assessment, patients will be asked to sign releases of information to verify all community-based treatment of SUDs.
 - d. The following information may be considered in making the diagnosis of a specific SUD:
 - 1) Outcomes of validated assessments tools
 - 2) History and severity of substance use
 - 3) Results from urine drug screens, current and past

- 4) Community health records verifying diagnosis and/or treatment for SUDs
 - 5) Evidence of emergency treatment for substance overdose
 - 6) Review of Montana Prescription Monitoring System
 - 7) Intake physical exam findings
 - 8) Substantiated collateral report
2. Referral to program
 - a. Once it is determined that a patient has a SUD that can be treated by MAT, and when the patient is 3-6 months from discharge or parole, the LAC will refer the patient to the contracted MAT prescribing practitioner.
 - 1) The MAT prescribing practitioner will review Montana's Prescription Monitoring System.
 - b. Once admitted to the program, the patient will be assigned to appropriate staff to facilitate continuance of MAT while in custody and after discharge.
 - c. Other referrals may be considered on a case-by-case basis.
 3. Patients who enter facility on MAT
 - a. Controlled medications arriving with inmates will be managed per DEA regulations.
 - b. Communication with community resource prescribers and pharmacies may be established to verify compliance with MAT medications.
 - c. A medical urine drug screen and urine pregnancy test (as applicable) shall be done prior to continuing dosing of MAT medications. Results of the drug screen should be reviewed and considered by the contracted MAT prescribing practitioner.
 - d. Once verified, the patient will be scheduled with the MAT prescribing practitioner. The practitioner will assess the ongoing use of the MAT medications.
 - e. Those entering the facility on medications to treat SUD will be scheduled to see LAC at the earliest possible appointment.

B. Treatment Requirements

1. Participation in the MAT program requires adherence to the following requirements:
 - a. Participation in or completion of a SUD/multi-targeted program;
 - b. Signing a medication-informed consent for the indicated medication modality;
 - c. Adherence with the individualized treatment plan, including:
 - 1) attendance at all scheduled appointments
 - 2) engagement with substance use behavioral health services, programming, and case management related services
 - 3) submission of medical and security urine drug screens as ordered
 - 4) the medication modality must be taken as prescribed, and the patient must adhere to the Department medication administration protocol
 - d. Respectful engagement with staff, ensuring a safe treatment environment.

C. Treatment Modalities

1. Medications that are approved to treat SUDs by the Department Medical Director are listed on the Montana Department of Corrections Formulary.
2. Substance Use Behavioral Health Services
 - a. Patients will be actively engaged with SUD behavioral health services as indicated in their treatment plan.
3. Mental Health Services
 - a. Patients who are referred will be actively engaged with mental health services as indicated in their treatment plan.

D. MAT Non-Adherence

1. Creating an unsafe treatment environment

- a. Patients who are actively enrolled in the MAT program and exhibit threatening or aggressive behaviors will be referred to a mental health provider to assess unsupportive behaviors. Prior to continuation of MAT related services, the patient must be stabilized, and both their mental health provider and substance use provider must approve their continued need for MAT program.
 - b. Patients who are identified as diverting MAT medications will be referred to the LAC for review and continued treatment recommendations.
 - 1) A patient found to be diverting MAT medications may be placed on an alternative treatment plan for SUD treatment; this plan will be documented in the electronic health record.
 - c. If participation in MAT is halted based on unsafe behaviors by the patient, the contracted MAT prescribing practitioner will make every effort to provide the patient with a humane and medically appropriate taper, if safely able to do so.
 - d. Patients discharged from the MAT program, based on safety concerns, who stabilize at a later period during their correctional confinement may be referred back to the program by an LAC who has assessed the clinical appropriateness for treatment re-engagement.
2. Non-adherence with scheduled appointments
 - a. Missed appointments will result in the patient meeting with an LAC to determine a reason for the absence and identifying a solution to avoid future occurrences.
 - b. Consideration of modification to the patient's individualized treatment plan, up to and including discharge from MAT for a documented pattern of non-compliance with scheduled appointments, may be considered.
 3. Non-adherence with ordered medical drug screens
 - a. A positive medical or security drug screen for substances other than prescribed medications will be evaluated by the contracted MAT prescribing practitioner and may result in the following:
 - 1) Consideration of adjustment to the individualized treatment plan
 - 2) Meeting with LAC to discuss the positive drug screen and potential changes to treatment
 - 3) A positive drug screen may not automatically result in dismissal from MAT
 - 4) A positive drug screen for benzodiazepines or other sedating substances may result in MAT medication adjustments, for the safety of the patient
 - b. A medical drug screen that is refused or tampered with by the patient will result in an inference that a specimen would be positive for substances other than prescribed medications.
 - c. Refusal or tampering with ordered medical drug screens by a patient may lead to the modification of the patient's individualized treatment plan, up to and including an alternate treatment plan that includes discontinuation from MAT medications.
 - d. A drug screen that is negative for the patient's MAT medication may lead to the modification of the patient's individualized treatment plan, up to and including an alternate treatment plan that includes discontinuation from MAT medications.
 4. Non-adherence with Department medication administration protocols
 - a. Patients attempting to divert MAT medications, during direct observation medication administration may result in the following:
 - 1) The patient will meet with LAC to determine the reason for the diversion.
 - 2) The contracted MAT prescribing practitioner will be notified.
 - 3) Evaluation and adjustment of the individualized treatment plan will be considered, up to and including an alternate treatment plan that includes discontinuation from MAT medications.
 - 4) If the MAT medication is discontinued, the contracted MAT prescribing practitioner will determine whether the patient may be re-inducted during their present incarceration or remain in the alternative treatment program. The determination will be documented in the electronic health record.

E. Impairment

1. If there is concern for patient impairment, an urgent dose adjustment may be necessary. To screen for objective signs of impairment, an emergent medical evaluation will be requested. An impairment assessment can be requested by:
 - a. The patient
 - b. Medical staff/ LAC/ mental health staff
 - c. All facility staff with the opportunity to observe the patient
2. Referrals for assessment of impairment will be considered urgent, and the assessment must be completed as soon as possible
3. The impairment assessment is performed by nursing staff or a facility medical practitioner
 - a. If a patient is found to have a positive impairment assessment, the contracted MAT prescribing practitioner must be contacted immediately for dose adjustment.

F. Alternative Treatment Plans

1. Patients diagnosed with an OUD will not be removed from the MAT program, once accepted. However, they may be provided with an Alternative Treatment plan that does not include medication administration.
2. Patients who do not receive medication for an OUD will be tracked by LAC and referred for substance use and mental health interventions as needed.
3. Patients may be considered for re-induction pending release by the contracted MAT prescribing practitioner.

G. Care Coordination

1. All patients in the MAT program will be assigned to an appropriate Case Manager who works in conjunction with a Case Specialist and the MAT prescribing practitioner and assists with:
 - a. setting up services for aftercare in the community including an appointment with a MAT practitioner in their community
 - b. managing the treatment plan
 - c. communication with new MAT practitioner at discharge
 - d. training
2. All Qualified Health Care Professional (QHCPs) involved in administering MAT medications will first be provided training that includes known or potential risk associated with MAT medication, warnings, and precautions. Training will include general instructions on storage, handling, and administration of MAT medications.

H. Storage

1. Medications used for MAT that are classified as controlled substances will be stored, counted, and logged in compliance with all applicable state and federal regulations.

I. Handling

1. MAT medications will only be administered by a QHCP.
2. Designated QHCPs will count all narcotics/controlled drugs at the end of each shift and maintain written records documenting these counts.
3. Medications used for MAT will not be dispensed directly to patients for self-administration.
4. Medications that are classified as controlled substances will not be transferred, loaned, or sold to any other facility.

5. Disposal of expired or discontinued narcotic medications will be completed in compliance with DEA regulations. Single doses will be disposed of via the "Rx Destroyer" receptacle and documented as per DEA regulations.
6. The QHCP will verify each patient by their DOC ID prior to administration.

J. Administration

1. Buprenorphine strips
 - a. Patients receiving medications will be required to drink a small cup of water prior to administration.
 - b. The nurse will place strip under the patient's tongue. If more than one strip is prescribed, they should be placed on opposite sides of tongue to ensure strips do not stack on top of each other.
 - c. Patients will be observed by security staff the entire time it takes to dissolve.
 - d. Patients will be required to keep hands on knees or flat surface palms facing up as the strip is dissolved.
 - e. Patients will be required to open their mouth, show roof of mouth, lift tongue, and roll each lip for staff to view after dose is dissolved.
 - f. Patient can be dismissed after strip is dissolved and there are no concerns.
2. Buprenorphine injections
 - a. The week prior to the day of the MAT injection clinic, nursing staff will verify that adequate doses are available for each patient prescribed.
 - b. The patients may be held in on the scheduled day and released to work after their injection is complete.
3. The injection will be administered by a licensed health care professional according to manufacturer instructions and any REMS requirements. Other MAT medications may be prescribed per the practitioner's discretion, such as Vivitrol, Naloxone, etc.

K. Medical Urine Drug Screening

1. Medical Urine Drug Screening (UDS) will be completed prior to treatment initiation and at least monthly thereafter on all offenders receiving MAT medications.
2. Nursing staff or designated health care professionals will arrange with security staff to await a witnessed specimen collection. Patients will be provided with water as needed to facilitate a specimen collection.
3. The Medical UDS will be sent to a contracted laboratory that will process the specimen.
4. Refusal of a Medical UDS will result in an inference of a positive screen.
5. The Medical UDS result will be forwarded to the MAT prescribing practitioner or designee with a copy sent to the Health Services Manager.
6. Patients who are found to be non-adherent with the MAT program, by evidence of a positive Medical UDS screen, will be referred to LAC to receive counseling regarding the current MAT treatment plan.
7. Patients with evidence of repeat or multiple positive Medical UDS screens may be placed on an alternative treatment program.
8. To protect patient confidentiality, the results of urine drug screens along with patient-identifying information will not be shared with Department security staff. The Health Services Manager, or designee, may share evidence of general substance use data with facility security staff, excluding patient-identifying information, to help monitor facility substance use patterns and help ensure a safe environment.

9. Prior to release, patients who are on MAT must have completed a Medical UDS within the last thirty days prior to discharge or parole.

L. Discharge Planning

1. Discharge planning shall be completed to ensure that the patient has an appointment with their community MAT Practitioner.

VI. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VII. REFERENCES

- A. *NCCHC Standard PE-10; NCCHC Standard PF-04*
- B. *SAMHSA*



POLICY DIRECTIVE

Policy:	DOC 4.5.57 ON-SITE DIAGNOSTIC SERVICES	
Effective Date:	04/19/2021	Page 1 of 2
Revision Date(s):	04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will ensure that facilities provide the necessary on-site diagnostic services for offender care.

II. APPLICABILITY

All Department secure facilities.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The responsible health authority maintains documentation that on-site diagnostic services (for example, laboratory and radiology) are certified or licensed to provide that service.
2. There is a facility manual for each on-site diagnostic service, including protocols for the calibration of testing devices to ensure accuracy.
3. On-site diagnostic services are registered, accredited, or otherwise meet applicable state and federal law.
4. Whether the testing occurs on-site, or samples are sent off-site for testing, results are available in a timely fashion.

B. Diagnostic Services

1. Facilities have at minimum, multiple-test dipstick urinalysis, finger-stick blood glucose tests, peak flow meters (handheld or other), stool blood-testing material, and in facilities housing women, pregnancy test kits.
2. Health services have access to blood, urine, and oral fluid testing to monitor medication levels or to confirm or rule out the presence of a variety of drugs including opioids.
3. Health services have access to diagnostic X-Ray (for example, skull, computerized tomography, and MRI scanning).
4. Advanced psychological testing resources are available.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-D-04; National Commission on Correctional Health Services, 2018*
- B. *MH-D-04; National Commission on Mental Health Services in Correctional Facilities, 2015*
- C. *Y-D-04; National Commission on Correctional Health Services in Juvenile Detention and Confinement Facilities, 2022*



POLICY DIRECTIVE

Policy:	DOC 4.5.58 PRIVACY OF CARE	
Effective Date:	04/19/2021	Page 1 of 1
Revision Date(s):	04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will ensure that discussion of offender information and clinical encounters are conducted privately.

II. APPLICABILITY

All Department secure facilities.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Discussions of protected patient health information and clinical encounters are conducted privately, without being overheard or observed by offenders and non-health staff.
2. Privacy (for example, privacy screen, curtain, private area) should be afforded during physical exams, with special considerations for breast, rectal, pelvic, and external genital exams.
3. At minimum, verbal permission is obtained and consideration of gender-appropriate chaperone is made when a breast, rectal, pelvic, or external genitalia examination is indicated.
4. Ancillary staff including security personnel who are present, when necessary, must also maintain privacy when protected health care information is exchanged either written or verbally, or witnessed.
5. Instruction on maintaining confidentiality is given to security staff and interpreters who observe or hear health encounters.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. P-A-07; *National Commission on Correctional Health Services in Prisons, 2018*
- B. MH-A-09; *National Commission on Mental Health Services in Correctional Facilities, 2015*
- C. Y-A-09; *National Commission on Health Services in Juvenile Detention and Confinement Facilities, 2015*



POLICY DIRECTIVE

Policy:	DOC 4.5.59 HEALTH CARE STAFFING	
Effective Date:	04/19/2021	Page 1 of 1
Revision Date(s):	04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will ensure that sufficient numbers and types of health and mental health staff are scheduled to care for the offender population.

II. APPLICABILITY

All Department secure facilities.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. The responsible health authority approves the facility's clinical staffing plan.
2. The adequacy and effectiveness of the staffing plan are assessed by the facility's ability to meet the health and mental health needs of the offender population.
3. Responsible physician time must be sufficient to fulfill both clinical and administrative responsibilities.
4. A documented plan must be in place for custody staff to follow when a health situation arises, and health or mental health staff are not present.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-C-07; National Commission on Correctional Health Services in Prisons, 2018*
- B. *MH-C-07; National Commission on Correctional Mental Health Services in Correctional Facilities, 2015*
- C. *Y-C-07; National Commission on Correctional Health Services in Juvenile Detention and Confinement Facilities, 2015*



POLICY DIRECTIVE

Policy:	DOC 4.5.60 THERAPEUTIC RELATIONSHIP PROTECTION	
Effective Date:	04/19/2021	Page 1 of 2
Revision Date(s):	04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Dr. Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will ensure that health staff protect the integrity of the therapeutic relationship with their patients.

II. APPLICABILITY

All Department secure facilities.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. Health and mental health staff will not be involved in the collection or reporting of forensic information.
2. Health staff may not participate in disciplinary action and cannot be compelled to provide clinical information about offenders solely for the purpose of discipline.
3. Treatments and medications for offenders may never be withheld as a form of punishment.
4. Segregation and restraints may never be clinically implemented as disciplinary action.

B. Mental Health Staff

1. Mental health staff may not release offender mental health information for forensic (for example, investigative, evidence-gathering) purposes except when:
 - a. conducting offender-specific, court-ordered psychiatric or psychological examinations or evaluations with the informed consent of the offender;
 - b. conducting offender-specific evaluations for the Board of Pardons and Parole or court regarding continuity-of-care needs with the informed consent of the offender;
 - c. providing consultation to the disciplinary committees regarding the role of mental illness in a particular event; and
 - d. conducting blood or urine testing for alcohol or other drugs as needed for psychiatric evaluations.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. *P-G-04; National Commission on Correctional Health Services in Prisons, 2018*
- B. *MH-I-03; National Commission on Mental Health Services in Correctional Facilities, 2015*
- C. *Y-I-03; National Commission on Correctional Health Services in Juvenile Detention and Confinement Facilities, 2015*



POLICY DIRECTIVE

Policy:	DOC 4.5.61 MENTAL HEALTH AND SEVERE MENTAL ILLNESS CLASSIFICATION
Effective Date:	11/04/2021 Page 1 of 3
Revision Date(s):	04/24/2026
Department Director Signature:	/s/ Eric Strauss, Director
Medical Director Signature:	/s/ Dr. Paul Rees, MD
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN

I. POLICY

Establish standard protocols for the determination of the mental health status and mental health service needs of offenders.

II. APPLICABILITY

All secure care facilities Department-owned and contracted, as specific in the contract.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. At Department facilities, the Mental Health Level Classification System (MHL) provides a standard approach through which the mental health status and service needs of individual offenders may be examined.
2. The Mental Health Level Classification System (MHL) provides information regarding offenders who have special treatment needs or who may present special management concerns.
3. The MHL Classification System provides information that can be used for program planning and administrative purposes, as well as in the allocation of current and future resources.
4. When an MHL Classification is assigned, it should reflect the offender's current mental status and service needs and not be based solely on a history of treatment.

B. Criteria

1. A Qualified Mental Health Professional (QMHP) will determine MHL and SMI during intake and will assess regularly, but no later than annually as determined by NCCHC standards. The QMHP will utilize a *Severe Mental Illness Determination* form for the initial evaluation.
2. The Mental Health Level Classification system criteria are as follows:
 - a. MH-4 Severe Impairment:

- 1) The offender has a current mental health diagnosis and is currently experiencing acute symptom severity and needs.
 - 2) The offender could be Severely Mentally Ill (SMI).
 - 3) The offender is either a danger to self or to others or is substantially unable to care for self.
 - 4) The offender may be prescribed psychotropic medications.
 - 5) The offender must have a documented current significant DSM diagnosis that led the individual to experience significant functional impairment or has consistently demonstrated dysfunctional or disruptive social interactions including withdrawal, bizarre or disruptive behavior, etc., as a consequence of any mental health diagnosis set out in the DSM.
 - 6) Acute, intensive, or stabilization mental health treatment is recommended.
- b. MH-3 Moderate Impairment:
- 1) The offender has a current DSM mental health diagnosis and is currently experiencing significant symptom severity and needs or is currently properly managing acute symptoms.
 - 2) The offender has an ongoing mental disorder and may be frequently unstable. The offender typically cannot function in the general population for extended periods of time and requires ongoing or periodic mental health monitoring or mental health monitoring and treatment.
 - 3) The offender may be prescribed psychotropic medications.
 - 4) This category typically includes:
 - a) offenders previously assigned as MH-4 who have been stabilized; or
 - b) offenders receiving stabilization treatment
- c. MH-2 Mild Impairment:
- 1) The offender has a current DSM mental health diagnosis and is currently experiencing moderate impairment and needs or is currently properly managing significant symptoms.
 - 2) The individual can typically function satisfactorily in a general population setting for extended periods. Monitoring by a therapist may be necessary.
 - 3) The offender may be prescribed psychotropic medication.
- d. MH – 1 Minimum Impairment:
- 1) The offender may have a history of mental health issues or current mental health diagnosis but is stable and has a high degree of symptom management.
 - 2) The offender does not currently require mental health treatment but has a history of self-directed violence, suicidal gestures or attempts, or mental health treatment within the past two years.
 - 3) The offender is not prescribed psychotropic medication and can function satisfactorily in a general population setting.
- e. MH-0 No Evidence of Mental Health Needs:
- 1) The offender has no documented history of mental health treatment within the past year (documented history does not include treatment for substance use alone, nor for evaluation purposes alone).
 - 2) There is no documented or reported behavior that currently indicates any mental health service needs.
 - 3) No monitoring or treatment by mental health is currently required.

C. Severe Mental Illness Classification

1. An offender with an MH 03 and 04 classification may be considered Severely Mentally Ill and will be subjected to additional criteria. The QMHP makes determinations regarding classification by the information provided by the offender and the resources made available to the QMHP. The offender must meet at least one of the following:

- a. the offender has undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime, such as emergency services, alternative residential living, or inpatient psychiatric hospitalization;
 - b. the offender has experienced a single episode of psychiatric hospitalization with a diagnosis of a major disorder, or
 - c. the offender has frequent crisis contact with a community health center or another mental health provider for more than 6 months as a result of a mental illness.
2. The offender must also meet at least 3 of the following criteria:
- a. the offender is unemployed or has markedly limited job skills or poor work history;
 - b. the offender exhibits inappropriate social behavior that results in concern by the community or requests for mental health or legal intervention;
 - c. the offender has been unable to obtain public services without assistance;
 - d. the offender requires public financial assistance for out-of-hospital maintenance, has difficulty budgeting public financial assistance, requires ongoing training in budgeting skills, or needs a payee;
 - e. the offender lacks social support systems in a natural environment, such as close friends and family, or the client lived alone or is isolated; or
 - f. the offender is unable to perform basic daily living skills without assistance.

D. Mental Health Modifiers

1. Mental Health modifiers are attached to the Mental Health Level to act as descriptors of an offender's behavior and as indicators of what support or service an offender may need.
2. Mental Health modifiers are assessed at every clinical interaction. The modifier that is most fitting for the current period of time is the one that is used.
 - a. The following modifier comes before the mental health classification number and indicates if the offender has a Severe Mental Illness (SMI), for example, MH-S3 (offender with a mental health level of 3 and meets SMI criteria).
 - 1) S - Severely Mentally Ill (SMI)
 - b. The following modifiers come after the number and are descriptive for both clinicians and other staff who work with the offender, for example, MH-S3P (offender with a mental health level of 3 that meets the SMI criteria and has a psychotic disorder, so the offender can be expected to talk to the offender's self and not be in the right mind, etc.).
 - 1) C – Cognitive impairment (for example, TBI, FAS, dementia, Huntington's symptoms, substance-induced cognitive symptoms).
 - 2) P – Psychotic disorder (for example, Schizophrenia)
 - 3) M – Mood disorder (for example, depression, bipolar)
 - 4) A – Anxiety disorder (including PTSD, generalized anxiety)
 - 5) PD – Personality disorders (for example, Borderline, Antisocial, Narcissistic)
 - 6) T – Temporary (used for those who have adjustment issues or going through process of ruling out diagnoses; T qualifiers should not be retained for more than 6 months).

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

- A. 53-21-102, MCA
- B. *Bureau of Prisons Policy Statement 5310.16, Treatment and Care of Inmates with Mental Illness*

VII. FORM

Severe Mental Illness Determination



POLICY DIRECTIVE

Policy:	DOC 4.5.62 SUICIDE PREVENTION AND INTERVENTION	
Effective Date:	11/23/2021	Page 1 of 2
Revision Date(s):	04/24/2026	
Department Director Signature:	/s/ Eric Strauss, Director	
Medical Director Signature:	/s/ Paul Rees, MD	
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN	

I. POLICY

The Department will prevent offender suicide whenever possible by implementing prevention efforts and intervention.

II. APPLICABILITY

All secure facilities.

III. DEFINITIONS (see Glossary)

IV. REQUIREMENTS

A. General Requirements

1. All facilities must develop written requirements for suicide prevention.
2. The responsible health authority and facility administrators will approve a facility's written requirements for suicide prevention.
3. Inmates may not be used to fulfill any supervision requirements of a suicide prevention plan.

B. Requirements of a Suicide Prevention Plan

1. Facilities will provide training of all staff who work with inmates to recognize cues of a potential suicide and how to respond. Initial and annual training is provided.
2. Qualified Mental Health Providers (QMHPs) will develop treatment plans that identify strategies and services that address the underlying reasons for suicidality as well as strategies when at a heightened risk as well as follow up intervention.
3. QMHPs shall promptly evaluate suicidal inmates.
4. QMHPs are the only individuals authorized to remove inmates from suicide precautions.
5. Acutely suicidal inmates shall be monitored by facility staff through constant observation.
6. Non-acutely suicidal inmates shall be monitored by facility staff at unpredictable intervals with no more than 15 minutes between checks.

7. Facilities will establish requirements for suicide prevention that include:
 - a. Written requirements to assess inmates during high-risk periods, including
 - 1) admission to the facility;
 - 2) following legal proceedings;
 - 3) after admittance to restrictive housing or single-cell housing;
 - 4) after receipt of bad news regarding self or family;
 - 5) after suffering humiliation or rejection; and
 - 6) pending release after a long period of incarceration.
 - b. written requirements to assist staff in screening, observing, and interviewing inmates in relation to the inmates' potential suicide risk.
 - c. monitoring of non-acutely suicidal and acutely suicidal inmates;
 - d. specific timelines for referral of potentially suicidal inmates and those who have attempted suicide to a QMHP;
 - e. QMHP evaluation criteria including level of suicide risk, level of supervision needed, need for additional supports, or potential transfer to an inpatient unit;
 - f. specific timelines for QMHP reassessment of suicidal inmates to determine changes in condition and need for a change in supervision level;
 - g. housing for suicidal inmates that provides for observational needs and suicide-resistant cells;
 - h. communication processes between mental health, medical, and security or correctional personnel as well as transferring authorities;
 - i. how to respond to an in-progress suicide attempt, including the provision of first aid;
 - j. written requirements to communicate attempted or completed suicides to correctional administrators, outside authorities, and family members;
 - k. documentation of completed and attempted suicides;
 - l. mental health, medical, and administrative review, including a psychological autopsy for completed suicides;
 - m. timely debriefing of all affected personnel and inmates; and
 - n. patient follow up, as clinically indicated.

V. CLOSING

Questions about this policy should be directed to the Health Services Bureau Chief.

VI. REFERENCES

A. *P-B-05; National Commission on Health Services in Prisons*

B. *MH-G-04; National Commission on Mental Health Services in Correctional Facilities*

Policy No. DOC 4.5.63	Effective Date: 12/20/2024	Revised:
Signature:	Position Title: Rehab and Programs Bureau Chief	



DEPARTMENT 340B OPERATION POLICY MANUAL

APPLICABILITY

All divisions, facilities, and programs of the Department of Corrections.

DEPARTMENT 340B Operational Policy Manual**TABLE OF CONTENTS**

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I. Introduction and Purpose

A. Introduction

This document encompasses the policies and procedures governing the Montana Department of Corrections' 340B Program. Its contents are subject to regular evaluation and can be updated by the Authorizing Official to align with the evolving nature of the State of Montana's 340B Program and any changes in programing parameters. Serving as a roadmap for success, the policy and procedure document reinforces the Department of Corrections' commitment to operating a compliant 340B Program that aligns with the State's overall mission of delivering exceptional healthcare and pharmacy services to the incarcerated population.

B. Purpose

To provide guidance and establish standard operating procedures for the 340B Program at the Montana Department of Corrections. The manual outlines the responsibilities and processes related to eligibility, program management, purchasing, inventory management, pharmacy operations, program integrity, recertification, program evaluation, documentation, training, and revisions. This manual applies to all employees and contractors involved in the 340B Program at Montana Department of Corrections. It covers all aspects of program implementation and compliance. This manual specifically addresses the requirements and considerations for a Covered Entity with the STD Clinic designation under the 340B Program as defined by Health Resources & Service Administration and the Office of Pharmacy Affairs.

II. 340B Program Overview

A. Background

Established in 1992, the 340B Program aims to maximize federal resources by granting Covered Entities access to heavily discounted medications and reducing the need for additional government subsidies. These savings are vital for enabling diverse grantees to sustain exceptional services and keep their doors open. In Montana, where pharmacy benefits and health services must be provided to the incarcerated population, the 340B Program expands the State's service capacity by significantly lowering pharmaceutical costs while maintaining high-quality care.

B. Program Goals

The State of Montana is mandated to provide healthcare and medical benefits to its incarcerated population. To achieve cost savings in pharmacy drug expenses for this population, the Montana Department of Corrections utilizes the 340B Program. The program allows the Department to allocate the generated savings towards other state-funded services. By leveraging the 340B Program, the State not only ensures exceptional care for the incarcerated population but also expands upon its commitment to achieving the overall mission and objectives set by the State.

C. Covered Entity Responsibilities

Covered Entities bear the responsibility for all aspects of compliance for the 340B Program, as mandated by the federal government. In line with this, the Montana Department of Corrections is obligated to fulfill various requirements, including preventing duplicate discounts, verifying patient and provider eligibility, managing pharmacy replenishment and inventory, and ensuring data accuracy in preparation for audits conducted by HRSA. Additionally, the State is required to maintain an accurate database and complete the recertification process annually. It is important to note the State reviews responsibilities every six months and updates when applicable. Please find below a list and description of Covered Entity responsibilities:

1. **Compliance with program requirements:** Covered Entities must adhere to the rules and regulations set forth by the Health Resources and Services Administration (HRSA) to ensure compliance with the 340B Program.
2. **Patient eligibility verification:** Covered Entities are responsible for confirming the eligibility of patients who receive 340B discounted medications, ensuring that they meet the program's criteria.
3. **Provider eligibility verification:** Covered Entities must verify the eligibility of healthcare providers to prescribe or dispense 340B drugs, ensuring they meet the program's requirements.
4. **Duplicate Discount Prevention:** Covered Entities must take measures to prevent the occurrence of duplicate discounts by ensuring that patients do not receive both 340B discounted medications and Medicaid drug rebates for the same drugs.
5. **Pharmacy inventory management:** Covered Entities need to effectively manage their pharmacy inventory to track 340B drugs, maintain proper records, and prevent diversion or misuse of medications.
6. **Data management and reporting:** Covered Entities are responsible for managing and maintaining accurate data related to 340B drug purchases, patient utilization, and compliance. They may be required to submit reports to HRSA as part of the program's auditing and oversight processes.
7. **Compliance audits:** Covered Entities may undergo audits conducted by HRSA or third-party auditors to assess compliance with the 340B Program. They must cooperate and provide necessary documentation and information during these audits.
8. **Recertification:** Covered Entities must complete an annual recertification process to verify their continued eligibility and compliance with the 340B Program. This process involves updating information and attesting to compliance with program requirements.

III. Eligibility Requirements

As a Covered Entity, the Montana Department of Corrections has the responsibility to ensure compliance with all requirements necessary to maintain eligibility in the 340B Program. This includes fulfilling the obligations and criteria set forth by the Health Resources and Services Administration (HRSA) to participate in the program successfully. By fulfilling these requirements, the Montana Department of Corrections can continue to benefit from the advantages and opportunities provided by the 340B Program. The State places significant focus on mitigating risks related to the patient, prescribing physician, medication, and site location within the 340B Program. This includes implementing measures to ensure patient safety, such as verifying patient eligibility and preventing medication errors. The State also works to maintain an eligible database and accurate medical records, which are essential for determining and maintaining program eligibility. By prioritizing these areas, the State aims to minimize risks and maintain compliance with the 340B Program's requirements.

A. Sexually Transmitted Disease (STD) Clinic Designation

The Public Health Service Act specifies which Covered Entities are eligible to participate in the 340B Program. There are currently fifteen grantee designation types under four covered entity classes qualifying for 340B. The Montana Department of Corrections qualifies for the 340B Program as a Sexually Transmitted Disease Clinic under Section 318, 42 USCS § 247c. Section 318 of the Public Health Service Act authorizes STD funding. Projects under Section 318 are awarded to the state and local health departments, academic, and public health organizations. The U.S. Department of Health and Human Services' Center for Disease Control

and Prevention (CDC) oversees and funds the prevention of sexually transmitted diseases (STD's).

The State must submit site locations to the Office of Pharmacy Affairs for eligibility approval. Sites can be submitted on a quarterly basis during an open Office of Pharmacy Affairs registration window outlined below for the following quarter:

1. January 1st - January 15th
2. April 1st - April 15th
3. July 1st - July 15th
4. October 1st - October 15th

Following the approval of an eligible site location, contract pharmacy implementation can occur. Upon the completion of contract pharmacy implementation, pharmacy claims submitted for eligible inmates from the designated site can be submitted for 340B eligibility. Site Locations (site locations are provided in the appendix) must be recertified annually during the STD recertification window.

IV. 340B Program Management

A. Montana Department of Corrections Program Primary Contacts

1. Authorizing Official: Health Service Bureau Chief
2. Primary Contact: Medical Health Services Manager
3. 340B Program Manager: Managed Care Registered Nurse
4. 340B Finance Manager: Sr. Accounting Manager
5. Outside Consultant: Pharmaceutical consultant contractor

B. Compliance Oversight Roles and Responsibilities

1. OPAIS 340B Authorizing Official (AO):

The AO is the final decision maker for all aspects of the program and is responsible for maintaining the integrity of the 340B Program. The AO is accountable for all aspects of program compliance. In addition to maintaining signatory rights all registration confirmations and program updates need to be confirmed by accepting emails sent directly to the authorizing officials email linked to the OPAIS database.

2. OPAIS Primary Contact:

The primary contact plays a crucial role in supporting the authorizing official in ensuring overall compliance with the 340B Program. Depending on the specific task, the primary contact has the authority to make certain updates in the OPAIS database. However, it is important to note that any changes made by the primary contact still require approval from the AO, which is confirmed through email confirmation.

3. 340B Program Manager:

The 340B Program manager holds the responsibility for the day-to-day operations of the 340B Program. This includes overseeing the management of Third-Party Administrators (TPAs) and contract pharmacy operations. Additionally, the program manager plays a vital role in maintaining compliance by conducting spot checks on the recommended number of claims by HRSA monthly. They collaborate with TPAs and contract pharmacies to resolve issues related to ineligible claims or inventory reconciliation. The program manager also updates policies and procedures as necessary, ensuring they align with program requirements. They are responsible for organizing and managing data reporting, as well as other components

required for an HRSA audit preparation. Furthermore, during the implementation phase, the 340B Program manager assumes full responsibility for all aspects of TPA implementation.

4. 340B Finance Manager:

The finance manager assumes responsibility for inventory reconciliation by processing payments for selected wholesaler invoices to replenish the pharmacy's 340B inventory. During the implementation phase, this individual is tasked with establishing a dedicated 340B wholesaler account. Moreover, the finance manager is also responsible for receiving checks from the pharmacy as part of pharmacy collections, which are then utilized for 340B replenishment. The difference between the collected amount and the replenishment cost is recorded as savings for the state, and the finance manager reports the financial aspects to the authorizing official.

5. Outside Consultant:

The outside consultant will partner with the State on all aspects of the 340B Program helping maintain compliance and mitigate risk. Consultant will work closely with all stakeholders and their respective 340B deliverables well as anything else the State needs to operate a successful 340B Program. Consultant will also assist with the TPA and contract pharmacy.

Please see Mock Audit Sample Universe & Audit Requirements

C. Claim Auditing and Monitoring

Monthly Claim Monitoring:

The State is required by HRSA to validate twenty (20) claims each quarter to ensure program integrity is maintained. The State will validate twenty (20) claims **monthly**, documenting findings and correcting errors if applicable. The State will check that the following eligibility criteria are met; Patient, Provider, Covered Entity Location, Medication, & Date of Service.

1. Monthly the Covered Entity will run a captured claims report for the previous months' activity.
2. The State will randomly select twenty (20) claims to validate.
3. The State will confirm data components within internal EMR/EHR or required state records:
 - a. **Patient:** Patient Name & DOB are consistent with the transaction record
 - b. **Provider:** The provider responsible for writing the script is credentialed, employed, or has a working relationship with the Montana Department of Corrections.
 - 1) In the event a provider terminates with the state refills are eligible for up to one year following the provider's departure.
 - 2) New prescriptions following the providers departure are not eligible.
 - c. **Covered Entity Location:** The script record is sent from an eligible state Department of Corrections 340B location as represented as active on the OPAIS database or a referral clinic.
 - d. **NDC:** Medication dispensed to the patient is clearly documented in the patients' medical record.
 - e. **DOS:** The Date of Service for the transaction is closely aligned with what is referenced in the medical record.
4. Monthly results from spot checks will be documented and utilized to display checks and balances during an HRSA audit.
5. If corrective action is needed like reversals, etc., it will be submitted to the 340B TPA Account management team. At the States discretion confirmation of fix may be kept along with monthly audit results.

D. Third Party Administrator

The Third-Party Administrator (TPA) will identify claims that are eligible for 340B, create invoicing, and facilitate replenishment back to the contract pharmacy.

1. See Appendix: 340B (TPA) Operational Description and Responsibilities

E. Third Party Consultant - Compliance

On a biannual basis, the consultant will conduct mock audits on the behalf of the State. The mock audit will be consistent with the actual HRSA audit. At the State's discretion, consultant can also support the Montana Department of Corrections with ongoing monthly claim spot checking and program maintenance. The consultant is committed to operating as an additional resource of the Montana Department of Corrections helping the state maintain a sustainable compliant 340B Program.

Please see 7.2 for a description of biannual mock auditing services.

V. Purchasing and Inventory Management

A. Drug Procurement

Upon the identification of an eligible 340B transaction, and after meeting or exceeding the minimum threshold for package quantity, replenishment will be triggered by 340B TPA back to Contract Pharmacy (CP). The State will be invoiced 340B pricing through the 340B Wholesaler. Please find below an example from 340B TPA virtual accumulation platform displaying purchase orders with 855 and 810 confirmation tracking.

B. Inventory Management

The program will operate on a virtual accumulation model managed by 340B TPA. The pharmacy will begin with their existing inventory. Replenishment for identified eligible 340B prescriptions will therefore restock the pharmacy at no cost eliminating the need to stock separate inventory for 340B and retail. Please find below a description of each major data component pertaining to the State's virtual accumulation model.

1. Inventory Due Accumulation Tracking:
 - a. The 340B price file will contain the package quantity per National Drug Code.
 - b. When an eligible claim is identified units dispensed will apply towards accumulations for the corresponding NDC. Following the minimum package quantity threshold being met or exceeded the TPA will trigger replenishment.
 - 1) An 855 file will be sent to the wholesaler accounting for the request to order.
 - 2) An 810 file will be sent back to the TPA upon fulfillment of delivery at the pharmacy. Following confirmation, the accumulations will be adjusted by NDC reflecting the delivery and recipe of medications.
 - 3) The virtual accumulation model eliminates potential diversion of inappropriately utilized medication by only replenishing medication after 1. Claims have been identified as eligible and 2. NDC's have met or exceeded the designated minimum package threshold required for replenishment included on the price file loaded by the TPA.
2. Overstock Data Tracking:
 - a. Following a reversal of a claim identified as ineligible when replenishment has already occurred the units affiliated with the reversal will be listed in the accumulative total for each NDC.
 - b. Units associated with dispensations to eligible patients of an NDC listed in Overstock will trend lower rather than be replenished resulting from the overstock adjustment.
 - 1) Example: NDC: 88888888888 Overstock QTY: 30
 - 2) 30 units of NDC 88888888888 dispensed to eligible Montana Department of Corrections patient
 - 3) 0 units due to pharmacy as the medication was replenished previously when determined eligible and reapplied to a new eligible patient following the reversal.

3. Orders for eligible 340B medications will be triggered by the 340B TPA and replenished through a wholesaler account owned and operated by the Covered Entity. Purchase Order Tracking will be made available to the state by the TPA in the event of an audit. The consultant will support the Montana Department of Corrections at the states discretion to help the process run smoothly.
 - a. Please reference the picture in 5.1 displaying the TPA Order Platform
 - b. Please find below Wholesaler Account Numbers by grantee site
 - 1) STD59620; Helena (Administration)
 - 2) STD596201; MWP
 - 3) STD59632; RSNU
 - 4) STD593014; Pine Hills
 - 5) STD59722; MSP

C. Diversion and Duplicate Discount Prevention

Below please find the measures in place to prevent drug diversion and ensure that 340B drugs are used solely for eligible patients.

1. Diversion of Medication to Non-340B Patients:
 - a. Montana Department of Corrections will operate a virtual inventory model. The contract pharmacy partner will begin the program with the pharmacies' existing inventory purchased through the standard retail account owned and operated by the pharmacy. The pharmacy will use medications purchased at the pharmacies pricing (non-340B) when dispensing to Montana Department of Corrections patients.
 - b. The state will replenish medications based on an NDC match back to the pharmacy at 340B pricing **only after** claims have been identified as eligible for the 340B Program and medications have met or exceeded package quantity.
 - c. Upon the replenishment of NDC's tied to eligible transactions, the State's 340B responsibility is complete per eligible transaction.
 - 1) The pharmacy can restock inventory on the shelf and dispense as normal.
2. Medicaid Fee for Service & 340B Duplicate Discount:
 - a. The State of Montana has elected to **CARVE OUT** Medicaid from 340B.
 - b. Patients will only be sent to the contract pharmacy utilizing eligible non-Medicaid fee for service BIN and PCN payor groups.
 - c. Medicaid BIN and PCN's blocked globally and applied to Montana Department of Correction's 340B Program.
 - 1) Please find below the current list of BIN and PCN Medicaid Blocks applied in the business logic of the states 340B Program:
 - d. Patient Medicaid Change - Montana Department of Corrections

VI. Patient Eligibility Verification and Confidentiality

A. Patient Eligibility Verification

Offenders within the custody of the Department of Corrections, and housed within the covered entity, have suspended Medicaid coverage. Suspended coverage automatically assures patient eligibility for the 340B Program.

B. Patient Confidentiality

The Department of Corrections protects the rights of employees, enforces high standards of professional conduct, and provides guidelines of performance and conduct for Department employees. See DOC Policy 1.3.2, Performance and Conduct, as well as the Montana Department of Corrections HIPAA Confidentiality Agreement.

VII. Program Integrity and Compliance

A. Compliance with 340B Program Requirements

Operating a compliant 340B Program in line with the program's intent as defined by the Health Resources and Services Administration (HRSA), is of significant benefit to the Montana Department of Corrections including yet not limited to the following elements:

1. Access to Affordable Medications:

The 340B Program was created to help eligible healthcare organizations, known as Covered Entities, stretch their scarce resources to serve vulnerable or underserved populations. Compliance with HRSA guidelines ensures that the state can access discounted drugs, helping the Montana Department of Corrections provide essential medications to patients at significantly reduced costs.

2. Financial Sustainability:

By adhering to 340B Program requirements, the State can maximize savings on pharmaceuticals the Montana Department of Corrections is entitled to and help prevent duplicate discounts. This enables the state to allocate more of their limited resources to other critical healthcare services, infrastructure improvements, or expanding services to reach more patients in need.

3. Improved Patient Outcomes:

Access to affordable medications can lead to better patient compliance with prescribed drug regimens, ultimately resulting in improved health outcomes. By adhering to HRSA guidelines, the State can enhance the quality of care they provide to their patients.

4. Community Health Impact:

The 340B Program aims to improve the health of underserved populations. By operating a compliant program, the State can positively impact Montana's incarcerated population by ensuring discounted drugs are available to those who need them and prevent diversion from ineligible patients, enabling the State to stretch resources as far as possible.

5. Enhanced Program Integrity:

Adhering to HRSA's strict guidelines and reporting requirements and maintaining program integrity will ensure the State avoids legal and financial repercussions, such as fines or exclusion from the program, that could result from non-compliance. Non-compliance with program requirements can lead to HRSA audits, which may result in recoupment of savings and other penalties. Operating a compliant program minimizes the risk of audits and associated financial consequences.

6. Transparency and Accountability:

Operating a compliant 340B Program by ensuring OPAIS records are accurate and up to date, promotes transparency, accountability, as well as the long-term viability of the State's 340B Program. At the State's discretion and upon request by the United States Department of Health and Human Services, or the subordinate agencies, such as the HRSA, which administer the national 304B Program, the State will demonstrate how savings benefit patients and the overall mission of the Department of Corrections.

7. Audits and Self-Audits:

The State will conduct a mock audit biannually in line with the exact methodology defined by HRSA. Please see below a description of the State's audit procedures and data universe elements.

Covered Entity Data Request

1. Provide policies and procedures on the following topics:

- A. Description of covered entity's registration and recertification process
- B. Process for ensuring that the 340B OPAIS record is up to date and accurate for the parent, applicable off-site outpatient facilities/grant-associated sites, and contract pharmacies (including regular review and timely update of 340B OPAIS records)
- C. Process for determining which sites are eligible; address whether each service area in which 340B drugs are purchased, ordered, or provided is included on the grant or reimbursable on the covered entity's most recently filed Medicare cost report (MCR)
- D. Description of procurement process (including contract pharmacy, if applicable)
- E. Prevention of GPO Prohibition violations (applies only to DSH, PED, and CAN)
- F. Definition for any exclusions to the definition of covered outpatient drugs (e.g., bundled drugs, orphan drugs, or inpatient drugs)
- G. Covered entity's process for conducting oversight of its contract pharmacy(ies):
 - Internal audits
 - Independent audits
- H. How the covered entity accounts for 340B inventory or accumulation, if applicable (physical inventory vs. virtual inventory replenishment)
- I. Prevention of diversion at **covered entity**—process for confirming the following:
 - Site eligibility location
 - Referral/responsibility of care remained with covered entity
 - Medical/patient health record
 - Patient eligibility (including status change)
 - Provider eligibility (relationship)
 - Service in the scope of grant (if applicable/non-hospital)
- J. Documenting and accounting for wastage of a drug not administered Prevention of diversion at **contract pharmacy**—process for confirming the following:
 - Site eligibility location
 - Referral/responsibility of care remained with covered entity
 - Medical/patient health record
 - Patient eligibility
 - Provider eligibility (relationship)
 - Service in the scope of grant (if applicable / non-hospital)

1. Provide policies and procedures on the following topics: (cont.)

- K. Mechanism to prevent duplicate discounts at **covered entity** and off-site facilities/grant associated sites for:
 - Physician administration
 - Outpatient prescriptions
 - Billing multiple state Medicaid agencies, if applicable
- L. Mechanism to prevent duplicate discounts at **contract pharmacies** for outpatient prescriptions
- M. When and how covered entity would self-disclose and covered entity's definition of noncompliance material breach
- N. Definition of eligible site when the location is not on the MCR yet or for a special circumstance (e.g., COVID-19, flooding)

2. Provide Covered Entity Eligibility Documentation

Hospitals

- A. A listing of locations where health care services are provided to persons for whom the hospital deems itself responsible for the health care services provided for purposes of meeting 340B eligibility, including physical addresses
- B. The applicable MCR(s), including the encrypted signature stamp on worksheet S:
 - The MCR that was used at the time of the last recertification in OPAIS
 - The MCR filed closest to the start of the sample period
- C. The MCR(s) filed since the start of the sample period through the date of the on-site/remote audit For each off-site outpatient facility that utilizes 340B drugs (at the facility or through contract pharmacy), provide the trial balance that was **submitted to CMS** with the MCR(s). For each MCR and corresponding trial balance, include a trial balance crosswalk.

For each off-site facility, the trial balance crosswalk should include:

- 340B ID
- Name of each off-site outpatient facility as identified on 340B OPAIS
- Address of the off-site outpatient facility
- MCR line number and cost center description, as listed on MCR worksheets A and C
- Trial balance name and department code/account
- The location code or shorthand used to identify the site in the electronic health record (EHR)
- Whether 340B drugs are utilized during encounters at each site

2. Provide Covered Entity Eligibility Documentation (cont.)

Grantees

- A. A listing of locations where health care services are provided to persons for whom the grantee deems itself responsible for the health care services provided for purposes of meeting 340B eligibility, including:
- Name
 - Physical address
 - Location code or shorthand used to identify the site in the covered entity's electronic health record (EHR).
- B. Notice of Grant Award (NGA) and/or sub-grantee documentation, or FQHC-LA designation or FQHC638 compact agreement.
- Include forms 5A (scope of services) and 5B (service locations) if grantee is listed in HRSA's Electronic Handbook (EHB)
 - Sub-grantee documentation may include:
 - a. Notice of Funding Award between the primary grantee and sub-grantee
- C. NGA project narrative that clearly indicates the sub-grantee's receipt of funding In-kind support (e.g., contracts, agreements, or memoranda of understanding)

3. Provide a 340B Universe for the Sample Period

- A. Include a narrative describing the methodology, system/software by which the data were gathered, and any limitations or exclusions (e.g., whether reversed transactions or any other elements were excluded, other 340B orders or dispenses, direct purchases included, or other purchasing mechanisms). Define each area of service on the spreadsheet(s) with column headings name and indicate which area the spreadsheet represents.
- B. Provide a list of all 340B drugs that were administered or dispensed to patients from the parent site, off-site facilities/grant-associated sites, and pharmacies (entity-owned and contracted) during the 6-month sample period (preferably in Excel format or another electronic format).

Include the following data elements in the listing:

- The drug/product name
- NDC
- The acquisition cost
- The type of account the drug was purchased through, purchase account, and the associated 340B ID number
- The quantity issued
- The patient ID number (this is typically the medical record number or prescription number, but can be any number you assigned that will allow tracking through the covered entity's system to retrieve all information associated with the order)
- The payer (all payers including Medicaid, primary, secondary and tertiary payers)
- The date the order (mixed-use pharmacy) or prescription (entity-owned or contract pharmacy) was written
- The ordering provider

3. Provide a 340B Universe for the Sample Period (cont.)

C. The location/site at which the 340B drug was administered/ordered (mixed-use pharmacy) or prescribed (in-house or contract pharmacy)

- The date the drug was administered or dispensed

A sample of administrations/dispenses will be selected for testing during the on-site/remote audit. For the selected items, individual records will need to be available in either electronic or paper format. If EHRs are used, provide an individual with system knowledge to navigate the EHR (including billing information) and the split-billing software/third party. Scans of hard copies of selected documents may be requested to be uploaded to the NIH secure site.

*The **covered entity** must ensure that no protected health information (PHI) and personally identifiable information (PII), such as a patient's name, date of birth, and address, is submitted in the data request list uploads*

4. Provide a Provider List

Provide a list of the covered entity's eligible providers, including:

- First name
- Last name
- NPI
- Whether employed/contracted, including start and termination dates of employment/contract (preferably in Excel format)

Note: Be prepared to show the auditor proof of employment, contract, or credentialing for providers during the on-site/remote audit.

5. Provide Purchasing Documentation

A. Provide a list of all accounts (wholesaler, direct, and consignment) used to purchase drugs for the parent, off-site facilities/grant-associated sites, and all pharmacies (entity-owned and contracted),

- Wholesaler name
- Account number
- Account name
- Location that receives the drugs (e.g., unique identifier for covered entity site or pharmacy)
- Locations that dispense the drugs (e.g., unique identifier for covered entity site or pharmacy)
- For 340B accounts, include the 340B ID associated with account (the 340B ID used to open/establish the account)

B. Provide a copy of one invoice, during the sample period, for each account identified in the listing of accounts requested above. If an invoice is not available within the sample period, provide the most recent invoice available.

C. Provide a list of covered entity (parent, off-site facilities/grant-associated sites, and all pharmacies (entity-owned and contract pharmacies) 340B drug purchase orders made during the 6-month sample period (preferably in Excel format).

5. Provide Purchasing Documentation (cont.)**Include the following data elements in the listing:**

- Ordering location (parent, off-site facilities/grant-associated sites, or contract pharmacy)
- Wholesaler name
- Account number
- Invoice number
- Invoice date
- Drug description
- Drug NDC
- Quantity ordered
- Price paid

6. Provide Contract Pharmacy Documentation

- A. Provide a list of all covered entity's contract pharmacies since the beginning of the audit period through the date of the on-site/remote audit.

For each contract pharmacy location, indicate whether the pharmacy is used by the covered entity.

- B. For each of the contract pharmacies, provide the original agreement and any amendments/addenda. Highlight the following areas in each contract pharmacy agreement/amendment/addendum:
- Signatures, including dates, of both parties executing the contract
 - Name and address for each contract pharmacy location participating in the contract pharmacy agreement
 - Each covered entity location by name and address **or** a general statement that inclusively identifies the parent and all covered entity location(s) participating in the contract pharmacy agreement
- C. Provide a cover page or a statement on letterhead from the organization that conducted the last independent audit of the covered entity's contract pharmacies.
- The document should include:**
- Audit date
 - Period audited
 - Who performed the audit
 - Scope of the audit
- D. Provide supporting documentation of any internal contract pharmacy audits conducted by the covered entity from the start of the sample period through the date of the on-site/remote audit.

B. Reporting Requirements

The state of Montana will require electronic, standard and customizable reports for all areas required for implementation, operation, and compliance to federal and state requirements related to a 340B discount pharmaceutical program.

C. Material Breach and Corrective Action

The Authorizing Official solely has the discretion to determine if a breach of compliance is deemed material as outlined by HRSA. The State of Montana and consulting partner will proactively mitigate risk reducing the chance to near zero of a material breach.

On a case-by-case basis in the unlikely event of a breach determined to be material the state will determine the best plan needed for self-reporting or financial reconciliation.

VIII. Recertification Process

Annually during the designated window for STD grantees upon notification from HRSA the primary contact or authorizing official will facilitate the recertification process on the OPAIS database.

An email will be sent to both parties with a unique link to login and recertify each site location:

- a. STD59620; Helena (Administration)
- b. STD596201; MWP
- c. STD59632; RSNU
- d. STD593014; Pine Hills
- e. STD59722; MSP

IX. Program Evaluation, Performance Reviews, and Quality Improvement

A. Annual Program Evaluation

The outside consultant will formally conduct a 340B Program annually review. Program opportunities and threats will be identified if applicable. The outside consultant will deliver an action plan to the state's primary contact and support the states action plan for quality improvement upon request.

B. Biannual Performance Reviews

The consultant will conduct a strategic performance review on a biannual basis. In addition to mitigating risk the performance review will outline savings, program performance, inventory reconciliation reviews as well as TPA technical solution reviews.

Following the delivery of the performance review and collaboration between the consultant and Montana Department of Corrections will orchestrate program enhancements, if necessary, with the appropriate 340B Program stakeholders such as the TPA, contract pharmacy, wholesaler etc.

X. Documentation and Record Keeping

A. Documentation Requirements

OPAIS Database:

Eligibility documentation will be maintained and current on the OPAIS database. The Authorizing Official will review quarterly and make appropriate changes as needed.

Captured Claims:

Captured claims will be housed at the 340B TPA for a minimum of seven (7) years and available to the state upon request at any time. The state will have access to the cloud-based platform offered by 340B TPA to physically pull claims in real time if needed.

Purchase Order History:

Purchase orders will be housed both at the TPA level within the platform as well as in the wholesalers. In the event of an audit purchase order history will be able to be presented to HRSA. The TPA will house purchase order history for seven years.

Policy and Procedures:

The policy and procedure document is an evolving product that should be validated as current at a minimum every year; however, every six months is recommended. When program changes or stakeholder changes occur, the policy and procedure document should be updated immediately. This document is required to be presented to HRSA when the onsite audit occurs.

340B Pharmacy Service Agreements:

The state is required to maintain the Pharmacy Service Agreement (PSA) with Diamond Pharmacy. If changes occur, an amendment is sufficient to be included with the existing contract. The PSA will be required to present to HRSA in the event of an audit.

XI. Record Retention

The Department of Corrections understand that health care information is protected by a right of privacy and will maintain health record confidentiality as well as retain and store offender health records in accordance with Montana statute, 41-3-201, MCA; Title 50, Chapter 16, MCA, and DOC Policy 1.5.5, Offender Records Management, Access and Release. DOC Policies 1.5.6, Offender Records Access and Release, and 4.5.38, Offender Health Record Access, Release, and Retention. Offender's protected health information (PHI) shall not be made accessible to Legislative Auditor Division without a HIPAA-compliant release and if applicable 42 CFR Part-2 compliant releases signed by the offender.

XII. Programing Training and Education

The Consultant Group will support the Montana Department of Corrections in providing staff training to new program managers, primary contacts, authorizing officials, or other state employees.

XIII. Policy and Procedure Updates

The policy and procedures template will be reviewed yearly and made current. Each section will need to be validated as well as the Operational components found in the Appendix.

XIV. Glossary and Appendix

A. Glossary

1. **340B Program:** A federal program that provides eligible healthcare organizations access to discounted pharmaceuticals.
2. **340B TPA:** Third Party Administrator responsible for adjudicating claims and determining claim eligibility for 340B. Maintains virtual accumulation inventory tracking and auditable records to be used during an audit.
3. **45 CFR parts 160,162, and 164:** The Security Rule requires appropriate administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.
4. **American Society for Industrial Security (ASIS):** Largest membership organization for security management.
5. **Authorizing Official:** Per HRSA, an authorizing official is someone who represents and confirms that he/she is fully authorized to legally bind a 340B covered entity into a relationship with the federal government and has knowledge of the practices and eligible programs at that site.
6. **Bank Identification Number (BIN):** 1st part of payer identification used to process a prescription.
7. **Blocks:** Application of program parameters preventing undesired (NDC's or payer groups primarily) claims from processing through the 340B Program.
8. **Buy-outs:** Synonymous with True-Up as defined in 10. Different offerors will refer to this process either as a "True-Up or "Buy-out."
9. **Covered Entity:** An eligible healthcare organization that participates in the 340B Program.
10. **Health Insurance Portability and Accountability Act (HIPAA):** Law in 1996, as amended, that restricts access to private medical information.
11. **Health Resources & Services Administration (HRSA):** Department within the U.S. Department of Health and Human Services. Combined with the Office of Pharmacy Affairs 340B

was established and maintained by these governmental organizations part of U.S. Department of Health and Human Services.

12. **HITECH**: Act of 2009 legislation that was created to drive the adoption of Electronic Health Records.
13. **Information Systems Security Association International (ISSA)**: membership organization for security management.
14. **InfraGard**: National non-profit organization serving as a public-private partnership between U.S. businesses and the FBI.
15. **Intrusion Detection System (IDS)**: application that monitors network traffic.
16. **Intrusion Prevention System (IPS)**: Intrusion Prevention System used for data security measures preventing breaches.
17. **National Drug Code (NDCs)**: NDC -9, NDC-11
 - a. 9-Digit replenishment occurs when first 9 numbers are matched together
 - b. 11 Digit replenishment occurs when all 11 digits match
18. **Offeror's Contract Liaison** – Contracting stakeholder at 340B TPA.
19. **Product Code Number (PCN)**: Product Code Number – 2nd part of payer identification used to process a prescription.
20. **Security Information and Event Management (SIEM)**: enables centralized compliance auditing and reporting across an entire business infrastructure.
21. **Sexually Transmitted Disease (STD) Clinic**: Eligible grantee designation that the state of Montana Department of Corrections qualifies for the 340B Program as.
22. **SOC II**: One of the most reputable and standardized auditing requirements for respected Pharmacy Benefit Management companies.
23. **State's Contract Liaison**: Contracting stakeholder at Montana Department of Corrections.
24. **True-ups**: Process of reconciling captured NDC's in the 340B Program after 90 or 120-day window after being dispensed and not able to be replenished back to the pharmacy. Reasons for unfulfillment include manufacturer discontinuation, ongoing out of stock or below the minimum replenishment threshold.
25. **Type III third party audit**: reports that test the operation of measures periodically using robust standards or frameworks such as ISAE 3402/SSAE16 and SOC reports.

B. Appendix**Documentation of Eligibility:**

STD59620 Montana DPHHS (Active)

Main Details

Name	Montana DPHHS
Subdivision Name	Montana Department of Corrections
Type	Sexually Transmitted Diseases
340B ID	STD59620
Grant Number	NH25PS005168-05-00
Nature of Support	Direct Funding (dollars received from CDC or an intermediate organization) Note: In-kind contributions may be in the form of real property, equipment, supplies and other expendable property, and goods and services directly benefiting and specifically identifiable to the project or program.
Please Describe the "in-kind" Support	
Time period section 318 funding or in-kind support was received	7/13/2022

Contacts

Authorizing Official	Primary Contact
Montana Department of Corrections Cindy McGillis-Hiner, Health Services Bureau Chief (406) 444-5439	Montana Department of Corrections Margaret BROCKHAUS, PROJECT MANAGER (406) 410-1401

STD593014 Montana Department of Public Health and Human Services/Pine Hills (Active)

Main Details

Name	Montana Department of Public Health and Human Services/Pine Hills
Subdivision Name	
Type	Sexually Transmitted Diseases
340B ID	STD593014
Grant Number	NH25PS005168-05-00
Nature of Support	Direct Funding (dollars received from CDC or an intermediate organization) Note: In-kind contributions may be in the form of real property, equipment, supplies and other expendable property, and goods and services directly benefiting and specifically identifiable to the project or program.
Please Describe the "in-kind" Support	
Time period section 318 funding or in-kind support was received	8/11/2022

STD596201 Montana Department of Public Health and Human Services/MWP (Active)

Main Details

Name	Montana Department of Public Health and Human Services/MWP
Subdivision Name	
Type	Sexually Transmitted Diseases
340B ID	STD596201
Grant Number	NH25PS005168-05-00
Nature of Support	Direct Funding (dollars received from CDC or an intermediate organization) Note: In-kind contributions may be in the form of real property, equipment, supplies and other expendable property, and goods and services directly benefiting and specifically identifiable to the project or program.
Please Describe the "in-kind" Support	
Time period section 318 funding or in-kind support was received	8/11/2022

STD59632 Montana Department of Public Health and Human Services/RSNU (Active)

Main Details

Name	Montana Department of Public Health and Human Services/RSNU
Subdivision Name	
Type	Sexually Transmitted Diseases
340B ID	STD59632
Grant Number	NH25PS005168-05-00
Nature of Support	Direct Funding (dollars received from CDC or an intermediate organization) Note: In-kind contributions may be in the form of real property, equipment, supplies and other expendable property, and goods and services directly benefiting and specifically identifiable to the project or program.
Please Describe the "in-kind" Support	
Time period section 318 funding or in-kind support was received	8/11/2022

STD59722 Montana Department of Public Health and Human Services/MSP (Active)

Main Details

Name	Montana Department of Public Health and Human Services/MSP
Subdivision Name	
Type	Sexually Transmitted Diseases
340B ID	STD59722
Grant Number	NH25PS005168-05-00
Nature of Support	Direct Funding (dollars received from CDC or an intermediate organization) Note: In-kind contributions may be in the form of real property, equipment, supplies and other expendable property, and goods and services directly benefiting and specifically identifiable to the project or program.
Please Describe the "in-kind" Support	
Time period section 318 funding or in-kind support was received	8/11/2022

Contacts

Authorizing Official	Primary Contact
Montana Department of Corrections	Montana Department of Corrections
Cindy McGillis-Hiner, Health Services Bureau Chief	Todd Boese, Managed Care RN
(406) 444-5439	(406) 444-4761



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 4.6.2	Subject: RELEASE, TRANSFER, AND MOVEMENT PROCEDURES	
Chapter 4: FACILITY/PROGRAM SERVICES	Page 1 of 4	
Section 6: Release/Placement	Effective Date: April 1, 1998	
Signature: /s/ Mike Batista, Director	Revised: 11/27/2013	

I. POLICY

The Department of Corrections adheres to legal requirements and procedures that balance the safety needs of victims and the public with the needs of offenders when it releases, transfers, or moves offenders from, or within, Department facilities/programs or from Department custody and jurisdiction.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in the contract.

III. DEFINITIONS

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Adult Community Corrections Division (ACCD) – Composed of facilities and programs that include: Probation and Parole Bureau; Prerelease Centers (PRC); Sanction, Treatment, Assessment, Revocation & Transition (START); Warm Springs Addictions Treatment and Change Program (WATCH); Connections Corrections Program (CCP); Passages Alcohol and Drug Treatment (Passages ADT); Intensive Supervision Program (ISP); Missoula Assessment and Sanction Center (MASC); Passages Assessment, Sanction & Revocation Center (Passages ASRC); NEXUS Correctional Treatment Center (NEXUS); Elkhorn Treatment Center (Elkhorn); and Treasure State Correctional Training Center (TSCTC).

Admission/Discharge Report (ADR) – The mandatory reporting form completed by staff when offenders move from one program location to another.

Authorizing Authority – Individuals who have the authority to authorize a release or transfer, e.g., administrators, records supervisors, institutional probation and parole officers, classification managers, or the Board of Pardons and Parole.

Gate Money – Monetary benefit provided to eligible inmates at the time of discharge/parole from the custody and supervision of a secure adult facility up to \$100.

Offender Management Information System (OMIS) – The Department's electronic data collection and reporting system.

Release from Custody – Placement of an offender outside the confines of a state correctional

Policy No. DOC 4.6.2	Chapter 4: Facility/Program Services	Page 2 of 4
Subject: RELEASE, TRANSFER, AND MOVEMENT PROCEDURES		

facility, private prison, regional adult correctional facility, or adult community corrections facility/program within or outside the State of Montana.

IV. DEPARTMENT DIRECTIVES

A. Release Requirements

1. Department divisions, facilities, and programs will develop procedures to address the release or transfer of offenders. General release procedures will include proper documentation, including the following:
 - a. authentication of release authorization documents by the assigned staff member and verification that there are no outstanding warrants, detainers, or notifications;
 - b. verification by telephone with a recognized representative of the authorizing agency regarding faxed computer-generated release authorizations; no offender will be released solely on the basis of a faxed or computer-authorized message;
 - c. verification that supervising agencies, community criminal justice officials, and registered victims have been notified pursuant to 46-24-212, MCA;
 - d. authentication of the offender's identity by photograph and comparison of physical description; and
 - e. copy of the order for release or transfer received by the facility/program, prior to the release.

B. Admission/Discharge Reporting and OMIS Data Entry

1. The DOC Admission/Discharge Report (ADR) is a document that assists in ensuring that the release and placement information of offenders under Department jurisdiction is documented, directed, and communicated in an accurate and expeditious manner.
2. Administrators will ensure that the appropriate staff completes the DOC Admission/Discharge Report (ADR), in accordance to the DO Admissions and Discharge Reporting (ADR) (Processing) Matrix for all offender admissions, discharges, or transfers excluding cell-to-cell moves that are inside a single unit or pod and does not modify the custody status of the offender.
3. The DOC Admission/Discharge Report (ADR) must be completed and received by the Classification and Placement office for male offenders or to the MWP Movement Coordinator for female offenders by 3:00 p.m. the day before an offender is scheduled to discharge.
4. Staff will make location entries in OMIS in accordance with the DOC Admissions and Discharge Reporting (ADR) (Processing) Matrix.

C. Processing & Releasing Offenders

1. Notification:
 - a. the appropriate staff member will notify the authorizing authority when an offender is scheduled for release;
 - b. in the case of discharge, discharge balance suspended, parole, or conditional release, the staff member responsible for maintaining offender records will ensure that the release information is entered in OMIS in accordance with the DOC Admissions and

Policy No. DOC 4.6.2	Chapter 4: Facility/Program Services	Page 3 of 4
Subject: RELEASE, TRANSFER, AND MOVEMENT PROCEDURES		

- Discharge Reporting (ADR) (Processing) Matrix;
- c. the authorizing authority, or designee, will:
 - 1) notify any victims who are registered for notification with the Department;
 - 2) ensure that the treatment plan is completed; check for applicability of Sex Offender/Violent Registration Act notification requirements;
 - 3) send a memorandum or form to all applicable internal units and outside entities notifying them of the offender's release date;
 - 4) obtain the proper release forms; and
 - 5) instruct the offender on transfer procedures that may entail a contract and travel permit.
- 2. Accounts and Gate Money:
 - a. the appropriate staff member will notify the offender accounts office of the date of release; and
 - b. the accounts office will issue a check for the balance in the offender's account, and when applicable, gate-money, upon the offender's release in accordance with DOC Policy 1.2.15, Gate Money.
- 3. Medical Clearance for offender release will follow the guidelines of DOC Policy 4.5.22, Offender Health Care Continuity.
- 4. Physical Release:
 - a. designated facility/program staff may make transportation arrangements prior to the offender's release and will complete and forward release authorization forms to the appropriate staff members. The authorization forms will include the following:
 - 1) offender's name and DOC ID number;
 - 2) current location (housing unit or facility/program); and
 - 3) type of release.
- 5. Records:
 - a. facility/program staff will forward offender files to the appropriate records office for storage according to direction provided in DOC Policy 1.2.7, Inventories/Records Management.
- 6. Personal Property:
 - a. when an offender is released from custody, all state property will be collected by the facility/program;
 - b. clothing appropriate to the season will be provided to offenders who were committed without salvageable or suitable clothing; and
 - c. established offender personal property procedures will be followed when transferring offender property to another facility/program.

V. CLOSING

Questions concerning this policy should be directed to the appropriate administrator.

VI. REFERENCES

- A. 2-15-112, MCA

Policy No. DOC 4.6.2	Chapter 4: Facility/Program Services	Page 4 of 4
Subject: RELEASE, TRANSFER, AND MOVEMENT PROCEDURES		

- B. 46-24-212, *MCA*
- C. 53-1-203, *MCA*
- D. 53-30-111, *MCA*
- E. DOC 1.2.7, Inventories/Records Management
- F. DOC 4.5.22, Offender Health Care Continuity
- G. DOC 1.2.15, Gate Money

VII. ATTACHMENTS

[DOC Admission/Discharge Report \(ADR\)](#)

[PDF](#)

[DOC Admissions and Discharge Reporting \(ADR\) \(Processing\) Matrix](#)

[PDF](#)



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 4.6.3	Subject: DOC COMMITMENTS
Chapter 4: FACILITY/PROGRAM SERVICES	Page 1 of 2
Section 6: Release/Placement	Effective Date: Oct. 29, 1999
Signature: /s/ Mike Batista, Director	Revised: 05/10/2016

I. POLICY

The Department of Corrections refers adult offenders and criminally convicted youth committed to the Department to appropriate placements in Department and contracted facilities or programs including assessment centers, prerelease centers, specialized treatment programs, and secure care facilities and may place offenders committed to the Department in the community on conditional release status upon recommendation of Probation and Parole Division staff.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Assessment Center – A Probation and Parole Division facility or program that evaluates the needs of offenders for placement in the community.

Conditional Release – A status that applies to offenders who are committed to the Department of Corrections, placed in a community corrections program, and may be released to community supervision.

Criminally Convicted Youth – Any youth convicted in district court pursuant to 41-5-206, MCA except a youth convicted of a crime that carries a possible punishment by life, death, or 100 years in prison is a criminally convicted youth.

DOC Commitment – A commitment by the district court of an adult offender, criminally convicted youth, or extended jurisdiction youth pursuant to 41-5-1602, MCA, for placement in a state correctional facility or program operated by the Department or under the authority of the Department pursuant to 46-18-201, MCA.

Probation and Parole Division (PPD) – The division that oversees the probation and parole regional offices, interstate transfers, and the facilities providing assessments and sanctions, training, prerelease, and treatment services.

IV. DEPARTMENT DIRECTIVES

A. General Requirements of DOC Commitments

1. Each DOC commitment must be placed in the county jail until the offender has been assessed and classified by the Probation and Parole (P&P) Bureau for appropriate placement within the corrections system. If the offender has been assessed and classified prior to sentencing, the offender may be immediately placed in the appropriate facility or program.

Policy No. DOC 4.6.3	Chapter 4: Facility/Program Services	Page 2 of 2
Subject: DOC COMMITMENTS		

2. P&P is responsible for determining the appropriate placement of all offenders given DOC commitments. The regional administrator or P&P Officer II (PO II) must approve each placement.
3. If a DOC committed offender is not considered appropriate for initial community placement by the regional P&P office, the offender may be placed in an assessment center or directly placed in a secure care facility if approved by the PPD administrator.
4. PPD will develop procedures to implement placement of DOC commitments that include screening and classification to determine appropriate placement.
5. The Department will assume financial responsibility for the care and custody of DOC commitments in district court from the time of sentencing.
6. Placement of criminally convicted youth in an adult secure facility will follow the guidelines of *DOC 4.6.9 Placement & Reporting of Youth with Adult Sentences*.

B. Conditional Release of DOC Commitments

1. When conditionally releasing DOC commitments, the Department will:
 - a. follow established PPD procedures for the release and supervision of DOC commitments;
 - b. release only eligible offenders; and
 - c. ensure that the requirements of the victim notification statute 46-24-212, *MCA* has been met.
2. PPD facilities and programs and the P&P Bureau may use an assessment center for sanctions. PPD will establish procedures for the use of assessment centers for sanctions.

C. Offender Status – Disciplinary/Absconders

1. Adult offenders on conditional release status who fail to comply with conditions of supervision will be arrested and provided minimal due process as provided in PPD procedures. For DOC committed offenders failing to report as instructed or absconding supervision, officers will follow warrant and arrest procedures outlined by PPD.
2. A DOC committed offender found guilty of a disciplinary violation may be returned to a higher level of custody including incarceration.

V. CLOSING

Questions concerning this policy should be directed to the Probation and Parole bureau chief or Probation and Parole division administrator.

VI. REFERENCES

- A. 2-15-112, *MCA*; 41-5-1602, *MCA*; 46-18-201, *MCA*; 46-24-212, *MCA*; 53-1-203, *MCA*
- B. *DOC Policy 4.6.9 Placement & Reporting of Youth with Adult Sentences*

VII. ATTACHMENTS

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 4.6.5	Subject: ADULT DETENTION PLACEMENTS
Chapter 4: FACILITY/PROGRAM SERVICES	Page 1 of 3
Section 7: Release/Placement	Effective Date: 01/01/1997
Signature: Mike Ferriter	Revised:12/21/2012

I. POLICY

It is the policy of the Department of Corrections to utilize available bed space in detention centers when a Department-owned or contracted facility or program exceeds emergency capacity, or suitable housing for select inmates does not exist.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Detention Center - A facility operated by the federal government, a public or private corporation, other states, or a local county or unit of government for the purpose of detaining and/or incarcerating adult offenders.

Emergency Capacity - The maximum capacity of a correctional facility or program that does not compromise safe or secure operation; in accordance with [53-30-106, MCA](#), if a correctional facility or program exceeds emergency capacity for 30 consecutive days, the Department director may temporarily stop admissions.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. The Department director, or designee, may place an offender(s) under Department supervision in a detention center as outlined under [53-30-106, MCA](#) when the emergency capacity of a Department-owned or contracted facility or program is reached or the Department has no institution adequate for certain inmate(s) and no reasonable alternative exists, or for select inmate(s) when suitable housing has been established.
2. Prior to placement of adult offenders in a detention facility, the Department and detention facility must complete a contract outlining the following elements:
 - a. reimbursement rates;
 - b. expectations and obligations; and
 - c. the number of detention center beds available.
3. The Department may utilize publicly or privately owned detention centers when suitable and reimbursement is within budgetary limits.

Policy No. DOC 4.6.5	Chapter 4: Facility/Program Services	Page 2 of 3
Subject: ADULT DETENTION PLACEMENTS		

4. The Department will make a coordinated effort to expedite the transfer of offenders housed in detention facilities to a Department-owned or contracted facility or program and, if a detention center cannot continue to house an offender, the Department will transfer the offender as soon as possible.

B. Financial Responsibilities

1. When an offender is placed in a detention center, payment will be made at the basic rate established in contract unless the offender is placed on a county jail holding list, at which time the Department will pay the established per diem rate beginning on the date the sentencing order is signed. The Department will not pay greater than the established basic rate.
2. The Department will not reimburse detention centers for offenders arrested by Department staff who are Montana probation violators or fugitives from an out-of-state jurisdiction.
3. Financial responsibility of an offender removed from Department custody and transported to a local detention center by court order for a court appearance in a civil or criminal matter will adhere to the following:
 - a. the county of the detention center is responsible for costs associated with daily per diem, routine sick call, and medical care;
 - b. the Department is responsible for the cost of chronic and emergent medical care; and
 - c. if the offender is returned to Department custody and space is unavailable, the offender may be placed on the detention center's jail holding list at which time the Department will assume financial responsibility from when the county notified the Department until the offender is transferred to a Department correctional facility.
4. When an offender under Department-supervision is placed in a detention center the Department will assume financial responsibility for the following:
 - a. cost of housing an offender on escape status in a detention center when apprehended;
 - b. damage to the detention facility caused by an offender;
 - c. upon prior approval from the Department director, or designee, program services such as education, vocational programming, and substance abuse counseling; and
 - d. upon approval from the Health Services Bureau chief, or designee, medication, non-emergency medical service, and hospitalization expenditures, and dental services.

C. Health Care

1. When a detention center must secure emergency medical or dental services for an offender and prior approval is not possible, the detention center must notify the Health Services Bureau within 48 hours.

D. Out-of -State Placements

1. The Department may use of out-of-state placements in the following circumstances:
 - a. for long-term offenders previously received and classified at a Department-owned or contracted facility or program; or

Policy No. DOC 4.6.5	Chapter 4: Facility/Program Services	Page 3 of 3
Subject: ADULT DETENTION PLACEMENTS		

- b. to provide space at a Department-owned or contracted facility or program to place offenders housed in local detention centers.

E. Transportation

1. The Department will make every effort to cooperate with counties to support cost effective and secure transportation of inmates, transportation responsibilities will be determined according to the following:
 - a. transportation is the responsibility of a sentencing county when the following are met:
 - 1) an offender is sentenced to Department supervision;
 - 2) an offender is transferred to a detention center outside of the county in which the offender was convicted or sentenced; or
 - 3) an offender on probation is transferred from one detention center to another;
 - b. transportation is the responsibility of the Department when the following are met:
 - 1) an offender under Department-supervision not on probation is transferred from one detention center to another; or
 - 2) an offender placed out-of-state must be transported to a local detention center by court order for a court appearance in a civil or criminal matter.
2. Sentencing counties are responsible for transporting parole violators to Department custody as soon as possible after parole revocation proceedings are complete.

V. CLOSING

Questions concerning this policy are directed to the applicable facility administrator.

VI. REFERENCES

- A. [53-1-203, MCA](#); [53-30-106, MCA](#); [7-32-2222, MCA](#); [7-32-2242, MCA](#); [7-32-2243, MCA](#)

VII. ATTACHMENTS

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 4.6.7	Subject: MEDICAL PAROLE
Chapter 4: FACILITY/PROGRAM SERVICES	Page 1 of 5 and Attachments
Section 6: Release/Placement	Effective Date: Mar. 11, 1996
Signature: /s/ Reginald D. Michael, Director	Revised: 5/16/2018

I. POLICY

The Department of Corrections will assist the Board of Pardons and Parole in determining an offender's eligibility for medical parole before the Board considers an application for medical parole as provided in *Mont. Code Ann. § 46-23-210*.

II. APPLICABILITY

All Department adult facilities and programs.

III. DEFINITIONS

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

BOPP – The Board of Pardons and Parole.

Clinical Services Division (CSD) – The division that oversees all medical, mental health, dental and vision services for all offenders in the custody of the Department in secure and contracted facilities.

Designated Health Authority – Regardless of local title, the individual at the facility or program level who is responsible for health services, as designated by the Responsible Health Authority.

IPPO – The institutional probation and parole officer.

Medical Director – The physician(s) designated by the Clinical Services Division administrator to oversee clinical practice decisions requiring medical judgments for offenders under Department jurisdiction.

Medical Parolee – An offender who has been released on medical parole to community supervision by the Board of Pardons and Parole (BOPP).

Responsible Health Authority – The Clinical Services Division administrator who oversees all levels of health care and assures quality, accessible and timely clinical services for offenders. The individual is appointed by the Department director and reports directly to the Director or designee on matters of health care.

IV. DEPARTMENT DIRECTIVES

A. Eligibility Criteria

Policy No. DOC 4.6.7	Chapter 4: Facility/Program Services	Page 2 of 5
Subject: MEDICAL PAROLE		

1. An offender is eligible for medical parole if:
 - a. the offender is incarcerated in a state prison or adult community corrections facility or was sentenced to a state prison and is confined in a prerelease center;
 - b. the offender is not under sentence of death or life imprisonment without possibility of parole;
 - c. the offender is unlikely to pose a detriment to the victim or community;
 - d. the offender has a medical condition requiring extensive medical attention or has been determined by a physician to have a medical condition that will likely cause death within 6 months or less; and
 - e. the sentencing court has not restricted parole for the offender pursuant to *Mont. Code Ann. § 46-18-202* or if the sentencing court has restricted the offender's parole, the sentencing court has granted the offender approval for medical parole consideration.
 - 1) if the offender is under a parole restriction, the Institutional Probation and Parole Officer (IPPO) where the offender is incarcerated or confined, in consultation with medical staff, will send the [Court Approval/Denial](#) form to the sentencing judge and include a brief medical statement from Clinical Services Division staff.

B. Medical Parole Application

1. The IPPO or other Department representative, BOPP, the offender, or the offender's spouse, parent, grandparent, child, or sibling may apply for medical parole.
2. A person listed in section IV.B.1 must complete the [Medical Parole Application](#) in writing and submit it to the IPPO office at the facility where the offender is incarcerated or from which he or she was transferred.
3. The written application must include:
 - a. the reasons for the medical parole request;
 - b. the relationship of the offender to the requesting party;
 - c. a report of an examination and written diagnosis as specified in section IV.C of this policy; and
 - d. the medical parole plan, including:
 - 1) a detailed description of the offender's proposed placement and medical care including the name, address and telephone number of the individual or facility official who has agreed to provide medical care to the offender;
 - 2) an explanation of the proposed arrangements for transporting the offender to the caregiver or placement;
 - 3) a detailed explanation of how the offender's medical care will be financed; and
 - 4) a signed [Health Information Request to Release Records](#) form provided by the IPPO.
4. A [Medical Parole Application Routing](#) form will be used to track and ensure the medical parole application is returned to the IPPO at each stage of application process. Applications will be considered invalid if submitted to locations other than the IPPO's office.

C. Medical Documentation

Policy No. DOC 4.6.7	Chapter 4: Facility/Program Services	Page 3 of 5
Subject: MEDICAL PAROLE		

1. A physician licensed in Montana must complete a thorough medical examination of the offender and sign the written [Medical Examination Report](#). This report must be attached to the Medical Parole Application Routing Form and returned to the IPPO's office.
2. The Department may assist an offender in obtaining the appropriate medical documentation by arranging for a physician employed by the Department to complete the medical examination.
3. In the event that the applicant requests a medical examination by a licensed physician who is not a Department employee, payment will be the responsibility of the offender or the requesting party.
4. The written diagnosis resulting from the examination must include:
 - a. a detailed description of the offender's medical condition and the medical attention required to treat that condition;
 - b. an assessment of the offender's likelihood of recovery;
 - c. a description of the offender's most recent past medical condition and treatment, including medical conditions and treatments that are both related to and incidental to the condition that is the basis for the medical parole request; and
 - d. an assessment of whether, to a reasonable degree of medical certainty, there is a high probability the offender's medical condition will cause death within six months or less.

D. Placement Location

1. The applicant must identify the offender's proposed location for medical parole.
2. Placement may be in a hospital, nursing home, hospice facility, family home, or other location or program.

E. Procedure

1. The IPPO will forward the application and supporting documents to the Responsible Health Authority or Medical Director for CSD review and a recommendation to accept or reject the application.
2. Following the CSD review, if appropriate, the IPPO will forward the application to the administrator for review. The administrator will consult with BOPP concerning past BOPP dispositions and review the application for sufficiency and safety or security concerns.
3. If the IPPO, Responsible Health Authority, Medical Director, or administrator or designee determines at any time during the review process that the medical parole application does not meet the minimum requirements, a [Notice of Deficient Medical Parole Application](#) will be issued providing the reasons for the disapproval in writing to the offender or the individual who requested the medical parole if different from the offender. The person issuing the notice will ensure that the IPPO, Responsible Health Authority, Medical Director, and administrator all receive a copy.
4. If the administrator or designee determines the request meets the minimum requirements,

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Subject: MEDICAL PAROLE		

- he or she will forward the application, [Medical Parole Application Routing](#) form and required attachments to the IPPO office at the facility where the offender is incarcerated or from which the offender was transferred.
5. The IPPO, in consultation with the appropriate staff, will:
 - a. prepare or request the preparation of all pre-parole documents required by the BOPP; and
 - b. forward all pre-parole documents including the application and attachments and Medical Parole Application Routing Form to the BOPP.
 6. Upon receipt of the application and attachments and Medical Parole Application Routing Form the BOPP will set a hearing date and notify the applicant.

F. Medical Parole Plan Approval or Rejection

1. If the BOPP approves the medical parole, a probation and parole (P&P) officer in the region in which the offender will reside will investigate the medical parole plan and send the findings to the BOPP and the designated health authority.
2. If the BOPP approves the medical parole plan, the offender must sign and accept the standard conditions of parole and any special conditions set by the BOPP including:
 - a. the specific placement ordered by the BOPP; and
 - b. any condition of parole ordered by the BOPP that the offender agree to periodic medical examinations and updated prognoses at the offender's expense.
3. If the BOPP imposes a special condition of parole that the offender to agree to periodic examinations and diagnosis, the examining physician will submit copies of the reports on the examinations and diagnoses to the BOPP and to the designated health authority.
4. The offender and the P&P officer assigned to supervise the offender must follow the parole sign up and supervision procedures.
5. The offender must sign a health information release form for all medical treatment received during the medical parole.
6. If the BOPP rejects the offender's medical parole plan, the IPPO, in conjunction with the designated health authority or designee, will determine if the concerns identified by the investigating P&P officer and the BOPP can be addressed and the plan resubmitted to the BOPP for its approval.

G. Consideration for Non-Medical Parole

1. When a medical parolee is 60 days from his or her non-medical parole eligibility date, the appropriate records department supervisor will inform the BOPP and supervising P&P officer of the non-medical parole eligibility date.
2. Upon notification that the offender is being considered for non-medical parole status, the supervising P&P officer is responsible to provide the BOPP with all pre-parole documents, reports and recommendations.

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Subject: MEDICAL PAROLE		

3. Within its regular course of business, the BOPP will conduct a hearing to determine whether the offender should remain on medical parole status or be granted a non-medical parole.

H. Violations of Conditions of Medical Parole

1. If it is alleged that the offender has violated the conditions of medical parole, or that the offender's medical condition has improved to the extent that the offender no longer requires extensive medical attention or is likely to pose a detriment to the offender, victim, or community, the supervising P&P officer will submit in writing a report of violation to the BOPP with a copy of the report submitted to the designated health authority.
2. If the P&P officer submits a report of violation, the Department will follow its standard procedures for revocation of parole.

V. CLOSING

Questions concerning this policy should be directed to the appropriate administrator, Board of Pardons and Parole, or Department director.

VI. REFERENCES

A. 46-18-202, MCA; 46-23-210, MCA; 46-23-1025, MCA

VII. ATTACHMENTS

[Court Approval/Denial Form](#)
[Health Information Request to Release Records](#)
[Medical Examination Report](#)
[Medical Parole Application](#)
[Medical Parole Application Routing Form](#)
[Notice of Deficient Medical Parole Application Form](#)



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 4.6.9	Subject: PLACEMENT & REPORTING OF YOUTH WITH ADULT SENTENCES	
Chapter 1: ADMINISTRATION AND MANAGEMENT	Page 1 of 3 and Attachment	
Section 5: Case Records Management	Effective Date: 07/01/08	
Signature: /s/ Mike Ferriter, Director	Revised: 03/26/12	

I. POLICY

The Department of Corrections requires the placement of and reporting on youth with adult sentences in accordance with the Youth Court Act and the provisions of this policy.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Administrator - The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Criminally Convicted Youth – Any youth who is convicted in adult court pursuant to [41-5-206](#), MCA, except a youth convicted of crime that carries a possible punishment of life, death, or 100 years in prison is a criminally convicted youth.

Youth with Adult Sentences – An individual under the age of 18 who has been committed to the Department or sentenced to prison in accordance with the Youth Court Act including a criminally convicted youth or a youth with an adult sentence pursuant to [41-5-1605, MCA](#) the Extended Jurisdiction Prosecution Act.

IV. DEPARTMENT DIRECTIVES

A. Placement

1. Youth with adult sentences committed to the Department will be placed according to the following:
 - a. youth must be evaluated and assessed in the designated Department assessment center or by other Department-approved means and placed, following evaluation and assessment, in one of the following:
 - 1) an Adult Community Corrections Division (ACCD) facility or program;
 - 2) a youth correctional facility; or
 - 3) if the youth is at least sixteen years old, in a state prison.
2. Youth with adult sentences over the age of 16 sentenced to a state prison will be evaluated at a state prison and placed, following evaluation, in the state prison or transferred to a youth correctional facility.
3. A youth under 16 years of age who is sentenced to a state prison must be evaluated in a

Policy No. DOC 4.6.9	Chapter 1: Administration and Management	Page 2 of 3
Subject: PLACEMENT & REPORTING OF YOUTH WITH ADULT SENTENCES		

department facility or program or in the detention center. The youth must be placed in a secure facility until the youth becomes 16 years of age at which time the youth may be transferred to a state prison.

B. Transfer and Removal

1. The administrator of a youth correctional facility and the administrator of the state prison or ACCD must agree and execute the [Juvenile Placement Agreement](#) prior to the transfer of a youth committed to the Department or a state prison to a youth correctional facility.
2. A youth with an adult sentence will be removed from a youth correctional facility if any of the following are met:
 - a. the youth turns 18 years old; or
 - b. the youth becomes inappropriate for continued placement in the facility as determined by the facility administrator, or designee, at which time the following requirements apply:
 - 1) if the youth is under ACCD jurisdiction, ACCD must assume custody of the youth within 72 hours; and
 - 2) if the youth has been transferred to the youth correctional facility from a state prison or is under jurisdiction of the state prison, the prison will assume custody of the youth within 72 hours.

C. Reporting Requirements for Criminally Convicted Youth

1. For every criminally convicted youth, the Department must electronically submit a status report to the court, county attorney, defense attorney, and youth probation officer every six (6) months until the offender is 21 years old or out of custody and off supervision. Status reports will be prepared according to the following:
 - a. if the offender is incarcerated, the offender's case manager will prepare and submit the report;
 - b. if the offender is on probation or parole, the offender's supervising officer will prepare and submit the report; or
 - c. if the offender is in prerelease or other Department Community Corrections program, the prerelease or other program case manager will prepare and submit the report.
2. The status report must include:
 - a. a brief statement of the offender's conviction and sentence;
 - b. a brief overview of the offender's movement history in the past six months;
 - c. the treatment and self-improvement classes in which the offender has engaged in the past six months;
 - d. the work or schooling in which the offender has engaged in the past six months;
 - e. the offender's incarceration disciplinary history and/or history of compliance with probation/parole conditions;
 - f. the date on which the offender will turn age 21; and
 - g. the writer's opinion about whether the offender has been substantially rehabilitated.

V. CLOSING

Questions concerning this policy should be directed to the Department's Legal Services Bureau.

Policy No. DOC 4.6.9	Chapter 1: Administration and Management	Page 3 of 3
Subject: PLACEMENT & REPORTING OF YOUTH WITH ADULT SENTENCES		

VI. REFERENCES

- A. [41-5-1605, MCA](#); [41-5-206, MCA](#); [41-5-2503, MCA](#); [41-5-2510, MCA](#); [46-18-201, MCA](#); [46-18-203, MCA](#)

VII. ATTACHMENTS

[Juvenile Placement Agreement](#) [PDF](#)



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No.: DOC 4.6.10	Subject: DISCHARGE, RELEASE, AND TRANSFER FROM YOUTH SERVICES DIVISION	
Chapter 4: FACILITY/PROGRAM SERVICES	Page 1 of 2	
Section 6: Release/Placement	Effective Date: 10/31/2013	
Signature: /s/ Mike Batista, Director	Revised: 07/25/2016	

I. POLICY

The Department of Corrections adheres to legal and procedural requirements when discharging, releasing, or transferring youth committed to the custody and supervision of the Department's Youth Services Division.

II. APPLICABILITY

All youth facilities and programs under the authority of the Department's Youth Services Division (YSD).

III. DEFINITIONS

Discharge from YSD – Is the formal action of terminating YSD and youth court custody and supervisory authority over a youth who has been formally committed to custody and supervision.

Release from YSD – Is the formal action that terminates YSD court ordered custody and supervision over a youth and remands the youth back to youth court supervision.

Transfer from YSD – A formal action that terminates YSD of all court ordered responsibility by transferring custody and supervision of all court ordered supervision to a Department adult facility or program.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. All YSD facilities and programs will create standardized procedures to guide the transfer, release, or discharge of youth from YSD custody and supervision.
2. Youth on parole will be discharged from YSD supervision after one year unless good reasons exist to show that such continued supervision is required.
3. Staff must submit written reports requesting a transfer, release, or discharge from YSD supervision to their supervisor for approval prior to submission to the YSD administrator.
4. Written reports requesting a transfer, release or discharge from YSD supervision must summarize the performance of the youth during the youth's entire YSD commitment.

V. CLOSING

Questions concerning this policy should be directed to the YSD Administrator.

Policy No. DOC 4.6.10	Chapter 4: Facility/Program Services	Page 2 of 2
Subject: DISCHARGE, RELEASE, OR TRANSFER FROM YOUTH SERVICES DIVISION		

VI. REFERENCES

- A. 41-5-205; 41-5-208; 41-5-1604; 41-5-1605; 52-5-127, MCA
- B. 20.9.707 ARM, *Release, Supervision Status Change, and Discharge of Youth*
- C. 2-7129; 2-7145; 2-7212; 2-7213; 2-7144 ACA Standards

VII. ATTACHMENTS

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No.: DOC 4.6.11	Subject: OUT OF HOME PLACEMENT OF YOUTH
Chapter 4: FACILITY/PROGRAM SERVICES	Page 1 of 2
Section 6: Release/Placement	Effective Date: 06/26/2015
Signature: /s/ Mike Batista, Director	Revised:

I. POLICY

The Department of Corrections adheres to legal and procedural requirements when referring and placing youth out of home.

II. APPLICABILITY

All youth facilities and programs under the authority of the Department's Youth Services Division (YSD).

III. DEFINITIONS

Out of Home Placement – Placement of a youth in a program, facility, or home, other than a custodial parent's home, for purposes other than preadjudicatory detention.

Youth Services Division (YSD) – The division within the Department of Corrections responsible for all services to youth committed to the Department.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. YSD will maintain standardized procedures to guide out of home placement of youth.
2. Out of home placements may include psychiatric residential treatment facilities (PRTFs) or other medical-related programs, chemical dependency programs, any level of group home care, any level of foster care, kinship care, placement with other approved individuals, and independent living.
3. All out of home placements requiring licensure must be licensed by the proper state or local authority. Department employees are responsible for verifying a placement is currently licensed before placing a youth.
4. YSD procedures will provide for periodic placement inspections by Department staff.
5. Department employees will ensure funding for out of home placements using all available resources.
6. While a youth is in an out of home placement, YSD staff will maintain ongoing contact with the youth; the out of home placement provider or staff; and the youth's parent/guardian/custodian/representative.

Policy No. DOC 4.6.11	Chapter 4: Facility/Program Services	Page 2 of 2
Subject: OUT OF HOME PLACEMENT OF YOUTH		

7. YSD procedures will address appropriate notifications to a parent/guardian/custodian/representative when a youth is in an out of home placement.
8. For out of home placement in other states, Department employees will follow applicable Interstate Compact for the Placement of Children (ICPC) and/or Interstate Compact on Juveniles (ICJ) rules.

V. CLOSING

Questions concerning this policy should be directed to the Youth Services Division administrator.

VI. REFERENCES

- A. 41-4-1, 41-6-1, 41-5-103, 41-5-1504, 52-5-105, 52-5-127 MCA
- B. 20.9.210, 37.50.901 ARM

VII. ATTACHMENTS

None



POLICY DIRECTIVE

Policy:	DOC 4.6.15 PRE-PAROLE INSTITUTIONAL SCREENING PROCESS	
Effective Date:	03/29/2024	Page 1 of 3
Revision Date(s):	10/01/2024	
Signature/Title:	/s/ Brian Gootkin, Director	

I. POLICY

There is a pre-parole institutional screening process during which designated staff may review eligible inmates for potential placement in a treatment and/or prelease facility prior to their parole eligibility for the purpose of preparing inmates for release into the community.

II. APPLICABILITY

All divisions, facilities, and programs of the Department, owned and contracted, as specified in contract.

III. DEPARTMENT DIRECTIVES

A. Staff Designated for Pre-Parole Institutional Screening

1. Institutional screening is conducted by:
 - a. the Department's Institutional Screening Coordinator (Coordinator);
 - b. an assigned Board of Pardons and Parole (BOPP) staff member; and
 - c. designated Department representatives from secure facilities.
2. Designees may be assigned to ensure process continuity.

B. Pre-Parole Institutional Screening Process

1. The Coordinator will:
 - a. use the offender management system to identify inmates for entry into the review process 14 months prior to an inmate's parole eligibility date;
 - b. review the list of inmates and assign each inmate to a specific Facility Case Manager for review to determine if the inmate meets the initial eligibility criteria using the established checklist; and
 - c. track the status of all inmates identified throughout the process to include final decisions.
2. If an inmate meets the initial eligibility criteria, the Facility Case Manager will meet with the inmate to explain the institutional screening process and will confirm and document the inmate's interest in participation.
3. If an inmate does not meet the initial eligibility criteria, the Facility Case Manager will notify the inmate in writing of their status and the reason(s) they did not meet the criteria.
4. Once the review is complete and the inmate has been notified of their status, the Facility Case Manager notifies the Coordinator and documents the inmate's status in a chronological entry in the offender management system.
5. When the Coordinator is notified that an inmate meets initial eligibility criteria, the Coordinator will:
 - a. schedule the institutional screening final review date;

- b. at least 30 days prior to the institutional screening review date, when appropriate, notify the BOPP Victim Liaison of the pending review to allow time for the Liaison to contact the victim and gather input; and
 - c. coordinate any necessary interview schedules.
6. Each month, the designated staff will review inmates who meet initial eligibility criteria and make a final determination. The Coordinator will notify the inmate of the final determination.

C. Initial Eligibility Criteria and Factors

1. To be considered an eligible inmate, the inmate must meet all the following criteria:
 - a. be currently under physical custody of the Department as a secure placement inmate;
 - b. be within up to 14 months of parole eligibility;
 - 1) *Note: Offenders who have already seen the BOPP and received a disposition are not eligible*
 - c. not have any active detainers or warrants;
 - d. have 120 days clear conduct at a secure facility at the time of the Facility Case Manager review;
 - e. have not refused a community corrections placement within the last 180 days prior to the Facility Case Manager review;
 - f. have not refused recommended treatment or other recommended programming within the last 180 days prior to the Facility Case Manager review; and
 - g. have not been removed from recommended treatment or other recommended programming for disciplinary reasons within 180 days prior to the Facility Case Manager review.
2. In making their decision, the designated staff will weigh and consider the following factors:
 - a. time until parole eligibility;
 - b. current risk assessment of the eligible inmate;
 - c. eligible inmate's compliance with recommended treatment or other recommended programming;
 - d. the type of crime for which the sentence is being served;
 - e. whether the eligible inmate is required to register as a sexual or a violent offender upon release;
 - f. whether the eligible inmate's sentence contains any parole restrictions;
 - g. victim input;
 - h. eligible inmate's overall conduct while in secure custody;
 - i. eligible inmate's expressed interest in placement in a treatment and/or prerelease facility; and
 - j. any other factor that may be relevant based on the individual circumstances of the eligible inmate being considered.
3. The designated staff may, in their sole discretion, interview the eligible inmate being considered as part of their decision process. If they choose to conduct an interview, the interview may be conducted in person or by video or telephone conference.
4. Any one factor may be sufficient to deny an eligible inmate's potential placement outside of the secure facility prior to the inmate's parole eligibility.
5. If the designated staff decide that placement outside of the secure facility is not appropriate prior to the eligible inmate's parole eligibility, they must state the reason for the decision in the notification provided to the inmate. If the designated staff decide that placement outside of the secure facility is appropriate prior to the eligible inmate's parole eligibility, that determination does not guarantee the inmate will be placed in any specific facility or placed at all.
6. The decision of the designated staff is final and is not subject to appeal or grievance.

7. An eligible inmate may be considered by the designated staff only one time for any one particular sentence.
8. All determinations made under this policy will be documented in a chronological entry in the offender management system.

D. Screening and Placement

If an eligible inmate has been granted approval by the designated staff, the Coordinator will request initiation of the community corrections facility screening process.

IV. CLOSING

Questions about this policy should be directed to the Coordinator or the Community Corrections Facilities and Programs Bureau Chief.



POLICY DIRECTIVE

Policy:	DOC 5.1.1 INMATE ASSIGNMENTS
Effective Date:	04/01/1998 Page 1 of 5
Revision Date(s):	08/28/2019; 07/01/2025
Signature/Title:	/s/ Natalie Smitham, Chief Financial Officer

I. POLICY

The Department of Corrections may provide inmates with the opportunity for productive assignments in facilities or industries.

II. APPLICABILITY

All Department secure facilities.

III. DEFINITIONS (see Glossary)

IV. DEPARTMENT DIRECTIVES

A. Inmate Compensation

1. Each secure facility will comply with the requirements set forth in this policy.
 - a. Specific guidelines for youth correctional facilities and programs are outlined in IV.D below.
2. The Warden or respective Bureau Chief or designee is responsible for spending inmate compensation funding within the facility's or program's annual budget allocation.
3. The Department Executive Team may or may not classify an assignment as compensable; if compensable, the following provisions apply:
 - a. the rate is based on category to ensure compensation is administered in an equitable and consistent manner throughout the Department;
 - b. the compensation rate for in-facility assignments will be based on *Attachment A: Inmate Compensation Table* and the following:
 - 1) work completed within 4 hours in a 24-hour period will be compensated as a half day;
 - 2) work completed within more than 4 but less than or equal to 8 hours in a 24-hour period will be compensated as a whole day; and
 - 3) compensation will not exceed more than a whole day (8 hours) in a 24-hour period regardless of the number of inmate assignments or hours worked, except as provided in IV.A.3.d below;
 - c. the compensation rate for MCE will be based on *Attachment B: MCE Inmate Compensation Table* and the following:
 - 1) work completed within less than 3 hours in a 24-hour period will be unpaid;
 - 2) work completed within 3 hours to less than 6 hours in a 24-hour period will be compensated as a half day;
 - 3) work completed within 6 to 8 hours in a 24-hour period will be compensated as a whole day; and
 - 4) compensation will not exceed more than a whole day (8 hours) in a 24-hour period regardless of number of inmate assignments or hours worked, except as provided in IV.A.3.d below;
 - d. if an inmate works more than 8 hours in a 24-hour period, the inmate's supervisor(s) will adjust the inmate's schedule on one or more days close in time so the inmate averages no more than 8 hours per day;

- e. compensation periods shall:
 - 1) be consistent to allow the inmate to establish a financial plan;
 - 2) provide compensation beginning on the first day of assignment; and
 - 3) not allow retroactive compensation;
- f. all inmate work assignments must fall within an assignment category; and
- g. designated secure facility staff must submit accurate inmate pay information:
 - 1) to Inmate Accounting;
 - 2) by the 5th business day of each month; and
 - 3) on a form provided by the Financial Services Bureau.

B. Inmate Assignments

1. Facilities and programs will operate all assignments consistent with applicable federal, state, and local health and safety standards.
2. Assignments will be consistent with the inmate's classification identified in *DOC 4.2.1 Offender Classification System*; for inmates with special skills, reasonable effort will be made to secure assignments based on the security and safety needs of the facility or program.
3. The Warden or respective Bureau Chief or designee will identify the assignment title, duties, and responsibilities for inmate assignments.
4. Assignments should afford inmates the opportunity to learn skills and develop habits and attitudes that will fit occupational needs upon release.
5. The Warden may deem it necessary to assign inmates to special or designated housing areas related to their assignments.
6. Under no circumstances may assignments:
 - a. exceed a standard forty-hour work week, unless otherwise approved by the Warden or respective Bureau Chief or designee;
 - b. allow inmates to serve food to other inmates housed in restrictive housing;
 - c. include any duty that would place an inmate in a position to be in contact or in close proximity to confidential or security records without direct supervision;
 - d. be given to an inmate whose access or privileges necessary for the assignment have been revoked; and
 - e. allow inmates to exercise control or authority over other inmates.
7. Assignment performance feedback will be conducted at least semi-annually with criteria including, but not limited to, the following:
 - a. grade reports for inmates in education and training assignments;
 - b. demonstrated skills and knowledge;
 - c. observed habits;
 - d. attitude toward fellow inmates and Department employees;
 - e. quality and quantity of tasks;
 - f. care and use of equipment;
 - g. learning ability and adaptability to new processes;
 - h. general comments from supervisor; and
 - i. compensation, if applicable.
8. An inmate may hold up to two assignments with permission from the Warden or respective Bureau Chief or designee.
9. Assignment programs will accommodate inmates with disabilities in accordance with *DOC 3.3.15 Americans with Disabilities Act (ADA) Offender Accommodations*.

10. The supervisor or individual requesting an inmate for assignment shall review the inmate's offender management system record for previously identified work restrictions, for example, no lifting over fifteen pounds, restriction from heights, etc.
 - a. If work restrictions are identified, the supervisor or individual requesting an inmate for assignment will consult with the Department ADA coordinator or facility ADA coordinator to determine whether a reasonable accommodation can be made in accordance with *DOC 3.3.15 Americans with Disabilities Act (ADA) Offender Accommodations*.

C. Inmate Accident Compensation

1. Assigned inmates are not eligible for workers' compensation.

D. Youth Correctional Facilities and Programs

1. Youth correctional facilities may establish an allowance system based on an earned privilege program and/or a token economy system.
2. Youth correctional facilities will use designated inmate pay accounts for specific assignments that may only be used to allow youth to pay restitution. These assignments are not subject to the attached inmate compensation tables.

V. CLOSING

Questions about this policy should be directed to the Warden or respective Bureau Chief.

VI. REFERENCES

- A. 53-1-203, MCA; 53-30-131, MCA; 53-30-132, MCA
- B. DOC 3.3.15; DOC 4.2.1

VII. ATTACHMENTS

DOC 5.1.1 Attachment A: Inmate Compensation Table
DOC 5.1.1 Attachment B: MCE Inmate Compensation Table



ATTACHMENT A: INMATE COMPENSATION TABLE

**starred items may be paid by Inmate Welfare Fund*

Category	Daily
*Barber Assignment	\$2.40
*Chemical Dep. ITU Participants	\$0.60
*Educational Participants	\$1.20
Educational Aide Assignments	\$1.50
*Facility Aide	\$2.40
Food Services	\$3.36 or \$4.32
Infirmery Aide	\$1.80 or \$3.60
Non-MCE Laundry	\$1.50 or \$2.40
*Library	\$1.50
Maintenance	\$2.10 or \$3.90
*Photographer	\$1.50
*Recreation	\$1.50
Non-MCE Hobby	\$1.80
Janitorial	\$1.50 or \$2.40
Warehouse	\$4.20 or \$5.40
IWF Representatives	\$1.20
Facility Specific	
*Dog Handlers CCC	\$2.70
WRC Workers	\$4.20 or \$5.40
Special Assistance Crew	\$3.60 or \$6.00
Vocational and Educational Training	
Grade I	\$1.56
Grade I Student Aide	\$1.86
Grade II	\$2.04
Grade III	\$2.52
Grade IV	\$3.00

1. The Warden or designee may designate certain position categories as skilled work or difficult to fill may temporarily or permanently assign pay rates not to exceed the highest rate on this table, and must notify Inmate Accounting of the designation and whether it is temporary (including the time frame) or permanent.
2. All facilities must work within their current budget for inmate compensation.
3. The Department encourages facilities to assign the maximum number of inmates available to promote future job skills.
4. IWF Representatives can only be compensated for up to 5 days per week.



ATTACHMENT B: MCE INMATE COMPENSATION TABLE

	Pay Category	
	Hourly	Daily
Grade I	\$.45	\$5.00
Grade II	\$.55	\$5.50
Grade III	\$.65	\$6.50
Grade IV	\$.75	\$7.50
Grade V	\$.90	\$8.50
Sprinkler Pipe Movers	\$.02/per pipe	

1. The MCE Bureau Chief or designee may designate certain position categories as skilled work or difficult to fill, may temporarily or permanently assign hourly pay rates not to exceed the highest hourly rate on this table, and must notify Inmate Accounting of the designation and whether it is temporary (including the time frame) or permanent. If the MCE Bureau Chief has not made such a designation for a category listed on this table, the category will be paid based on shift completions; *see IV.A.3.c of DOC 5.1.1 Inmate Assignments.*
2. All programs must work within their current budget for inmate compensation.
3. The Department encourages programs to assign the maximum number of inmates available to promote future job skills.



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 5.1.3	Subject: ADULT OFFENDER COMMUNITY WORK PROGRAMS/PROJECTS	
Chapter 5: OFFENDER PROGRAMS	Page 1 of 6 and Attachments	
Section 1: Work Programs	Effective Date: Jan. 31, 2000	
Signature: /s/ Loraine Wodnik, Interim Director	Revised: 04/28/2017	

I. POLICY

The Department of Corrections applicable divisions and contracted secure care facilities provide offenders who have demonstrated sufficient reliability and trustworthiness the opportunity to participate in facility work projects and/or programs.

II. APPLICABILITY

Adult secure care facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Community Work Program – Work programs located in the community for eligible offenders provided for governmental agencies or nonprofit organizations pursuant to *Mont. Code Ann. § 53-30-131 (2009)*.

Community Work Program Supervisor – The staff member from a governmental agency, nonprofit organization, or applicable division or facility designated to supervise offenders in a community work program.

Community Work Projects – Short-term work projects at state-owned or leased properties or in community settings requiring facility supervision.

Community Work Project Supervisors – The division or facility staff members who directly supervise offenders on community work projects.

Victim – A person who suffers property loss, physical or emotional injury, fear of physical or emotional injury, or death because of a felony crime, attempts to prevent a crime or apprehend a suspect, or a family member of a victim. Others may be recognized as victims on a case-by-case basis.

IV. DEPARTMENT DIRECTIVES

A. General Requirements for Community Work Programs/Projects

1. Staff supervising offenders will provide the level of support and monitoring necessary to promote offender and program success and ensure public safety.
2. Offenders' participation in community work will be administered in compliance with *DOC*

Policy No. DOC 5.1.3	Chapter 5: Offender Programs	Page 2 of 6
Subject: OFFENDER COMMUNITY WORK PROGRAMS		

Policy 3.3.15 Americans with Disabilities Act (ADA) Offender Accommodations.

3. Division and facility operational procedures will comply with the provisions of this policy.
4. Prior to assignment to community work, offenders must sign the [Work Responsibilities Form](#) acknowledging understanding of the rules and regulations.

B. Community Work Programs/Projects Offender Eligibility Criteria

1. An offender may be eligible for community work when classified as minimum custody or “long-term offender” as outlined in facility procedures, or is within three years of release either by parole eligibility or discharge, and has:
 - a. completed or enrolled in recommended or court-ordered treatment, work or skill development programs;
 - b. acknowledged and accepted responsibility for crime(s);
 - c. received positive work reports; and
 - d. proven the ability to work independently.
2. An offender is ineligible for community work if classified as a predatory offender, or has:
 - a. medical restrictions that conflict with work requirements;
 - b. incurred major violations within the past six months;
 - c. incurred felony convictions while incarcerated;
 - d. outstanding detainers, warrants, notifications, or pending sentence reviews;
 - e. escape history from a secure facility within the past ten years;
 - f. history of trafficking in dangerous contraband within the past ten years while incarcerated; or
 - g. an escape or walk-away attempt from prerelease, work release, or monitoring program within the past three years.
3. Sex offenders must have completed or be actively participating and progressing in sex offender treatment as determined by a treatment provider to be considered for community work.
4. Offenders who transfer from out-of-state must have the approval of the controlling state before they are screened for community work.
5. All offenders who participate in community work may be subject to drug testing and unclothed body searches in accordance with *DOC Policies 3.1.20 Offender Drug Testing Program* and *3.1.17 Searches and Contraband Control*.

C. Transportation of Offenders

1. Facility staff will arrange offender transport to and from community work unless a written alternative plan is agreed upon by all parties prior to placement.
2. Transport staff must return offenders to their respective facilities at the end of each work period unless other arrangements are made and approved by the administrator, or designee, in advance.
3. If overnight travel is anticipated, staff must arrange for the offender's supervision or placement in a locked facility (e.g., at a prerelease, county jail, or firefighter crew camp).

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D. Incident Reporting

1. If an offender fails to return to the facility from community work, or fails to remain within the limits of the approved plan, the community work program/project supervisor must immediately report the incident in accordance with *DOC Policy 1.1.6 Priority Incident Reporting and Acting Director*.

E. Law Enforcement Notification

1. Facility procedures must include instructions for notifying local law enforcement of an offender's community work program/project by telephone, fax, or email prior to the offender's placement at the worksite.

G. Specific to Community Work Projects

1. Offenders may perform general maintenance and repair work on state-owned or leased properties, or in short-term projects in community settings, and assist in providing essential services to the prison administration in accordance with *53-30-141, MCA* and *53-30-151, MCA*.
2. Designated work project staff shall develop an internal notification document including, at a minimum, the following information:
 - a. name of supervisor that requested and is supervising offender worker(s);
 - b. details of assignment, e.g., nature and location of project, dates, time frames, etc.;
 - c. contact requirements such as notifying local law enforcement;
 - d. list of equipment required for work project;
 - e. name, identification number, and housing unit of offender(s) assigned to work project;
 - f. signatures required to ensure offenders listed are approved for project participation;
 - and
 - g. list of posts or staff to whom notification document will be distributed.

H. Specific to Community Work Programs

1. Additional general requirements for community work programs include:
 - a. responsibility of offender participation in a community work program is shared among administrators, screening committees, program supervisors, and the offender approved; and
 - b. administrators shall ensure required paperwork with community-based program employers and supervisors is complete before offenders are placed in community work programs. This may include:
 - 1) Memo of Understanding (MOU), or other written agreement;
 - 2) names and contact numbers of applicable administrators and community agency or organization officials;
 - 3) required standards of offender conduct and prohibited conduct;
 - 4) work area rules and regulations; and
 - 5) emergency procedures.
2. To request offender workers, the [Community Work Program Request Form](#) must be completed with all details outlined after which:

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- a. government agencies or nonprofit organizations must submit the Community Work Program Request Form to the appropriate administrator; and
 - b. contracted regional or private prison administrators must submit the Community Work Program Request Form to the Department's Contract Placement Bureau chief.
3. The community work program offender selection process requires that:
 - a. administrators establish procedures to screen and select offenders for community work program assignments;
 - b. administrators ensure that each step of the approval process is thoroughly documented by staff;
 - c. staff designated to evaluate both potential offenders and locations for assignments shall:
 - 1) complete a [Community Work Program Screening Form](#);
 - 2) investigate the capabilities of community-based employers;
 - 3) inspect the proposed worksite before approving placement; and
 - 4) when necessary, recommend additional screening and input from other Department staff, e.g., the Department's communications director, victim programs manager, or facility public and victim information officers. These individuals, or designees, may notify and solicit offender information from Probation and Parole regional administrators, the sentencing judge, and the appropriate county attorney.
 - d. if a victim has submitted a written request pursuant to 46-24-212, MCA to be notified when the offender leaves the facility, the designated facility staff will notify the victim and/or victim's family of the offender's eligibility for the community work program and recommended level of supervision. If the victim objects to the community placement, staff evaluating the placement will pursue additional screening, as referenced above, to determine the suitability of the assignment.
 - e. staff designated to evaluate and solicit information relevant to work assignment decisions must submit written documentation, including the Community Work Program Screening Form to the appropriate staff or committees authorized to approve or deny the offender's assignment; and
 - f. procedures shall identify individuals to be notified upon assignment decision and filing locations for relevant records and reports.
4. Prohibited conduct by community work program supervisors include:
 - a. giving, trading, or receiving favors or gifts;
 - b. allowing offenders to supervise one another;
 - c. allowing offenders to receive/send personal mail, or make/receive personal phone calls;
 - d. leaving keys in vehicles or vehicles unlocked or unattended around offenders; and
 - e. concealing any information that might be critical or detrimental to the accomplishment of the mission of the Department or the goals of the community work program.
5. Community work program supervision requires that the administrator, or designee, determine if there is a need to assign facility staff to directly supervise offenders working in the community. In making this determination the following must be addressed:
 - a. safety orientation for offender workers;
 - b. procedures for the evaluation of each offender's work performance;
 - c. procedures for documenting and submitting hours worked by the offender(s);

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- d. a review of the Work Responsibilities Form with the offender, explaining duties, rate of pay, hours of work, etc.;
 - e. procedures to immediately notify the appropriate administrator, or designee, any time there is reason to believe an escape or rule infraction has occurred or may occur;
 - f. the ability to provide consistent and reasonable supervision of offenders, based on realistic work expectations and mutual respect;
 - g. possession and security of each offender's picture ID;
 - h. training in facility offender count procedures; and
 - i. the ability to communicate with the facility at all times either by radio or telephone to ensure contact during offender count and emergencies.
- 6. Monitoring the offender work program requires:
 - a. after the offender begins work, designated staff maintain regular contact with the community-based employer and supervisor to ensure the offender is abiding by community work agreement terms; all contacts must be documented;
 - b. community work program supervisors must document all counts, census checks, and random spot checks of offenders; and
 - c. community work program supervisors must maintain records on the performance of each offender involved in community work programs and ensure that all incidents or problems are promptly reported to the appropriate administrator as they occur.
- 7. Requirements specific to offender removal from a community work program include:
 - a. facilities shall establish procedures for removing offenders from assignments that include the following elements:
 - 1) complete a [Work Assignment/Removal Form](#);
 - 2) thoroughly document reasons for removal;
 - 3) submit the form to the administrator for review and approval; and
 - 4) notify the community-based agency or organization administrators and supervisors;
 - b. if the victim of the offender's crime or the community in which the offender is placed objects to the placement, the offender may be removed from the program pending review and disposition as noted in Section IV.H.3.d. above; and
 - c. administrator may, at any time, authorize an offender's assignment to, or removal from, a community work program.
- 8. Requirements for medically-related work absences include:
 - a. staff shall refer any offender with minor medical problems to the facility health care unit;
 - b. if offender is hurt on assignment or requires immediate medical attention, the community work program supervisor will take appropriate action and promptly notify facility medical staff or appropriate emergency medical providers; and
 - c. operational procedures must include:
 - 1) reason(s) offenders may be excused from work;
 - 2) who authorizes absences;
 - 3) length of time offender may be absent without a medical excuse; and
 - 4) the individual responsible for notifying the community work program supervisors.

V. CLOSING

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Questions concerning this policy should be directed to the appropriate administrator.

VI. REFERENCES

- A. 46-24-212; 53-1-202; 53-30-101; 53-30-131; 53-30-141; 53-30-151, MCA
- B. 4-4451, 4-4452, 4-4454; *ACA Standards for Adult Correctional Institutions*, 4th Edition
- C. *DOC Policies 1.1.6 Priority Incident Reporting and Acting Director; 3.1.17 Searches and Contraband Control; 3.1.20 Offender Drug Testing Program; 3.3.15 Americans with Disabilities Act (ADA) Offender Accommodations*

VII. ATTACHMENTS

[Community Work Program Request Form](#)
[Community Work Program Screening Form](#)
[Work Responsibilities Form](#)
[Work Assignment/Removal Form](#)



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 5.1.5	Subject: OFFENDER COMMUNITY PRESENTATIONS
Chapter 1: OFFENDER PROGRAMS	Page 1 of 4
Section 1: Work Programs	Effective Date: December 20, 2001
Signature: /s/ Mike Ferriter, Director	Revised: 08/03/11

I. POLICY

It is the policy of the Department of Corrections to establish guidelines for secured facilities regarding offender presentations in the community.

II. APPLICABILITY

Adult secure care facilities under supervision of, or contracted to, the Montana Department of Corrections.

III. DEFINITIONS

Administrator - The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Offender Community Presentation - Program that allow eligible offenders to leave the confines of an assigned facility/program, under supervision, for the purpose of presenting a program of information with the intended benefits for the offender of assuming increased personal responsibility, skills and development and with benefit to the community.

Public Information Officer (PIO) - An official spokesperson designated by the administrator to provide facility or program information to the public.

Victim Information Officer (VIO) - A facility or program staff person who provides information and advocacy services for victims.

IV. DEPARTMENT DIRECTIVES

A. General Provisions

1. The Department supports efforts to maximize positive offender/community relationships and recognizes the importance of opportunities for offenders to share their experiences as an effective and constructive tool in providing an open and honest exchange of information with the public.
2. Each facility utilizing a community presentation program shall, in accordance with custody and security level, implement a procedure with facility specific guidelines in compliance with this policy including:
 - a. methods of screening and validating request(s) for presentations;
 - b. offender screening, selection, and orientation;

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Subject: OFFENDER COMMUNITY PRESENTATIONS		

- c. staff selection and orientation;
- d. victim notification, when applicable;
- e. guidelines for supervision during community presentations;
- f. notification of law enforcement; and
- g. a form requesting all pertinent information in regards to presentation, offender, transportation, and staff including, at minimum:
 - 1) the date, time, and location of the proposed event;
 - 2) a brief outline of the chronological schedule;
 - 3) an explanation of the reason for the request;
 - 4) the anticipated benefit to the community;
 - 5) identity of the inmate(s);
 - 6) names and signatures of escorting officers/staff;
 - 7) a full description of the escort vehicle(s);
 - 8) inmate supervision, restraint (if necessary), search, and transport requirements; and
 - 9) name and signature of the facility staff member sponsoring / requesting the event.

- 3. Acceptable community presentation venues include, but are not limited to:
 - a. public and private schools;
 - b. universities, colleges, and trade schools;
 - c. addictive disease programs;
 - d. nursing homes and hospitals;
 - e. church organizations; and
 - f. civic organizations.

B. Community Presentation Requests

- 1. Requests for presentations will be submitted orally or in written form to the facility administrator, or designee.
- 2. Designated staff will evaluate requests and make a determination based on the following criteria, at minimum:
 - a. mission and goals of the facility;
 - b. anticipated benefit to the community;
 - c. benefit to the facility; and
 - d. potential benefit to the offender.
- 3. Designated staff shall complete the required facility documentation for presentation approval and offender selection.

C. Offender Screening and Selection

- 1. The safety of the public and staff are the first priority in offender selection; potential negative repercussions, security threats, and public perception must all be considered.
- 2. Offender selection shall be based, at minimum, on the following criteria:
 - a. offender custody classification;
 - b. behavior and compliance to rules and authority;
 - c. commitment to change;
 - d. acknowledged and accepted responsibility for crime(s);

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Subject: OFFENDER COMMUNITY PRESENTATIONS		

- e. assignment reports;
 - f. sex offenses; and
 - g. outstanding detainers, warrants, notifications, or pending sentence reviews;
3. The nature and severity of an offender's crime must be assessed; individuals incarcerated for serious and/or violent crimes may not be appropriate for this program.

D. Offender Orientation

1. Administrator, or designee, shall ensure offenders have been counseled by designated staff regarding expectations and requirements for participation in the program prior to presentation.
2. Designated staff may provide orientation through the following methods:
 - a. discussion with offender emphasizing the nature of the presentation and consequences if expectations are not met;
 - b. members of the community individual/organization requesting a presentation may be invited to attend orientation sessions; and
 - c. a debriefing session after a community presentation has concluded, if necessary.

E. Notification

1. If a victim has submitted a written request for information pursuant to 46-24-212, MCA to be notified when the offender leaves the facility, the PIO/VIO shall notify the victim and/or victim's family of the offender's eligibility for the community presentation program and recommended level of supervision. If the victim objects to the offender's participation in the community presentation program, the offender may not be selected for the program unless the Department Director, or designee and facility administrator agree with the selection.
2. Prior to a presentation scheduling, a designated staff member must send written notification to the local chief of police and/or sheriff providing information including presentation:
 - a. date;
 - b. time;
 - c. location;
 - d. type of activity;
 - e. offender(s) involved;
 - f. transportation arrangement; and
 - g. supervision and security procedures in place.
2. Any changes in date, time, or schedules must be provided in advance to all involved parties including local law enforcement and victims, when applicable.

F. Program Supervision

1. The administrator, or designee, will ensure that qualified staff is supportive and aware of all expectations for the community presentation program.
2. Supervisory staff must remain professional and conduct themselves in a manner which

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encourages public trust.

3. Supervisory staff may not:
 - a. fraternize with offenders;
 - b. provide any favors or preferential treatment to any offender, family or agent of the offender outside of official performance of duties; and
 - c. consume alcoholic beverages or non-prescribed drugs;

G. Transportation of Offenders

1. Transportation of offenders shall comply with *DOC 3.1.12, Offender Escort and Transport*.
2. Staff must return offenders to their respective facilities at the end of each presentation unless other arrangements are made and approved by the administrator, or designee, in advance.
3. If overnight travel is anticipated, staff must arrange for the offender's supervision or placement in a locked facility.
6. The requesting community individual/organization may be required to pay the cost of offender meals when outside of state facilities. When possible, meals shall be eaten in vehicles at drive-in restaurants unless exception is approved in advance and in writing by administrator.

V. CLOSING

Questions concerning this policy should be directed to the appropriate administrator.

VI. REFERENCES

- A. [2-15-112](#), MCA; [53-1-203](#), MCA
- B. *DOC Policy [3.1.12](#), Escorted Trips*

VII. ATTACHMENT

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 5.1.6	Subject: WILD LAND FIRE SUPPRESSION CREWS
Chapter 5: OFFENDER PROGRAMS	Page 1 of 4
Section 1: Work Programs	Effective Date: July 2, 2001
Signature: /s/ Mike Ferriter, Director	Revised: 05/16/12

I. POLICY

It is the policy of the Department of Corrections to develop adult offender wild land fire suppression programs in secure care facilities to select, train, and supervise offenders who demonstrate records of good institutional behavior.

II. APPLICABILITY

Adult secure care facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Contracting Agency - Means the Department of Natural Resources, US Forest Service, and Bureau of Land Management.

DOC ID Number - Means the Department of Corrections identification number assigned to each offender, previously referenced as the AO number.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. The facility administrator, or designee, will develop and maintain operational procedures that adhere to requirements established within this policy and by the contracting agency prior to the development and/or deployment of a wild land fire suppression crew; requirements include, but are not limited to, the establishment of the following:
 - a. training and testing schedules based on standard wild land fire fighting curriculum;
 - b. fair and equitable offender compensation plan in cooperation with the contracting agency and in compliance with [DOC Policy 5.1.1, Inmate Assignments](#);
 - c. ensure a contract exists between the facility and contracting agency and is processed in accordance with [DOC 1.2.9, Contracts](#) prior to a crew deployment;
 - d. a process to document inappropriate offender behavior and remove an offender, when necessary, from a crew for inappropriate behavior;
 - e. procedures in conjunction with the contracting agency to address call-out, dispatch and deployment of the wild land fire suppression crew; and
 - f. procedures dictating a minimum of four formal counts during each 24-hour period in accordance with the facility's count schedule and called into the facility regularly.
2. A wild land fire suppression crew may not be sent across state lines or out of the country by the Department nor contracting agency.
3. Offenders convicted of a sex offense, arson, or kidnapping are not eligible for

Policy No. DOC 5.1.6	Chapter 1: Administration and Management	Page 2 of 4
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participation in a wild land fire suppression program.

B. Offender Screening, Selection, Training and Supervision

1. The facility administrator, or designee, must ensure that the Department director, or designee, approves the screening and selection process for offenders considered for the wild land fire suppression program. The screening process must:
 - a. meet criteria established in [DOC Policy 5.1.3, Adult Offender Community Work Programs/ Projects](#);
 - b. maintain an ongoing status to ensure a current list of eligible offenders; and
 - c. include physical fitness standards and medical screening to meet the criteria of the contracting agency.
2. Offenders will only be allowed use of equipment once specific training has been completed. Documentation of all training including safety procedures, equipment, tools, and specialty materials shall be kept and updated as necessary.
3. A method of evaluation for each offender will be developed by the participating facility and completed after each deployment.

C. Staff Screening, Selection, Training and Timekeeping Requirements

1. Notice of staff position availability shall include, at minimum:
 - a. training and physical fitness requirements;
 - b. schedule of on and off duty assignments;
 - c. on call expectations;
 - d. security experience and certification requirements;
 - e. compensation;
 - f. requirement of positive communication with offenders and contracting agency; and
 - g. requirement to understand, communicate and enforce emergency procedures for any situation including: escapes, medical emergencies, and evacuations.
2. A fair, equitable, and documented formal screening process must be established that includes, at minimum:
 - a. a subjective application review;
 - b. supplemental questions;
 - c. a personal interview;
 - d. a review of written criteria; and
 - e. physical fitness testing standards.
3. The staff training program shall include, at minimum:
 - a. security and job safety requirements;
 - b. contraband control;
 - c. offender drug and alcohol testing;
 - d. medical and emergency procedures; and
 - e. any additional training required by the contracting agency.
4. Staff shall be given clear expectations for behavior during resting status, including:
 - a. leaving the fire camp site;

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- b. attending to personal business including phone calls; and
- c. the use or possession of alcohol or drugs including prescription drugs both during resting status and when on call.

D. Offender Property, Mail, Telephone Use and Visits

- 1. Each participating facility shall address an offender allowed property list during training and deployment, sending and receiving of mail, telephone calls, and visitation during program participation.

E. Offender Discipline

- 1. Each participating facility will develop a standard set of rules for offender participation including, at a minimum:
 - a. behavior at fire camp and in training;
 - b. appropriate boundaries and communications with contracting agency staff;
 - c. prohibition of fraternization;
 - d. curfews; and
 - e. offender accountability via disciplinary action and/or removal from crew.

F. Record keeping

- 1. The participating facility shall maintain a deployment record including, at minimum:
 - a. offender name and DOC ID Number;
 - b. name of the supervising officer(s);
 - c. destination of crew;
 - d. time of departure and return to the facility;
 - e. travel mode and vehicle license number;
 - f. type of voice communication to the facility and call sign of the vehicle or contracting agency;
 - g. destination arrival time;
 - h. time of departure to other work sites and/or return from other work sites;
 - i. unscheduled stops or incidents while travelling;
 - j. time, location and results of all counts;
 - k. a record of all call-ins to the facility;
 - l. a brief description of activities, i.e. team attitude, illness, injuries, disciplinary actions, security concerns, and unusual activities; and
 - m. notifications to local law enforcement agencies.

G. Communications

- 1. Supervising staff must have communication with the participating facility by radio or land line; communication may be either direct or indirect, through the contracting agency, or through local law enforcement agencies.
- 2. Staff members accompanying the crew must be equipped with a hand held radio capable of contacting the facility, law enforcement agencies, or the contracting agency base camp. Back up battery supplies must be adequate to ensure uninterrupted contact.

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3. At least one cell phone with extra batteries should accompany the supervisor while on duty. Under no circumstances will cell phones be available to any offender.
4. No offender may be allowed access to Department communication equipment; when an offender must be issued a radio during operations a supervisor must ensure the radio does not have frequencies that might compromise the security of the facility, other crew members, Department personnel, contracting agency personnel, local law enforcement, or public.

H. Transportation and Offender Access to Vehicles

1. All vehicles accompanying or transporting fire crews must be equipped with a hi-band radio capable of communicating either with the facility, local law enforcement, or the contracting agency base camp or headquarters.
2. Offenders may not be allowed to operate a motor vehicle while on duty except in an emergency with no alternative to prevent loss of life.

I. Supervision

1. The participating facility must develop procedures ensuring 24-hour offender supervision, which may consist of a cooperative effort involving facility relief staff, the contracting agency, local law enforcement, Department personnel, and/or private security agencies. The relief and supervision plan must address expectations for relief staff, count procedures, rules for offender crew, and responses to emergency situations.

J. Notifications

1. At all times, the Sheriff where crew is deployed must be apprised of the following:
 - a. where crew is stationed and will be working;
 - b. names of all offenders on the crew; and
 - c. all additional information requested by the Sheriff's Department.

V. CLOSING

Questions concerning this policy should be directed to the appropriate administrator or Contracts Management Bureau chief.

VI. REFERENCES

- A. [*The Fair Labor Standards Act of 1938*](#)
- B. [*53-1-203, MCA*](#)
- C. [*DOC Policies 1.2.9, Contracts; 5.1.1, Inmate Assignments; DOC Policy 5.1.3, Adult Offender Community Work Programs/ Projects*](#)

VII. ATTACHMENT

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No.: DOC 5.2.1	Subject: MONTANA CORRECTIONAL ENTERPRISES
Chapter 5: OFFENDER PROGRAMS	Page 1 of 2
Section 2: Work and Training Programs	Effective Date: 8/1/97
Signature: /s/ Mike Ferriter, Director	Revised: 10/24/11

I. POLICY

The Montana Department of Corrections, Correctional Enterprises Division provides offender vocational education and on-the-job training work programs consistent with the Department's mission and goals.

II. APPLICABILITY

Adult secure care facilities Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Montana Correctional Enterprises (MCE) – The Department division responsible for providing offender vocational education and on-the-job training work programs consistent with the Department's mission and goals.

IV. DEPARTMENT DIRECTIVES

A. Montana Correctional Enterprises (MCE) Mission Statement

1. MCE provides employment and training opportunities to offenders that enhance public safety, promote positive change in offender behavior, reintegrate offenders into the community, and support victims of crime.

B. Programs

1. MCE Programs include:
 - a. Agriculture;
 - b. Industries;
 - c. Vocational Education;
 - d. Food Factory;
 - e. License Plate Factory;
 - f. Canteen; and
 - g. Facility and Program Support Service.

C. Goals

1. Provide offenders vocational education and on-the-job training in various work programs to encourage pride in workmanship, instill basic values, and develop skills, ethics, and self-esteem to help offenders succeed as productive, law-abiding citizens with marketable skills, and to reduce recidivism.

2. Ensure all operations maintain security of the institution and retain public safety and trust.
3. Produce and deliver quality products and services designed to meet customer needs in a timely manner.
4. Provide accurate, timely information regarding MCE operations to the Department, the public, and the legislature.

D. Objectives

1. MCE will formulate measurable objectives based on the established mission and goals that are clear, concise, and identify specific dates for implementation and completion.
2. MCE will provide regular reports to the Department director that outline the objectives that have been accomplished to include, at a minimum, financial status, plans, and offender employment numbers.

E. Benefits

1. Recidivism is reduced by developing skills and work ethics which enhance an offender's chance for success upon reintegration into the community.
2. Reduction of general funding needs by avoiding normally required additional security supervision during MCE working hours.
3. Reduces problems associated with offender idleness.
4. Offenders' sense of self-worth is developed through the accomplishment of goals.
5. MCE produces quality products and services for customers.

F. Funding

1. MCE operations have several sources of funding; the MCE budget is derived primarily from self-supporting programs as well as the:
 - a. Self-Proprietary fund;
 - b. General fund;
 - c. Internal fund; and
 - d. Special Service fund.

V. CLOSING

Questions concerning this policy should be directed to the MCE Administrator.

VI. REFERENCES

- A. [53-1-203, MCA](#); [53-30-131, MCA](#)
- B. [2-CI-6A-1, ACA](#)

VII. ATTACHMENTS

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No.: DOC 5.2.2	Subject: MONTANA CORRECTIONAL ENTERPRISES PROGRAM IMPLEMENTATION CHECKLIST	
Chapter 5: OFFENDER PROGRAMS	Page 1 of 1	
Section 2: Work and Training Programs	Effective Date: Aug. 1, 1997	
Signature: /s/ Mike Ferriter, Director	Revised: 10/24/11	

I. POLICY

The Department of Corrections tasks Montana Correctional Enterprises with establishing safe, efficient, and effective vocational education and on-the-job training work programs in its correctional facilities.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS

None

IV. DEPARTMENT DIRECTIVES

A. General Provisions

1. Administrators will develop programs in compliance with the needs of the correctional facility in which it is located and will adhere to facility program and operational requirements.
2. When developing vocational and on-the-job training work programs, administrators will identify the following:
 - a. the type of program;
 - b. a review of policies;
 - c. support requirements;
 - d. physical facility needs;
 - e. work force requirements;
 - f. equipment needs; and
 - g. certification requirements.

V. CLOSING

Questions concerning this policy should be directed to the MCE Administrator.

VI. REFERENCES

- A. [53-1-203, MCA](#); [53-30-131, MCA](#)

VII. ATTACHMENTS

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 5.2.3	Subject: DEPARTMENT / MCE PRODUCT SALES	
Chapter 5: OFFENDER PROGRAMS		Page 1 of 2
Section 2: Montana Correctional Enterprises		Effective Date: August 1, 1997
Signature: /s/ Loraine Wodnik, Deputy Director		Revised: 12/23/2016

I. POLICY

The Department of Corrections Montana Correctional Enterprises Division (MCE) offender education and job training programs support the Department's mission to reintegrate offenders into the community successfully. Administrators support offender rehabilitation and work programs through the purchase of MCE products.

II. APPLICABILITY

All divisions, facilities, and programs Department-owned and contracted, as specified in contract.

III. DEFINITIONS

Administrator – The official, regardless of local title (division or facility administrator, bureau chief, warden, superintendent), ultimately responsible for the division, facility or program operation and management.

Montana Correctional Enterprises (MCE) – The Department division that operates offender work and training programs at Department and contracted facilities, including agriculture, industries, vocational education, license plate factory, food factory, canteen, and the offender hobby store.

MCE Products – Products and services manufactured or provided by Montana Correctional Enterprises.

IV. DEPARTMENT DIRECTIVES

A. MCE Program Goals

1. MCE will operate offender work and training programs that emphasize offender accountability and rehabilitation.
2. Revenue from the sale of MCE products supports offender work programs and provides offender workers with the means to meet financial obligations.
3. MCE programs are largely self-supporting, providing customers with high quality, satisfaction guaranteed products with minimal need for dependence from the state's general fund.

B. MCE Product Sales

1. MCE will maintain a website accessible from the Department's Internet page that lists MCE products including specifications and pricing.

Policy No. DOC 5.2.3	Chapter 5: Offender Programs	Page 2 of 2
Subject: DEPARTMENT / MCE PRODUCT SALES		

2. MCE management will consider special product and service requests on a case-by-case basis and will make every attempt to meet the unique needs of the customer within the capability of the respective MCE program.

C. Purchasing Requirements

1. Department staff are encouraged to support offender work programs through the purchase of MCE products unless it is determined by the staff member's administrator that purchase from MCE is not feasible due to one or more of the following reasons:
 - a. the product or service cannot be supplied by MCE within an acceptable schedule at which time the division must take into consideration that MCE may loan furniture to the requesting party until an order is produced and delivered; or
 - b. the MCE product or service does not meet the needs of the division or facility, as determined by the administrator, and a custom product is not available through MCE.
2. Administrators, or their designees, are encouraged to contact MCE before making an outside vendor purchase to discuss their needs regarding product availability, specifications, warranty, delivery, and price when considering a purchase from an outside vendor.
3. Administrators will contact the MCE administrator when purchasing needs are not being met. MCE will review all such inquiries to determine how best to remedy the problem and to ensure that the needs of all customers are met to the extent possible.

D. Compliance

The Director's Office, Quality Assurance Office may review agency purchases to ensure compliance with this policy.

V. CLOSING

Questions concerning this policy should be directed to the appropriate administrator.

VI. REFERENCES

- A. 53-1-203; 53-30-131, MCA

VII. ATTACHMENT

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 5.2.4	Subject: PRISON INDUSTRY ENHANCEMENT CERTIFICATION PROGRAM (PIECP)
Chapter 5: OFFENDER PROGRAMS	Page 1 of 2 and Attachments
Section 2: Montana Correctional Enterprises	Effective Date: May 10, 2007
Signature: /s/ Mike Batista, Director	Revision Date: 5/22/2013

I. POLICY

The Department of Corrections authorizes the Montana Correctional Enterprises Division to collect inmate wage deductions in federally certified work programs known as Cost Accounting Centers per federal statute.

II. APPLICABILITY

The Montana Correctional Enterprises Division.

III. DEFINITIONS

Authorized Deductions – Monies deducted from an offender's gross wages including crime victim compensation, family support, room and board, and federal and state withholding tax.

Gross Wages – All money earned by offenders for actual hours worked during the pay period.

Mandatory Savings – Funds deducted from an inmate's net pay, deposited into the offender's savings account, and held for disbursement upon discharge or parole.

Montana Correctional Enterprises (MCE) – The Department division that operates work and training programs at Department and contracted facilities, including agriculture, industries, vocational education, license plate factory, food factory, canteen, and the offender hobby store.

Net Pay – Monies remaining after payment of all applicable taxes and authorized deductions.

Prison Industry Enhancement Certification Program (PIECP) – A program administered by MCE certified by the Department of Justice, Bureau of Justice Assistance to allow the interstate sale and distribution of inmate-produced goods developed by the cost center.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. An accounting center with unique revenue, expense, and labor account codes for a specific program called a Cost Accounting Center (CAC) program will address specific wages for inmates.
2. Inmates assigned to a Prison Industry Enhancement Certification Program (PIECP) must sign an approved wage deduction agreement as a condition of program participation prior to beginning work in the program.
3. Program staff will deduct the following from the inmate's gross wages:
 - a. applicable taxes;
 - b. crime victim compensation;

- c. family support; and
 - d. room and board.
4. Program staff will complete the following requirements:
- a. inform participating inmates of authorized wage deductions;
 - b. deposit room and board deductions into the Correctional Enterprise proprietary fund to partially offset the cost of incarceration, including the cost of operating MCE and other work programs;
 - c. program staff may not authorize deductions exceeding 80% of gross wages but may deduct mandatory savings from the remaining 20% of net pay; and
 - d. provide participating inmates with a periodic deduction statement that itemizes gross wages earned, specific authorized deductions, net pay, and mandatory savings..

V. CLOSING

Questions concerning this policy should be directed to the MCE administrator.

VI. REFERENCES

- A. [53-1-203, MCA](#); [53-30-132, MCA](#);
- B. 98-473, Sec. 819, *Public Law Justice assistance Act of 1984*
- C. [101-647, Public Law Crime Control Act of 1990](#)

VII. ATTACHMENTS

[Approved Wage Deduction Agreement \(Customer Model\)](#) [PDF](#)
[Approved Wage Deduction Agreement \(Employer Model\)](#) [PDF](#)



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No.: DOC 5.3.1	Subject: OFFENDER EDUCATION
Chapter 5: OFFENDER PROGRAMS	Page 1 of 3
Section 3: Education Programs	Effective Date: 03/25/2015
Signature: /s/ Mike Batista, Director	Revised: 06/28/2016

I. POLICY

The Department of Corrections will provide a comprehensive basic education program for all eligible offenders.

II. APPLICABILITY

All Department-owned and contracted secure facilities, as specified in the contract.

III. DEFINITIONS

Accredited School – A school that has met the minimum standards determined by the board of public education.

Basic Education – Instruction in basic skills, such as reading, writing, arithmetic, and other skills required to function in society, which may include any subject normally offered in the basic curricula of an accredited elementary or secondary school in the state.

Diploma – A certificate issued from an accredited school indicating a student has successfully completed the minimum requirements prescribed by a state education agency.

High School Equivalency - A battery of tests, such as the HiSET or GED, that measures a person's academic skills as compared to a high school graduate.

Individualized Education Program (IEP) – A document that guides the delivery of special education supports and services.

Office of Public Instruction (OPI) – The office that provides advocacy, support and leadership in education for schools and communities.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. Each facility will provide a basic education program consistent with the needs of the offender population.
2. Juvenile facilities must provide education through an accredited school or high school equivalency program.
3. Facilities will request prior academic records for offenders under age 22.

Policy No. DOC 5.3.1	Chapter 5: Offender Programs	Page 2 of 3
Subject: OFFENDER EDUCATION		

4. Offenders in education programs with qualifying disabilities may be provided reasonable accommodations in accordance with *DOC Policy 3.3.15 Americans with Disabilities Act (ADA) Offender Accommodations*.
5. Educational services provided to offenders in administrative segregation and special management units may vary from those provided to the general population. Public safety and the health, safety, and security of all employees, service providers, volunteers, and offenders will be an overriding consideration when determining the extent of educational services provided to offenders in administrative segregation and special management units.
6. Offenders must meet the facility's educational requirements to be eligible for work assignments.
7. Education compensation will follow the compensation structure as provided in *DOC 5.1.1 Inmate Assignments*.

B. Assessment and Placement in Educational Programming

1. Upon intake or initial evaluation at a facility, an offender may be required to complete an assessment to determine educational skill levels.
2. Facilities will verify if an offender has a high school diploma or high school equivalency certificate. If the offender has a verified high school diploma or high school equivalency certificate, an assessment may not be necessary.
3. Reassessment and standardized testing of offender educational skill levels will be conducted on a regular basis as required by the Office of Public Instruction (OPI), grants or special academic program requirements.
4. Upon completion of assessments, adult offenders who have not attained a high school diploma or high school equivalency certificate may be placed in educational programming or program waiting list. Juvenile offenders who have not attained a high school diploma or high school equivalency certificate must be placed in educational programming.

C. Special Education Services

1. All education programs must comply with special education and IEP rules under state and federal law.
2. Facilities will provide eligible offenders with special education services until the age of 22.
3. Offenders age 18 or older who qualify for special education services but refuse services must sign a revocation form. Offenders under age 18 may not refuse services unless a parent or guardian signs a revocation form.

D. Exclusions from Educational Programming

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Subject: OFFENDER EDUCATION		

1. Offenders may be removed, suspended or waived from participation in education programs or classroom settings if continued participation jeopardizes safety, security, or is not in the best interest of the offender.
2. Adult offenders under the age of 22 who do not have a high school diploma or equivalency certificate must sign a revocation form to opt out of assessments or educational programs. Juvenile offenders may not opt out of assessments or educational programs.
3. All waivers, suspensions and removals will be documented and the documentation placed in the offender's education file. Facilities will have procedures for reviews and expiration of waivers, suspensions and removals.

E. Records

1. Offender education files will be kept in accordance with OPI standards, state and federal law.

F. Other Education Programs

1. In addition to traditional primary and secondary education programs, each facility may offer academic, vocational, occupational, career technical education or apprenticeship opportunities on or off site.
2. Offenders may pursue self-study, distance learning or correspondence programs provided through colleges, universities, vocational and technical schools. Offenders will pay the tuition for these programs from personal funds or other sources such as scholarship awards. Grants may be used to pay for offender participating in these programs.
3. Participation guidelines for other educational programs will be created by each facility.

V. CLOSING

Questions concerning this policy should be directed to the facility or program administrator.

VI. REFERENCES

- A. 53-1-203, 52-5-101, 52-5-106 MCA
- B. 4-4012, 4-4013; *ACA Standards for Adult Correctional Institutions, 4th Edition*
- C. *DOC Policy 3.3.15 Americans with Disabilities Act (ADA) Offender Accommodations; 3.5.1 Locked Housing Unit Operations; 5.1.1 Inmate Assignments*
- D. *Individuals with Disabilities Education Act (IDEA)*

VII. ATTACHMENTS

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 5.3.2	Subject: LIBRARY SERVICES
Chapter 5: OFFENDER PROGRAMS	Page 1 of 2
Section 3: Education Programs	Effective Date: Jan. 1, 1998
Signature: /s/ Loraine Wodnik, Interim Director	Revised: 04/28/2017

I. POLICY

It is the policy of the Department of Corrections to provide offenders with library services within secure care facilities and to ensure library materials are available in the languages represented by significant numbers of offenders in the population.

II. APPLICABILITY

Department secure care facilities for adult and youth offenders.

III. DEFINITIONS

None

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. Secure care facilities shall provide offenders access to a library organized within the facility containing general, specialized, and reference materials.
2. Library programs shall publish a schedule of service hours.
3. Facility procedure shall dictate whether offenders may check out materials.
4. Facility libraries shall participate in interlibrary loan programs and continuously acquire library materials.
5. Facilities shall utilize a library content survey that will, at minimum:
 - a. assist in determining material acquisition.
 - b. assist in determining the library service needs of the offender population; and
 - c. be completed annually.
6. Material reading levels shall be consistent with offender abilities.
7. Materials shall be selected using criteria including:
 - a. accuracy;
 - b. currency; and
 - c. cultural, inspirational, and/or recreational values.
8. Library materials including books, supplies, and resources will be accepted or declined in accordance with the above listed selection criteria and the safety and security needs of the facility.
9. Centralized library facilities should conform to contemporary library standards when

Policy No. DOC 5.3.2	Chapter 5: Offender Programs	Page 2 of 2
Subject: LIBRARY SERVICES		

possible.

10. Facilities housing fewer than 500 inmates may be exempt from the provisions of this policy when comparable services are provided to inmates.
11. Libraries located within youth facility schools must meet all standards of the accreditation requirements mandated by the Office of Public Instruction (OPI).

B. Staffing

1. The administrator, or designee, shall appoint a qualified individual as the library supervisor with the following responsibilities:
 - a. overall library program management;
 - b. ensure offender access to library services;
 - c. on-the-job training of library staff;
 - b. develop goals and objectives to include principles, purposes, and criteria for selection of library materials to meet the needs of the offender population;
 - c. ensure consultant or contracted library services are acquired when necessary;
 - d. select, train, and utilize offenders as library assistants, when applicable; and
 - e. conduct an annual evaluation of the library services program using stated performance goals and objectives. Evaluation shall be submitted to the administrator, or designee, for review and incorporation into the overall facility budget and goals.
2. Libraries located within youth facility schools must have endorsed school librarians in accordance with accreditation requirements.

C. Special Housing Units

1. Facility procedure shall address offenders in locked units and special housing areas to provide the library services of the centralized collection.

E. Offender Assistants

1. Offender assistants may be selected using criteria including: education, experience, and institutional record. Offender library assistants and clerks shall receive training from the library staff prior to assignment and on a regular basis thereafter.

V. CLOSING

Questions concerning this policy shall be directed to the appropriate administrator.

VI. REFERENCES

- A. 53-1-203, MCA
- B. 4-4273, 4-4505, 4-4506, 4-4508, 4-4509, 4-4511; *ACA Standards for Adult Correctional Institutions, 4th Edition*
- C. 3-JTS-5D-02, 3-JTS-5E-05, 3-JTS-5E-04; *ACA Standards for Juvenile Correctional Facilities*
- D. 4-JCF-5E-01; *Performance-Based Standards for Juvenile Correctional Facilities, 4th Edition*

VII. ATTACHMENTS

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 5.3.3	Subject: UNIVERSITY AID FOR YOUTH OFFENDERS
Chapter 5: OFFENDER PROGRAMS	Page 1 of 2
Section 3: Education Programs	Effective Date: March 12, 2001
Signature: /s/ Mike Batista, Director	Revised: 04/19/2016

I. POLICY

The Department of Corrections youth correctional facilities will establish criteria and procedures for distributing university aid to incarcerated youth offenders when residents are eligible for enrollment in a unit of the Montana university system.

II. APPLICABILITY

Youth offenders in, or on youth parole from, Department secure youth correctional facilities.

III. DEFINITIONS

Resident – A youth offender residing in, or on youth parole from, a state youth correctional facility.

State Youth Correctional Facility – Pine Hills or Riverside Youth Correctional Facilities.

Superintendent – The administrator ultimately responsible for the youth facility's operation and management.

Tuition Waiver – The action taken by the financial aid officers of a designated Montana university system unit to waive the cost of tuition for residents qualified under § 20-25-421, MCA, who meet the criteria set forth in § 52-5-112, MCA.

University Aid – Funding up to \$800 per year toward the expenses of a resident enrolled in a unit of the Montana university system that may be used for transportation, clothing, books, and/or board and room.

IV. DEPARTMENT DIRECTIVES

A. Eligibility Requirements

1. No more than eight residents per year from each state youth correctional facility may receive university aid and/or fee and tuition waivers to attend a unit of the Montana university system.
2. A resident must meet Montana university system entrance requirements.
3. Youth correctional facility procedures will determine the internal program and security criteria for a resident's eligibility to attend a university unit or to participate in a distance-learning program.

Policy No. DOC 5.3.3	Chapter 5: Offender Programs	Page 2 of 2
Subject: UNIVERSITY AID FOR YOUTH OFFENDERS		

4. The facility superintendent may recommend that the Department director approve funding for residents who meet the eligibility requirements.

B. Administrative Responsibilities

1. The Department director will review the superintendent's recommendations and may request fee waivers from the financial aid office at the Montana university system unit where the resident intends to enroll.
2. The Department director may recommend that the resident receive annual university aid up to \$800 per year based on budget authority for university aid.
3. The Department director will notify the Board of Regents prior to August 1st of each year of any resident approved to receive the benefits for the coming school year.

V. CLOSING

Questions concerning this policy should be directed to the facility superintendent.

VI. REFERENCES

- A. 20-25-421, MCA (2011) *Charges for Tuition—Waivers*; 52-5-112, MCA (2011) *University Aid to Residents of Schools*
- B. 3-JTS-5D-01,-03,-10,-13; *ACA Standards for Juvenile Correctional Facilities*, 2003

VII. ATTACHMENTS

None



POLICY DIRECTIVE

Policy:	DOC 5.4.1 OFFENDER PROGRAM APPROVAL PROCESS	
Effective Date:	07/01/2008	Page 1 of 4
Revision Date(s):	06/03/2019; 06/08/2023; 12/18/2024	
Signature/Title:	/s/ Scott Eychner, Rehabilitation and Programs Chief	

I. POLICY

Prior to being implemented in the Department, all programs of all types offered to offenders under the supervision of the Department must be submitted to the Department for review and approval. All programming will meet applicable requirements of federal and state law.

II. APPLICABILITY

All programs offered to offenders under the supervision of the Department.

III. DEFINITIONS (see Glossary)

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. Administration of Offender Programs
 - a. Offender programming will be offered as either:
 - 1) core risk reducing; programs available to a particular offender will depend on various factors, including the offender's risk and needs assessment scores (priority to high-risk and moderate-risk offenders), approved secondary assessments as applicable, and whether the program is offered by the program or facility where the offender is located; or
 - 2) other programming such as general education, post-secondary education, vocational education, and on-the-job training and programs.
 - b. Qualified staff will provide appropriate screenings and assessments, case management, progress reports, and clinical documentation when applicable.
 - c. Administrators will establish formal mechanisms to determine the appropriate staffing levels for the number and type of offenders served, locations, and the programming goals to be accomplished.
 - d. Since most offenders cannot accept paid work assignments during intensive programming, administrators may elect to pay offenders a daily wage during program participation.
 - e. The Department prohibits disability discrimination in providing programs to offenders. Programs and facilities may be required to take remedial action, when necessary, to facilitate offender participation as follows:
 - 1) make reasonable modifications to policies, procedures, or practices;
 - 2) provide auxiliary aids and services to the hearing and visually impaired;
 - 3) address the special needs of impaired offenders, for example, those with mental illness, or who are illiterate, head injured, or developmentally disabled;
 - 4) construct new or alter existing facilities; or
 - 5) deliver services at alternate accessible sites.
 - f. The Department will ensure no offender is prevented from attending programming for which they are eligible, based solely on an ADA accommodation, including housing assignment.

2. Program Provider Qualifications and Training
 - a. Behavioral health program directors or administrators will have the required credentials and experience for the position.
 - b. Sex offender programming providers will be, or supervised by an individual who is, certified by the Montana Sex Offender Treatment Association (MSOTA) or Association for the Treatment and Prevention of Sexual Abuse (ATSA) and will have successfully completed all training related to the delivery of these services. Additionally, individuals with professional licensure or eligibility for licensure are preferred.
 - c. Substance-abuse focused programming providers will have successfully completed all training related to the delivery of these services. Additionally, individuals with professional licensure or eligibility for licensure are preferred.
 - d. Trained and qualified staff who administer, supervise, and provide offender programming will maintain applicable current licensure, certification, and continuing training requirements.
 - e. All offender programs will receive appropriate levels of clinical or staff supervision and training according to licensing and credentialing standards and as necessary to maintain program fidelity.
3. Program Statistics
 - a. Designated staff associated with each component of offender programming will:
 - 1) have written goals and measurable objectives;
 - 2) as applicable, track the number of offenders:
 - a) in programs;
 - b) on waiting lists;
 - c) who have successfully completed programs; and
 - d) who have not completed programs and the reasons for not completing;
 - 3) track offender participation and involvement in programs;
 - 4) maintain and make program statistics available on request; and
 - 5) where applicable, document and submit required statistics for state agency databases.
4. Program Evaluation
 - a. In evaluating evidence-based/core risk reducing and adjunct programs, the Department uses an endorsed evaluation tool that addresses adherence to evidence-based practices. The Department has adopted the Correctional Program Checklist as its program evaluation tool, which is provided only to staff conducting the evaluations. At the direction of the QAEBPP Bureau Chief, certified staff will use this tool in periodically reviewing any implemented programs for fidelity and adherence to evidence-based practices.
 - b. For all other programs, the applicable Bureau Chief will periodically evaluate programs to ensure they are meeting the needs and goals of the Department and offenders.
 - c. Bureau Chiefs will analyze the collected data and report internally on program success and overall value at least annually to the Rehabilitation and Programs Chief.

B. Evidence-Based/Core Risk Reducing and Adjunct Program Approval Process

1. This area pertains to all evidence-based/core risk reducing and adjunct programming.
 - a. Adjunct programming may include but is not limited to parenting, victim impact, grief, eating disorders, body dysmorphia, mental health, and trauma-focused programming.
 - b. Questions should be directed to CORQAEBPP@mt.gov.
2. An employee will complete the applicable parts of the *DOC 5.4.1 (A) Request for Program Approval (Request)*. If the employee is:
 - a. a Department employee, the employee will send it to their supervisor;
 - b. a contracted facility employee, the employee will send it to correquests@mt.gov; or
 - c. a secure contracted facility employee, the employee will send it to the warden of that facility.

3. At any stage in the process, if the request is denied, it will be returned to the applicable individual(s) with reasons for the denial.
4. In reviewing a *Request*, the following factors of the proposed program should be considered at all stages of the process, as applicable:
 - a. in the public domain and evidence-based/core risk reducing,
 - b. research-driven,
 - c. studied on a criminal justice population,
 - d. culturally appropriate,
 - e. gender responsive,
 - f. trauma-informed, and
 - g. likely to result in ongoing costs for the offender or Department.
5. The recipient will review the *Request* for the above factors and associated costs, space, and staffing requirements. After review, if the *Request* is approved the recipient will forward it to CORQAEBPP@mt.gov.
6. After receiving the *Request*, the Bureau Chief or designee selects the members of the review team. The review team must include independent Department staff (not the Bureau Chief), at least three of whom must be CPC-certified and at least one of whom must be a licensed clinician. The review team will confirm whether the *Request* is evidence-based/core risk reducing or an adjunct program.
7. The members review the *Request* to determine by consensus whether the program is appropriate to implement, and forward their approval or denial recommendation to the Bureau Chief for final review and determination.
8. A program may not be used by the Department until the Bureau Chief gives final approval.
9. Designated staff with appropriate qualifications will observe and review evidence-based facilitator performance at least once per quarter. The designated staff will document the observation and submit it to the facilitator's supervisor and CORQAEBPP@mt.gov for recordkeeping.

C. Approval Process for Educational, On the Job Training, and All Other Types

1. This area pertains to programming and education other than evidence-based/core risk reducing and adjunct programming.
 - a. This programming and education may include but is not limited to general education, post-secondary education, vocational education, and on-the-job-training and programs.
 - 1) General, post-secondary, and vocational education programming includes efforts to deliver adult basic education; general high school equivalency; college-level education that may include classroom and experiential learning opportunities and may or may not result in college credit; and occupationally related skills development training that does not include paid wages.
 - 2) On-the-job training and programs include occupationally related skills development training that includes paid wages, and prison industries related job assignments that include paid wages and may or may not include an ongoing related skills development component.
 - b. Questions should be directed to the applicable Bureau Chief.
2. A program may not be used by the Department until the applicable Bureau Chief or Rehabilitation and Programs Chief gives final approval.
3. At any stage in the process, if the request is denied, it will be returned to the applicable individual(s) with reasons for the denial.

4. During the process, the following factors should be considered at all stages, as applicable:
 - a. introduces or expands relevant educational and/or occupational skills;
 - b. addresses a current or projected labor market demand;
 - c. establishes or directly supports a relevant and realistic business opportunity;
 - d. leads to a self-sustaining career (not job) opportunity (either directly or via a pathway);
 - e. has been successfully implemented for a criminal justice population;
 - f. utilizes/employs/offers technology as an option to engage beyond the classroom and beyond a single facility;
 - g. accounts for offering-equity across facilities;
 - h. includes engagement of/support from industry champions; and
 - i. includes engagement of/support from other government agencies and/or partners.
5. Staff will complete the applicable parts of *DOC 5.4.1 (A) Request for Program Approval (Request)* and forward it to their supervisor.
 - a. If the Bureau Chief is submitting the *Request*, they will review it as specified below.
6. The supervisor will review the *Request* for the above factors and associated costs, space, and staffing requirements. After review, the supervisor will forward the *Request* to the Bureau Chief.
 - a. If the Bureau Chief is submitting the *Request*, they will complete the above review and forward the *Request* to the Rehabilitation and Programs Chief.
7. The Bureau Chief/Rehabilitation and Programs Chief will review the *Request*, approve or deny it, and respond to the applicable staff.

V. CLOSING

Questions about this policy should be directed to CORQAEBPP@mt.gov or the applicable Bureau Chief.

VI. FORMS

DOC 5.4.1 (A) Request for Program Approval



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 5.5.2	Subject: INMATE ORGANIZATIONS
Chapter 5: INMATE PROGRAMS	Page 1 of
Section 5: Recreation Activities	Effective Date: July 1, 1998
Signature: /s/ Mike Batista, Director	Revised: 6/7/2013

I. POLICY

It is the policy of the Montana Department of Corrections to authorize inmate organizations in its facilities when such organizations are, in the view of staff, productive and facilitate rehabilitative processes and when staff can adequately supervise the programs.

II. APPLICABILITY

Adult secure facilities Department-owned and contracted, as specified in the contract.

III. DEFINITIONS

None

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. Inmate organizations may be approved at the discretion of the facility administrator if the organization contributes to the overall positive atmosphere or to the range of programs available.
2. Prospective inmate organizations must have the following prerequisites in place prior to consideration for approval:
 - a. demonstrate the positive contribution the organization would make to the inmate population;
 - b. statement of purpose, constitution, and by-laws that describe nondiscriminatory membership criteria, including that inmates shall not be denied membership due to lack of funds;
 - c. financial management and annual audit plan in accordance with Department policies if funds are involved in the operation of the organization;
 - d. staff sponsor volunteering to supervise all activities; may not be compensated by the organization for services provided, and will be scheduled for these duties by their respective department head; and
 - e. other information requested by the facility administrator.
3. Time, place, and content of meetings and activities of an inmate organization must be approved in advance by the Security Major/Manger, or other comparable facility position, and supervised by the staff sponsor.
4. The facility administrator may disband an inmate organization either temporarily or permanently, at any time without prior notice, if the activities of the organization are

Policy No.: DOC 5.5.2	Chapter 5: Offender Programs	Page 2 of 2
Subject: INMATE ORGANIZATIONS		

deemed disruptive, contrary to the security or safety of the facility, or for failure to meet audit or other requirements.

5. Publications reporting news, editorial content, or other non-program information are not permitted.

V. CLOSING

Questions concerning this policy should be directed to the facility administrator.

VI. REFERENCES

- A. [53-1-203](#), MCA

VII. ATTACHMENTS

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 5.5.3	Subject: RECREATION PROGRAMS
Chapter 5: INMATE PROGRAMS	Page 1 of 2
Section 5: Recreation Activities	Effective Date: July 1, 1998
Signature: /s/ Mike Ferriter, Director	Revised: 08/06/12

I. POLICY

It is the policy of the Montana Department of Corrections to provide recreational programs and activities to inmates based upon classification, safety and security, and available supervision.

II. APPLICABILITY

Adult secure care facilities Department-owned or contracted, as specified in contract.

III. DEFINITIONS

Recreation - Non-work related activity intended to refresh body or mind.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. Recreation activities shall be supervised and made available to each general population inmate at least one (1) hour each day with the exception of segregation inmates.
2. The facility administrator, or designee, shall assign a staff member to supervise recreational activities and complete the following duties:
 - a. annually assess the recreation needs and interests of the inmate population;
 - b. maintain recreation facilities and equipment in condition suitable for planned activities;
 - c. ensure the available recreational equipment is proportional to the participating inmate population;
 - d. inventory, secure, and store the recreational equipment;
 - e. select, train, and supervise inmate gym workers;
 - f. oversee recreation programs in locked housing units for special needs inmates; and
 - g. maintain physical fitness and wellness programs, where applicable.

B. Recreation Program

1. Recreation activities may include softball, basketball, volleyball, table games, sporting competitions, holiday activities, and hobby programs.
2. General population housing units with day rooms may provide activities such as dominoes, checkers, cards, and television.
3. General population inmates shall be granted access to supervised outdoor exercise on a daily basis, weather permitting, using a variety of equipment.

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Subject: RECREATION PROGRAMS		

4. Equipment items issued to inmates in secure facilities shall be inventoried daily and stored in a secure area. Staff is responsible for conducting searches of recreation areas for detecting altered or damaged equipment, hidden contraband, and security breaches.
5. Inmates housed in locked units shall not exercise with general population inmates; special precautions shall be taken to ensure that inmates needing separation from each other do not exercise together.
6. Supervision of recreation activities shall be constant; at least one staff member, equipped with a radio to maintain contact with the control center, shall supervise recreation activities. All inmates moving to recreation activity from locked unit cells shall be searched prior to and after the recreation period and escorted by security personnel.
7. Inmates may be permitted, within the limits imposed by security, safety, and sanitation, to engage in independent recreation activities such as board games, supervised small group activities, in-cell hobby craft, and similar time-structuring activities. Inmates may request additional activities and programs of an individual or group nature with approval contingent on availability of staff supervision, safety and security, and other resources.

C. Program Evaluation

1. Designated staff shall evaluate the program annually to assess effectiveness and determine the personnel and program requirements. This evaluation report shall include an assessment of major accomplishments, problems, plans and goals for the next year.

D. Staffing

1. Administrators shall review the personnel requirements for the recreational program at least annually. This evaluation shall include the following criteria:
 - a. number of staff assigned to the recreation program;
 - b. number of additional assigned staff including, but not limited to, correctional officers assigned to provide security supervision, volunteers, and medical staff; and
 - c. major program revisions that may affect staffing needs.
2. At the discretion of the administrator, trained volunteers from the local community may be utilized in the recreation program while supervised in accordance with [DOC 1.3.16 Volunteer Services](#).

V. CLOSING

Questions concerning this policy should be directed to the facility administrator.

VI. REFERENCES

- A. [53-1-203](#), MCA
- B. [DOC 1.3.16 Volunteer Services](#)
- C. 4-4484, 4-4485; *ACA Standards for Adult Correctional Association*, 4th Edition

VII. ATTACHMENTS

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 5.5.4	Subject: HOBBY PROGRAMS FOR ADULT FACILITIES
Chapter 5: INMATE PROGRAMS	Page 1 of
Section 5: Recreation Activities	Effective Date: July 1, 1998
Signature: /s/ Mike Ferriter, Director	Revised: 08/03/11

I. POLICY

The Department of Corrections will establish guidelines for hobby programs to encourage inmates to use leisure time constructively and to ensure the safety and security of the facility.

II. APPLICABILITY

Department-owned and contracted facilities, as specified in contract.

III. DEFINITIONS

Contraband - Any item possessed by an offender or found within the facility that is illegal by law, prohibited by policy or procedure, or unauthorized by those legally charged with the administration and operation of the facility.

Facility/Program - Refers to any division, prison, secure care correctional facility, correctional or training program, or community-based program under Department jurisdiction or contract. This term includes the facility building or residence, including property and land owned or leased and operated by the Department.

Hobby/Craft Shop - A designated room or area for the creation of hobby/craft items that require close supervision of offenders, tools and chemicals.

Housing Area Hobby - The creation of hobby/craft projects located in a housing area; limited to projects not requiring caustic/toxic/flammable chemicals, and tools or materials with the potential of compromising the safety or security of the facility.

Hobby Supervisor - The person appointed by the administrator to oversee the hobby program in the facility.

Premium Hobby Craft Activities - Designated hobby/craft activities possessing the highest earning potential and requiring large investments; activities generally require workspace in the hobby craft shop.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. Each facility will develop a procedure in accordance with this policy.
2. The administrator, or designee, upon determining the availability of facility-specific hobby/craft activities, will consider:
 - a. inmate custody levels;
 - b. tools and control of the tools;

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- c. availability of adequate space;
 - d. level of staff supervision necessary;
 - e. required chemicals, i.e. caustic, toxic, or flammable in accordance with *DOC Policy 3.2.12, Control and Use of Hazardous Materials*; and
 - f. the safety and security of the facility.
3. The administrator, or designee, will:
 - a. designate hobby/craft activities as housing area or premium programs;
 - b. determine locations activities are permitted; and
 - c. select the facility-specific permitted hobby/craft activities from the following options:
 - 1) Basic Art including pencil sketches, charcoal, crayon, or watercolor paints (non-acrylic);
 - 2) Yarn Crafts including crocheting, knitting, or similar crafts utilizing non-metallic needles/hooks;
 - 3) Needle Crafts including embroidery, needlepoint, cross-stitch, or similar crafts;
 - 4) Beading; and
 - 5) Fly-Tying including the fabrication of fishing lures.
 - 6) Advanced Art including acrylics, oils, or other similar paints, hazardous, toxic, or caustic chemicals requiring a MSDS sheet and inventory control;
 - 7) Horsehair including braiding, hitching, weaving, and pressing of horsehair; and
 - 8) Leather-Working.
4. Inmates may create products as gifts for family and friends.
5. Use of a business or company name or mass production manufacturing involving more than one inmate will not be permitted.

B. Eligibility Criteria

1. Inmates are allowed one hobby permit at a time, unless facility procedure specifies an incentive program providing an exception.
2. The hobby supervisor, or designee, will review and process all submitted hobby/craft permits and consider inmates sustaining a clear disciplinary record with no severe or major infractions for a minimum of:
 - a. three months for activities not designated as premium; and
 - b. six months on premium activities.
2. The administrator, or designee, will establish a minimum monetary investment for all approved activities; an inmate must have sufficient funds in his or her trust account and make the minimum investment to obtain a hobby permit.

C. Termination of Hobby/Craft Privileges

1. Participation in the hobby/craft program is a privilege and may be revoked at the discretion of administrator, or designee, for reasons including, but not limited to:
 - a. one severe or three minor disciplinary convictions within a six month period;
 - b. failure to comply with this policy or corresponding facility procedures;
 - c. failure to participate routinely in the hobby/craft program activities.

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2. Inmates whose privileges are terminated are not eligible for another permit for ninety (90) days for housing area programs and one-hundred and eighty (180) days for premium programs.
3. When an inmate terminates his or her involvement in a hobby/craft program, the permit must be surrendered to the hobby supervisor, or designee; tools and unused materials will be mailed out at the inmate's expense or disposed of in accordance with *DOC Policy 4.1.3, Offender Personal Property*.
4. An inmate in possession of unauthorized supplies will receive a hobby/craft program suspension for ninety (90) days for housing area programs and one-hundred and eighty (180) days for premium programs and may be subject to additional disciplinary action.

D. Hobby/Craft Tools, Materials, and Products (Supplies)

1. The administrator, or designee, will determine which tools are permitted within the housing areas; use and control of tools will be in accordance with *DOC Policy 3.1.14, Tool Control*.
2. Supplies used as a weapon or devise of destruction or insurrection will be permanently confiscated and the violator may be subject to disciplinary action.
3. Inmates are required to keep accurate records of their supplies, including invoices and receipts.
4. Supplies must be mailed out of the facility, disposed of, or taken with the inmate when transferring or discharging; no inmate will receive items from another under any circumstances.
5. In the event an inmate is reclassified to a higher custody level or privileges are terminated, all supplies will be confiscated. If the higher custody level does not allow the supplies they will be mailed out of the facility or disposed of within thirty (30) days of confiscation; authorized supplies may be returned to the inmate after the removal of unauthorized supplies.

E. Ordering Supplies

1. Facility procedure will establish maximum purchase amounts per pay period based on the type of hobby/craft permit and custody level.
2. Inmates will purchase their own supplies through the hobby supervisor, or designee.
3. The administrator, or designee, will approve a hobby/craft supplies vendor; catalogs will be provided through the hobby supervisor, or designee.
4. Catalog order forms will be used when possible; orders must contain a stamped envelope addressed to the vendor with the inmate's return address, order form, and inmate money transfer form. Orders must be prepared; no COD orders will be accepted.
5. The hobby supervisor, or designee, will provide the receptionist, or the designated staff member, updated lists of incoming packages to be accepted.

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6. Packages will be documented and inspected for contraband by the mailroom supervisor, or a designated staff member, prior to issuance to the offender.

F. Contracts

1. Prior to work initiation, product sales require a contract between the purchaser and the offender approved by the hobby supervisor, or designee.
2. A hobby counter contract will be utilized for DOC staff members and others who enter in to contract with the hobby store for hobby craft items to be made by a specific offender.
3. An inmate may not initiate work on a hobby contract until MCE has received full payment unless it is a hobby store counter contract.
4. The purchaser and inmate must complete contract and forms before submission to the hobby supervisor and upon down payment; the approved contract will be distributed to the hobby supervisor, or designee, inmate, and purchaser and must include the:
 - a. type of craftwork to be done;
 - b. estimated date of completion;
 - c. price;
 - d. required deposit;
 - e. balance due; and
 - f. signatures of the inmate and purchaser.
5. If an inmate is transferred, discharged, hobby/craft privileges are terminated, or for any other reason the contracted product is not completed the contract will be voided and all money returned to the purchaser.
6. An inmate's failure to deliver according to contract may result in disciplinary action including, but not limited to, revocation of privileges and a hold placed upon the inmate's account until a refund is provided. The Department is not liable for broken contracts though the purchaser may seek legal resolution against the inmate.
7. Delivery of product to purchaser will be complete upon payment in full via the hobby supervisor, or designee; inmates are not permitted to deliver products.
8. Inmates may not enter into contracts with other inmates.

G. Shipping Finished Products

1. Inmates are responsible for packing products for mailing in accordance with U.S. Postal regulations and *DOC Policy 3.3.6, Offender Mail*.
2. Products must be mailed immediately and display in rooms, cells, or the hobby craft shop is not authorized.

H. Visitor Product Pick-Up

1. At the discretion of the hobby supervisor, and with prior approval, visitors may pick-up products.

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I. Outside Sales

1. The facility may provide sites for the sale of products including off-site retail outlets.
2. A surcharge will be assessed for each item sold at the hobby store, by contract, or at another retail outlet to cover the costs associated with the operation of the hobby store. The surcharge will be 25% of the selling price for products sold through the hobby store or other retail outlets, and 10% of the selling price on contracts and counter contracts. Freight charges will be the purchaser's responsibility.
3. Outside sales will be processed by the hobby supervisor, or designee; products will be properly labeled with a description, name of the inmate, and price.

V. CLOSING

Questions concerning this policy should be directed to the appropriate facility administrator.

VI. REFERENCES

- A. [2-15-112](#), MCA, [53-1-203](#), MCA
- B. DOC Policies [1.1.3](#), Organization and Responsibility; [1.3.2](#), Employee Performance and Conduct Guidelines; [1.3.12](#), Staff Association and Conduct with Offenders; [3.1.14](#), Tool Control; [3.1.17](#), Searches and Contraband Control; [4.1.3](#), Offender Personal Property
- C. 4-4481; 4-4484; 4-4486; ACA Standards for Adult Correctional Institutions, 4th Edition

VII. ATTACHMENTS

None



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE**

Policy No. DOC 5.6.1	Subject: RELIGIOUS PROGRAMMING
Chapter 5: OFFENDER PROGRAMS	Page 1 of 3
Section 6: Religious Programs	Effective Date: May 1, 1998
Signature: /s/ Mike Batista, Director	Revised: 11/07/2014

I. POLICY

It is the policy of the Department of Corrections to provide reasonable and equitable opportunities to pursue religious activities.

II. APPLICABILITY

Department-owned and contracted facilities and programs, as specified in contract.

III. DEFINITIONS

Religious Activities Coordinator - An individual designated to coordinate religious programming for offenders.

IV. DEPARTMENT DIRECTIVES

A. General Requirements

1. Each facility or program will develop a procedure in compliance with this policy.
2. Facility administrators are responsible for allocating funding for religious programs within the annual budget.
3. Neither the Department, religious activities coordinator (RAC), nor staff may compel an offender to attend religious activities or attempt to influence an offender to change religious preference or faith.
4. Offenders may receive religious publications and other materials in accordance with *DOC Policy 3.3.6, Offender Mail*.
5. Offenders will be provided the opportunity to participate in activities deemed essential by the governing body of the offender's faith when consistent with safety and security requirements.
6. The facility must provide, to the extent practical, resources to support religious activities including adequate space and staff supervision.
7. Under the supervision and direction of the RAC, properly screened, interviewed, and trained volunteers and contract employees with written endorsement of their religious certifying body may provide the following:
 - a. baptism, communion, and other sacramental rituals;
 - b. religious classes, lectures, instruction, and discussions;
 - c. religious forums;
 - d. prayer therapy and religious group counseling;
 - e. religious choirs, ensembles, and singing groups;

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Subject: RELIGIOUS PROGRAMMING		

- f. self-taught study courses; and
 - g. spiritual maturity groups.
- 8. Special religious activities must be in accordance with DOC policies and local procedure, accessible to all faith groups, and authorized by an administrator, or designee.
- 9. Religious articles may be worn when consistent with the safety, security, and orderly operation of the facility or program and according to facility or program procedures.
- 10. Staff will notify the RAC immediately in the event of death or serious illness in an offender's family or other events that may be disturbing to the offender.
- 11. When a representative of the faith to which an offender subscribes is not available in the facility, the offender must be permitted contact with a properly credentialed representative of that faith via visits, phone, or correspondence; offenders classified to a locked housing unit status may receive visits from approved, escorted representatives of the offender's faith group.

B. Religious Activity Coordinator (RAC)

- 1. In facilities with 500 or more offenders, at least one full-time RAC must be employed; facilities with less than 500 offenders must provide adequate religious staffing or access to local religious services within the community.
- 2. The RAC will have physical access to all areas of the institution in compliance with the facility's safety and security regulations.
- 3. Responsibilities and duties of the RAC include, but are not limited to, the following:
 - a. oversee the equitable delivery of religious activities and programs;
 - b. in cooperation with the administrator, or designee, develop and maintain communications with faith communities;
 - c. approve donations of equipment or materials for use in religious activities;
 - d. visit offenders classified to a locked housing unit status on a regularly scheduled basis;
 - e. interview and refer offenders to the appropriate representative of the offender's faith;
 - f. respond in a timely manner to requests from offenders to visit the RAC;
 - g. post scheduled religious activities in locations available to all offenders;
 - h. personally contact, or have the offender's spiritual representative contact and counsel, an offender in the event of a death or serious injury in the offender's family or other events that may be disturbing to the offender; and
 - i. ensure, to the extent practical, that representatives of all faiths are available to offenders.

V. CLOSING:

Questions concerning this policy shall be directed to the facility administrator.

VI. REFERENCES

- A. [53-1-203](#), MCA

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VII. ATTACHMENTS

None.