

PS5310.13 MENTALLY ILL INMATES, INSTITUTION MANAGEMENT OF



Program

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SUBJECT: Mentally Ill Inmates,
Institution Management of

Statement

1. PURPOSE AND SCOPE. To provide policy, procedures, standards, and guidelines for managing mentally ill inmates in all regular (i.e., non-medical) correctional institutions.

As the inmate population has grown in recent years, so also has the number of mentally ill inmates in Bureau custody. While the Bureau's Psychiatric Referral Centers are often used to handle the most severe of these cases, the vast majority of mentally ill inmates in the system are maintained in regular institutions. Although the number of mentally ill inmates in any one institution may be small, the high visibility of this special population, their potential for disruption, and their concentration in higher security institutions dictates that they be closely monitored.

Traditionally, Psychology Services departments in regular institutions have provided services to these inmates, emphasizing, whenever possible, institutional management/treatment rather than referral for hospitalization. Successful long-term management of these cases requires a comprehensive program of institution-based care that includes accurate and early identification procedures, effective treatment programs, and, in cases of acute psychological disturbance, timely referral to a specialty institution.

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

a. The need for hospitalization of mentally ill inmates will be reduced further by more effectively managing and treating these cases in regular correctional facilities.

b. All inmates arriving at an institution will be screened within specified time frames to determine presence and degree of mental impairment and/or suicidal tendencies.

c. For each inmate identified as needing treatment services, a treatment plan outlining needs, goals, and periodic progress notes (at least monthly) will be developed.

d. Necessary management/treatment information will be entered into the inmate medical record, the Psychological Data System (PDS), and on SENTRY in the Medical Duty Status (MDS).

e. Any transfer of an acutely mentally ill inmate to a Psychiatric Referral Center or to another correctional facility for psychological treatment reasons will be coordinated by the Chief Psychologist from the sending institution. Information about this transfer will be routed through the Regional Psychology Administrator and provided to the receiving institution and any en route holdover facilities.

3. DIRECTIVES REFERENCED

- P.S. 5290.07 Intake Screening (07/20/92)
- P.S. 5270.07 Inmate Discipline and Special Housing Units (12/29/87)
- P.S. 5310.12 Psychology Services Manual (08/13/93)
- P.S. 5324.01 Suicide Prevention Program (04/20/90)
- P.S. 5566.04 Use of Force and Application of Restraints on Inmates (06/13/94)
- P.S. 6000.04 Health Services Manual (12/15/94)

4. STANDARDS REFERENCED

a. American Correctional Association Foundation/Core Standards for Adult Correctional Institutions: C-4221, C-4148.

b. American Correctional Association 3rd Edition Standards for Adult Correctional Institutions: 3-4292, 3-4369.

c. American Correctional Association Foundation/Core Standards for Adult Local Detention Facilities: C2-5187, C2-5182.

d. American Correctional Association 3rd Edition Standards for Adult Local Detention Facilities: 3-ALDF4B-03, 4E-28, 4E-37.

e. American Correctional Association 2nd Edition Standards for Administration of Correctional Agencies: 2-CO-4B-04.

f. American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct (1992).

g. APA General Guidelines for Providers of Psychological Services (1987).

h. APA Specialty Guidelines for Providers of Psychological Services (1987).

i. APA Standards for Educational and Psychological Testing (1985).

5. DEFINITION. For the purposes of this Program Statement, mental illness is defined as any emotional or mental condition which substantially impairs the inmate's ability to function within the institutional setting. Using criteria presented in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), substantial impairment is defined as the presence or history of a major Axis I disorder and/or a severe Axis II disorder, along with either a history of or a current Axis V (Global Assessment of Functioning Scale) of 40 or below.

6. RESPONSIBILITIES. To ensure consistent treatment throughout the system, each institution shall develop a comprehensive approach for managing mentally ill inmates which emphasizes the management of these cases in a regular correctional setting, rather than in a hospitalized setting, as the preferred treatment strategy whenever and wherever feasible.

a. Warden. Each Warden is responsible for the adequate management of mentally ill inmates in his/her institution and shall designate a full-time staff member (ordinarily the Chief Psychologist) as the Program Coordinator.

Also, the Warden shall provide the Program Coordinator with opportunities to educate staff about the need to detect and report any changes in inmate behavior that might suggest mental illness. In most institutions these opportunities typically present themselves at department head meetings, staff recalls, lieutenant's meetings, and annual refresher training.

b. Chief Psychologist. Each Chief Psychologist shall ensure that the provisions of this Program Statement are implemented.

Program Coordinator responsibilities for the ongoing management of mentally ill cases may be delegated at the Chief Psychologist's discretion to a staff psychologist.

c. Program Coordinator. The Program Coordinator shall manage the treatment of mentally ill inmates and ensure that all provisions of this Program Statement are implemented.

d. Psychiatrist. In institutions with a full-time psychiatrist, the Program Coordinator shall refer all cases in need of a psychotropic medication evaluation to the psychiatrist. Responsibility for other aspects of the mentally ill inmate's management and/or treatment may be provided by either the psychiatrist or the Program Coordinator, but must be monitored regularly by the Program Coordinator to ensure compliance with provisions of this program statement. Regular consultation between clinicians is expected on all cases.

In institutions which utilize a contract psychiatrist, the Health Services Administrator will be responsible for contract development and oversight with input from the Program Coordinator. The Program Coordinator is responsible for maintaining ongoing consultation and follow up as specified in Section 11 of this Program Statement.

7. PROGRAM COMPONENTS. The standard program for managing mentally ill inmates at each institution shall address a minimum of six concerns:

- E Assessment and Treatment Planning.
- E Treatment Compliance.
- E Special Housing and Management.
- E Crisis Intervention and Emergency Transfer.
- E Consultation and Follow-up.
- E Communication Regarding Transfer.

8. ASSESSMENT AND TREATMENT PLANNING. The Coordinator shall ensure that assessment and treatment planning procedures exist to identify all inmates entering the institution with either a recent history or current symptoms of significant mental illness and/or risk of suicide. At a minimum, this assessment procedure should follow the time frames and guidelines specified below:

a. Initial Intake Screening. All inmates arriving at the institution will be screened consistent with procedures and time frames specified in the Psychology Services Manual. Inmates identified as having either a recent history or current symptoms of significant mental illness and/or risk of suicide will be immediately referred to the Program Coordinator who will schedule the inmate for a more thorough assessment. Ordinarily, this follow up assessment will occur within one working day of the initial intake screening and subsequent referral.

In addition, any inmate returning from a Psychiatric Referral Center following the completion of psychiatric treatment shall be evaluated by the Program Coordinator, ordinarily within one working day after arrival at the institution. This evaluation should occur prior to the inmate's entry into the general population of the institution. As part of this evaluative process, the Program Coordinator is expected to review the inmate's treatment summary which is a document prepared by a treating clinician at the Psychiatric Referral Center and which can be found in the inmate's medical record.

b. Scope of Follow up Assessment and Treatment Planning. The Program Coordinator shall review the referred inmate's history of mental illness/suicide and assess the inmate's current mental status, ability to function in the general population, need for special housing or work assignments, previous compliance with prescribed treatment regimens, and other relevant information.

Based on this assessment process, the Program Coordinator shall:

È complete an initial screening summary report detailing the inmate's history of mental illness, current mental status, and future treatment needs,

È document this information in the Psychological Data System (PDS), and

È forward relevant information to appropriate medical, unit, correctional, and/or work detail supervisor so that necessary changes in the inmate's medical, work, or housing status may be made.

For an inmate with more extensive treatment needs, the Program Coordinator shall:

È schedule additional interview/assessment sessions as needed,

È establish a treatment plan outlining specific treatment needs and goals, and

È document the treatment plan and periodic progress notations in PDS.

9. TREATMENT COMPLIANCE. The Program Coordinator shall monitor mentally ill inmates to assess treatment compliance.

Any inmate placed in a special housing assignment for mental health reasons, deemed to need special attention as a result of a significant mental impairment, or receiving psychoactive medication for a significant psychiatric problem (for example, psychosis, severe depression, or bipolar disorder) shall be interviewed at least monthly to assess his or her level of functioning and need for changes in treatment strategy.

These monthly contacts shall also focus on assisting the inmate in efforts to reduce interpersonal conflict, increase responsibility for treatment compliance, learn basic social skills, develop better problem-solving behaviors, and understand the effects and side-effects of his/her medication.

In preparation for these monthly contacts, the Program Coordinator shall obtain information concerning medication compliance, changes in medication or medication dosage, or related medical conditions from medical staff and/or records.

The Program Coordinator shall document relevant findings from these monthly contacts in the PDS and ensure that a copy of this information is forwarded to the Health Services Administrator for inclusion in the medical record.

The Program Coordinator shall monitor ongoing treatment needs for mentally ill inmates. This may include, in addition to the above, any interventions deemed appropriate during the inmate's incarceration. Again, the Coordinator shall ensure that adequate notes on all interventions, contacts, and program or status changes are maintained in the PDS and that copies are forwarded to the Health Services Administrator for inclusion in the medical record.

10. SPECIAL HOUSING AND MANAGEMENT. To assist with the adjustment of mentally ill inmates and to reduce the number of referrals to Psychiatric Referral Centers, it may occasionally be necessary to modify a mentally ill inmate's housing, work, or program assignment. This may include placement in a single cell, assignment to a special unit or program, removal from the general population for a brief period of time, assignment to a specific work detail, approval for a "mental health" idle, or other measures the Program Coordinator considers appropriate.

The Program Coordinator shall serve as the institution's contact person regarding all questions about the mentally ill inmate's housing, work, program, and treatment needs. When changes are required in one or more of these areas, the Program Coordinator will consult with appropriate medical, correctional, unit, work, and/or administrative staff to ensure that all aspects of the case are adequately considered and integrated. The Program Coordinator should then recommend through a memorandum and PDS entry all housing, work, and/or programmatic changes which meet the mentally ill inmate's treatment needs.

To facilitate coordination of treatment activities, the Program Coordinator or his/her designee shall have the authority to:

Ë recommend single cell status for inmates who have documented histories or current mental health needs,

Ë authorize an inmate's absence from work or other institutional activities for mental health purposes (i.e., issue a "mental health idle"), and

Ë recommend special conditions in work and/or housing assignments.

11. CRISIS INTERVENTION AND EMERGENCY TRANSFER. The Program Coordinator shall be responsible for the emergency treatment and referral of mentally ill inmates to a Psychiatric Referral Center, when these needs arise.

Consistent with the goal of coordinating the management and treatment of mentally ill inmates through a single contact person, the Program Coordinator shall be contacted, as soon as possible, when crises or emergency situations arise involving mentally ill inmates. During a crisis or emergency situation involving a mentally ill inmate, the Program Coordinator shall be

responsible for developing, initiating, and documenting a treatment strategy aimed at successfully resolving the crisis situation at the local institutional level.

If this treatment strategy fails, the Program Coordinator shall, after consultation with the Warden, initiate referral procedures to a Psychiatric Referral Center using procedures specified in Section 12 of this Program Statement.

12. CONSULTATION AND FOLLOW-UP. The Program Coordinator shall ensure that adequate consultation and follow-up occur with all staff, contract personnel, and/or volunteers involved in the treatment and/or management of mentally ill inmates.

The Program Coordinator's ability to maintain regular, ongoing contact with the institution's consultant psychiatrist is critical to the successful management and treatment of mentally ill inmates. Consequently, all referrals to a consultant psychiatrist for medication evaluation shall be routed through the Program Coordinator and the Program Coordinator shall monitor all inmates, placed on psychotropic medication for significant mental illness by the consultant psychiatrist, periodically.

The Program Coordinator shall establish regular (i.e., at least quarterly, but preferably monthly) case consultation meetings with Health Services staff including the Clinical Director, Health Services Administrator, and Pharmacist to ensure coordination of treatment services for mentally ill inmates. Treatment recommendations emerging from these meetings will be documented in the PDS by the Program Coordinator and in the medical record by a member of the Health Services Department.

Case consultation meetings between the Program Coordinator and other institution departments shall be arranged as needed at the initiation of any concerned staff member.

At least monthly, the Program Coordinator shall document in the PDS, with a copy to the medical record, a progress/case note on each mentally ill inmate:

- È receiving psychoactive medication for a significant psychiatric problem,
- È involved in a current treatment or special housing program,
- È returned within the last six months from a psychiatric treatment facility after completion of treatment for a significant psychiatric impairment, or
- È placed on formal suicide watch within the last six months.

13. COMMUNICATION REGARDING TRANSFER OF MENTALLY ILL INMATES. When the Program Coordinator determines that a mentally ill inmate should be referred to a Psychiatric Referral Center for

more intensive treatment, the Program Coordinator shall assume primary responsibility for:

È telephonically contacting Psychiatric Referral Center staff to determine the feasibility of transfer to that facility,

È completing Form 204 on SENTRY and routing this form to the institution's Health Services Department for medical input from the Clinical Director and for forwarding by the institution's Health Services Administrator to the Psychiatric Referral Center, medical designator, and Regional Psychology and Health Services Administrators, and

È ensuring that relevant information regarding the mentally ill inmate's treatment needs while in transit is included on the BP 149(60) "In Transit" form.

The Program Coordinator at the sending institution shall prepare a brief summary describing the nature of the inmate's presenting problem(s), recent treatment history, current mental status, and recommended treatment needs, when a mentally ill inmate with the following characteristics is transferred to another (non-psychiatric) correctional facility:

È current, mental health treatment needs,

È recent (within last six months) history of suicide risk as determined by placement on suicide watch, or

È recent (within last six months) history of treatment for significant mental impairment.

The sending institution's Program Coordinator should forward this summary to the receiving institution's Program Coordinator. The sending institution's Program Coordinator should also ensure that relevant information about the mentally ill inmate's treatment needs while in transit be included on the BP 149(60) "In Transit" form.

When a mentally ill inmate completes his/her treatment at a Psychiatric Referral Center and is being returned to a regular institution, the Medical Designator shall notify via SENTRY the Regional Psychology Services Administrator in the receiving region and the Program Coordinator at the receiving institution. This notification will serve to alert the Program Coordinator about the impending transfer of a mentally ill inmate in advance of the actual move.

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Director