



Program Statement

OPI: HSD/PSY
NUMBER: P6340.04
DATE: 1/15/2005
SUBJECT: Psychiatric Services

1. **PURPOSE AND SCOPE.** To provide Psychiatric Services which address the physical, medical, psychological, social, vocational and rehabilitative needs of inmates in the Bureau's custody who suffer from mental illnesses and disorders. The Bureau provides essential, cost-effective, high-quality, and humane diagnostic and treatment services throughout the inmates' incarceration.

By doing so, we strive to improve the inmates' condition, enhance the process of ongoing recovery and reduce the chances of relapsing and/or re-offending. Psychiatric services provided to inmates improves the safety and security of institutions and communities.

- All psychiatric services within the Bureau will be provided in accordance with the Bureau's overall mission, goals, and policies, and specifically, as they are outlined in other Program Statements on the provision of health care.
- This Program Statement does not cover forensic services which are covered under the Program Statement on Institution Management of Mentally Ill Inmates.

2. **PROGRAM OBJECTIVES.** The expected results of this program are:

- a. Inmates in need of psychiatric services will be identified.
- b. Essential psychiatric diagnostic and treatment services will be available for all Bureau inmates.
- c. High-quality and cost-effective psychiatric services will be provided at all institutions where such services are rendered.

d. Continuity of psychiatric care during incarceration and upon release will be enhanced.

3. DIRECTIVES REFERENCED

- P5050.46 Compassionate Release, Procedures for Implementation of 18 U.S.C. §§ 3582/4205 (5/19/98)
- P5070.11 Study and Observation Report (12/31/97)
- P5212.07 Control Unit Programs (2/20/01)
- P5270.07 Inmate Discipline and Special Housing Units (12/29/87)
- P5310.12 Psychology Services Manual (8/13/93)
- P5310.13 Mentally Ill Inmates, Institution Management of (3/31/95)
- P5324.05 Suicide Prevention Program (3/1/04)
- P5566.05 Use of Force and Application of Restraints (7/25/96)
- P6010.01 Psychiatric Treatment and Medication, Administrative Safeguards for (9/21/95)
- P6027.01 Health Care Provider Credential Verifications, Privileges and Practice Agreement Program (1/15/05)
- P6090.01 Health Information Management (1/15/05)
- P6270.01 Medical Designations and Referral Services for Federal Prisoners (1/15/05)
- P6360.01 Pharmacy Services (1/15/05)
- P7331.04 Pretrial Inmates (1/31/03)

4. STANDARDS REFERENCED

a. American Correctional Association 4th Standards for Adult Correctional Institutions: 4-4347, 4-4368, 4-4369, 4-4370, 4-4371, 4-4372, 4-4374, 4-4376, 4-4381, 4-4382, 4-4384, 4-4392, 4-4397, 4-4399, 4-4400, 4-4401, 4-4404, 4-4405, and 4-4411

b. American Correctional Association Standards for Adult Local Detention Facilities, 3rd Edition: 3-ALDF-4E-11, 3-ALDF-4E-12, 3-ALDF-4E-18, 3-ALDF-4E-32, 3-ALDF-4E-37, and 3-ALDF-4E-38

5. DEFINITIONS

a. **Behavior Therapy.** A form of psychological treatment aimed at modifying behavior in a direction that improves a patient's mental health condition. It includes specific methodology and technology used to bring about the behavior change.

b. **Competence to Give Informed Consent.** The inmate has an understanding of his/her diagnosis or condition, the treatment being offered, the potential risks, benefits and side-effects of treatment, especially serious ones, what to do in the event of such effects, the alternatives to the treatment being offered (including no treatment), and risks associated with the alternatives.

c. **Least Restrictive Clinical Interventions.** The minimum intervention necessary to control the situation including the use of non-physical interventions, as well as voluntary medication, voluntary special housing, seclusion, involuntary medications, and restraints.

d. **Mental Health Emergency.** For the purposes of the potential use of mental health seclusion or restraint, a mental health emergency is defined as a situation in which an inmate is suffering from a mental illness which creates an immediate threat of:

- Bodily harm toward self;
- Bodily harm toward others;
- Serious destruction of property which would immediately endanger self or others; or
- Serious disruption of the therapeutic milieu that places the inmate at risk of harm by others.

For the purposes of emergency medication, a mental health emergency includes all of the above situations, as well as a situation in which there is an immediate risk of extreme deterioration of functioning secondary to a psychiatric illness.

e. **Mental Health Restraint.** The direct application of physical force or device(s) to an inmate without his/her permission, to restrict his/her freedom of movement when a mental health emergency exists.

f. **Mental Health Unit.** The designated part of an institution which houses inmates with a mental health designation. This may include units providing the following kinds of services, as defined at the individual institution: inpatient, outpatient, forensic, diagnostic and observation, seclusion, administrative detention, disciplinary segregation, and other housing statuses as defined in the institution's policies and procedures.

g. **Psychiatric Medication.** Medication prescribed for the treatment of signs or symptoms of mental disorders or illnesses.

h. **Psychiatric Referral Center (PRC).** An institution (usually a Medical Referral Center (MRC)) which has as part of its mission the provision of inpatient psychiatric services.

i. **Seclusion.** Involuntary confinement of an inmate in a locked room when a mental health emergency exists.

6. **PSYCHIATRIC SERVICES AND ORGANIZATION.** Bureau Psychiatric Services are under the direction of the BOP Chief Psychiatrist. The Medical Director gives privileges to and supervises the BOP Chief Psychiatrist.

Psychiatric services are delivered at PRCs and non-PRC institutions through the services of staff and contract/consultant psychiatrists, other mental health care providers and allied health professionals.

a. **PRCs.** The Medical Director will designate the PRC's mission. PRCs provide a full range of psychiatric diagnostic and treatment services consistent with their missions.

- Psychiatric services at PRCs will be under the direction of the institution Chief of Psychiatry. Each Chief of Psychiatry will have a documented external peer review at least every two years.
- PRCs will seek and maintain accreditation by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) under the appropriate behavioral health standards.
- PRCs will maintain accreditation by the American Correctional Association (ACA) in accordance with the missions the Medical Director assigned.
- Each PRC will establish an organizational plan designed to meet the needs of both the institution and the Bureau. The plan is subject to the Medical Director's approval.

b. **Other Institutions.** Ordinarily, psychiatric services at institutions other than PRCs will be under the Clinical Director's direction. When such institutions have more than one psychiatrist on staff, the Warden may select a Chief of Psychiatry with the Medical Director's approval.

- It is recommended that each institution not having a full-time psychiatrist or regular access to tele-psychiatry, contract for psychiatric services.
- Inmates with severe mental illness or who are severely developmentally disabled, will receive a mental health evaluation and, where appropriate, will be referred for placement in a facility or unit specifically designated for managing this type of individual.

7. **STAFFING.** PRCs will have an organized medical staff subject to medical bylaws consistent with JCAHO standards. Medical bylaws are subject to negotiation in accordance with the Master Agreement. Psychiatrists and licensed psychologists are eligible for membership on the medical staff and for all privileges within the scope of their licenses, including admitting and discharging privileges.

- All privileges are subject to the provisions outlined in the Program Statement on Health Care Provider Credential Verification, Privileges, and Practice Agreement Program.

The roles of other staff in the psychiatric program, such as social workers, mid-level practitioners, activity therapists, etc., will be determined by the institution organizational plan and approved by the Medical Director.

a. **Chief Psychiatrist.** The Warden will select the Chief Psychiatrist with the Medical Director's approval. The Medical Director will be the privileging authority for all Chiefs of Psychiatry. Privileging authority may be delegated to the BOP Chief Psychiatrist.

The Chief Psychiatrist has overall responsibility for the supervision and implementation of the psychiatric program. This responsibility includes:

- Supervising staff;
- Overseeing contract psychiatrists;
- Providing other supervisory duties as determined by the institution's organizational plan;
- Serving as a member of the institution Pharmacy and Therapeutics Committee, the Quality Improvement Program Committee, and other committees as determined by the needs of the institution and the Bureau; and
- Coordinating the in-house Continuing Professional Education (CPE) program for the psychiatrists and any other clinical staff he/she directly supervises.

The Chief Psychiatrist works closely with Social Work Services, Nursing Services, Psychology, and Correctional Services to address issues surrounding care and treatment of inmates with mental illnesses and disorders. He/she will be actively involved in the education of staff in the:

- Recognition of signs and symptoms of mental illness;
- Management of the mentally ill inmate; and
- Risk management issues pertaining to working with the mentally ill.

b. **Staff Psychiatrist.** Mental health care will be provided by individual professionals and/or by a multi-disciplinary team. As a team member, the psychiatrist responsible for the psychiatric care being provided to the inmate will provide diagnostic and treatment services consistent with the field of psychiatry and Bureau policy and guidelines.

- The psychiatrist will manage those inmates with complex psychiatric conditions directly. Complex conditions include, but are not limited to, those requiring multiple psychiatric medications, psychiatric illnesses complicated by medical conditions, psychiatric symptoms not responding to usual treatments, etc.
- The psychiatrist will consult with, provide training to, and mentor other team members and staff involved in the medical care, mental health care, or supervision of mentally ill inmates.

Psychiatrists who perform clinical services on an inpatient psychiatric unit have responsibility for coordinating the inmate's psychiatric and medical care while the inmate is an inpatient.

- Members of the Health Services Unit may provide medical care; however, responsibility for coordination and continuity of medical care lies with the psychiatrist assigned to the inmate.

8. **SERVICES.** The exact nature of psychiatric services available at institutions will be based on the institution's mission as well as the staff and community psychiatric resources available at the institution (including tele-psychiatry).

- PRCs specified as forensic sites will provide forensic evaluations pursuant to 18 U.S.C. §§ 4241 - 4247.

All institutions will provide the following services either through medical and mental health care staff at the institution or through consultation with community resources (the services may be delivered by clinicians and staff other than psychiatrists):

- Crisis intervention;
- Emergency services;
- Risk assessment for acts of self-harm or harm towards others;
- Mental health screening of inmates suffering from symptoms or behavioral disturbances indicative of possible mental illnesses or disorders;
- Detoxification from alcohol, benzodiazepines, and barbiturates;
- Diagnosis and treatment of mild to moderate mental illnesses such as non-psychotic major depression, anxiety disorders, or sleep disorders;
- Continuation of psychiatric treatment initiated at other institutions or prior to incarceration; and
- Monitoring of inmates on psychiatric medications for side-effects and drug interactions.

PRCs provide all services necessary to meet their mission either on-site or through community resources. At a minimum, this includes:

- Complete diagnostic services; and
- Inpatient and outpatient psychiatric treatment services for the severely mentally ill.

9. **EVALUATIONS.** The Medical Director will provide guidance for standards and formats for psychiatric evaluations.

a. **Intake Screening.** Staff performing intake screening will assess and make appropriate referrals to a mental health professional when an inmate:

- Has a mental health designation;
- Exhibits signs or symptoms consistent with a possible mental disorder; or
- Is on medication for treatment of a mental illness or disorder.

Screening will be of sufficient detail to determine appropriate housing for the inmate until a thorough mental health evaluation can be completed.

b. **Outpatient Evaluations.** Institutions will have a system in place by which inmates can be referred to a psychiatrist for a psychiatric evaluation. At non-PRCs this will generally be through Health Services or Psychology Services.

Inmates referred for psychiatric evaluation who have not received a psychological/mental health evaluation within the previous 30 days, will be seen within 14 days from the date of referral. Inmates who have received a psychological/mental health evaluation within the previous 30 days, will be seen in a timely manner consistent with the inmate's clinical needs.

- The evaluation will be consistent with ACA standards on mental health evaluations. Further guidance for the content and format for psychiatric evaluations will be provided by the Medical Director.

Inmates with a Mental Health designation who do not need inpatient treatment or refuse admission to an inpatient unit, will undergo a complete psychiatric evaluation by either a psychiatrist or a licensed psychologist.

- The psychiatric evaluation will occur within a clinically appropriate time frame, not to exceed 14 days from arrival.
- The evaluation will be consistent with ACA standards on mental health evaluations. Further guidance for the content and format for psychiatric evaluations will be provided by the Medical Director.

Some PRCs may designate an area of the Mental Health Unit as a "Diagnostic and Observation (D and O) Unit." The D and O unit is an outpatient unit with clearly established admission, transfer and discharge criteria, reasonable time frames for completion of psychiatric evaluations, and length of stays.

- These criteria are subject to the Medical Director's approval.
- All psychiatric treatment provided on the D and O Unit, other than emergency treatment, will be voluntary and with the inmate's informed consent.

c. **Inpatient Admissions.** Inmates will only be admitted to an inpatient unit after giving informed consent for admission or under an appropriate court order (see the Program Statements on Administrative Safeguards for Psychiatric Treatment and

Medication and Institution Management of Mentally Ill Inmates). PRCs will develop and implement admission and discharge criteria approved by the Medical Director.

(1) **Voluntary Admissions**

- The inmate will be informed of his/her rights through the use of the Consent to Admission for Mental Health Treatment (BP-S801) form.
- The informed consent for admission will be in a language understood by the inmate.
- The completed form will be placed in the inmate's health record.

Inmates admitted to an inpatient unit will undergo a psychiatric evaluation within 24 hours of admission. Either a psychiatrist or licensed psychologist with admitting privileges may perform this evaluation. A medical history and physical will be performed in accordance with local policy.

(2) **Involuntary Admissions**

- Involuntary inpatient admission or treatment can occur only with a court order under 18 U.S.C. §§ 4241 - 4247.
- 18 U.S.C. §§ 4241 - 4247 does not apply to un-sentenced Bureau of Immigration and Customs Enforcement (BICE), formerly the Immigration and Naturalization Service, detainees, un-sentenced prisoners in Bureau custody as a result of a court order, and state or territorial prisoners.
- For those persons not covered by 18 U.S.C. §§ 4241 - 4247, the decision to admit or treat the person involuntarily must be made through an administrative hearing in accordance with Vitek v. Jones, 445 U.S. 480 (1980).

Pursuant to 10 U.S.C. § 876(b), military prisoners who are incompetent to stand trial or who have been found not guilty by reason of lack of mental responsibility may be committed to the custody of the Attorney General and are subject to the procedures authorized under 18 U.S.C. §§ 4241, 4243, and 4246. Similarly, under 18 U.S.C. § 4247(j), District of Columbia Code offenders are subject to commitment procedures specified under §§ 4245 and 4246.

d. **Psychiatric Evaluation for Correctional Purposes.** Inmates receiving an incident report and who are psychiatric inpatients, or whose mental status is questionable, will be referred to a psychiatrist or psychologist for an assessment regarding competency and responsibility. The mental health clinician will use the same standards that apply in establishing competency and responsibility pursuant to 28 CFR 541.10(b)(6) (contained in the Program Statement on Inmate Discipline and Special Housing Units).

- It is strongly recommended that PRCs establish separate Special Housing Units (SHU) for inmates with mental illnesses or disorders that are physically distinct from the SHUs used to house general population inmates.
- Non-PRCs are encouraged to identify a specific area in SHU where inmates suffering from active symptoms of a mental illness and who require SHU placement can be housed. These inmates are at increased risk of behaviors of self-harm or harm towards others. The area chosen should facilitate frequent observation by and contact with staff.
- Whenever any inmate is transferred into a SHU, health care staff will be informed immediately and will provide assessment and review as indicated by local protocols established by the local health authority.
- A mental health professional must evaluate inmates being referred to a control unit. Refer to the Program Statement on Control Unit Programs for requirements and the format of the evaluation.

10. **TREATMENT.** Psychiatric treatment, except in an emergency, will begin only after a psychiatric evaluation and plan have been completed. Inmates who have received psychiatric evaluation and treatment services at another Bureau institution will have that treatment continued at the new institution pending further evaluation.

- Further guidance on psychiatric treatment will be provided by the Medical Director.

The timing and extent of the evaluation undertaken at the receiving institution will depend on several factors, including:

- Time elapsed since the last complete psychiatric evaluation;

- The comprehensiveness of the last complete psychiatric evaluation; and
- The inmate's clinical presentation.

Psychiatric treatment, regardless of the unit in which the inmate resides, will be voluntary except when:

- Treatment has been ordered by the court; or
- A mental health emergency exists.

Pretrial inmates and inmates committed by the court can be treated only under certain conditions and usually only after following procedures outlined in the Program Statements on Institution Management of Mentally Ill Inmates and Administrative Safeguards for Psychiatric Treatment and Medication.

a. **Psychiatric Medication.** Except in an emergency, informed consent will be obtained and documented prior to administering medication for psychiatric symptoms or conditions (refer to the Program Statement on Pharmacy Services). Ordinarily, the prescribing physician will be responsible for obtaining the informed consent.

Patient education for obtaining informed consent includes the following information:

- Symptoms of the illness;
- Potential benefits of treatment;
- Potential risks and side-effects (especially serious ones);
- Appropriate use of the medication;
- When to notify staff of problems;
- Consequences of noncompliance; and
- Alternative treatments, including no treatment, and associated risks.

The inmate's competency to give informed consent will be assessed and documented on the corresponding "Consent to Use (name of medication)" form. An informed consent form will be obtained when:

- A psychiatric medication is prescribed for which an informed consent has not previously been obtained;
- An inmate has previously given informed consent, but has been off the medication for at least a year;
- Clinical judgment deems that a new informed consent is appropriate because of a significant change in the inmate's clinical status; or

- An inmate on psychiatric medication is newly committed to the Bureau and does not have informed consent documented on any of the standard forms noted above.

Inmates on psychiatric medication will be monitored regularly in Chronic Care Clinics. Noncompliance should not be the determining factor for exclusion from the Mental Health Chronic Care Clinic. Inmates with mental illness present potentially important risk management issues.

- Inclusion in the Chronic Care Clinic should continue as long as the inmate has active symptoms of mental illness or is on psychiatric medication.

All institutions will have a system(s) in place for assuring continuity of care for all inmates receiving psychiatric treatment even if such treatment was started before incarceration at the current institution.

- Continuity of care is required from admission to transfer or discharge from the Bureau, including referral to community-based providers, when indicated.
- Such a system will include monitoring compliance with psychiatric medications and maintaining documented informed consent in the health record.
- At non-PRCs, timely notification of noncompliance will be made to the Clinical Director and other relevant mental health staff, such as the Chief of Psychology, staff psychiatrist, or contract psychiatrist.
- At PRCs, the treating psychiatrist and Chief Psychiatrist will be informed of any noncompliance issues.

b. **Electroconvulsive Therapy.** Electroconvulsive therapy (ECT) will only be considered for inmates at PRCs, except in an extreme emergency. Prior to administering any ECT, the Medical Director must approve the procedure in writing.

- Once it has been determined that ECT is an appropriate treatment for the inmate and the treatment has been approved, ECT will be performed in the community by a qualified consultant psychiatrist privileged to administer the treatment.

c. **Behavior Therapy.** Behavior therapy may be an appropriate treatment for certain conditions and inmates. When this treatment modality is used, the institution will be in compliance with JCAHO Behavioral Health Care Standards.

- Painful stimuli will not be used as a mental health intervention.

d. **Mental Retardation.** Inmates who are considered mentally retarded will be thoroughly evaluated for their potential psychiatric needs. Not all inmates with mental retardation require intensive psychiatric services.

- Placement at PRCs will be consistent with their clinical needs.

e. **Dementia.** Inmates with possible dementia will undergo a complete psychiatric and medical evaluation. Those with moderately severe or severe dementia should be considered for a reduction in sentence/compassionate release. (Refer to the Program Statement on Compassionate Release.)

- Not all inmates with dementia will require placement at a PRC. Designation and treatment will be consistent with their medical and psychiatric needs.

11. **EMERGENCY TREATMENT.** Interventions during a mental health emergency may include nonphysical interventions, voluntary medication, seclusion, involuntary medication, and/or restraint.

- The **least restrictive method** for controlling the situation will be employed and documented in the inmate health record.

a. **Emergency Medication.** Psychiatric medication may be administered in a mental health emergency only by order of the physician, and if the inmate is at immediate risk of:

- Bodily harm toward self;
- Bodily harm toward others;
- Serious destruction of property which would immediately endanger self or others;
- Serious disruption of the therapeutic milieu that places the inmate at risk of harm from others; or
- Extreme deterioration of functioning secondary to a psychiatric illness.

Documentation of emergency medication administration will include the following:

- Type of emergency;
- Interventions attempted and the result(s);
- Reason that less restrictive interventions were not used or were ineffective;
- When, where and how the medication is to be administered; and
- Assessment and monitoring of the inmate for adverse reactions and side-effects.

The inmate's treatment plan will be reviewed, and, if necessary, revised, as soon as possible.

At non-PRCs, the Clinical Director will consult with the office of the Medical Director within 24 hours of administering emergency medication (excluding weekends and holidays). The Medical Director will provide guidance on further evaluation, treatment, referral to a PRC, or other appropriate clinical interventions.

Ordinarily, emergency treatment with psychiatric medications at non-PRCs will not be continued for more than 72 hours without the Medical Director's approval.

- Ordinarily, long-acting psychiatric medications such as Haldol Decanoate and Prolixin Decanoate will not be used in emergencies except at PRCs.

For guidance on emergency treatment of pretrial, pre-sentence, and other forensic inmates, refer to the Program Statements on Institution Management of Mentally Ill Inmates and Administrative Safeguards for Psychiatric Treatment and Medication.

b. **Seclusion.** Seclusion may be an appropriate clinical intervention during a mental health emergency. All institutions using mental health seclusion must have an Institution Supplement consistent with JCAHO Behavioral Health Standards.

- The Institution Supplement will be negotiated in accordance with the Master Agreement after approval by the Medical Director. (Refer to the Program Statement on Mental Health Seclusion and Restraints).

c. **Restraints.** Restraints may be an appropriate clinical intervention during a mental health emergency. In many cases, the use of restraints during a mental health emergency may be more restrictive than the use of emergency medication. All

institutions using restraints will have an Institution Supplement consistent with JCAHO Behavioral Health Standards and ACA standards on the use of restraints.

- The Institution Supplement will be negotiated in accordance with the Master Agreement after approval by the Medical Director (see the Program Statement on Mental Health Seclusion and Restraints).

12. **DOCUMENTATION.** All documentation related to psychiatric evaluations and treatment (inpatient, outpatient, and forensic) will be available in the inmate's health record and the requirements noted in the Program Statements on Patient Care and Health Information Management will be adhered to.

- All psychiatric diagnoses will adhere to the nomenclature set forth in the most recent Diagnostic and Statistical Manual of Mental Disorders.
- All five Axes will be noted in the diagnosis section of the evaluation.
- The clinician performing the mental health evaluation will be responsible for documenting Axes I, II and V on the problem list of the inmate's health record. When the evaluation is completed via tele-psychiatry, or performed by a contract psychiatrist, the physician on the inmate's primary care provider team will be responsible for noting the diagnoses on the problem list.

Documentation of emergency interventions will include the following:

- Type of emergency;
- Intervention(s) attempted and their result(s); and
- Reason that less restrictive interventions were not used or were ineffective.

If the emergency intervention includes medication, refer to Section 11.a. If the intervention includes seclusion or restraints, documentation will meet the requirements set forth in the Program Statement on Mental Health Seclusion and Restraints.

- The Medical Director will provide additional guidance regarding documentation for psychiatric evaluation and treatment.

13. **EDUCATION.** The Bureau will provide regular professional training opportunities for mental health care staff consistent with their clinical duties and responsibilities.

PRCs are encouraged to provide training for medical and allied health care professionals, including students. They are also encouraged to provide post-graduate training to residents and fellows.

- Residency programs and fellowships may be established with the Medical Director's approval.

/s/
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Director