

**DEPARTMENT OF CORRECTIONS  
BUREAU OF HEALTH CARE SERVICES  
MENTAL HEALTH SERVICES PROGRAM**



**PROGRAM STATEMENT  
DECEMBER 2011**

Reviewed and Approved By:

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## **INTRODUCTION**

This program statement was promulgated in accordance with the Department of Corrections (DOC) Policy Directive PD 04.06.180, "Mental Health Services." The components of the mental health services continuum of care include a Counseling Services and Interventions (CSI), Outpatient Mental Health Programs (OPT), Secure Status Outpatient Mental Health Treatment Program (SSOTP), Adaptive Skills Residential Programs (ASRP), Residential Treatment Programs (RTP), Secure Status Residential Treatment Programs (SSRTP), Crisis Stabilization Programs (CSP), and Inpatient Hospital Units (Acute Care [AC] and Subacute/Rehabilitation Treatment Services [RTS]).

Treatment needs, goals and methods are determined by an Interdisciplinary Treatment Team under the leadership/clinical direction of a Qualified Mental Health Professional (QMHP) Unit Chief and are documented in an Individualized Treatment Plan. The Individualized Treatment Plan identifies the problems, goals and objectives of treatment, as well as, treatment modalities and interventions, including time, frequency and staff responsible. Therapeutic programming and skill acquisition training is delivered by treatment team members. Under this model it is critically important that corrections custody staff and mental health professionals work closely, clinically, and operationally, to maintain the integrity of the treatment model and to assure early detection and preventive intervention to avoid serious deterioration in condition. The treatment team is the decision making body for treatment of prisoners, including decisions regarding initial admission to Mental Health Services, discharge from the mental health services program and referral to other levels of mental health care. The team chairperson/supervisor will assign case managers/therapists with the responsibility to implement the treatment plan.

## **INSTITUTIONAL PROGRAM**

**The Institutional Program** is provided to all prisoners in need of institutional mental health treatment. They will receive services in a timely manner, have reasonable access to care and be afforded continuity of care, including aftercare planning and follow-up as indicated. Institutional Programming within Mental Health Services (MHS) includes but is not limited to:

1. Reception Center Psychological Assessments
2. Crisis Intervention
3. Segregation Monitoring
4. Suicide Prevention Services including screening, assessment and treatment
5. Assessment, Identification and Referral of prisoners for treatment of mental illness
6. Parole Board Evaluations
7. Assaultive Offender Programming and Sex Offender Programming
8. Integrated Treatment for Co-occurring Disorders
9. Aftercare planning including relapse prevention and transition/discharge planning
10. Individual and Group Psychotherapy
11. Services to developmentally disabled and cognitively impaired prisoners including, but not limited to, assessment, referral and treatment
12. Behaviorally based treatment for incarcerated youth

Institutional programming is provided by qualified mental health professionals (QMHP's).

### **Counseling Services and Interventions**

The Counseling Services and Interventions Program involves brief counseling/psychotherapy. It includes, but is not limited to, supportive counseling, brief therapy, solution focused therapy, cognitive - behavioral therapy and dialectical behavior therapy. Prisoners are admitted and discharged from the counseling program by a qualified mental health professional. The prisoners served with Counseling Services and Interventions are housed in general population housing and do not meet the threshold for admission to the Corrections Mental Health Programming.

### **Assaultive Offender Programming and Sex Offender Programming**

#### **Background**

The Assaultive Offender Program (AOP) and the Sex Offender Program (SOP) are organized group psychotherapy programs delivered by mental health clinicians in the treatment of assaultive offenders and sex offenders. Prisoner referrals for AOP and SOP are based on the prisoner's offense and the validated risk assessment tools employed by MDOC.

Referrals for AOP are based on the offense, the inmate's commitment date, and the COMPAS violence risk assessment score. COMPAS is a statistically based risk assessment designed to assess key risk and needs factors in a correctional setting, and to provide decision support when placing offenders into institutional programs.

SOP referrals are based on the offense and the Vermont Assessment of Sex Offender Risk (VASOR) and STATIC-99R assessment tools for program placement. Offenders who happen to meet the screening criteria for both SOP and AOP are recommended for SOP only. Below is a table illustrating group placement into SOP.

<b>VASOR Reoffense Score and STATIC-99R</b>	<b>COMPAS Violence Risk Score</b>	<b>Type of Program</b>
Low	Low	Psychological Evaluation
Low	Moderate	Psychological Evaluation Thinking 4 Change
Low	High	Psychological Evaluation AOP 6 month program
Moderate	Low/Moderate/High	6 to 9 months (200 hours) of psychologist led Sex Offender Therapy
High	Low/Moderate/High	9 to 18 months (300 hours) of psychologist led Sex Offender Therapy

#### **AOP:**

Currently, the total number of prisoners needing AOP programming is 5,363.

Offenders who meet the guidelines for AOP are placed in therapy groups of 13 offenders per therapist. The therapy groups meet 2 times per week for 2 hours. Program duration is six

months (44-52 sessions). Documentation includes a Therapy Admission or Non-Admission Note, Monthly Group Progress Note and Therapy Termination Report which are provided to the health record, the parole record, and offender. Approximately 100-125 groups are completed annually.

**SOP:**

The total number of prisoners requiring SOP programming is 5,906.

At present, the current SOP is a six month treatment program. The existing program is being redesigned based on a review of the literature related to evidence based practices, and a series of recommendations from the Center for Sex Offender Management. A pilot program is proposed to begin after the beginning of the year. In the redesigned Sex Offender Treatment Program, there will be a total of 10 offenders in a group which will be co-facilitated by masters' level clinicians. The group will meet 2 times a week for 2 hours, and individual sessions will be facilitated with each offender every other week. Documentation involves results of risk assessment instruments, motivational interviews, Therapy Admission and Non-Admission Reports, Therapy Termination Reports, and Monthly Therapy Progress notes. All documentation, including SOP referrals, admissions, nonadmissions, and termination reports are documented in the medical record and CMIS Six prisons have been designated as Sex Offender Treatment hubs which will have units which house offenders who have been convicted of one or more sex offenses and have been assessed at high, moderate or low risk level according to the risk assessments. Approximately 100-125 groups are completed annually.

**AOP and SOP Lists**

A list of offenders referred for AOP is currently maintained by staff in the Central Office of BHCS. Additionally, a program list for SOP is maintained centrally along with manual lists of offenders who need to receive a STATIC-99R assessment, offenders who need a psychological evaluation, and a listing of offenders who have requests for AOP or SOP from the Parole Board. Offenders are placed into programming according to their earliest release dates (ERD), with those nearest to their ERDs are placed highest on the list. Due to a recent change in the program criteria for AOP and SOP, the program lists are generated manually on a monthly basis. A technology solution that would automate program recommendations is not currently in place. As part of this RFP, the contractor will be responsible for both program lists.

Approximately 57 psychologists currently deliver AOP and SOP groups as part of their job duties. Approximately 50% of their time is spent delivering group, documenting information for group, and completing psychological evaluations at the request of the Parole Board. Annually about 100-125 AOP and SOP groups are completed.

**AOP Numbers**

The total number of prisoners needing AOP programming is 5,363.

Security Level	Numbers
Level 1	2066
Level 2	1781
Level 4	1290
Level 5	226
<b>TOTAL</b>	<b>5,363</b>

*\*Approximately 200-300 offenders are added to the AOP list every month.*

## SOP Numbers

The total number of prisoners needing SOP programming is 5,906

Security Level	Numbers
Level 1	2431
Level 2	2132
Level 4	1105
Level 5	238
<b>TOTAL</b>	<b>5,906</b>

### Assaultive Offender Programming

In September 2009, MDOC identified a need for providing evidence-based violence prevention programming that is based on a valid risk and need assessment. The Violence Prevention Program (VPP) delivered by the Correctional Service of Canada (CSC) was selected as the program that would be delivered at all facilities, which would replace AOP. VPP would be delivered by CFA facility staff, and not psychologists. At this time, VPP has not been implemented Statewide so AOP continues for offenders who meet the criteria and are housed at a level I or II facility. The timeframe for VPP implementation is 2012, but it may only be implemented at select facilities, which would mean AOP would still be offered and delivered by psychologists.

Offenders who meet the guidelines for AOP are placed in therapy groups of 13 offenders with one therapist. The therapy groups meet 2 times per week for 2 hours. Program duration is *six months* (44-52 sessions). Group psychotherapy techniques, which generally include cognitive-behavioral interventions, are employed at the discretion of the program therapists. All AOP offenders work to complete (a) required AOP Therapy Goals I, II and III (and the corresponding objectives) as shown in the attachment, *AOP Procedural Guidelines and Objectives*, and (b) additional goals, objectives, homework assignments, etc., as needed or recommended by the therapist.

For continuity of care, the therapist prepares a Monthly Therapy Progress Note (CHJ-622) on each group member during the course of the program. Offenders shall receive a copy of their Monthly Therapy Progress Notes to provide feedback on what they have done and need to do in order to demonstrate greater progress.

Documentation of satisfactory completion of the AOP is contingent upon demonstrated achievement of the goals and objectives prescribed for the AOP participants. Therapists prepare a Therapy Termination Report (CHJ-623) when a prisoner has completed the program (or discontinued program involvement for any reason). These reports summarize the prisoner's attendance, group participation, level of goal achievement and reason for termination. They also address any needed further program involvement or aftercare. Therapy Admission, Non-Admission and Termination Reports are provided to the health record, the parole board and offender.

Therapy Admission (CHJ-620) or Therapy Non-Admission (CHJ-621) must be completed for each inmate. All documentation including AOP referrals, admissions, nonadmissions, and

terminations are entered in the CMIS Substance Abuse (SAU) screen. Progress reports and termination reports are documented in the NextGen Electronic Medical Record.

The requirement for the delivery of assaultive offender treatment is that staff are master's level clinicians. The clinicians will need to have experience with group therapy and must be comfortable working with the offender population.

**Sex Offender Programming**

At present, the current SOP is a six month treatment program. The existing program is being redesigned based on a review of the literature related to evidence based practices, and a series of recommendations from the Center for Sex Offender Management.

The Sex Offender Treatment Program is rigorous, and will be delivered to offenders at all security levels. It educates sex offenders to the fact that controlling sexual deviance and not creating any more victims is a lifelong process. To accomplish these goals, SOP requires each offender to identify sexual deviant variables, antisocial orientation and self regulation difficulties. Intimacy deficits and pro-offending attitudes and schemas are processed and defined in order to assist offenders in developing a self-management plan. Offenders will develop personal treatment goals which incorporate their values, replace distorted thinking and behaviors, and regulate emotional expression within their relationships, themselves, and working environment. Within this self management plan, offenders also develop a support system to assist them with their individualized plan for a good life and no more victims.

The Sex Offender Treatment Program consists of three levels of risk for sex offenders; low, moderate and high therapy that will be delivered as followed:

**SOP Program Recommendations**

VASOR/STATIC 99 Score	Type of Program
Low	Psychological evaluation and observation
Moderate	6 to 8 months of psychologist led Sex Offender Therapy
High	8 to 12 months of psychologist led Sex Offender Therapy

SOP is a multi-component program, based on significant research and the designs of successful programs in other states. The program covers the necessary areas of focus to help sex offenders take responsibility for a criminal and deviant sexual behavior free lifestyle. These areas include:

Assessments	Empathy Skills
Responsivity (Defense Mechanisms)	External/Internal Skills
Emotional Regulation	Sexual Intimacy
Developmental, Sexual and Non-Sexual History	Self Management Plan (SMP)
Disclosure of Current Offense	Peer Support

Six prisons have been designated as Sex Offender Treatment hubs. Within each of these prisons, a Residential Treatment Unit (RTU) will be created. These units will house offenders who have been convicted of one or more sex offenses and have been assessed at high, moderate or low risk level according to the risk assessments. Each treatment unit is comprised of housing and

psychological staff that operate as a treatment team. In addition, a self-help library and self-help group facilitators are part of the unit.

The Sex Offender Treatment Program will utilize an open group therapy format. The open group format allows for a constant flow of offenders in and out of the program. There will be a total of 10 offenders in the group, and it will be co-facilitated by master level clinicians. The group will meet 2 times a week for 2 hours, and will conduct individual sessions with each offender every other week.

Two to three months prior to the start of group therapy, a comprehensive risk assessment process will take place. Treatment clinicians will provide motivational interviews, administer additional assessment instruments, and provide offenders with self-report/survey documents to complete. Static risk instrument results are reviewed and the initial Sex Offender Needs and Progress Scale (TPS) is administered. Clinicians will also use the Functional Risk Assessment (FRA) for documentation purposes throughout the treatment process. There will be at minimum at least two of these documents - an entrance FRA prior to the beginning of treatment and a termination FRA at the end of treatment. In special situations, the PCB may request a FRA during the time the offender is in group, for instance when the PCB is considering a commutation. For treatment purposes the FRA will drive the individualized treatment plan. Additionally, a Monthly Therapy Progress Note (CHJ-622) must be completed on a monthly basis. The progress note will describe the offender's motivation and functioning, and should be linked to an offender's individual treatment plan.

Therapy Admission (CHJ-620) or Therapy Non-Admission (CHJ-621) Reports must be completed for each inmate. All documentation including SOP referrals, admissions, nonadmissions, and terminations are entered in the CMIS Substance Abuse (SAU) screen. Progress reports and termination reports are documented in the NextGen Electronic Medical Record.

This redesigned sex offender treatment program will begin with a pilot in early 2012. Additional documents describing SOP are attached include: Residential Treatment Unit Guidelines, Draft SOP Operating Procedure, Draft SOP Therapist Manual, Draft Syllabus, Draft Syllabus Modules, Sex Offender Needs and Progress Scale and the Functional Risk Assessment.

The requirement for the delivery of sex offender treatment is that staff are master's level clinicians. The clinicians must be familiar with the Risk-Needs-Responsivity (RNR) model, knowledge of the Self-Regulation Model of Offending and the Good Lives Model. Clinicians will need to have experience with treatment groups, working with the offender population and administering established evidence-based risk assessments.

## **CORRECTIONS MENTAL HEALTH PROGRAM**

### **OUTPATIENT TREATMENT PROGRAM**

The Outpatient Mental Health Treatment program (OPT) is an integral component of the mental health continuum of care. The outpatient team serves two main functions. One is to ensure continuity, quality and accessibility of care for prisoners discharged from Inpatient Acute Care and Rehabilitation Treatment Division and Residential Treatment Programs. Secondly, this program serves as a point of entry into the Mental Health Services (MHS) for prisoners requiring

services in mental health. The outpatient team verifies whether prisoners identified by referrals to the program are suffering from major mental illness and require mental health treatment. The OPT is based on a bio-cognitive behavior model, emphasizing correction of thought distortion, interpersonal interactions and bio-psychosocial rehabilitation. This model goes beyond the elimination of positive symptomatology, such as hallucinations and delusions, through the use of psychotropic medication. It incorporates various methods to deal with the negative symptoms such as severe, impoverished functioning skills, problems dealing with other individuals, presence of negative cognitive shifts, anhedonia, etc. This approach emphasizes the individuals' changing behaviors and feelings by teaching alternative patterns of thinking, developing skills through psycho-education modules, equipping the individual to engage in problem solving. The goal is to help the prisoner deal with long lasting mental illness by compensating for any deficiencies the mental illness may cause and by development and implementation of a relapse prevention plan.

In addition, treatment for individuals with moderate impairments of a short-term duration is also provided using cognitive and behavioral approaches, and problem solving techniques. The emphasis here is to help the individual gain the skill and ability to function and deal with problems encountered in the prison setting, thus, avoiding the development of any long term chronic illness.

Prisoners on Outpatient Mental Health Programming live in general population housing. They normally receive treatment by visiting the outpatient therapists' offices for group, individual therapy or case management services.

### **SPECIAL ALTERNATIVE INCARCERATION**

Special Alternative Incarceration Facility (SAI) is an alternative to prison for male and female prisoners and probationers (called trainees) who meet specific criteria such as being convicted of certain crimes and who are selected by courts. This military-type program is designed to teach positive values and attitudes. The program is bifurcated with trainees in a regular track and those in the medical track. The trainees in the medical program do not have the physical demands placed on them as in the regular program. In addition to having trainees with medically stable conditions, the medical track also includes prisoner trainees who are actively receiving Outpatient level mental health treatment and who meet certain criteria.

Mental health programming offered at SAI is limited. Prisoner trainees who are receiving mental health treatment arrive at SAI with psychotropic medication and prescription renewals to sustain them while in the program. Upon discharge into the community, an appointed psychiatrist writes a 30-day prescription similar to those in the prison who are re-entering the community. Otherwise, there is limited psychiatric involvement. If a prisoner trainee requires additional psychiatric services, the trainee is discharged from SAI and returned to the prison.

A QMHP is assigned part-time and usually commits approximately 4 hours twice a week. The QMHP provides evaluations that stem from the nursing staff intake assessment on all incoming trainees who meet the threshold for a referral. The QMHP provides brief individual and group therapy focusing on adjustment difficulties. The QMHP also provides other evaluations requested by custody and/or nursing as needed.

### **SECURE STATUS OUTPATIENT TREATMENT PROGRAM**

The Secure Status Outpatient Treatment Program (SSOTP) provides treatment to prisoners with a serious mental illness who, because of safety/security issues, would otherwise be in administrative segregation. It is the goal of the SSOTP to treat these prisoners in a secure setting, and increase their self-control and appropriate behavior-through various treatment and management interventions. Although highly structured and secure, the SSOTP treats prisoners who are classified as general population prisoners with Mental Health Management Plans developed to provide needed safety and security to the prisoner and staff while providing access to treatment. The SSOTP consists of four (4) phases of treatment and management.

SSOTP is designed to provide a secure and safe alternative treatment option for prisoners with a major mental illness who otherwise functionally meet admission criteria for an OPT treatment and who would be in Administrative Segregation because of behavior that is considered a threat to safety and security of staff or other prisoners. Prisoners classified to protective segregation do not qualify for this program. Prisoners who have a minimal misconduct history (in terms of serious misconduct or number of misconduct reports) are also not suitable for consideration for this program. It is not appropriate to classify a prisoner to administrative segregation solely for the purpose of referring and transferring the prisoner to a facility housing an SSOTP unit. Prisoners who appear to be inappropriately placed, or do not appear to meet the criteria for the program should be brought to the attention of the Warden by the Deputy Warden at the facility housing the SSOTP program. Inappropriately placed prisoners should be brought to the attention of the CFA Deputy Director, or designee, for resolution.

Prisoners who qualify exhibit behaviors which are:

1. Clinically assessed as related to a personality disorder rather than being a product of major mental illness,
- AND**
2. Intractable and unresponsive to the usual therapeutic and management interventions available in the regular general population outpatient setting.

SSOTP interventions are based upon a cognitive behavioral model. The primary goal and treatment focus is to increase the prisoner's ability to control his or her behavior, thus permitting a transition to regular OPT outpatient programming in general population housing.

Due to the disruptive nature of the target population, it is expected that frequent and intensive individual and small group interventions by both mental health and corrections staff will be required. Treatment and management plans may require frequent review and modification.

Those who successfully complete the four-phase program will be moved to regular OPT program status. As permitted by the Treatment and Management Plans, SSOTP prisoners may have access to institutional programs and services available at the institutions including education, general health services and employment/vocational training.

#### **PHASE I: - ASSESSMENT/CLASSIFICATION**

This Phase Is the assessment/classification phase prior to admittance to the SSOTP and for those prisoners currently classified to administrative segregation, reclassification to general population.

Clinical interventions and assessment activities will proceed in the context of necessary security precautions and limitations on the prisoner's movement commensurate with security level status.

During this phase the prisoner remains classified to their current status (segregation or general population) while two determinations are made.

- The first decision is a clinical determination made by the Outpatient Team mental health team as to whether or not the prisoner meets the admission criteria.
- The second decision is a classification determination made by the Deputy Warden as to whether or not the prisoner's behavior can be safely managed in a secure status general population setting. This determination is typically for those prisoners who are currently classified to administrative segregation and not for prisoners referred and transferred from an SSRTP program (as they are already classified as general population prisoners).

Both determinations shall be made within the first ten (10) business days.

If the outpatient team determines the prisoner meets the clinical admission criteria for the SSOTP and; or for those prisoners classified to administrative segregation, the Deputy Warden determines that the prisoner **can** be safely managed in SSOTP general population, the prisoner shall be reclassified to general population SSOTP - Phase II or III, as recommended by the treatment team. Prisoners already classified to general population would be admitted to the program upon the determination of the outpatient team that they meet the clinical admission criteria.

If the outpatient team mental health team determines the prisoner meets the clinical admission criteria for the SSOTP and, for those prisoners classified to administrative segregation, the Deputy Warden determines that the prisoner **cannot** be safely managed except in segregation without seriously jeopardizing the safety of staff or other prisoners, or, if the prisoner is in segregation due to a serious assault on staff, s/he shall immediately refer the case to the Warden for review.

If the Warden disagrees with the Deputy Warden's determination and determines that the prisoner **can** be safely managed in SSOTP general population, the prisoner shall be reclassified to general population SSOTP - Phase II or III, as recommended by the treatment team.

If the Warden agrees with the Deputy Warden's determination, or if the prisoner is in segregation due to a serious assault on staff, s/he shall immediately refer the case to the CFA Deputy Director or designee, for resolution. A prisoner in segregation shall remain classified to Administrative Segregation while the classification and admittance to the program is being appealed.

The CFA Deputy Director or designee shall immediately confer with the CMHP Director to determine proper placement. The determination shall be made as soon as possible but no later

than five (5) business days after the initial recommendation by the SSOTP team. If it is determined that the prisoner is to be admitted to SSOTP general population, the prisoner shall be reclassified to general population SSOTP Phase II as soon as possible but no later than ten (10) business days after the determination has been made.

If the prisoner is denied reclassification by the Deputy Director or designee for serious reasons of safety and security, reconsideration of reclassification request will occur every six (6) months. If the prisoner is not housed at the facility housing the SSOTP unit, the prisoner shall remain classified to Administrative Segregation at their current facility, or transferred to another facility able to meet their mental health and security needs as soon as possible.

**During Phase I:**

1. The Outpatient Mental Health staff evaluates and completes the assessment, medication review and evaluation of the diagnosis. A Mental Health Management Plan shall be developed which addresses symptoms and behaviors and recommends interventions necessary to keep the prisoner and staff safe. If restrictions are involved, the management plan will be reviewed and approved by the Deputy Warden or designee.
2. The QMHP orients the prisoner and explains the program requirements. If the prisoner declines the offer for placement into the SSOTP, he/she shall be considered for involuntary treatment. A Mental Health Management Plan encouraging participation in the program will be implemented.
3. The RUM/ARUS conducts orientation regarding custody issues, unit and facility rules.
4. Facility Health Care Staff shall dispense all medication to the prisoner in his/her cell.
5. Administrative Segregation prisoners housed in Phase I shall be placed in handcuffs for all general in house out-of-cell movement and in belly chains for visits, escorted by a minimum of two housing/custody officers.
6. General population prisoners housed in Phase I shall be escorted without restraints by a minimum of two housing/custody officers.
7. Subject to restrictions set forth in the prisoners mental health management plan, or for those prisoners classified to administrative segregation, subject to restriction of segregation property and privileges utilizing form CAJ-687 in accordance with PD 04.04.120 "Segregation Standards"; prisoners in Phase I shall be provided with or allowed access to the following property programs and activities:

1. Health care, including prescription medication and medically necessary diets, as authorized by health care staff.
2. Wheelchair, walker, hearing aid, prostheses, eyeglasses, and other medically necessary items authorized pursuant to PD 04.06.160 "Medical Details and Special Accommodation Notices".
3. State-issued clothing, including winter coat and winter gloves, in accordance with PD 04.07.110 "State-Issued Items and Cell/Room Furnishings".
4. A mirror, as approved by the CFA Deputy Director, which shall be provided only as part of the cell furnishings.
5. Sitting surface.
6. Writing surface.
7. Toothbrush (short handled only), toothpaste or powder, denture cup if needed, soap, shampoo, deodorant, toilet paper, comb/pick/hairbrush, shaving gear, and, for female prisoners, sanitary napkins.
8. Three meals per day served from the same menus available to general population prisoners. This includes, as required, meals from the therapeutic diet menu and, if available at that facility, meals from a menu developed to meet the necessary religious dietary restrictions of the prisoner.
9. Opportunity to shave and shower at least three times weekly.
10. Mattress, blanket, pillow, pillow case and two sheets with weekly linen changes, and a towel and face cloth with changes three times weekly.
11. Hair care services commensurate with general population prisoners.
12. Mail privileges in accordance with PD 05.03.118 "Prisoner Mail", including the receipt of personal correspondence and photographs.
13. Visits in accordance with PD 05.03.140 "Prisoner Visiting", except when restricted as a sanction for major misconduct.
14. Reasonable access to legal property, including materials pertaining to the prisoner's personal litigation. Access to legal property must be provided within 48 hours of the prisoner's request.
15. Institution law library services in accordance with PD 05.03.115 "Law Libraries".

16. Access to institutional general library services in accordance with PD 05.03.110 "Institutional Library Services".
17. Writing materials, including paper and pens or pencils. Pens and pencils shall not exceed 4 inches in length.
18. Written copy of housing unit rules which shall include directions for requesting personal services.
19. Telephone privileges for verified serious family emergencies, as determined by the Warden or designee, and for communicating with an attorney regarding official business of the prisoner, including litigation, upon request of the attorney.
20. Reading materials from the prisoner's personal collection.
21. A minimum of one hour per day, five days per week of out-of-cell exercise. Except that, for reasons of safety or security, a prisoner serving a loss of privileges sanction which includes the loss of yard, may be provided such exercise only after s/he has served a period of time determined by the Warden or Deputy Warden; however, the prisoner shall not be deprived of out-of-cell exercise for more than 30 consecutive days without being provided a seven-day break during which the prisoner shall be given the opportunity for out-of-cell exercise at least one hour per day, five days per week.
22. Notary public services, which shall be provided within two business days of request.
23. Limited prisoner store privileges.
24. If married or widowed, one plain wedding band/set without stones or insignia.
25. Personal property necessary to the practice of the prisoner's designated religion, as set forth in PD 05.03.150 "Religious Beliefs and Practices of Prisoners".

During Phase I of the SSOTP, if the mental health team determines the prisoner does not meet the admission criteria or if the appeal process has been exhausted and the prisoner is denied reclassification, he/she shall be:

- A. Returned to the sending facility still classified to his/her arrival status (administrative segregation, general population),  
or;
- B. Returned to their current classification at the same facility housing the SSOTP,  
or;
- C. Transferred to another facility able to meet his/her mental health and security needs

as soon as possible.

## **PHASE II: - INITIAL TREATMENT**

This phase begins when the prisoner has been determined to meet the clinical admission criteria for the SSOTP and, for those prisoners classified to administrative segregation, have been reclassified to general population status within the SSOTP unit. At the start of this phase, the treatment team, in cooperation with the prisoner, shall develop an SSOTP comprehensive individual treatment plan. Placement in this phase is reviewed by the treatment team at 30-day intervals, or more frequently if needed. Treatment plan implementation (including the implementation of mental health management plans), review, evaluation and documentation, etc. shall follow the established CMHP standards and procedures.

### **During Phase II:**

1. Prisoners are housed on general population status in the SSOTP unit.
2. Prisoners shall be escorted by one (1) housing/custody officer during in-house out-of-cell movement and for all movement outside the unit housing the SSOTP program.
3. Three meals per day, breakfast, lunch and dinner shall be provided in cell.
4. A Mental Health Management Plan may be instituted which addresses symptoms and behaviors and recommends interventions necessary to keep the prisoner and staff safe while allowing for treatment to occur. The management plan will be reviewed and approved by the Deputy Warden or designee.
5. Small group sessions shall be conducted.
6. A behavior reinforcement regimen may be used to reinforce misconduct-free behavior and compliance with training and treatment programs. Reinforcement will be identified by the Treatment Team and may include such things as extra yard time, positive reading materials, positive verbal praise for appropriate behavior, or other reinforcers identified as appropriate by the Treatment Team. All identified reinforcers must be identified in the prisoner's Comprehensive Individual Treatment Plan and be approved by the Treatment Team.
7. In-cell academic studies, as coordinated by educational staff.
8. Facility Health Care Staff shall dispense all medication to the prisoner in his/her cell.
9. Prisoners shall be provided a general population store list.

10. A minimum of five (5) hours per week of out of cell programming will be provided to prisoners in Phase II.
11. Prisoners shall be provided with a minimum of one (1) hour per day of yard recreation, limited to six (6) prisoners per yard period.
12. Prisoners shall be provided law library and general library access.
13. Prisoners shall be provided access to telephone calls during their yard periods.
14. Prisoners shall be provided Chaplaincy services.
15. Prisoners shall be allowed access to visits.

The completion of this phase requires that the prisoner has demonstrated the ability to consistently attend and participate in group therapy/treatment programs, in addition to achieving specific objectives which are addressed in the prisoner's comprehensive treatment plan.

### **PHASE III:**

The prisoner is seen as successfully completing Phase II and ready to be in Phase III of the SSOTP Program once he/she has successfully demonstrated to the treatment team that he/she is able to manage his/her behavior and has control over the thought processes leading to his/her acting out behavior. The treatment team reviews and modifies the comprehensive treatment plan at 30-day intervals, or more frequently if needed. A minimum of ten (10) hours per week of out of cell programming and activities will be provided to prisoners in Phase III.

### **During Phase III:**

1. Prisoners are housed in a general population cell.
2. Prisoners shall be escorted by one (1) housing/custody officer during in-house out-of-cell movement and for all movement outside the unit housing the SSOTP program.
3. Three meals per day, breakfast, lunch and dinner, shall be provided in small group settings (limited to six (6) prisoners at one time) out of cell in unit day room.
4. A Mental Health Management Plan shall be instituted which addresses symptoms and behaviors and recommends interventions necessary to keep the prisoner and staff safe while allowing for treatment to occur. The management plan will be reviewed and approved by the Deputy Warden or designee.

5. Small group sessions, limited to six (6) prisoners at one time, shall be conducted.
6. A behavior reinforcement regimen may be used to reinforce misconduct-free behavior and compliance with training and treatment programs. Reinforcement will be identified by the Treatment Team and may include such things as extra yard time, positive reading materials, or other reinforcers identified as appropriate by the Treatment Team. All identified reinforcers must be identified in the prisoner's Comprehensive Individual Treatment Plan and be approved by the Treatment Team.
7. In-cell academic studies, as coordinated by educational staff.
8. In the event of a non-bondable assaultive or major destructive ticket occurring during this phase, the situation will be evaluated by the team and a determination made as to whether to continue the individual in the current phase of the program or return him to a previous phase of the program.
9. Facility Health Care Staff shall dispense all medication to the prisoner in his cell.
10. Prisoners shall be provided a general population store list.
11. Prisoners shall be provided with a minimum of one (1) hour per day of yard recreation, limited to twelve (12) prisoners per yard period.
12. Prisoners shall be provided law library and general library access.
13. Prisoners shall be provided access to telephone calls during their yard periods.
14. Prisoners shall be provided Chaplaincy services.
15. Prisoners shall be allowed access to visits.
16. Work Assignments shall be provided within the unit in accordance with the prisoner's capabilities, progress in the program and availability.

**PHASEIV:**

After the prisoner has completed the first three (3) phases of SSOTP treatment, he/she is evaluated/reviewed by the Treatment Team and considered for placement in this final phase. The treatment team will review all prisoners every thirty (30) days and revise the Comprehensive Individual Treatment Plan as needed.

**During PhaseIV:**

1. Prisoners are housed in a general population cell in the facility transition unit and subject to the same out of cell activities as other prisoners situated in that unit; including yard recreation, phone calls, access to law and general library, religious services and visits.
2. Meals are eaten in the unit dining area.
3. Facility Health Care Staff shall dispense all medication to the prisoner in his unit.
4. Prisoners attend academic school and institutional programs in accordance with existing unit operations.
5. Prisoners continue to participate in therapeutic programs per their individual treatment plans. When possible, the group therapy sessions will be co-facilitated by a QMHP and RUM or ARUS.
6. Prisoners participate in programs conducted by the RUM, ARUS and/or RUOs.
7. A behavior reinforcement regimen may be used to reinforce misconduct-free behavior and compliance with training and treatment programs. Reinforcement will be identified by the Treatment Team. All identified reinforcers must be identified in the prisoner's Comprehensive Individual Treatment Plan and be approved by the Treatment Team.
8. In the event a prisoner engages in unmanageable or destructive behavior, or incurs a non-bondable major misconduct, the situation will be evaluated by the team and a determination will be made whether to continue the prisoner in Phase IV or return him/her to a previous phase of the program.
9. Prisoners in this phase may have the opportunity to secure available employment within the housing unit. Once employed, the prisoner is responsible for maintaining employment while in this phase of treatment.

Completion of this phase occurs when the treatment team recommends reintegration into the general population of a facility appropriate to the prisoner's custody level where the appropriate level of mental health treatment is available. Consideration for discharge/reintegration into general population shall begin after the prisoner has successfully completed sixty (60) days of Phase IV programming.

#### **ADAPTIVE SKILLS RESIDENTIAL PROGRAM**

The Adaptive Skills Residential Program (ASRP) is designed to serve male prisoners with moderate to serious adaptive problems due to a developmental disability. These prisoners may or may not have a co-occurring serious mental illness.

The ASRP is based on a bio-psychosocial rehabilitation model. Most prisoners admitted to the program will have moderate to serious functioning limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency. Many of the prisoners may have co-occurring mental illness. Those prisoners will also receive psychiatric treatment. However, if mental illness is their primary and most prevalent problem, they will be placed in a RTP or Inpatient Program depending upon their functioning level.

Many of the individuals with developmental disabilities, such as mental retardation, have difficulty comprehending and responding to instructions, low frustration tolerance, impulsivity, and aggressive behavior that could occur as a result of limited communication skills, misinterpretation of social cues, sense of being threatened, or flawed concrete logic.

The ASRP utilizes a range of behavioral techniques including behavior reinforcement schedules, a visually enhanced communications, an enriched schedule of prisoner reinforcement and social skills training. Program activities are designed to enhance independent living skills, psychosocial skills, leisure skills, academic skills, stress management, self-management, anger management, problem solving, etc. In addition, basic cognitive skills groups necessary for successful living in both prison and the community will be conducted. Substance abuse treatment will also be provided when diagnosed. Treatment will be conducted in clear, simple language, giving the prisoner additional time to learn and incorporate behavior changes and responses. Staff will also need to re-direct and intervene in a calm manner. Extra care must be taken that these prisoners are not ridiculed or preyed upon by other prisoners.

The mission of the ASRP is to improve the functioning and self-management of prisoners with developmental disabilities so they can adapt to the prison setting, thereby decreasing the likelihood of being victimized, becoming disruptive, or engaging in behavior which could result in a reclassification to administrative segregation and to prepare them for community re-entry.

### **RESIDENTIAL TREATMENT PROGRAM**

The Residential Treatment Program (RTP) is an appropriate level of care for seriously mentally ill prisoners whose primary symptoms of psychiatric/psychological conditions have begun to remit but who continue to demonstrate significant impairments in social skills and limited ability to participate independently in activities of daily living. These individuals cannot function adequately in the general population without significant supports and modified behavioral expectations.

The RTP is based on a bio-psychosocial rehabilitation model. Central to this concept is the notion that seriously mentally ill individuals cannot be successfully treated solely with psychotropic medications. The primary treatment focus of the RTP is provision of those skills necessary to enable prisoners to independently function within the general prison population or in the community following placement in a correction center or parole release. The RTP also provides treatment and support services to prisoners who no longer require psychiatric hospitalization, but have not progressed behaviorally to the point where they can function independently in general prison population without significant behavioral supports and modified behavioral expectations.

Special program considerations for the RTP include the following:

- **Orientation Status**

A prisoner transferring into the RTP will be placed on this status for up to three (3) business days. Prisoners may be restricted to their room during the three days. Prisoners will be evaluated by a QMHP assigned by the unit chief and oriented to the unit by the RUM/ARUS. They do not yet have yard privileges. If they need to leave the unit for any reason, they will be escorted to and from their destinations. Unless otherwise indicated by observed behavior or security factors, s/he will be given general population status following this review period. Movement of a prisoner from orientation status to general population status requires notification and approval of the shift commander. The shift commander must also be apprised if the prisoner is restricted to his or her room.

- **Observation Status**

The primary purpose of observation status is for the observation and behavioral management of a prisoner to allow him or her to regain self-control. This status includes room lock-in and may involve use of an observation room. It may include restriction of personal property. A prisoner is placed on this status because of behavior problems that are severely disruptive as defined in Policy Directive 04.05.112, "Managing Disruptive Prisoners." A prisoner may be placed on observation status after evaluation by a QMHP who determines the behavior is not the result of mental illness or, in the absence of a QMHP, a RUM/ARUS or shift commander may initiate this status (in which case a QMHP must evaluate the prisoner within 24 hours). This status must be reviewed daily by a QMHP who must make recommendations to the treatment team, which in turn makes recommendations to the Deputy Warden. These recommendations may include:

- 1) the behavior is not the result of mental illness and observation status can continue;
- 2) changes in the limitations of the status;
- 3) indications for another type of status; or
- 4) conclusion that the behavior no longer warrants observation status.

Decisions to remove a prisoner from observation status must be reviewed and recommended by the treatment team; however, removal requires approval from the designated Department of Corrections staff, i.e., Warden, Deputy Warden or Shift Commander. Daily reports for prisoners on this status must be made in both the unit logbook and the health record.

- **Non-bondable Status**

Prisoners are placed on non-bondable status subsequent to receiving a non-bondable ticket. This is a replacement for temporary segregation. The designated Department of Corrections staff orders this status, i.e., Warden, Deputy Warden or Assistant Deputy Warden. The QMHP should evaluate the circumstances of this status and determine if change of status (i.e., observation, safety precautions, management precautions, inpatient hospital treatment) should occur. The prisoner will remain on non-bondable status until the misconduct ticket has had Hearing Officer review.

On this status, prisoner movement is restricted to his or her cell. An exception to movement restriction is made for mental health treatment programs and is included in the treatment plan and occurs on the housing unit if the team determines the prisoner is capable of safely attending these programs. Daily review by a QMHP should occur to determine if

any change in behavior warrants change of status. Once the Hearing Officer reviews the misconduct ticket, non-bondable status ends.

- **Management Plan Status**

Management plan status is given to a prisoner who requires some limitations or restrictions but may remain in the general population unit. This is a plan of action to be taken if a pattern of disruptive or dangerous behavior occurs which jeopardizes the safety/security of the unit/facility and is not a product of mental illness (i.e., previous attempts to escape, extremely limited coping skills, difficulty following unit rules, or behaviors that may foreshadow a temporary exacerbation of mental health symptoms). Management plans are developed jointly by treatment and custody staff to maintain and manage the prisoner on the unit. This is a time-limited plan and must be reviewed by the treatment team and Deputy Warden no less than every thirty (30) days. If restrictions are involved, the Deputy Warden reviews and approves them per Policy Directive 04.05.112, "Managing Disruptive Prisoners." This status is intended to alert staff to specific problematic behaviors and recommended methods for managing these behaviors. The plan will include the following sections: Title of plan, restrictions, frequency of observation, behaviors noted, interventions, and frequency of further evaluation.

### **SECURE STATUS RESIDENTIAL TREATMENT PROGRAM**

SSRTP is used for a prisoner whose short term Axis I condition appears to be in partial remission and who displays deviant and difficult to manage behaviors related to his or her Axis II condition. When these behaviors, for which the prisoner is legally considered responsible, include assaultive and/or destructive events, application of Policy Directive 03.03.105, "Prisoner Discipline," may result in a sanction of detention and/or reclassification to administrative segregation. For some of these individuals (e.g., those with serious borderline personality disorder), placement in segregation may contribute to a relapse or deterioration of their condition. It is this group of prisoners which forms the target population for SSRTP.

SSRTP is designed to provide an alternative treatment option for prisoners who otherwise meet admission criteria for an RTP and whose pattern of assaultive and/or destructive behavior is:

1. Clinically assessed as related to a personality disorder rather than being a product of major mental illness,  
AND
2. Intractable and unresponsive to the usual therapeutic and management interventions available in the RTP setting.

Clearly, there may also exist some prisoners who, as determined through the appeal process through Central Office, cannot be managed outside of segregation without presenting a serious threat to the safety and security of staff and other prisoners. These individuals are not candidates for the SSRTP.

SSRTP interventions are based upon a cognitive behavioral model. The primary goal and treatment focus is to increase the prisoner's ability to control his or her behavior, thus permitting a transition to regular RTP programming with greater emphasis on psychosocial rehabilitation.

Prisoners are in the SS RTP unit because of assaultive, destructive, disruptive or unmanageable behaviors; every effort must be made to manage the prisoner's behavior in the unit. If necessary, the prisoner may be placed in a locked observation room, furnished to avoid destruction or inadvertent injury, to provide a "cooling down" period. If the prisoner continues to endanger others due to assaultive or destructive behavior after other interventions have been tried, including use of restraints or placement in an observation room as set forth in Policy Directive 04.05.112 "Managing Disruptive Prisoners," the prisoner may be referred for reclassification to administrative segregation in accordance with Policy Directive 04.05.120 "Segregation standards."

**Referral Transfers and Placement for SS RTP Prisoners:** When a CMHP staff at another facility identifies a prisoner who appears to meet SS RTP admission criteria, the staff shall submit the request for transfer for Health Care reasons to the Deputy Warden. If the Deputy Warden concurs with the request, he/she shall ensure the prisoner is released from any Administrative Segregation status to General Population status and transferred to the facility housing the SS RTP as soon as possible. S/he also shall ensure that any necessary security precautions to be taken by the receiving facility are noted in the Transfer Order (CSJ-134).

Similar to prisoners in an RTP, treatment and management needs and intervention goals and methods on SS RTP status are determined by an Interdisciplinary Treatment Team under the clinical leadership of a QMHP Unit Chief and are documented in an individualized treatment/management plan. Treatment team members include mental health professionals, corrections staff, such as Custody Officers (CO), Resident Unit Officers (RUO), Resident Unit Manager (RUM), Assistant Resident Unit Supervisor (ARUS), Facility Chaplain and others as necessary. To assure that treatment and security concerns are addressed appropriately, the initial management plan and subsequent modifications to change Phase status for prisoners in SS RTP status must be jointly approved by the Unit Chief and Deputy Warden.

Prisoners classified to Protective Segregation do not qualify for the SS RTP.

Prisoners in the SS RTP shall have progressively increased mobility, social interaction, and access to treatment which is intended to decrease their isolation and reduce the potential for deterioration of mental status. Programming in the SS RTP may include the treatment services provided by mental health teams as provided to regular RTP prisoners.

Those who successfully complete the four-phase program will be moved to regular RTP program status.

The number of prisoners on SS RTP status in an RTP unit may vary over time, but should never exceed 25% of the unit's capacity. Since the SS RTP is viewed as a status level within an existing RTP, no additional mental health staffing is required.

#### **(Four Phase Program)**

SS RTP interventions are based upon a cognitive behavioral model. The primary goal and treatment focus is to increase the prisoner's ability to control his or her behavior, thus permitting a transition to regular RTP programming with greater emphasis on psychosocial rehabilitation.

Due to the disruptive nature of the target population it is expected that frequent and intensive individual and small group interventions by both mental health and corrections staff will be required. Treatment/management plans will require frequent review and modification. As permitted by the Treatment and Management Plans, SSRTP prisoners may have access to institutional programs and services available at the institutions including education, general health services and employment/vocational training.

There are four phases for the SSRTP. The time frame for participation in each phase is dependent upon individual progress. During Phase I a few prisoners may be screened out by the team and determined to be inappropriate for either clinical reasons. Such cases will require a review by the Director of the Corrections Mental Health Program or designee, and if refused for security reasons, approval of the Deputy Director of CFA or designee.

### **Phase I: - Assessment**

This phase is the assessment phase upon admittance to the SSRTP. Clinical interventions and assessment activities will proceed in the context of necessary security precautions and limitations on the prisoner's movement commensurate with security level status. This Phase shall not exceed 5 business days.

During this phase, there is a clinical determination made by the Residential Treatment Team as to whether or not the prisoner meets the admission criteria. This determination shall be made within ten (10) business days. If it is determined that the prisoner does not meet mental health criteria for admission to the SSRTP program (for reasons such as the prisoner having a GAF score that is not between 36 and 50 or the prisoner having no mental illness or developmental disorder), the treatment team will then determine the appropriate placement for the inmate. If the inmate is functioning at an outpatient level but continues to require secure status placement, s/he will be referred to the SSOTP program. If the inmate is functioning at a lower level (GAF under 36), s/he will be referred to the appropriate program (CSP, Acute Care, RTS).

#### **During Phase I:**

- I. The SSRTP Mental Health staff evaluates and completes the assessment, medication review and evaluation of the diagnosis. A Mental Health Management Plan shall be developed which addresses symptoms and behaviors and recommends interventions necessary to keep the prisoner and staff safe.
2. The QMHP orients the prisoner and explains the program requirements. If the prisoner declines the offer for placement into the SSRTP, he/she shall be considered for involuntary treatment. A Mental Health Management Plan encouraging participation in the program will be implemented.
3. The RUM/ARUS conducts orientation regarding custody issues, unit and facility rules.
4. RTP nursing staff shall dispense all medication to the prisoner in his/her cell.
5. Phase I will have the following custody restrictions: full restraints for all out of cell movement, in-cell meals, housed in a hardened cell and will wear jumpsuits that uniquely identify them as requiring secure status management.

### **Phase II: - Initial Treatment**

Once the initial management plan is approved, Phase II begins. Placement in this phase is reviewed by the treatment team at 30-day intervals, or more frequently if needed. Treatment implementation, review, evaluation and documentation, etc. shall follow the established CMHP standards and procedures. A minimum of twelve (12) hours per week of out of cell programming will be provided to prisoners in Phase II.

During Phase II:

1. Prisoners are housed on Phase II status within the designated RTP unit.
2. Meals are provided in cell.
3. A Mental Health Management Plan will be instituted which addresses symptoms and behaviors and recommends interventions necessary to keep the prisoner and staff safe while allowing for treatment to occur. The management plan will be reviewed and approved by the Deputy Warden or designee.
4. Small group sessions shall be conducted.
5. Phase II may have the following custody restrictions based on the prisoner's behavior: full restraints for all out of cell movement, in-cell meals and housed in a hardened cell.
6. Phase II prisoners will wear jumpsuits that uniquely identify them as requiring secure status management.
7. A behavior reinforcement regimen may be used to reinforce misconduct-free behavior and compliance with training and treatment programs. Reinforcement will be identified by the Treatment Team and may include such things as extra yard time, positive reading materials, positive verbal praise for appropriate behavior, or other reinforcers identified as appropriate by the Treatment Team. All identified reinforcers must be identified in the prisoner's Comprehensive Individual Treatment Plan and be approved by the Treatment Team.
8. In-cell academic studies, where available, are coordinated by educational staff.
9. RTP nursing staff shall dispense all medication to the prisoner in his/her cell.
10. Prisoners shall be provided a limited general population store list.
11. Prisoners shall be provided with a minimum of one (1) hour per day of yard recreation, in either small yard or to single occupancy yard modules dependent on prisoner's behavior.
12. Prisoners shall be provided law library and general library access by making a request for books which shall be delivered to the prisoner in their cell.
13. Prisoners shall be provided access to a telephone in accordance with the prisoner telephone policy.
14. Prisoners shall be provided access to the Facility Chaplain.
15. Prisoners shall be allowed access to visits.
16. Prisoners shall be provided 1 haircut per month, to be given on the SS RTP unit.

The completion of this phase requires that the prisoner has demonstrated the ability to consistently attend and participate in group therapy/treatment programs, in addition to achieving specific, measurable, behavioral objectives which demonstrate accountability and responsibility and are addressed in the prisoner's comprehensive treatment plan.

**Phase III:**

The prisoner is seen as successfully completing Phase II and ready to be in Phase III of the SS RTP Program once he/she has successfully demonstrated to the treatment team that

he/she is able to manage his/her behavior and has control over the thought processes leading to his/her acting out behavior. The treatment team reviews and modifies the comprehensive treatment plan at 30-day intervals, or more frequently if needed. The inmate will be provided access to all on-unit groups during this phase.

During Phase III:

1. Prisoners are housed in a general population cell and are eligible for double bunking.
2. A Mental Health Management Plan will be instituted recommending in-unit treatment and addressing symptoms and behaviors, making recommendations regarding interventions necessary to keep the prisoner and staff safe while allowing for treatment to occur. This plan will be reviewed and approved by the Deputy Warden or designee.
3. Prisoner may sign up for any on-unit therapy groups. Phase III prisoners may attend day room and small yard.
4. Two meals per day, breakfast and dinner, shall be provided in small group settings (limited to between four (4) and six (6) prisoners at one time) out of cell in unit day room and lunch provided in cell.
5. Escort and/or restraint for out-of-unit movement by Phase III prisoners will be as specified in a mental health management plan.
6. A behavior reinforcement regimen may be used to reinforce appropriate behavior and compliance with training and treatment programs. Reinforcement will be identified by the Treatment Team and may include such things as extra yard time, positive reading materials, or other reinforcers identified as appropriate by the Treatment Team. All identified reinforcers must be identified in the prisoner's Comprehensive Individual Treatment Plan and be approved by the Treatment Team.
7. In-unit academic studies, where available, are coordinated by educational staff.
8. In the event of a non-bondable assaultive or major destructive misconduct occurring during this phase, the situation will be evaluated by the team and a determination made as to whether to continue the individual in the current phase of the program or return him to a previous phase of the program.
9. RTP nursing staff will dispense psychotropic medications to prisoner at RTP medline. The Treatment Team, with input from the Health Care staff, will make a decision whether to allow the prisoner access to over-the-counter medications. Restriction of medication will be addressed in the Comprehensive Individual Treatment Plan and in the Management Plan (CHJ- 177).
10. Prisoners shall be provided a regular general population store list.
11. Prisoners shall be provided with a minimum of one (1) hour per day of small yard recreation.
12. Prisoners shall be provided law library and general library access by making a request for books which shall be delivered to the prisoner in their cell.
13. Prisoners shall be provided access to a telephone in accordance with the prisoner telephone policy.
14. Prisoners shall be provided access to the Facility Chaplain.
15. Prisoners shall be allowed access to visits.
16. Work Assignments shall be provided within the unit in accordance with the prisoner's capabilities, progress in the program and availability.

17. Prisoners shall be provided 1 haircut per month, to be given on the SSRTP unit.

**Phase IV:**

After the prisoner has completed the first three (3) phases of SSRTP treatment, he/she is evaluated/reviewed by the Treatment Team and considered for placement in this final phase. The treatment team will review all prisoners every thirty (30) days and revise the Comprehensive Individual Treatment Plan as needed.

**During Phase IV:**

1. Prisoners are housed in a general population cell in the RTP unit (and are eligible for double bunking) and subject to the same out of cell activities as other prisoners situated in that unit; including yard recreation, phone calls, access to law and general library, religious services and visits.
2. Meals are eaten in the unit dining area.
3. Medications are dispensed by RTP nursing staff following the RTP unit med-line procedure.
4. Prisoners attend academic school and institutional programs in accordance with existing unit operations.
5. Prisoners continue to participate in therapeutic programs per their individual treatment plans. When possible, the group therapy sessions will be co-facilitated by a QMHP and RUM or ARUS.
6. Prisoners participate in programs conducted by the RUM, ARUS and/or RUOs.
7. A behavior reinforcement regimen may be used to reinforce appropriate behavior and compliance with training and treatment programs. Reinforcement will be identified by the Treatment Team and may include such things as extra yard time, positive reading materials, or other reinforcers identified as appropriate by the Treatment Team. All identified reinforcers must be identified in the prisoner's Comprehensive Individual Treatment Plan and be approved by the Treatment Team.
8. In the event a prisoner engages in unmanageable or destructive behavior, or incurs a non-bondable major misconduct, the situation will be evaluated by the team and a determination will be made whether to continue the prisoner in Phase IV or return him/her to a previous phase of the program.
9. Prisoners in this phase may have the opportunity to secure available. Once employed, the prisoner is responsible for maintaining employment while in this phase of treatment.

Completion of this phase occurs when the treatment team recommends reintegration into the general population of a facility appropriate to the prisoner's custody level where the appropriate level of mental health treatment is available. Consideration for discharge/reintegration into general population shall begin after the prisoner has successfully completed sixty (60) days of phase IV programming.

**CRISIS STABILIZATION PROGRAM**

Crisis stabilization services are an integral component of the mental health continuum of care, which includes outpatient mental health services, residential treatment programs, and inpatient hospital units (acute care and rehabilitative services). The unit provides services for managing disruptive prisoners whose behavior is linked to symptoms of mental illness or who are engaging in or threatening to engage in suicidal/self-injurious behavior.

The mission of the Crisis Stabilization Program (CSP) is to provide prisoners experiencing any mental health crisis whose behavior is grossly inappropriate due to mental illness and demonstrates a high risk for immediate danger to self or others or destruction of property with a short-term crisis stabilization service. The Crisis Stabilization Program uses a solution-focused treatment to allow quick re-establishment of a more stabilized coping behavior so the prisoner can be reintegrated into the prison general population. The services are intended to achieve the following purposes:

- I. Provide expedited access to psychiatric evaluation in a mental health emergency through a combination of on-site and on-call services.
2. Provide a safe and secure setting for further or more intensive assessment and evaluation of mental illness.
3. Provide short-term evaluation and stabilization with solution-focused treatment for prisoners experiencing a crisis of such intensity that their normal level of coping is no longer sufficient to allow them to stay in general population. The goal is to return the prisoners to their previous level of functioning and/or send them on to the most appropriate level of care.
4. Provide a setting for conducting involuntary treatment hearings under the provisions of P.A. 252 of 1993 when unable to provide on-site or through telemedicine.

The Crisis Stabilization Program service is not intended to supplement or substitute for current or planned observation cells within the correctional facilities. The correctional facilities are to continue to comply with existing policies and procedures with respect to the use of observation cells. Use of the CSP shall take place only after a Qualified Mental Health Professional (QMHP) has determined that a prisoner has an urgent need for mental health services, or believes a prisoner may be exhibiting emergent or acute mental illness or high-risk suicide or more intensive evaluation is required before a final disposition can be made. The maximum length of a stay in the Crisis Stabilization Program will be seven days. Prisoner beds will be held up to seven (7) days unless notified by the CSP that the prisoner is being referred to another level of care at another facility. If longer treatment or an extended evaluation is needed, the prisoner will be transferred to a longer term or more intensive treatment program. If the prisoner's coping skills have been restored and the crisis can be resolved within seven days or less, the prisoner will remain in the program and then be sent to the appropriate care level, if any is needed.

The principles and focus of the Crisis Stabilization Program consist of the following: The crisis that is occurring in the prisoner's life, how the crisis is affecting his/her behavior, the problems that need to be addressed and that a significant change can be made in a brief period of time. The Crisis Stabilization Program's goal is to encourage and enable these changes for the prisoners and emphasize their role in bringing about change in their lives. Treatment will encourage the prisoner to take responsibility for making positive change, regain self-control, and minimizing aggression.

#### **ACUTE CARE**

The Acute Care (AC) Inpatient Services is an integral component of the Corrections Mental Health Program (CMHP) continuum of care. The primary mission of the prison-based AC is to

provide intensive assessment and treatment, and rapid disposition for prisoners with acute mental illness, severe emotional disorders and possible co-existing disorders.

Acute Care is an inpatient program providing 24-hour access to psychiatric, psychiatric nursing, and correctional services 7 days per week. It is the preferred level of care for prisoners with serious mental illness and co-existing disorders and prisoners who are exhibiting symptoms of psychosis or high suicide risk. A multidisciplinary team of mental health and correctional professionals provides mental health care and programmatic intervention. Custodial care is provided entirely by correctional personnel. Services provided in this setting are more comprehensive than that typically available elsewhere in the CMHP continuum.

The AC program follows a bio-psychosocial model, emphasizing intensive diagnostic assessment, stabilization with psychotropic medications, and brief psychotherapy. It offers a protective environment that facilitates stabilization of acute psychiatric disorders and rapid triage to other levels of care. Integrated services emphasize coordination with other service providers and organizations.

Inpatient psychiatric treatment services involve coordination of multiple, distinct processes, including psychiatric diagnosis, assessment of functional behavioral deficits, and development of a Comprehensive Individual Treatment Plan (CITP). The CITP is the framework for treatment that typically involves psychotropic medications, crisis intervention, and behavior management that promotes restoration of a previous level of functioning; and, when possible, discharges to the previous level of care. Discharge, referral, or transfer of prisoners for continuing care in less intensive settings is a major focus of planning from the time of admission.

An interdisciplinary treatment team determines treatment needs, goals and methods under the supervision of the Unit Chief, with clinical direction provided by the psychiatrist. Acute Care prisoners require active psychological and behavioral interventions, frequent changes in medication regimens, and close medical monitoring because of concurrent medical conditions, complex medication needs, and poor self-care. Staff will conduct continual behavioral and medical monitoring of medication effects and side effects and evolving suicide and violence risk.

Therapeutic programming is delivered by an interdisciplinary treatment team, including Qualified Mental Health Professionals (QMHP's) (psychologists, social workers, nurses, and psychiatrists), Activity Therapists and correctional professionals. The AC program capacity will vary depending on demand for the number of prisoners requiring treatment.

A prisoner transferring into the Inpatient program may be placed on Admission Status. Prisoners will be evaluated by a psychiatrist and a nurse, and oriented to the unit by the RUM/ARUS or designee. The psychiatrist will order precautions necessary to ensure the safety of the prisoners and others during the inpatient admission status. When these precautions include the use of restraints, the local facility operating procedure, "Therapeutic Restraint and Seclusion of Mentally Ill Prisoners," must be utilized. If prisoners need to leave the unit for any reason, they will be escorted to and from their destinations. Unless otherwise indicated by behavior, the prisoner will be removed from inpatient admission status following this review. Placement of a prisoner on this status requires notification of the shift commander. The shift commander must also be apprised of the use of therapeutic restraint and seclusion.

The MDOC Policy Directive 04.05.112, "Managing Disruptive Prisoners" is not applicable to the management of prisoners currently being treated on an Acute Care unit.

Prisoners are placed on Non-Bondable status subsequent to receiving a non-bondable major misconduct. The Deputy Warden/Designee orders this status. Prior to any review or notice to the prisoner, the psychiatrist/QMHP evaluates the prisoners and circumstances. The psychiatrist/QMHP may waive inpatient non-bond status and order other precautions or seclusion and restraint as indicated by clinical status of the prisoner. The evaluation will be completed on the Misconduct Review form. Responsibility for the misconduct will be determined by the psychiatrist/assigned QMHP/on-call psychiatrist and will consist of the following: 1) Does prisoners have the capacity to know right from wrong; 2) Is prisoner able to conform his/her conduct to departmental rules; 3: Would the misconduct process be detrimental to the prisoner's mental health treatment. If the prisoner lacks the substantial capacity to know right from wrong, is unable to conform conduct to departmental rules, or the treatment team determines the misconduct process would be detrimental to the prisoner's mental health treatment, the misconduct process will not continue. If the evaluation determines the prisoner was responsible for his/her behavior, the prisoner will remain on inpatient non-bondable status until the misconduct report has been heard.

Prisoner's movement is restricted on this status to his/her cell except for mental health treatment programs and evaluations which are scheduled by the treatment plan and which occur on the housing unit. Daily review by the psychiatrist and/or treatment team QMHP will occur to determine if any change in behavior warrants change of status. Inpatient non-bondable status ends once the misconduct report is heard. If prisoner is found guilty of misconduct, the hearing officer may assign only the sanctions of loss of privileges. The privileges to be withheld will be determined by the unit chief/designee. **The prisoner cannot be reclassified to administrative segregation.**

When a prisoner in active treatment in CSP receives a major non-bond ticket, the on-duty nurse immediately contacts the team or on-call psychiatrist to evaluate the need for a seclusion or restraint order to ensure the safety and welfare of the prisoner.

A prisoner who is on discharge status can be held responsible.

### **REHABILITATION TREATMENT SERVICES**

Rehabilitation Treatment Services (RTS) is an integral component of the Mental Health Services continuum of care. Its primary mission is to provide inpatient treatment programs for prisoners with chronic serious mental illness/severe emotional disorders within a prison. The programs are designed to ameliorate psychiatric symptoms and improve daily functioning.

The RTS is an appropriate level of care for seriously mentally ill prisoners with symptoms and functional deficits that are chronic, resistant to treatment or disabling and who are not suitable for treatment in a less restrictive level of care. Often they have prominent negative symptoms of mental illness, severe difficulties with social skills, and difficulty in negotiating the activities of daily living without frequent supervision and assistance.

The RTS follows a biopsychosocial rehabilitation model of mental illness and treatment. The model emphasizes a prisoner's strengths and seeks to empower the individual to function as independently as possible in the prison setting. The model addresses the residual psychosocial

needs remaining after initial psychiatric treatment has been established. The goal is to enable prisoners to function in a less intensive level of care within the CMHP. The RTS also provides treatment and support services to prisoners who have received maximum benefit from acute psychiatric services but who, nevertheless, continues to require inpatient services. This may include prisoners who have had partial or poor responses to psychotropic medications.

Treatment needs, goals and methods are determined by an interdisciplinary treatment team under the leadership of a Unit Chief and are documented in the Comprehensive Individualized Treatment Plan (CITP).

Prisoners at this level of care often have not achieved the full benefits anticipated from psychotropic medications, and thus may require frequent changes in medication regimens. Prolonged medication trials, complex combinations of psychotropic medications, and novel uses of medications may be needed to overcome treatment resistance. Close behavioral and medical monitoring is necessary to assess the effects and side effects associated with these regimens.

## **TARGET POPULATION**

The target population for the **Counseling Services and Intervention** consists of prisoners who are not currently on the mental health services caseload, are evaluated by a QMHP either by sending a kite requesting mental health services, or in response to a mental health services referral and are assessed as requiring counseling and supportive interventions. Prisoners who have been discharged from OPT or K6 who require additional counseling and support are also a target population for the Counseling Services and Intervention programming. Typical reasons for admission and diagnoses include, but are *not limited to*, the following adjustment disorders, bereavement, eating disorders, impulse control disorders, conduct disorders, post traumatic stress disorder, dysthymia or anxiety disorders.

The target population for the **Outpatient Mental Health Treatment Program** consists of individuals with moderate functional impairment due to serious mental illness/serious mental disorders, who can care for their basic needs and live in the general population setting.

The **Secure Status Outpatient Mental Health program** is intended for prisoners in Out-Patient Mental Health Treatment (OPMHT) level of care who are clinically stable, have a serious mental illness, with relatively remitted symptoms, and have been or would be classified to administrative segregation by custody staff for safety and security reasons. Per the Corrections Mental Health Program Admission and Discharge Criteria and Guidelines, these prisoners are identified as having a Global Assessment of Functioning Score (GAF) of 51 or greater.

The **Residential Treatment Program** target population consists of those seriously mentally ill prisoners whose primary symptoms of mental illness have begun to remit but who continue to demonstrate significant impairments in social skills and limited ability to participate independently in activities of daily living. These individuals cannot function adequately in the general population without significant supports and modified behavioral expectations.

The target population for the **Adaptive Skills Residential Program** includes prisoners with mental retardation, dementia and other severe chronic brain disorders with moderate to substantial functional limitations, pervasive developmental disorders (PDD), and other moderate

to severe developmental disorders. Prisoners in the program will normally have a Global Assessment Functioning (GAF) score below 61, although prisoners achieving a higher GAF may remain in the program if deemed necessary to prevent relapse and to maintain acquired skills. This program utilizes consistent behavioral interventions to facilitate behavioral change. Refusal to participate in the program may result in consideration of the involuntary treatment process following the guidelines and criteria set forth in Public Act 252. A majority of prisoners will require this level of care for the duration of their prison term due to their need for the increased structure, specialized services, and trained staff. They may also have difficulties with moderate problematic behaviors.

Crisis Stabilization Program services are intended for prisoners whose symptoms and behavior initially appear to be indicative of a mental health crisis with a need for immediate intervention and further evaluation. The crisis may be an urgent or potentially emergent mental illness and/or a possible high risk of suicide.

Acute Care is a component of the Corrections Mental Health Program (CMHP) supplying services at the most intensive treatment level in the continuum. The target population for Acute Care is prisoners with a serious mental illness with prominent primary symptoms of psychiatric disorder, such as psychosis, suicidality, and extreme agitation resulting from the onset of new psychiatric illness, relapse, or deterioration from a previously stable condition. Such persons typically neglect self-care and cannot negotiate simple social transactions, or require close supervision because of suicidal preoccupations. All prisoners, commensurate with their capacity to participate, have access to institutional services offered on the Acute Care unit, such as special education, religious functions, and barber/hair care services. Prisoners admitted to the AC participate in a standard diagnostic intake process. Accurate diagnosis and prompt psychopharmacological interventions should facilitate symptom reduction within the first week of inpatient treatment. Psychotherapeutic interventions are tailored to the prisoner's needs and capacity to benefit from treatment. When assessment and stabilization have been achieved, the prisoner is transitioned to the most appropriate level of care within the CMHP continuum. Prisoners without severe mental illness or severe emotional disorder can be returned to general population with a recommendation for the Mental Health Services to follow up.

The target population for the Rehabilitation Treatment Services consists of male and female inmates with severe and chronic mental illness as defined by specific admission criteria. These are typically prisoners with treatment-resistant primary symptoms of mental illness who exhibit significant impairment in social skills and limited ability to conduct activities of daily living. Prisoners meeting the admission criteria, for which RTS is the least restrictive appropriate treatment, may be referred from CSP, RTP, or AC by a qualified mental health professional (QMHP), who must supply sufficient information to justify the admission. Prisoners are admitted to RTS as voluntary or involuntary admissions in accordance with Chapter 10 of the Michigan Mental Health Code (MCL.330.2-33a et seq.) The intake process for prisoners designated AC and RTS is similar, though aspects of the process may be modified or abbreviated.

## **STAFFING AND CASELOADS**

Staffing for OPT's typically consist of a Unit Chief (who is also a clinician), Psychiatrist, 2 QMHP's (may be a psychologist, clinical social worker, registered nurse or clinical nurse

specialist) and Secretary. The staffing pattern is based on an average active treatment caseload of 130-160 prisoners. The actual caseload may vary based on several factors. If large portions of the caseload are prisoners whose symptoms are in remission, and who require only maintenance support, the caseload may be larger. Caseloads in which large portions of prisoners are in segregation need to be smaller. The Outpatient team in the Reception and Guidance Center carries a smaller caseload due to the large number of evaluations required.

**The Secure Status Outpatient Mental Health Team** staffing pattern would typically consist of a Unit chief (who is also a clinician), Psychiatrist, 4 QMHP's (may be a psychologist, clinical social worker, registered nurse or clinical nurse specialist) and Secretary. The staffing pattern is based on an average active treatment caseload of 130-160 with 44 off those prisoners being in the Secure Status Outpatient Mental Health programming.

The mental health staffing pattern for an ASRP unit will typically consist of a Unit Chief, Psychologist (QMHP), 4 activity therapists, 4 Developmental Disabilities Programmers (Case Managers), a psychiatrist and a secretary. The staffing pattern is based on an average active treatment caseload of 160 prisoners. For this population, additional QMHP's, case managers, and activity therapists may be required based on the census, number of dually diagnosed prisoners and prisoners' acuity levels. Dedicated RUO positions will be assigned to this program, day and afternoon shift. Additional RUO/CO staffing is required to assist prisoners with adaptive skills deficits through instruction, guidance, counseling and direction in the areas of activities of daily living (ADLs), group participation, to accommodate possible restrictions on prisoner movement, and to provide escort and monitoring for a number of these prisoners during program activities when necessary. The cooperative effort of custody/housing, school, health care, and mental health staff is an essential component to the success of the program and treatment.

The staffing pattern for an RTP Unit of 70-85 prisoner/patients will typically consist of the same staffing as the OPT but will additionally have 3 Activity Therapists selected from among Occupational Therapist (OT), Recreational Therapists (RT), and Music Therapists (MT) who may be employed across units. Corrections staff complements include morning and afternoon shift, inclusive of primary program hours. Units with Secure Status Residential Treatment Program (SSRTP) status need enhanced custody staff beyond that required in a regular RTP. A minimum of one additional RUO during prime treatment hours is required, and since the number of prisoners on SSRTP status will vary over time, the officer-staffing pattern must remain flexible and will need to be determined for each facility. Additional staffing is required due to the disruptive nature of the target population, restrictions on prisoner movement, and the need to provide escort and monitoring during program activities.

The **Crisis Stabilization Program** and **Acute Care** staffing pattern consists of an interdisciplinary treatment team with 24/7 staffing provided by correctional staff, on-site nurses and psychiatrists. Support staff includes administrative and health record personnel. Staff members may, in certain instances, participate in multiple teams.

The staffing pattern for **Rehabilitation Treatment Services** consists of an interdisciplinary treatment team (Unit Chief, psychiatrist, nurse, social worker, psychologist, and activity therapist) with 24/7 staffing provided by correctional staffing, on-site nurses and on-call psychiatrists. Support staff includes administrative and health records personnel. Staff members may, in certain instances, participate in multiple teams.

For all programs offered, the Unit Chief is the administrative and clinical supervisor of the team and provides leadership in the delivery of services. The administrator is responsible for program management and supervision of the delivery of clinical services and chairs the team. The psychiatrist provides clinical expertise regarding delivered treatment. The psychiatrist retains responsibility for monitoring and delivery of services such as medication, lab work, and specialized psychiatric diagnostics and coordinates with Health Care Services staff to provide appropriate health care. Mental health professionals provide therapeutic services associated with their respective disciplines and credentials. Qualified mental health professionals share the responsibility of carrying out client service management activities and participate in the delivery of the psychotherapy and psychosocial rehabilitation programming. Resident Unit Managers (RUMs), the Assistant Resident Unit Supervisors (ARUS), and the Case Managers in the prisoner housing unit also participate in the treatment plan review process and may assist in prisoners management and in the early detection and preventive interventions to avoid deterioration. In addition, since the RUMs, ARUS and Case Managers are based on housing units, they can provide information regarding the prisoners' ability to function in the general population setting on a day-to-day basis.

### **PROGRAM ORGANIZATION AND SERVICES OFFERED**

All mental health treatment prisoners have access to regular institutional programming and services available to all prisoners, including education, general health care services and employment/vocational training as well as leisure/recreational/religious activities. Involvement in mental health services does not preclude prisoner involvement in other activities.

Mental health treatment services provided may include based on the level of treatment:

- Psychiatric evaluations
- Group psychotherapy (the preferred mode of therapy delivered)
- Individual psychotherapy
- Triage, treatment, discharge, and placement planning for appropriate level of care will begin upon admission.
- Psychopharmacology intervention
- Case management
- Activity Therapy
- Crisis mental health intervention (including the use of observation cells and access to inpatient services)
- Brief solution-focused therapies and/or counseling
- Psychosocial rehabilitation intervention (i.e., medication management, symptom management, cognitive skills training, problem solving skills training, social skill training, anger management, stress management, etc.)
- Cognitive Therapy
- Behavioral Therapy
- Assistance with activities of daily living (ADL)
- Provision of or linkage to educational and vocational activities
- Social Skill activities
- Leisure and Recreational activities
- Fitness/Wellness activities
- Psychotherapy

- Behavioral reinforcements can be used to bring about desired changes in behavior. Such reinforcements may include praise for positive behavior, personal items such as stationary or use of CD or radio for a prescribed amount of time, additional yard or day room time, coffee, tea, small edible items such as hard candy or popcorn.
- Treatment of Dual Diagnosis (Substance Abuse and/or Alcohol Abuse in mental illness)
- Community Reintegration and preparation of a relapse prevention plan for discharge from prison

Mental Health Services primarily delivers services between the hours of 8:00 a.m. - 4:30 p.m., Mondays through Fridays. Department of Corrections Health Care Services administers all medications, ensures doctors orders are given to pharmacy, provides all medication, completes all necessary call-outs for medication, and maintains records of medication administration in the appropriate health record section of the prisoner's medical record. Health Care Services provides a 24-hour coverage for emergencies. Mental Health Services staff provides coverage for mental health emergencies after hours, and on weekends and holidays.

Mental Health Services provides psychiatric evaluations for all individuals who are believed to be mentally ill after a thorough evaluation by a QMHP. The team also provides crisis intervention services to prisoners already on the caseload, and serves in emergencies for prisoners not on the team caseload.

## **SPECIAL PROGRAM CONSIDERATIONS**

### **Involuntary Treatment**

Treatment in the Mental Health Services Program is voluntary. If an individual refuses treatment, s/he will be discharged unless there is an evaluation by a qualified mental health professional and a comprehensive psychiatric evaluation certifying that the prisoner is mentally ill and needs treatment.

On November 29, 1993, Chapter 10 of the Michigan Mental Health Code (Public Act 252) was revised to establish a clinical hearing process in which prisoners with serious mental illness may be involuntarily treated. The involuntary treatment hearing process assembles a panel hearing committee of three clinicians which consist of a psychiatrist, psychologist and another qualified mental health professional (QMHP), none of whom are, at the time of the hearing, involved in the prisoner's treatment/diagnosis. The treating psychiatrist is present at the panel hearing to provide the hearing committee with the prisoner's diagnosis, a proposed plan of treatment and a rationale for recommended medication. The psychiatrist is also present to respond to prisoner cross-examination regarding psychiatric testimony. The hearing committee then considers the psychiatrist's testimony, the prisoner's testimony and response to committee questions, any witness testimony, all submitted written reports and any other admissible evidence presented. The hearing committee decides by a majority vote, which must include an affirmative vote by the panel psychiatrist, whether the prisoner is mentally ill and whether the proposed mental health services are suitable to the prisoner's condition. If the prisoner is found mentally ill, s/he is placed on an involuntary treatment order for a predetermined time period (90 days on an initial order, 90 days on a second order and 180 days for a third order). If the prisoner is found not mentally ill, s/he is discharged from the Mental Health Services Program.

### **Guilty But Mentally Ill (GBMI) Evaluations**

At the request of the Parold Board, a psychiatrist with the Michigan Department of Corrections is required by law to evaluate all Guilty But Mentally Ill prisoners for the purpose of determining their need for psychiatric treatment. The results of the evaluation is sent to the Parole Board including a description of the prisoner's condition; their diagnosis; a description of their treatment, if any, including medication; possibility of future problems; and recommendation for further treatment of the prisoner.

### **Hepatitis C Interferon Treatment Evaluations**

**For Prisoners who are participating in Corrections Mental Health Programming (OPT, RTP, CSP, RTS, AC),** the primary care physician must consult with the prisoner's psychiatrist before initiating Interferon treatment. The psychiatrist will complete the Baseline Depression Scale for Prisoners Receiving Interferon Treatment form and return it to Health Care. The QMHP case manager will monitor the prisoner, not less than monthly, during the six months of this chemotherapy. **For prisoners who are not receiving Corrections Mental Health Programming,** a QMHP must establish a baseline CES-D score utilizing the Baseline Depression Scale for Prisoners Receiving Interferon Treatment form, a review of the prisoner's mental health history, and current mental status on all prisoners before Interferon treatment is initiated. The completed form must be returned to Health Care. The QMHP will monitor the prisoner, not less than monthly, during the six months of this chemotherapy utilizing the Monthly CES-D Assessment For Prisoners Receiving Interferon Treatment form and providing Health Care with a copy of same. If it is found that the prisoner is experiencing significant depression symptoms, the QMHP must refer to a level of care in the Mental Health Services continuum.

### **Scheduling of Program Activities**

Security and scheduling of institutional housing unit activities are under the direct supervision of a RUM or designee. However, in the scheduling process, priority will be given to therapeutic program needs as determined by the Unit Chief. The exception will be in case of an imminent threat to the safety and security of the institution. Prisoners on top lock or sanction shall be released and allowed to participate in mental health treatment, including individual and group therapy and activities per Policy Directive 03.03.105, "Prisoner Discipline." Further, where security provisions permit, therapeutic program activities will be permitted to continue during count time. All staff is responsible for ensuring that prisoners report to scheduled programming or to alternative care areas.

### **Behavioral Collaborative Case Management**

The Michigan Department of Corrections' Collaborative Case Management (CCM) program focuses on those high risk prisoners who present challenges to facility staff in meeting their health care and/or mental health needs. This model identifies a case manager whose efforts to manage the various biological, psychological, social, and institutional factors impacting the client's health are facilitated by key stakeholders (i.e., staff directly providing services and responsible managers and administrators *who can enforce service and placement decisions* emanating from the CCM process), including custody, health care, and mental health staff. Particular emphasis is placed on organizational efforts to support service delivery and continuity of care. Towards that end, a critical principle of CCM is comprehensive assessment informing the individual's treatment plan. To the extent possible, the plan is developed in collaboration

with the client. The Case Manager coordinates the process, interfacing with key service providers to ensure that the plan is developed, contracted and monitored regarding outcomes.

The CCM approach assumes that clients with complex needs (i.e., co-morbidity) will access services from numerous providers and ongoing effort is needed to avoid fragmentation of services and achieve maximum continuity of care. This requires boundary spanning strategies to ensure service provision is based on prisoner need rather than organizational need. The CCM process has been implemented at the facility level as well as at the central office level. The Central Office CCM meeting occurs monthly. Prisoners can be referred to the CCM meetings by any stakeholder. As a rule, the general referral criterion is: an individual whose significant health care and/or mental health needs are not currently being met with available services.

### **Discipline and Management**

Individuals who receive misconduct violations while in treatment may request, or the hearing investigator or hearing officer may request, an evaluation for responsibility assessment. The evaluation consists of determining whether the prisoner was seriously mentally ill that this resulted in the inability to know right from wrong or the inability to conform to rules. If it is determined the prisoner was unable to conform to rules or know right from wrong, s/he will be referred to an inpatient setting for treatment. If prisoners are classified to Administrative Segregation, see next section, "Evaluation and Treatment in Segregation."

It is anticipated that some potentially assaultive prisoners may be admitted to the RTP. It is expected that prisoners' behavior will be managed primarily through interventions in the individualized treatment/management plan which will require approval by the Unit Chief and Deputy Warden.

However, events not anticipated in the plan may occur and require staff response and intervention. Unless a specific intervention is described in the treatment/management plan, an employee who observes a major misconduct violation by an RTP prisoner shall take necessary emergency actions to prevent the individual from engaging in behavior that is dangerous to self, others, or property, and shall confiscate any dangerous contraband items. Ordinarily the prisoner shall not be placed in segregation or on top lock pending a hearing. Every attempt shall be made to manage the behavior in the unit including verbal intervention by a QMHP, if available. If the prisoner continues to endanger others due to assaultive behavior after other interventions have been tried, s/he may be placed in a locked observation room on the unit to provide the individual an opportunity to de-escalate or cool down and regain self-control. If an assaultive prisoner has been physically subdued, per Policy Directive 04.05.112, "Managing of the Disruptive Prisoner," and continues to endanger others due to assaultive behavior after other interventions have been tried, physical restraints may be imposed first using soft restraints, and then following the remaining safeguards listed in the policy.

Whenever a charge of misconduct is made for a prisoner in OPT/ASRP/RTP/SSRTP/CSP/AC/RTS, procedures for implementing Policy Directive 03.03.105, "Prisoner Discipline," must be followed. A request to consider whether the individual may not be responsible due to mental illness must be addressed to the Unit Chief or designated QMHP. If found guilty, a sanction of detention may be given only if the designated QMHP has determined that the prisoner's mental health treatment needs can be met in detention.

If, however, after these alternative interventions have been tried, the prisoner still endangers others due to assaultive behavior, s/he may be placed in segregation as set forth in Policy Directive 04.06.182, "Mentally Ill Prisoners in Segregation-Identification, Referral Evaluation and Treatment."

A recommendation by the Security Classification Committee (SCC) to reclassify the prisoner to administrative segregation requires immediate notification of the Clinical Director/designee of the BHFMS/Corrections Mental Health Program and approval of the Deputy Director, CFA, or designee. The QMHP also participates in the SCC process and meetings at the facility level giving input on the prisoners on their caseload.

### **Evaluation and Treatment of Prisoners in Segregation**

Individuals who have engaged in aggressive behavior are often placed in high security cells or in what are termed "administrative segregation" units. Department of Corrections requires QMHP's to conduct segregation rounds to monitor all prisoners housed in segregation three (3) times per week for the purpose of identifying prisoners who display maladaptive behaviors or symptoms suggestive of mental illness. Individuals already in Mental Health Services treatment placed in this type of setting are seen a minimum of once per week by their case manager and have specialized management plans developed. Segregation prisoners receive mental health screenings by a QMHP after 30 days in Segregation and every 90 days thereafter.

Prisoners who are displaying serious mental illness, are on antipsychotic medications, are involuntarily treated or are functioning at a Global Assessment of Functioning (GAF) level of less than fifty-one (51), will be immediately referred for treatment in the Residential Treatment Program. Individuals who are classified to administrative segregation with these conditions are considered not suitable for treatment in the segregation unit because the considerable isolation and restrictions of segregation could cause deterioration in the mental status of the individual.

The removal of such prisoners from segregation begins with a request to the Deputy Warden. If approved, the individual is removed from segregation and transferred to a Residential Treatment Program unit. If the Deputy Warden disagrees, the request is then processed as an appeal and sent up the chain-of-command through the Department of Corrections for approval to remove the individual from segregation. If it is determined that the individual is too dangerous to be placed in the Residential Treatment Program, s/he will continue to be treated in the segregation unit. The qualified mental health professional(s) assigned to the segregation unit will follow up, evaluate and treat these individuals in segregation. Safety and security factors permitting, prisoners will be brought out of their cells to be seen by outpatient mental health staff in offices in that unit.

### **Sanctions and Reclassification to Administrative Segregation Following Successful Treatment in RTP/AC/RTS**

A prisoner in RTP who has accumulated a substantial amount of Top Lock, Detention or Loss of Privileges, upon recommendation of the RTP Psychiatrist or Psychologist, the Warden may excuse all of the remaining sanction periods that have not yet been served, in accordance with PD 03.03.105, "Prisoner Discipline," paragraph AAA #2.

A prisoner, who is misconduct-free for six (6) consecutive months in an AC, RTS, or RTP or in any combination of AC, RTS, and RTP, shall be eligible, at the Warden's discretion, for waiver of remaining detention time.

Seriously mentally ill prisoners shall not be routinely sent to Administrative Segregation without thorough PRIOR consideration of their mental condition and mental health treatment needs. Following successful treatment in an RTP/AC/RTS, SCC shall not reclassify a prisoner to administrative segregation without immediate notification of the Mental Health Services Program Director or designee, and with the concurrence of the Deputy Director, CFA, or designee.

### **PHYSICAL SETTING**

**Outpatient Mental Health** Services staff are housed in offices inside the prison's security perimeters and generally as close as possible to the health records office. The offices are suitably arranged to maintain safe, confidential and therapeutic contact. Suitable and safe space for necessary activities must be provided between the hours of 8:00 a.m. - 4:30 p.m., Monday through Friday, including areas for group psychotherapy. The physical setting for the **Secure Status Outpatient Mental Health** is the same as it is for regular Outpatient Mental Health.

Prisoners in the ASRP program will be housed in either single or double occupant rooms, depending upon their ability to cope with a roommate. Office space for mental health staff must be located in or in close proximity to the living unit and suitably arrayed to permit safe and confidential therapeutic contact. Suitable and secure space for all necessary treatment activities must be available during primary program hours (Monday-Friday, 8:00 a.m. - 4:30 p.m.). Adequate space is necessary in order to provide at least three hours of group activities per prisoner per day in addition to general population activities. Secure storage space must be provided and be conveniently accessible for necessary therapeutic program materials and equipment. Depending on the size of the unit, observation cells must also be available on the unit, typically a minimum of two (2) observation cells per unit.

Prisoners in the RTP program may be housed in single or double occupant rooms dependent on mental health needs. Office space for QMHP staff must be located in the living unit and suitably arrayed to permit safe, confidential therapeutic contact. Suitable, secure space for all necessary treatment activities must be provided during primary program hours (8:00 a.m. - 8:00 p.m.). Secure storage space must be provided and conveniently accessible for necessary therapeutic program materials and equipment. Depending on the size of the unit, observation cells must also be available on the unit, typically a minimum of two (2) observation cells per unit.

The maximum length of a stay in the **Crisis Stabilization Program** will be seven days. Prisoner beds will be held up to seven (7) days unless notified by the CSP that the prisoner is being referred to another level of care at another facility. If longer treatment or an extended evaluation is needed, the prisoner will be transferred to a longer term or more intensive treatment program. If the prisoner's coping skills have been restored and the crisis can be resolved within seven days or less, the prisoner will remain in the program and then be sent to the appropriate care level, if any is needed.

**Acute Care** prisoners are housed in single-occupant rooms. Suitable, secure space for all necessary treatment activities must be provided during primary program hours. Accessible and secure storage space must be provided for therapeutic program materials and equipment. **AC prisoners must be escorted outside of the AC unit. They are not considered general**

**population.** Treatment space and housing space will be organized flexibly to accommodate changing ratios of acute and chronic prisoners.

RTS prisoners are housed in single-occupant rooms unless otherwise recommended by the treatment team. Suitable, secure space for all necessary treatment activities must be provided during primary program hours. Accessible and secure storage space must be provided for therapeutic program materials and equipment.

### **STAFF TRAINING**

Orientation and ongoing training for mental health staff meet all the Michigan Department of Correction's rules, regulations, and requirements including all mandatory training requirements. On-the-job training would reflect specifics for the program and environment the staff work in. The unit chiefs/supervisors are expected to work cooperatively with the housing unit RUMS, ARUS, Case Managers, Deputy Warden, Wardens, etc., in providing any on-the-job training to custody staff as to therapeutic programming and mental illness. As new therapeutic modalities are introduced, staff may be required to participate in additional on-the-job training. Other training/staff development programs will be offered to address problems or enhance program effectiveness, as quality assurance mechanisms identify particular needs. The Michigan Corrections Office Training Council must approve training used to satisfy the Michigan Department of Corrections training requirements.

### **ADMISSION CRITERIA**

The criteria and guidelines in this section are to be used in determining whether prisoners require a level of care provided by the Mental Health Services continuum and where appropriate placement would be in the continuum. As such, they are designed to be used by Mental Health Services staff in determining whether prisoners should be referred for treatment.

**Counseling Services and Interventions** - Prisoners can be admitted to CSI in one of two ways:

- A. Prisoners who are not currently on the mental health services caseload are evaluated by a QMHP either by sending a kite requesting mental health services, or in response to a mental health services referral (ROBERTA-R), CHX-212.
- B. Prisoners who have been discharged from OPT or K6 who require additional counseling and support.

As determined by a QMHP evaluation, the prisoner is assessed as requiring counseling and supportive interventions. The typical reasons for admission and diagnoses include, but are *not limited to*, the following:

- A. Adjustment disorders
- B. Bereavement
- C. Eating disorders
- D. Impulse control disorders
- E. Conduct disorders
- F. Post Traumatic Stress Disorder
- G. Dysthymia

## H. Anxiety disorders

**Note:** A prisoner on CSI cannot be diagnosed with a major mental disorder such as Schizophrenia, Schizoaffective Disorder, Bi-polar Disorder, Psychotic Disorders, Major Depression, or any other condition considered to be a **severe disorder of thought or mood** that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life. Such prisoners should be referred for psychiatric evaluation for admission to outpatient (OPT) or higher level of care.

Primary symptoms associated with the condition are stabilized / in partial remission as indicated by a **GAF score of 61 or above**. A prisoner in CSI is determined to be capable of functioning in a correctional housing unit with regularly scheduled services provided by mental health services program. The patient must provide voluntary written consent to treatment in for CSI programming.

**Outpatient Mental Health** - Prisoners admitted for treatment by the Outpatient Mental Health Team must meet ALL three criteria A, B, and D or BOTH criteria C and D.

- A. As determined by a comprehensive psychiatric evaluation, the prisoner/patient is judged to present with serious mental illness indicated by one of the following diagnoses or clinical conditions:
  1. Schizophrenia
  2. Bipolar disorder
  3. Schizoaffective disorder
  4. Major depressive disorder
  5. Psychosis (psychotic disorder other than schizophrenia in DSM-IV)
  6. Chronic brain disorder with significant functional impairment, absent complicating medical conditions

OR

  7. Other condition considered being a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.
- B. Primary psychiatric symptoms associated with the condition are stabilized/in partial remission, as indicated by a GAF score in the 51-60 range (may be higher if secondary to medication maintenance); the prisoner is determined to be capable of functioning in a correctional housing unit with regularly scheduled services provided by the Outpatient Mental Health Team.
- C. Primary psychiatric symptoms associated with the condition are stabilized/in partial remission, as indicated by a GAF score in the 51-60 range (may be higher if secondary to medication maintenance); the prisoner is determined to, be capable of functioning in a correctional housing unit with regularly scheduled services provided by the Outpatient Mental Health Team.
- D. The patient provides voluntary written consent to treatment or is the subject of an Involuntary Treatment Order.

The Outpatient Mental Health Team is expected to admit individuals to their caseloads when the results of the Comprehensive Psychiatric Evaluation suggest uncertainty as to the symptomatology and behavior meeting Corrections Mental Health Program entry/exit criteria. This admission will be done to allow further assessment and evaluation of the individual's treatment needs.

**Guidelines for Application of Outpatient Mental Health Services Admission Criteria (Is this appropriate/necessary information for the Program Statement?)**

A. Diagnosis or clinical condition

1-5. See DSM-IV criteria

6. Chronic brain disorder with significant functional impairment, absent complicating medical conditions, is intended to include mental disorders previously identified as organic mental disorders (DSM-IV), whose predominant clinical presentation is a psychotic disorder, major mood disorder or equivalent severe emotional disorder. An example would be cases of relatively mild dementia with predominant delusions or depressed mood. Psychotic and mood disorders due to general medical conditions are, at most moderate, stable and manageable with routine appointments to an outpatient medical clinic. Persisting substance-induced psychotic or major mood disorders are appropriate for treatment and may require re-diagnosis as an independent non-substance induced mental disorder.

This category is not intended to include delirium, severe dementia, uncomplicated dementia, amnesic disorders, substance intoxication or withdrawal, attention deficit disorders, mental retardation, or developmental disorder. Mental disorders with serious underlying medical conditions requiring a medical hospital are also excluded.

7. Other Conditions

A severe disorder of thought may be implied from clinical signs and symptoms such as moderate and persistent ideas of reference, obsessions, magical thinking, frequent preoccupation with severe distrust/suspiciousness, moderate impairment in attention span or moderate but persistent flight of ideas. Prisoners' claims of continued delusions, hallucinations or illusions, although not confirmed through behavioral observation, may be considered.

A severe disorder of mood may be demonstrated by clinical symptoms and signs associated with a major depressive episode or manic episode as described in DSM-IV; or dysthymia or cyclothymia, as defined in DSM-IV; or frequent moderate anxiety/panic attacks, frequent intense mood swings, or expansive or euphoric mood.

- B. Continues to be able to carry out necessary activities of daily living without supervision. GAF 51-60, related to clinical condition, may be demonstrated by any of the following.

1. Able to independently dress, feed, groom, toilet and go to chow hall, health care appointments, work or school but may have trouble carrying out assignments, begin to show poor performance in work or school or avoids general social activities. Able to understand and conform to unit rules and is responsible for behavior. May display occasional threats or acts of violence by choice, but is able to control behavior and is responsible for behavior.
2. May display circumstantial speech, pressured speech, frequent (daily) compulsive/obsessive rituals; eating disturbance (loss or gain of 5% of weight in one-two months); insomnia (less than five hours sleep per day) or hypersomnia (ten hours sleep or more at a time, lasting two months or longer); significant and frequent impairment in decision-making over minor issues and problem-solving; excessive rigidity or significant lack of self-structure for two months or longer. Communications are understandable but may be vague, impoverished or inappropriately abstract. Bizarre behavior.
3. Returned from a psychiatric hospital within past three weeks when hospital admission was related to evaluation and/or treatment following clinical determination that prisoner was at high risk for suicide. Refer to suicide/self-injury risk assessment guidelines.

**Secure Status Outpatient Treatment Program** - Prisoners admitted for treatment in the Secure Status Outpatient Treatment Program must meet the admission criteria for the outpatient treatment as indicated above as well as the following criteria:

- A. The program is intended for prisoners in Out-Patient Mental Health Treatment (OPMHT) level of care who are clinically stable, have a serious mental illness, with relatively remitted symptoms, and have been or would be classified to administrative segregation by custody staff for safety and security reasons. Per the Corrections Mental Health Program Admission and Discharge Criteria and Guidelines, these prisoners are identified as having a Global Assessment of Functioning Score (GAF) of 51 or greater.

**Adaptive Skills Residential Program** - Prisoners admitted for treatment in the ASRP must meet the following criteria:

- A. Prisoner has a developmental disability or cognitive impairment with or without mental illness as determined by a comprehensive review of previous records and a thorough assessment of intellectual functioning conducted by a psychologist. If the prisoner is determined to have a co-occurring mental illness, there needs to be a comprehensive psychiatric examination completed by a CMHP psychiatrist.

**AND**

- B. The prisoner is having moderate to serious difficulties functioning in general population due to the mental disability and is in need of more structured, comprehensive programming. The level of functioning is related to moderate to significant deficits in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-

sufficiency, and inability to understand and cope with the prison structure and rules.

**AND**

- C. Prisoners must be sufficiently stable and able to function within the confines of a specialized general population unit. If there is a co-occurring mental illness, the symptoms must be in at **least partial remission** and not require inpatient care.

**Residential Treatment Program** - Prisoners admitted for treatment in the Residential Treatment Program must meet ALL of the following criteria:

- A. As determined by a comprehensive psychiatric evaluation, the prisoner/patient is judged to present with serious mental illness indicated by one of the following diagnoses or clinical conditions:
  1. Schizophrenia
  2. Bipolar disorder
  3. Schizoaffective disorder
  4. Major depressive disorder
  5. Psychosis
  6. Chronic brain disorder with significant functional impairment, absent complicating medical conditions

**OR**

  7. Other condition considered being a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.

**AND**

Primary psychiatric symptoms associated with the condition are stabilized/in partial remission, as indicated by a GAF score in the 36-50 range (may be higher if secondary to medication maintenance), however, residual symptoms of psychiatric impairment require daily presence of mental health staff and modified behavioral expectations in order for prisoner to function in a general population housing unit.

An exception related to classification to administrative segregation shall be made for prisoners with a current Axis I major mental disorder (as documented in the most recent Comprehensive Psychiatric Evaluation and/or those receiving maintenance antipsychotic medication). Prisoners in these circumstances, whose GAF score would be otherwise congruent with placement in outpatient treatment, must instead be referred to the RTP. When a referral is made under these circumstances, the Corrections Mental Health Program Director, or designee, must be notified. Subsequent placement of a prisoner in an RTP is subject to the approval of the Deputy Director of CFA, or designee.

- B. In addition, the prisoner provides voluntary written consent to treatment or is the subject of an involuntary treatment order.

**Secure Status Residential Treatment Program** - In addition, for placement on SS RTP status, a prisoner must meet ONE of the following:

- A. If currently in RTP placement, an observed pattern of frequent assaultive and/or destructive behavior is clinically assessed to be related to personality disorder rather

than the product of major mental illness, **and** determined to be intractable and unresponsive to less restrictive therapeutic interventions available in the RTP;

**OR**

- B. If currently in segregation or a psychiatric hospital setting, an observed pattern of frequent assaultive and/or destructive behavior is clinically assessed to be related to personality disorder rather than the product of major mental illness, **and** prognosticated to be intractable and unresponsive to less restrictive therapeutic intervention available in the RTP.

**Crisis Stabilization Program** - ADMISSION HOURS: 24 hours a day, 7 days a week. A prisoner is referred to the program after an evaluation by a QMHP. The QMHP evaluation of the prisoner must establish a deterioration of mental status resulting in a potential emergent or urgent mental health crisis or high suicide risk. The evaluation results must indicate how the prisoner meets the criteria for admission which are summarized as follows:

- A. The prisoner has a major mental disorder or is suspected of suffering from a serious major mental illness and the QMHP evaluation reveals symptoms indicative of major decompensation, including thought disorder, delusions, hallucinations, incoherence, problems with communication, and/or high risk for suicide or self-injurious behavior that seem to impact behavior and result in significant functional impairment. The prisoner cannot function effectively in the current setting and needs further evaluation to determine the most appropriate level of intervention and stabilization of decompensation.
- B. The prisoner has a major mental disorder or is suspected of suffering from a major mental illness and/or is at high risk for suicide. The prisoner experiences a change or decline in functioning level which leads to inability to meet basic needs, therefore resulting in a crisis for the prisoner. The current level of functioning cannot be improved on-site and appropriate treatment requires placement beyond one level of care higher than the current level of care.

All referrals to an acute care unit shall be reviewed by a CSP psychiatrist. The QMHP must complete the Mental Health Evaluation/Admission Referral (CHJ-332) justifying the need for this level of intervention.

The psychiatrist may discuss the case with the QMHP after receiving the information and may, if the psychiatrist finds it is beneficial or necessary, speak to the prisoner by phone to aid in his/her determination. Crisis stabilization placement can only be made with the approval of a Crisis Stabilization Program psychiatrist.

The sending facility QMHP shall ensure that the prisoner's Mental Health Evaluation/Admission Referral is in the health record and the management plan provided to the control center. The facility nurse ensures the health record and medications are delivered to control center. The shift commander will ensure that the counselor file and institutional file are brought to the control center. The officer in charge of the control center will ensure that all the above materials accompany the prisoner when transported to the CSP.

**Acute Care** - Prisoners admitted for acute care treatment must meet ALL **THREE** criteria.

- A. As determined by a Comprehensive Psychiatric Evaluation (CPE) the prisoner presents with serious mental illness indicated by **ONE** of the following diagnoses or clinical conditions:
  - 1. schizophrenia;
  - 2. bipolar disorder;
  - 3. schizoaffective disorder;
  - 4. major depressive disorder;
  - 5. psychosis (psychotic disorder other than schizophrenia in DSM-IV);
  - 6. other condition considered to be a severe disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life;
  - 7. a condition considered to be at HIGH risk of suicide.
- B. The severity of illness, as indicated by a GAF score in the 1-20 range, requires an intensity of medical/psychiatric treatment only available in an inpatient setting.
- C. The prisoner provides voluntary written consent to treatment or is the subject of an Involuntary Treatment Order.

**NOTE: Prisoners meeting the admission criteria must be referred by a Qualified Mental Health Professional (QMHP), who must supply sufficient information to justify the admission. Prisoners are admitted to AC as a voluntary or involuntary admission in accordance with Chapter 10 of the Michigan Mental Health Code (MCL 330.2003a et seq.)**

Guidelines for Application of Acute Care Admission Criteria

- A. Diagnosis or Clinical Condition
  - 1-5 See DSM-IV
  - 6. Other Conditions
    - A severe disorder of thought may be indicated by actions of the prisoner, which demonstrate genuine belief in reported delusions, hallucinations, illusions, or paranoia.
    - A severe disorder of mood may be demonstrated by clinical symptoms and signs associated with a major depressive episode or manic episode as described in DSM IV.
  - 7. High risk of suicide - refer to suicide / self-injury risk assessment guidelines.
- A. GAF 1-20, related to clinical condition, may be indicated by any of the following:
  - 1. Generally unable to communicate in an organized, understandable fashion, or to respond to communication by others; almost totally unable to follow instructions.

2. Markedly impaired attention span, constant obsessive ideas of death, rejection, worthlessness, etc. evidence of largely incoherent and illogical thought process, largely mute or catatonic, manic excitement, i.e., less than 3 hours of sleep a day, excessive activity, extreme psychomotor agitation or retardation, extreme fatigue.
3. Requires constant supervision and physical assistance in living skills such as self-feeding, dressing, bathing, oral hygiene, toileting, unable to find his/her way back to the unit by self, wanders without regard to danger (i.e., prison fence area which could result in death); unable to conform to unit rules.
4. Evidence of little or no control of impulses which may result in harm to self, others, or property, fire setting, frequent violent and/or destructive behavior or constant and persistent preoccupation with hurting others within the last week. Not responsible for behavior.

**Rehabilitation Treatment Services** - Prisoners admitted for treatment in the RTS must meet ALL **THREE** of the following criteria:

- A. As determined by a psychiatric evaluation the prisoner is judged to presents with serious mental illness indicated by **ONE** of the following diagnoses or clinical conditions:

1. schizophrenia
  2. bipolar disorder
  3. schizoaffective disorder
  4. major depressive disorder
  5. psychosis (psychotic disorder other than schizophrenia in DSM-IV)
  6. chronic brain disorder with significant functional impairment, absent complicating medical conditions
  7. other condition considered to be a severe disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.
2. The condition has been determined to be chronic or sub-acute and the severity of illness, as indicated by a GAF score in the 21-35 range, requires an intensity of psychiatric/psychosocial rehabilitation and/or supervision only available in this setting.
  3. The prisoner provides voluntary written consent to treatment or is the subject of an Involuntary Treatment Order.

Guidelines for Applying RTS Admissions Criteria

Admission Criteria:

1. Criterion 1: Diagnosis or Clinical Condition  
1-5 See DSM-IV criteria.

6. Chronic brain disorder with significant functional impairment, absent complicating medical conditions, is intended to include mental disorders previously identified as organic mental disorders (in DSM-III-R) and in DSM-IV usually classified as due to a general medical condition, substance-induced, mild dementia or cognitive disorder NOS, where the predominant clinical presentation is a psychotic disorder, major mood disorder, or other equivalent severe emotional disorder. Examples include cases of relatively mild dementia with prominent delusions or depressed mood, psychotic and mood disorders due to general medical conditions in which the underlying medical conditions are, at most moderate, stable, and manageable with routine appointments to the medical clinic. Persisting substance induced psychotic or major mood disorders are appropriate for treatment and may require re-diagnosis as an independent non-substance induced mental disorder.

This category is not intended to include delirium, severe dementia, uncomplicated dementia, amnesic disorders, substance intoxication or withdrawal, attention deficit disorders, mental retardation, or developmental disorders. Mental disorders with serious underlying medical conditions requiring medical hospital care are also excluded. Should medical needs indicate need for Infirmiry level of care, RTS programming can continue.

7. Other condition:  
A severe disorder of thought may be demonstrated by clinical signs and symptoms of delusions, hallucinations, illusions, paranoia, or obsessions, which are recognized by the prisoner as not part of reality but which still considerably influence behavior or are a marked distraction.
8. A severe disorder of mood may be demonstrated by clinical symptoms and signs associated with a major depressive episode or manic episode as described in DSM-IV.

2. Criterion 2: GAF 21-35, related to clinical condition, may be demonstrated by any of the following:

- a. Psychomotor agitation (i.e., pacing, rocking for hours on a daily basis for at least a week). Psychomotor retardation (abnormal marked fatigue/lethargy - stays in bed all day), poor appetite (weight loss of 10% in a month).
- b. Frequently unresponsive, unaware of or ignores social norms, i.e., openly masturbating oblivious to presence of others. Is unable to engage in unstructured social activity for 6 hours in a day, i.e., dayroom, movies, yard, or group activities. Unable to engage in 2 hours of structured activity with others, i.e., group therapy, activity

therapy, work, school, etc. At times, unable to understand or conform to unit rules and not responsible for behavior. At least weekly, attention span is markedly impaired, frequent (at least daily) preoccupation with death, dying, worthlessness, but no specific plan and not assessed as high risk. Frequently (at least daily) appears illogical or confused.

- c. Requires frequent supervision to carry out basic living activities such as self-dressing, eating, toileting, bathing, oral hygiene, going to activity room, gym, or lunch room, keeping room clean.
- d. Recurrent episodes (at least monthly) involving assault, hitting, pushing, biting others, or destruction of property but assessed clinically to have some control over violent/destructive impulses.

### **DISCHARGE/TRANSFER CRITERIA**

Prisoners discharged and/or transferred to another level of care must meet one or more of the following criteria:

- A. As determined by the treatment team and documented in the transfer summary, the prisoner continues to manifest a serious mental illness or has a developmental disability/co-occurring mental illness; however, the condition and severity meet criteria for transfer to another level of care. Discharge and Relapse Prevention Planning begins at the time of admission. The Plans are integrated into the treatment planning process with services provided, and specified in the Comprehensive Individual Treatment Plan (CITP). A QMHP has primary responsibility for communicating with appropriate service providers to ensure a smooth transition at discharge to a new setting or level of care. The treatment team recommends the type of services and level of care required when transferring to another level of care, while CFA determines the facility placement.
- B. The prisoner withdraws consent for voluntary treatment and does not meet criteria for an involuntary treatment order.
- C. When determined by a comprehensive psychiatric evaluation and documented in the discharge summary that the prisoner's condition no longer requires treatment within Mental Health Services.
- D. The prisoner leaves the custody of the Michigan Department of Corrections.
- E. Following a trial period of treatment in SSRTP status, the prisoner is determined by Security Classification Committee (SCC), with the endorsement of the Deputy Director, CFA, or designee, to be too dangerous to be treated outside of a segregation setting.
- F. In the ASRP in cases of co-occurring mental disorders, if the mental illness becomes the prominent issue, the prisoner may be referred to a RTP or Inpatient level of care depending on functioning.

- G. For a prisoner in the SSOTP who has accumulated a substantial amount of Top Lock, Detention, or Loss of Privileges who has successfully completed the SSOTP program, upon recommendation of the SSOTP Psychiatrist or Psychologist, the Warden may excuse all or any of the remaining sanction periods that have not yet been served, in accordance with PD 03.03.105, "Prisoner Discipline", Paragraph ZZ. The excused sanction periods shall be documented in writing by the Warden and placed in the prisoner's Record Office and Counselor files. An excused sanction may not be reinstated in whole or in part at a later date.

## **PRISONER RE-ENTRY: DISCHARGE PLANNING AND AFTERCARE COORDINATION**

The goal of re-entry planning for prisoners with mental illness or special needs is to ensure that each prisoner with mental illness or mental disability released to the community has a plan in place prior to release that addresses his/her need for housing/placement and provides for continuity of mental health, medical and substance abuse and other support services to increase the likelihood that the prisoner will be successful in the community and not return to prison.

Target Population - the target population for this program consists of all prisoners with mental illness and/or special needs who are releasing to the community through parole or at maximum sentence. This target population can be subcategorized as follows:

- ~ Special Needs Prisoners - identified primarily by the Parole Board for participation in the Special Needs program to address the needs of prisoners at high risk of returning to prison without adequate supports in the community. These prisoners are more likely to have functional deficits due to severe mental illness, lack stable housing and family and other supports, and have co-occurring substance abuse problems. This group also is more likely to be non-compliant with prescribed psychotropic medications and other mental health treatment. They are also more likely to be released from the higher levels of the Mental Health Services continuum of care, i.e., inpatient or residential treatment. In addition to prisoners with mental illness, "special needs" includes prisoners who are medically fragile, those with mental retardation/developmental disabilities, and youthful offenders sentenced under the Holmes Youthful Training Act (HYTA). Beginning in 2009, this category also includes a relatively small percentage of prisoners not actively being treated for mental illness.
- ~ Prisoners with Re-Entry or Regular Paroles - identified by the Parole Board for participation in one of the MDOC Re-Entry In-Reach facilities, or identified for a regular parole. Although some of these prisoners may be diagnosed with a severe mental illness, the majority are not, although all are being served by the MHS treatment teams. They are typically being treated at the lowest levels of care including outpatient or counseling services, and are not as likely to be on psychotropic medications as prisoners in the special needs group. Prisoners are referred for re-entry in-reach services because they can benefit from pre-release programming and/or may have issues with housing/placement and continuity of mental health services. Prisoners designated for regular parole are typically returning to family and are deemed to have few if any issues with continuity of mental health or other support services.

- ~ Prisoners Releasing at Maximum Sentence - determined by the Parole Board not to be candidates for parole. In some cases, the prisoner may choose not to parole. This category includes prisoners whose crime and/or behavior in prison makes it difficult to justify a parole due to possible public safety concerns. These prisoners may have a severe mental illness on Axis I but are more likely than prisoners in the parole categories to have significant issues related to Axis II diagnoses. They may be released from any level of care within the continuum of services, and are more likely to be released from segregation than are prisoners in the parole sub groups. Prisoners in this grouping are also more likely to meet Mental Health criteria for post-release involuntary treatment.

Pre-Release Programming - prisoners in the Special Needs or re-entry parole groups receive pre-release program services at the in-reach facility. For the Special Needs population, these services are provided at the Adrian Facility, while prisoners designated for the regular re-entry program receive services typically at the in-reach facility located nearest to the prisoner's county of return.

Service needs are normally determined in part based on the prisoner's COMPAS results which address correctional program requirements based on scoring on various dimensions of the COMPAS instrument. Also considered in programming decisions are the prisoner's needs as documented by their Transition Accountability Plan or TAP which is an individualized plan which follows the prisoner from reception and is revised as program needs are met or new program requirements identified.

Among the program considerations are prisoner need and eligibility for sex offender programming as well as assaultive offender program services. These program needs are usually provided by mental health services treatment team staff prior to Parole Board action. Following referral to the appropriate in-reach facility, prisoners may be assigned to one or more program offerings depending on need and program availability. Among the programs offered are:

- Cage your Rage
- Personal Finance and Budgeting
- Medication Management
- Symptom Management
- Assertiveness
- Going Home - Planning for Life in the Community
- Family Reunification Issues
- Relapse Prevention Planning

Procedural Requirements - separate procedural requirements apply to each of these target groups. Participants in the Special Needs program receive a deferred parole contingent on Parole Board review and approval of an aftercare plan compiled by a vendor agency. Aftercare plans are prepared by the vendor in response to documented assessments of need/risk prepared by Re-Entry Program staff. These same staff provide the vendor and community providers with two years of clinical documentation from the MDOC electronic medical record. The entire process beginning with referral through parole release takes an average of six months.

Prisoners paroling with positive parole action, normally through one of the In-Reach facilities, have their needs/risks assessed by the Mental Health Services (MHS) treatment team at that

facility, which provides this information to facility re-entry staff who are then able to document the needs in the **COMPAS** and Transition Accountability Plan (**TAP**) and ensure that mental health needs are considered in the in-reach and transition team process involving community providers. Pre-release programming is provided by the re-entry staff at the in-reach facilities. This is typically a 60 day process leading to parole.

Prisoners discharging at maximum sentence are assessed for aftercare needs/risks by the MHS treatment team responsible for the prisoner's treatment. For prisoners releasing from higher levels of care, or returning to Wayne County, these assessments are shared with the vendor agency which prepares aftercare plans for approval by the treatment team. Aftercare planning for other discharging prisoners is the responsibility of the MHS treatment team. It is expected that treatment teams will work with the prisoner to provide him/her with needed counseling and skill building in the six months prior to release.

The common elements of aftercare planning for all releasing prisoners with mental illness or special needs include the following:

- Tracking by the MHS treatment teams or the MHS Re-Entry Program of prisoners who are eligible for or received a parole or are discharging at maximum sentence. MHS treatment teams access the Ad Hoc CMIS report entitled Release Date Report which provides a listing for the facility of all prisoners whose Earliest Release Date or discharge date is within six (6) months.
- Thorough assessment of needs/risks documented on a standard form addressing housing, medical, and mental health needs, substance abuse issues, program benefits/finances available, family support; and education and employment history.
- With appropriate releases by the prisoner, provision of clinical information as requested by the vendor agency or community provider. For Special Needs program participants, the vendor agency is provided two years of electronic medical records documentation to assist with aftercare planning and applications for benefits including Medicaid and SSI - a protocol has been developed to allow electronic transfer of the **EMR** records.
- Documentation by the MHS treatment teams of each prisoner's need for post-release involuntary treatment. A special form is completed and submitted to the Re-Entry Program staff documenting whether a prisoner meets the requirements of the Mental Health Code, Chapters 4 or 5, for involuntary treatment. The guidelines used by the treatment teams in determining need for involuntary treatment are attached.
- For prisoners meeting Mental Health Code requirements for post release involuntary treatment, Re-Entry Program staff prepare and file the appropriate petition and first clinical certificate with the probate court in the county to which the prisoner is returning. If necessary depending on the type of order requested through the probate court, second clinical certificates are requested of the treating psychiatrist. The filing with the probate court typically requests one of several involuntary orders, including assisted outpatient treatment, alternative treatment order for community based treatment, or combined treatment order, which may include a request for initial inpatient hospitalization.

## **Key Responsibilities of the Mental Health Re-Entry Program**

1. Complete Needs Assessments and review and approve Aftercare Plans returned by the vendor, Professional Consulting Services (PCS), for prisoners designated with a deferred parole (D47) by the Parole Board; this includes provision of two years of medical/mental health information from the EMR to PCS for each referred prisoner. For details on key staff responsibilities, please see the last section below entitled Detail of Mental Health Prisoner Re-Entry Program Responsibilities.
2. Oversee, monitor, develop procedures for, and train MHS treatment teams to facilitate provision of needs assessments for prisoners paroling through regular re-entry at in-reach facilities. These teams assess mental health needs/risks and provide this information to facility re-entry staff who use it to complete the COMPAS and TAP and develop linkages to community providers.
3. Oversee, monitor, develop procedures for, and train MHS treatment teams to complete needs assessments for prisoners who are discharging at maximum sentence.
4. Work with treatment teams to document prisoner need for post-release involuntary treatment orders - for those meeting involuntary treatment criteria, program staff interview the prisoner, discuss with treatment team staff, research the electronic record, and write up and file the required petition requests and clinical certificates with appropriate county probate courts.
5. Provide consultation and education to MHS treatment teams and others on difficult cases.
6. Manage the Department's contract with Professional Consulting Services (Re-Entry Project for Offenders with Special Needs).

#### **Detail of Mental Health Re-Entry Program Responsibilities**

**Clinical staff** perform the following (currently these duties are performed by four clinical social workers and one registered nurse; the program also employs a fully licensed psychologist to complete, among other tasks, first clinical certificates for involuntary treatment):

- Interview the prisoner, consult with treatment team staff, review the EMR to assess needs and risks of each prisoner referred by the Parole Board as part of the Special Needs contract (Re-Entry Project for Offenders with Special Needs), and document these needs/risks on an electronic form. Several key areas are addressed including Need for Involuntary Treatment, Housing, Physical Health, Mental Health, Substance Abuse, Education and Employment, Financial Need, Employment and a few others. Please see the attached form referred to as the Needs Assessment and Aftercare Plan form. In FY 11, staff completed 954 Needs Assessments, a 38 percent increase over FY 09-10. Please see attached table, Workload Trends for Prisoners with Mental Illness Receiving Deferred Paroles, for a review of these data.
- Work with treatment team staff to review and reach a consensus regarding whether to approve Aftercare Plans returned by the vendor, Professional Consulting Services (PCS). In FY 11, 899 Plans were reviewed and/or edited and approved and forwarded on to the Parole Board for parole decisions (resulting in 743 paroles during FY 11).

- Several of the staff complete petitions for post-release involuntary treatment for those prisoners found to meet Mental Health Code criteria (Chapter 4 of the Mental Health Code). The program also has a fully licensed psychologist on staff who is responsible for completing the first clinical certificate. Either or both staff may be required to travel to probate court to provide expert testimony in defense of the petition and clinical certificate(s). Approximately one in seven Special Needs prisoners (with deferred paroles), or between 85 to 100 prisoners, needs involuntary treatment in a typical year. In addition, these same staff perform these duties for another 25-30 prisoners per year who are discharging at maximum sentence.
- As a follow up to the petition and certificate duties, staff are responsible for serving the appropriate court documents to the prisoner and for coordinating with court appointed attorneys who are required to meet with the prisoners pre-hearing to advise them of their rights to attend the hearing or to waive their right to attend and stipulate to the remedy provided in the Aftercare Plan.
- Provide coordination between Mental Health Services treatment teams and community providers via on-site visits, teleconferences, or telephone calls regarding specific prisoners.
- Provide expertise and training to treatment team staff on discharge planning and the re-entry process, pre- and post-release involuntary treatment process, and with regard to difficult cases that are releasing at maximum sentence. Part of the training involves teaching treatment team staff to complete needs assessments for prisoners discharging on maximum sentence and reviewing each prisoner's need for post-release involuntary treatment.
- Assist program director in management of the MDOC contract - Re-Entry Project for Offenders with Special Needs.

**Clerical/Technical Staff** perform the tasks outlined below (currently these responsibilities are accomplished with one Secretary 9 and a part time contractual secretary, although approval has been granted for an additional full time equated general office assistant position):

- Maintain and update two Access data bases designed to track all Special Needs paroling prisoners and those discharging at maximum sentence. These data bases assist in keeping track of Parole Board referrals, "maxout" dates for those releasing at maximum sentence, receipt from treatment teams of petition and clinical certificate reviews, flagging those needing post-release involuntary treatment, tracking closed cases (those with parole decisions). These data bases are used to organize and assign the work, track program performance in meeting timelines, and track status of individual cases, and the information is disseminated to MDOC decision makers including BHCS, FOA and Parole Board, Re-Entry program staff, PCS and others as requested.
- Receive and document all petition and cert reviews forwarded by the teams. This meets requirements in Chapter 10 of the Mental Health Code and facilitates the probate process for prisoners requiring post-release involuntary treatment.

- Receive/Route all email correspondence, needs assessments, and aftercare plans to the vendor, the Institutional Parole Agents, Parole Board, institutional records.
- Track all referrals and provide documentation on Parole Board referrals and Discharges to the Financial Services division to facilitate review of monthly invoices submitted by PCS. Provide supporting documentation and background for recommended changes to the Special Needs contract for FY 12 and for re-bid during FY 12.
- Provide two years of medical and mental health information to PCS for each Special Needs referral and each prisoner with mental illness who is discharging at maximum sentence. This information is taken from the EMR and transferred electronically to the vendor using a protocol developed by Ms. Luttrell at ARF. In FY 11, 920 clinical packets were forwarded to PCS to facilitate review by community providers and to assist in seeking Medicaid and SSI eligibility for paroling and discharging prisoners.
- Coordinate with probate courts the filing of required documents seeking post-release involuntary treatment for paroling or discharging prisoners. In FY 11, this required filing petitions and clinical certificates for approximately 170 prisoners, tracking the cases for receipt and dissemination of court orders, and working with institutional records offices to arrange transportation for prisoners to attend hearings, and documenting the hearings, court orders and related information in the Access data bases.

### **QUALITY IMPROVEMENT AND PROGRAM EVALUATIONS**

The mission of Mental Health Services is to deliver quality mental health care, employing the cognitive, psychosocial, and supportive rehabilitative models. The supervisor/unit chief will work, with direction and guidance from the Bureau of Health Care Services, Mental Health Services, and CQI Committee to develop and implement:

1. Standards of mental health care for all clients
2. Measures actual practices in terms of the predefined standards on an ongoing basis, at least annually
3. Identify the causes and problems when the adopted standards are not met
4. Prescribe the needed corrective action
5. Follow up corrective action and determine their effectiveness
6. Meet the accountability in delivery of services and needs of both clients and staff

Continuous program evaluations will be the responsibility of the Unit Chief/supervisor, the Regional Program Director and the Quality Improvement Committee. The ongoing evaluation process will assess a variety of factors including delivery of services to prisoners/patients in terms of relevant, humane, and efficacious treatment. Further, there will be emphasis on the timeliness, depth and accuracy of treatment plan goals, and correspondence of services delivered to treatment plan goals. Adherence by staff to established DOC policies and procedures will be evaluated.

### **BRIEF DOCUMENTATION GUIDELINES FOR ALL LEVELS OF CARE**

**CORRECTIONS MENTAL HEALTH PROGRAM**  
**Admission Forms / Brief Documentation Guidelines**

**Referrals**

Prisoners may be referred by any and all staff for evaluation because they believe the individual is seriously mentally ill, is severely mentally disabled or has significant psychological impairment. Referring staff must complete a Mental Health Services Referral (ROBERTA-R) and send to the Mental Health Services Program for evaluation.

The **Intake/Admission Evaluation** is completed by QMHP.

If treatment is not recommended, the **Mental Health Referral/Evaluation CHJ-246** middle portion shall be completed with completed disposition of TNR - treatment not required. QMHP must complete the response portion of the **ROBERTA-R** and return to the referral source.

If QMHP determines inmate has significant psychological impairment, the **Mental Health Referral/Evaluation CHJ-246** middle and bottom portion shall be completed with completed disposition of CSI. QMHP must complete the response portion of the **ROBERTA-R** and return to the referral source. QMHP completes the **Admission/Rights/Consent to Treatment CHJ-321**. QMHP completes the BSI according to the OP 04.06.180G and records results in the EMR Testing template.

If QMHP determines inmate meets criterion for admission to CMHP, the **Mental Health Referral/Evaluation CHJ-246** middle portion shall be completed with recommended disposition. QMHP must complete the response portion of the **ROBERTA-R** and return to the referral source. Requests secretary to schedule Comprehensive psychiatric Evaluation according to the urgency:

Urgent referrals - the Psychiatrist will complete the Comprehensive Psychiatric Evaluation within 2 business days of receipt of referral.

Emergent Referral - the referring provider will personally contact the outpatient psychiatrist o needed evaluation. Psychiatrist will complete the Comprehensive Psychiatric **Evaluation** vuthin one working day of referral.

This evaluation will determine if the prisoner meets criterion for admission to CMHP, in other words, is mentally ill and in need of treatment.

Upon completion of the **Comprehensive Psychiatric Evaluation** if the psychiatrist agrees the prisoner is in need of treatment, admission shall occur. Then the **Mental Health Referral/Evaluation CHJ-246** with evaluation completed, and with the recommended disposition to CMHP. The **Mental Health Record Data Entry CHJ-194** shall be completed and forwarded to the MH secretary or designee for entry into HMIS database, creating an admission to CMHP.

The QMHP, psychiatrist, and prisoner/guardian shall complete the **Admission/Rights/Consent to Treatment CHJ-321 upon admission.**

A **Treatment Plan** shall be completed by the QMHP within 5 business *days* of admission, business days upon arrival.

Completes the **BSI/BPRS** according to CMHP OP 04.06.1801. Results are documented on the Behavioral Health Testing Template.

**Treatment Plan** is created and updated as needed.

**CORRECTIONS MENTAL HEALTH PROGRAM**  
**Admission Forms / Brief Documentation Guidelines**  
**CO ION**

**Admission**

The **Intake/Admission Evaluation** is completed by QMHP.

**Admission/Rights/Consent to Treatment** is completed by the QMHP and inmate.

QMHP completes the **BSI** according to OP 04.06.180G.

Completes a Treatment Plan within five (5) business days of admission.

The **Mental Health Record Data Entry CHJ-194** and the **Mental Health Referral/Evaluation Data Entry (CHJ-246)** shall be completed and submitted to the MH secretary to create an admission to CSI.

**Transfers**

\* **NOTE** - If any of the required forms are not present upon transfer it is the receiving unit's responsibility to create them.

**The Intake/Admission Evaluation, BSI and Admission/Rights/Consent to Treatment** should already be completed and in the health record.

Treatment Plan is revised or reviewed within ten (10) business *days* of transfer.

The **Mental Health Record Data Entry CHJ-194** shall be completed and submitted to the MH secretary to create an admission to CSI.

**Progress Notes:**

**Progress Note - "Individual"** therapy notes, shall be completed within one (1) business day.

**Progress Note - "Crisis Intervention"** shall be completed on the same business day. The frequency of entry will be determined by the intervention required.

**Progress Note - "Case Management"** shall be completed monthly. May combine Treatment Plan Review Progress Note and Monthly Case Management Note.

**Group Therapy Progress Note** shall be completed monthly for **each group** the prisoner is involved in

**Bh Segregation Progress Note** shall be written for every segregation contact and completed within one (1) business day.

**Bh Observation Progress Note** shall be written for each contact with the prisoner while in observation and completed within one (1) business day.

### **Six (6) Month Evaluation**

QMHP Evaluation is completed for inmates receiving CSI services within ten (10) business days of 6) month date.

**Treatment Plan** is created for those inmates needing continued services at the same time the **QMHP Evaluation** occurs.

**Review of Prisoner Rights** for those inmates needing continued services.

### **Discharge**

**QMHP Evaluation** is completing indicating the reason for discharge.

Completes the **BSI** with the inmate.

The **Mental Health Record Data Entry CHJ-194** shall be completed and submitted to the MH secretary to input discharge.

## **CORRECTIONS MENTAL HEALTH PROGRAM Admission Forms / Brief Documentation Guidelines**

### **Admissions and Transfers**

\* **NOTE** - If any of the required forms are not present upon transfer it is the receiving team's responsibility to create them.

**A Comprehensive Psychiatric Evaluation and Admission/Rights/Consent to Treatment** should already be within the health record.

The **Intake / Admission Evaluation** shall be completed on all Transfer/Admissions to OPT by the QMHP within 5 days of admission.

The **Mental Health Record Data Entry CHJ-194** shall be completed by the secretary or designee on transfers using the transferring information in CMIS database creating an admission to OPT.

**A Treatment Plan** shall be completed within five (5) business days of admission and a Revised **Treatment Plan** within ten (10) business days of transfer in.

The **Mental Health Record Data Entry CHJ-194** shall be completed at the time there are any changes in the prisoners status including Treatment Plan or Reviews and forwarded to the MH secretary or designee for entry into the CMIS database.

Completes the **BSI/BPRS** according to OP 04.06.180G. Results are documented on the **Behavioral Health Testing Template**.

**Treatment Plan Reviews** shall be completed 6 months from the date of admission. The **Treatment Plan** should be updated as needed and yearly at same level of care.

### **Progress Notes:**

**Progress Note - "Individual"** therapy notes shall be completed within one (1) business day.

Progress Note - "Crisis Intervention" shall be completed on the same business day. The frequency of entry will be determined by the intervention required.

**Progress Note - "Case Management"** shall be completed monthly. May combine Treatment Plan Review Progress Note and Monthly Case Management Note.

**Group Therapy Progress Note** shall be completed monthly for **each group** the prisoner is involved in

**Bh=Segregation Progress Note** shall be written for every segregation contact and completed within one (1) business day.

Bb Observation Progress Note shall be written for each contact with the prisoner while in observation and completed within one (1) business day.

Psychopharm Progress Note will be written each time a physician's order is written, a minimum of every three months (90 days) for maintenance, and whenever there is a change in medication. Shall not be used to change a diagnosis.

An **Order Document** will be created whenever medications are ordered or renewed.

AIMS will be completed every 90 days for inmates treated with psychotropic medications.

CPE is used whenever there is a change in diagnosis giving justification that supports the reason for change along with a CHJ- 194 for data entry.

### **Annual:**

The **Annual Assessment** shall be completed annually for prisoners remaining within the same level of care or team for one (1) year using the **Intake/Admission Evaluation**. This will be completed within a 10-day period before the annual treatment plan review date.

An **Annual Treatment Plan** shall be completed within 10 days of annual date.

**Review of Prisoner Rights** - Reviewed with prisoner and documented on Annual Treatment Plan

**BSI/BPRS** - tests and scores according to OP 04.06.1801. Results are documented on the **Behavioral Health Testing Template**.

### **BI-Annual**

**Comprehensive Psychiatric Evaluation** shall be completed by the Psychiatrist/NP bi-annually.

## **CORRECTIONS MENTAL HEALTH PROGRAM Admission Forms / Brief Documentation Guidelines**

**QE11**

OREM inmates are OPT inmates who have a GAF of 61 or higher, and whose symptoms are in remission. May be non-MMD or MMD.

### **Admissions & Transfers**

\* **NOTE** - If any of the required forms are not present upon transfer it is the receiving team's responsibility to produce them.

**A Comprehensive Psychiatric Evaluation and Admission/Rights/Consent to Treatment** should already be within the health record.

The **Mental Health Record Data Entry CHJ-194** shall be completed by the secretary or designee on transfers using the transferring information in CMIS database creating an admission to OREM.

A Treatment Plan shall be completed within five (5) business days of admission and a Revised **Treatment Plan** within ten (10) business days of transfer in.

The **Mental Health Record Data Entry CHJ-194** shall be completed at the time of the Treatment Plan or Reviews by the QMHP or Psychiatrist and forwarded to the MH secretary or designee for entry into the CMIS database.

**Treatment Plan Reviews** shall be completed 6 months from the date of the last treatment plan. The **Treatment Plan** should be updated/revised as needed and yearly if at same level of care.

### **Progress Notes:**

**Progress Note - "Crisis Intervention"** shall be completed on the same business day. The frequency of entry will be determined by the intervention required.

**Group Therapy Progress Notes** shall be written monthly for each group the prisoner attends.

Progress Note - "Case Management" shall be completed every 90 days. The Treatment Plan Review Progress Note may be combined with the Monthly Case Management Note.

**Bh Segregation Progress Note** shall be written for every segregation contact and completed within one (1) business day.

**Bb Observation Progress** Note shall be written for each contact with the, prisoner while in observation and completed within one (1) business day.

**Psychopharm Progress Note** will be written each time a physician's order is written, a minimum of every three months (90 days) for maintenance, and whenever there is a change in medication. Shall not be used to change a diagnosis.

An **Order Document** will be created whenever medications are ordered or renewed.

AIMS will be completed every 90 days for inmates treated with psychotropic medications.

**CPE** is used whenever there is a change in diagnosis giving justification that supports the reason for change along with a CHJ-194 for data entry.

### **Annual:**

The Progress Note - Annual Assessment shall be completed annually for prisoners remaining within the same level of care or team for one (1) year using the Intake **Admission/Evaluation**. This will be completed within a 10-day period before the annual treatment plan review date.

An **Annual Treatment Plan** within 0 days of annual date.

**Review of Prisoner Rights** - Reviewed with prisoner and documented on Annual Treatment Plan.

**BSI/BPRS** - tests and scores according to OP 04.06.180G. Results are documented on the **Behavioral Health Testing Template**.

### **BI-Annual**

**Comprehensive Psychiatric Evaluation** shall be completed by the Psychiatrist/NP bi-annually.

## **CORRECTIONS MENTAL HEALTH PROGRAM**

**Admission Forms / Brief Documentation Guidelines**  
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**Admissions and Transfers**

\* **NOTE** - If any of the required forms are not present upon transfer it is the receiving team's responsibility to create them.

**A Comprehensive Psychiatric Evaluation and Admission/Rights/Consent to Treatment** should already be within the health record.

The Intake / Admission Evaluation shall be completed on all admissions to RTP, by the QM14P within 5 business days of admission or transfer in.

Completes the **BSI/BPRS** according to CMHP OP 04.06.180G and records scores in the Behavioral Health Testing Template.

The **Mental Health Record Data Entry CHJ-194** shall be completed by the Secretary or designee on transfers using the transferring information in CMIS database.

**Progress Note - "Admission Assessment"** is completed by the assigned RN on all transfers within 5-business day of arrival.

Activity Therapy Assessment shall be completed by the Activity Therapist for all transfers within 5 business days of arrival. \*Note - for RTP to RTP transfers this is not required as long as prior RTP completed one.

A Treatment Plan shall be completed on all admissions within five (5) business days of admission and 10 business days of all transfers into the RTP.

The **Mental Health Record Data Entry CHJ-194**-shall be completed at any time there are changes in prisoner status, at the time of Treatment Plan or Reviews and forwarded to the Secretary or designee for entry into the CMIS database.

**Treatment Plan Reviews** shall be completed 6 months from date of admission. The **Treatment Plan** should be updated as needed and yearly if at same level of care.

**Progress Notes:**

**Progress note - "Individual"** shall be completed within one (1) business day.

**Progress Note - "Crisis Intervention"** shall be completed on the same business day. The frequency of entry will be determined by the intervention required and completed within one (1) business day.

**Group Therapy Progress Notes** shall be written monthly for each group the prisoner attends.

**Progress Note - "Case Management"** shall be written monthly (every 30 days) by the case manager. May combine Treatment Plan Review Progress Note and Monthly Case Management Note.

**Bh Segregation Progress Note** shall be written for every segregation contact and completed within one (1) business day.

**Bh Observation Progress Note** shall be written for each contact with the prisoner while in observation and completed within one (1) business day.

**Psychopharm Progress Note** will be written each time a physician's order is written, a minimum of every three months (90 days) for maintenance, and whenever there is a change in medication. Shall not be used to change a diagnosis.

An **Order Document** will be created whenever medications are ordered or renewed.

AIMS will be completed every 90 days for inmates treated with psychotropic medications.

CPE is used whenever there is a change in diagnosis giving justification that supports the reason for change along with a CHJ-194 for data entry.

### **Annual**

**BSI/BPRS** - tests, scores and records according to OP 04.06.180G. Results are documented on the **Behavioral Health Testing Template**.

**The Annual Assessment** shall be completed annually for prisoners remaining at the same level of care or team for 1 year using the **Intake/Admission Evaluation**. This will be completed within a 10-day period before the annual treatment plan review date.

**Comprehensive Psychiatric Examination** is completed by the Psychiatrist for prisoners remaining at the same level of care or team for one (1) year. These will be completed within ten (10) days of the annual review date.

**Annual Treatment Plan** shall be completed within ten (10) days of the annual treatment plan review date.

**Review of Prisoner Rights** - Reviewed with prisoner and documented on Annual Treatment Plan.

### **Discharge/Transfer forms / Brief Documentation Guidelines**

Completed by a QMHP/Psychiatric provider before the request for transfer or before discharge to inactive status, those maxing out, release from prison and those leaving prison due to parole. A **Discharge/Transfer Summary** shall be completed when a prisoner is placed on K status, is paroled, is determined to be inactive status or is maxing out. If the Discharge/Transfer Summary

is greater' than 30 days, an addendum to the Discharge/Transfer Summary is required. Assessment must be documented at time of interview.

When a prisoner is transferred from one level of care to same level of care (RTP to RTP) a **Discharge/Transfer Summary** needs to be completed. Recent events leading up to the transfer should be included in the transfer summary (i.e., assaultive behavior, SPON situation, numerous tickets, etc.). The transfer summary should be forwarded to the receiving team prior to transfer; however, in the event the transfer is expedited, the summary is to be completed as soon as possible. If the summary is not completed prior to transfer, the sending team should notify the receiving team and provide any pertinent information and notify the team that the summary will be forthcoming.

A **Transfer Summary** is a document that is used when a prisoner transfers to another level of care within our continuum.

A **Discharge Summary** is completed when a prisoner is discharged from the CMHP (INA) indicating the prisoner is no longer mentally ill and or no longer in need of treatment. A psychiatrist signature is required on the discharge summary (see signature criteria below).

### **SIGNATURE CRITERIA**

If a QMHP completes the Discharge /Transfer Summary, it must be signed off by the psychiatric provider. This summary is automatically sent to the Provider Approval Que (PAQ) for psychiatric provider's approval. Psychiatric providers are required to check their PAQ daily.

**NOTE:** A Discharge Summary from may serve as a CPE. The Discharge Summary must contain all required elements of a CPE, and be approved (signed) by the attending, discharging physician or psychiatrist/NP. This approval will be indicated next to the Discharge Summary in the history bar by a checkmark. If these criteria are not met, the receiving program must complete a CPE.

When a prisoner is transferred from a higher to a lower level of care (RTP to OPT) a **Discharge/Transfer Summary** needs to be completed using the approved format.

Shall also complete the following forms upon discharge:

Mental Health Record Data Entry CHJ- 194  
BSPBPRS - according to OP  
Satisfaction Survey