

# **CHAPTER 1**

## **Program Guide Overview**

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The California Department of Corrections and Rehabilitation (CDCR) Mental Health Services Delivery System (MHSDS) provides inmates access to mental health services. The MHSDS is designed to provide an appropriate level of treatment and to promote individual functioning within the clinically least restrictive environment consistent with the safety and security needs of both the inmate-patient and the institution.

The intent of the MHSDS is to advance the CDCR's mission to protect the public by providing timely, cost-effective mental health services that optimize the level of individual functioning of seriously mentally disordered inmates and parolees in the least restrictive environment. The MHSDS has been functioning in CDCR since 1994. The MHSDS utilizes a variety of professional clinical, custody, and support staff to provide the best available quality of care to seriously mentally disordered inmates.

Outpatient care is provided in an array of treatment levels and modalities including a day treatment program and an outpatient clinic level of care. The MHSDS is a decentralized, system-wide concept using standardized evaluation and treatment. The MHSDS provides universal screening for all incoming inmates at Reception Centers and direct transfer from the Reception Center to the treatment facility for further evaluation and/or treatment if needed. The MHSDS utilizes case management techniques to manage the majority of mentally disordered inmates in the general population and provides for their access to care as needed. The MHSDS provides a continuum of inpatient care from a contractual relationship with Department of Mental Health (DMH) for acute and intermediate and a short-term crisis inpatient care program within CDCR institutions. The goal is to provide constitutionally appropriate levels of mental health treatment to the incarcerated serious mentally ill inmate in the least restrictive environment. The MHSDS continues to develop a standardized, automated system of records management and case tracking.

Some key concepts are inherent in the design and administration of these services. These concepts are:

1. To deliver services that promote mental health, by developing and reinforcing individual responsibility. A mental disorder does not necessarily excuse individual responsibility and accountability. The inmate-patient's ability to achieve their clinical goals is enhanced by a therapeutic emphasis on responsibility for one's own behavior.

2. To promote understanding that mental health treatment is a sensible administrative approach to managing inmate-patients when behavioral expressions of their mental disorder disrupt their ability to adequately function and program during confinement.
3. To provide all services with strict observance of Utilization Management guidelines, as a reminder to fiscal responsibility regarding the use of taxpayer funds, which are a limited resource.

The MHSDS uses a variety of therapeutic strategies. The goals of treatment in MHSDS are to help inmates adjust to the prison environment, to optimize appropriate personal functioning, and to help inmates accept responsibility for their behavior. An inmate's offense and institutional behavior, rather than the need for treatment, determine the level of custody placement.

At each institution, the MHSDS operates under the management of the Chief of Mental Health or the Clinical Director. This individual is typically the Chief Psychiatrist, Chief Psychologist, or Senior Psychologist. Mental Health staff are under the supervision of the institution's Health Care Manager. Success of the MHSDS requires that the mental health staff work cooperatively with other Health Care units in the institution, including Health Records, Pharmacy, Lab, and Nursing. It also requires that mental health staff work cooperatively with the institution's correctional and institution support staff.

#### **A. REASONABLE ACCOMMODATIONS FOR INMATES**

The CDCR provides access to its programs and services to inmates with disabilities, with or without reasonable accommodation, consistent with legitimate penological interests. No qualified inmate with a disability as defined in Title 42 of the United States Code, Section 12102 shall, because of that disability, be excluded from participation in or denied the benefits of services, programs, or activities of the CDCR or be subjected to discrimination. All institutions housing inmates with disabilities will ensure that housing and programming are reasonable and appropriate in a manner consistent with their mission and CDCR policy.

Reasonable accommodations shall be afforded to inmate-patients with disabilities, e.g., visually impaired, hearing impaired, speech impaired, learning disabled, and developmentally disabled, to ensure equally effective communication during contacts of any kind that occur within the MHSDS. Auxiliary aids that are reasonable, effective, and appropriate to the needs of the inmate-patient shall be provided when simple written or oral communication is not effective. Such aids may include qualified sign language interpreters, readers, sound amplification devices, captioned television/video text displays, Telecommunication Devices for the Deaf (TDD), audio taped texts, Braille materials, large print materials, and signage. For developmentally disabled inmate-patients, equally effective communication may require reviewing the CDCR 128C-2, *Developmental Disability Program Screening Results*, that documents the adaptive support services required by the inmate-patient.

It is the obligation of CDCR staff, including mental health clinicians, to provide effective communication under all circumstances. The degree of accommodation that is required shall be determined on a case-by-case basis.

In any case in which a question may arise as to the inmate's ability to comprehend, staff shall document the determination that the inmate understood the process during all clinical contacts and shall record the basis for that determination and how the determination was made. This shall be recorded on the documentation of the clinical contact, such as the CDCR Form 7230-MH, Interdisciplinary Progress Note. Examples of documentation of effective communication include, "the responsive written notes generated by a hearing impaired inmate indicated that he/she understood the process," "the sign language interpreter appeared to communicate effectively with the hearing impaired inmate as indicated by the inmate's substantive response via sign language," or, "the inmate was able to summarize instructions given to him/her." To the extent that written notes are used to effectively communicate with an inmate-patient, those notes shall be attached to the documentation of that clinical contact and filed in the Unit Health Record (UHR).

## **B. PRIMARY COMPONENTS**

*Crisis Intervention* A crisis is defined as a sudden or rapid onset or exacerbation of symptoms of mental illness, which may include suicidality or other aberrant behavior which requires immediate intervention. Crisis intervention is provided at all institutions to inmate suffering from a situational crisis or an acute episode of mental disorder. The first step in providing crisis intervention is adequate training for all institutional staff in the recognition of mental health crisis symptoms, a plan for immediate staff response, and procedures for referral to clinical staff. Custody and clinical staff cooperation is critical to ensure that an inmate in a mental health crisis is treated as soon as possible.

*Comprehensive Services* The MHSDS offers comprehensive services and a continuum of treatment for all required levels of care. In addition to standardized screening and evaluation, all levels of care found in a county mental health system are represented in the CDCR MHSDS programs. All levels of care include treatment services provided by multiple clinical disciplines, and development and update of treatment plans by an Interdisciplinary Treatment Team (IDTT), which includes appropriate custody staff involvement.

*Decentralized Services* Mental health services are geographically decentralized by making basic services widely available. All levels of care, except inpatient hospitalization, are available at most geographically-defined Service Areas (see Section E). Case management and crisis intervention are provided at all institutions.

*Clinical and Administrative Oversight* In coordination with each institution, the CDCR Division of Correctional Health Care Services (DCHCS) and Division of Adult Institutions

will continue to update standardized program policy and develop a system for monitoring delivery of program services. The CDCR shall develop an annual review schedule of the MHSDS Program Guide, according to the Inmate Medical Services Policies and Procedures, Chapter 8, Implementation and Review of Health Care Policies and Procedures. A system-wide automated tracking and records system continues to evolve to support administrative and clinical oversight.

Standardized Screening Access to mental health services is enhanced for all inmates through standardized screening of all admissions at Reception Centers. Standardized screening ensures that all inmates have equal and reliable access to services. The data generated by standardized screening provides the CDCR with necessary information to improve the assessment of mental health service needs. If screening reveals indicators of mental disorder, such as prior psychiatric hospitalization, current psychotropic medication, suicidality or seriously maladaptive behaviors, follow-up evaluation by a clinician shall determine the immediate treatment needs of the inmate. Early identification of an inmate's mental health needs will provide an appropriate level of treatment and promote individual functioning within the clinically least restrictive environment consistent with the safety and security needs of both the inmate-patient and the institution. Avoiding the utilization of more expensive services will aid in budget containment.

Pre-Release Planning This component of service, in conjunction with the Correctional Counselor's preparation of the CDCR 611, *Release Program Study*, focuses on preparing the seriously mentally disordered inmate-patient for parole. Its objective is to maximize the individual's potential for successful linkage and transition to the Parole Outpatient Clinic, or, if required, to inpatient services in the community or the Mentally Disordered Offender Program operated at the DMH facilities. In the case of paroling inmate-patients, this includes facilitating the work of the Parole and Community Services Division's Transitional Case Management Program.

### **C. REFERRALS TO MENTAL HEALTH**

Any inmate can be referred for mental health services at any time. Inmates who are not identified at Reception or upon arrival at an institution as needing mental health services, may develop such needs later. Any staff members that have concerns about an inmate's mental stability are encouraged to refer that inmate for evaluation by a qualified mental health clinician (psychiatrist, psychologist, or clinical social worker). Under certain circumstances, referral to mental health may be mandatory. A referral to mental health should be made whenever:

- An inmate demonstrates possible symptoms of mental illness or a worsening of symptoms.

- An inmate verbalizes thoughts of suicide or self-harm behavior.
- Upon return from court when an inmate has received bad news such as a new sentence that may extend their time.
- An inmate has been identified as a possible victim per the Prison Rape Elimination Act.
- An inmate demonstrates sexually inappropriate behavior as per the Exhibitionism policy.
- An inmate who is written up for a disciplinary infraction was demonstrating bizarre, unusual, or uncharacteristic behavior when committing the infraction.
- An inmate placed into Administrative Segregation indicates suicidal potential on the pre-screening, or rates positive on the mental health screening, or gives staff any reason to be concerned about the inmate's mental stability, such as displaying excessive anxiety.
- Upon arrival to an institution when the inmate indicates prior mental health treatment and medications, especially if not previously documented.

Referrals to mental health may be made on an Emergent, Urgent, or Routine Basis. An inmate deemed to require an Emergent (immediate) referral shall be maintained under continuous staff observation until evaluated by a licensed mental health clinician. An Urgent referral is to be seen within 24 hours. A Routine referral should be seen within five working days.

Referrals are made on the CDCR-MH5, *Mental Health Referral Chrono*, and forwarded to the mental health office. Emergent and Urgent referrals should also be made by phone to facilitate a timely response. The referral chronos, when received at the mental health office, are logged, entered into the data tracking system, and scheduled for follow-up with the appropriate clinician.

Inmates may also self-refer for a clinical interview to discuss their mental health needs. Inmate self-referrals shall be collected daily from each housing unit, and processed the same way as staff referrals.

#### **D. TREATMENT CRITERIA FOR THE LEVELS OF CARE**

##### **Overall Treatment Criteria**

Overall treatment criteria have been developed for the MHSDS. An inmate must meet the criteria in 1, 2, or 3 below, in order to receive MHSDS treatment at any level of care:

1. Treatment and monitoring are provided to any inmate who has **current** symptoms and/or requires treatment for the current Diagnostic and Statistical Manual diagnosed (may be provisional) Axis I serious mental disorders listed below:

**Schizophrenia (all subtypes)**

**Delusional Disorder**

**Schizophreniform Disorder**

**Schizoaffective Disorder**

**Brief Psychotic Disorder**

**Substance-Induced Psychotic Disorder (exclude intoxication and withdrawal)**

**Psychotic Disorder Due To A General Medical Condition**

**Psychotic Disorder Not Otherwise Specified**

**Major Depressive Disorders**

**Bipolar Disorders I and II**

2. Medical Necessity Mental health treatment shall be provided as needed. Treatment is continued as needed, after review by an IDTT, for all cases in which:

**Mental health intervention is necessary to protect life and/or treat significant disability/dysfunction in an individual diagnosed with or suspected of having a mental disorder. Treatment is continued for these cases only upon reassessment and determination by the IDTT that the significant or life threatening disability/dysfunction continues or regularly recurs.**

3. Exhibitionism Treatment is required when an inmate has had at least one episode of indecent exposure in the six-month period prior to the IDTT that considers the need for exhibitionism treatment and the inmate patient is either:

- Diagnosed with Exhibitionism, or
- Meets the alternate criteria. (*Alternate Criteria:* An inmate who meets all criteria for the diagnosis of Exhibitionism, except that the victim was not an “unsuspecting stranger” but was a staff member or inmate who did not consent to or encourage the behavior.)

(A diagnosis of Exhibitionism is not required for inmates who meet the alternate criteria.)

### **Specific Treatment Criteria**

In addition to the overall treatment criteria above, an inmate must meet the following specific treatment criteria to receive treatment at a specific level of care:

### 1. Correctional Clinical Case Management System

- Stable functioning in the general population, Administrative Segregation Unit (ASU) or Security Housing Unit (SHU); and
- Criteria not met for higher levels of care; and
- Exhibits symptom control, or is in partial remission as a result of treatment.
- These conditions usually result in Global Assessment of Functioning (GAF) scores of 50 and above.

Correctional Clinical Case Management System (CCCMS) is located at all institutions [except California Conservation Center (CCC), Calipatria State Prison (CAL), Centinela State Prison (CEN), Chuckwalla Valley State Prison (CVSP), and Ironwood State Prison (ISP). These prisons provide necessary care until the inmate-patient can be transferred] to provide care, monitoring and follow-up services to inmate-patients whose condition is relatively stable and whose symptoms are largely controlled. This may include a response to symptoms that require only a brief intervention, such as a psychotherapy session or an adjustment in medications. While mentally disordered, these inmate-patients can function in the general population and do not require a clinically structured, therapeutic environment.

All inmates, including those in SHU or ASU, needing crisis intervention and/or continued treatment also receive services from CCCMS staff. Details for provision of services in ASU and SHU are found in their respective chapters of the Program Guide.

### 2. Enhanced Outpatient Program

- Acute Onset or Significant Decompensation of a serious mental disorder characterized by increased delusional thinking, hallucinatory experiences, marked changes in affect, and vegetative signs with definitive impairment of reality testing and/or judgment; and/or
- Inability to function in General Population based upon:
  - a. A demonstrated inability to program in work or educational assignments, or other correctional activities such as religious services, self-help programming, canteen, recreational activities, visiting, etc. as a consequence of a serious mental disorder; or

- b. The presence of dysfunctional or disruptive social interaction including withdrawal, bizarre or disruptive behavior, extreme argumentativeness, inability to respond to staff directions, provocative behavior toward others, inappropriate sexual behavior, etc., as a consequence of serious mental disorder; or
  - c. An impairment in the activities of daily living including eating, grooming and personal hygiene, maintenance of housing area, and ambulation, as a consequence of serious mental disorder.
- These conditions usually result in a GAF of less than 50.

Enhanced Outpatient Program (EOP) provides care to mentally disordered inmate-patients who would benefit from the structure of a therapeutic environment that is less restrictive than inpatient settings. This may include response to crisis symptoms which require extensive treatment, but can be managed as outpatient therapy with several psychotherapy sessions or medication adjustment with follow-up visits.

These inmate-patients do not require continuous nursing care. Often, they are transitioning from inpatient care in a DMH hospital or the Mental Health Crisis Bed (MHCB). They may also have a serious mental illness that is of long duration with moderate to severe and persistent functional impairments. The EOP's structured program of treatment and supportive activities will, in many cases, build on therapeutic improvements made in a hospital program or MHCB. EOP will release cases which have successfully completed treatment to CCCMS. The EOP is located in a designated living unit at the hub institution.

### 3. Mental Health Crisis Bed Placement

- Marked Impairment and Dysfunction in most areas (daily living activities, communication and social interaction) requiring 24-hour nursing care; and/or
  - Dangerousness to others as a consequence of a serious mental disorder, and/or dangerousness to self for any reason.
- These conditions usually result in a GAF score of less than 30.

All inmate-patients admitted to a MHCB are discharged within ten days, with scheduled appropriate clinical follow-up, to outpatient care or the general population or are transferred to DMH inpatient care. Stays of over ten days must be approved by the Chief of Mental Health, or designee. The MHCB also provides short-term inpatient care for seriously mentally disordered inmate-patients awaiting transfer to a hospital program or being stabilized on medication prior to transfer to a less restrictive level of care. The



MHCB is a part of a licensed General Acute Care Hospital (GACH), Skilled Nursing Facility (SNF), or a Correctional Treatment Center (CTC) offering 24-hour basic medical, nursing, and other health services. A Central Health Services building which houses CTC services houses the MHCB beds, staff offices and therapy space. In the CTC, the MHCB runs its short-term crisis care program under the CTC “optional mental health treatment program” regulations. In a GACH or SNF, the MHCB are under the “distinct part Psychiatric” licensing regulations.

#### 4. DMH Inpatient Hospital Care

Referral to inpatient programs provided via contract with the DMH is available for inmate-patients whose conditions cannot be successfully treated in the outpatient setting or in short-term MHCB placements. Both acute and intermediate care programs are offered in facilities for both male and female inmate-patients. Specific criteria are noted in

Chapter 6, *Department of Mental Health Inpatient Program*.

The IDTT shall generally be responsible for developing and updating treatment plans. This process shall include input from the inmate-patient and other pertinent clinical information that may indicate the need for a different level of care. Referrals to higher levels of care shall be considered when the inmate-patient’s clinical condition has worsened or the inmate-patient is not benefiting from treatment services available at the current level of care. Consideration of appropriate level of care shall be documented by the IDTT on a CDCR 7230-MH, *Interdisciplinary Progress Notes*, and shall include the justification for maintaining the current level of care or referral to a different level of care.

### **E. SERVICE AREAS**

The principal infrastructure for service delivery is the Service Area. A mental health Service Area assumes responsibility for mental health services; a medical Service Area, while it generally overlaps with that for mental health, is responsible for medical services. Several Service Areas report to a Regional Administrator.

Each Service Area consists of a group of two or more institutions in relative geographic proximity that share the full complement of services directly provided by CDCR. These services include all levels of care, except the Acute and Intermediate inpatient care provided through DMH. Each mental health Service Area has from one to three MHCB locations and one EOP located at its hub institution. CCCMS completes the delivery system within a Service Area. Staff handling CCCMS caseloads are at every institution.

**F. CLINICAL PROGRAM GUIDE**

MHSDS Program Guide chapters have been developed for the MHCB, EOP, and CCCMS levels of care. Each chapter is organized into the following sections: Program Objectives, Population Served, Treatment Modalities, Staffing, and Patient Assessment and Case Review Procedures. Although these chapters define essential program content and delineate system-wide policies, each Service Area is expected to have written policies and specific operational procedures (derived from the Program Guide) articulated in ways that best address the unique needs of the specific Service Area and its institutions. Written policies and procedures are especially necessary for the MHCB to meet health facility licensing requirements.

**G. STANDARD PROGRAM STAFFING**

Staffing for all programs is based on the Mental Health Staffing Workload Study, completed June 2007, which allocates both clinical and clerical support staff whom perform duties related to the provision of mental health services. CDCR may utilize contract staff as necessary to fulfill staffing requirements. Use of unlicensed psychologists and clinical social workers during the period they are gaining qualifying experience for licensure is governed by Section 1277 of the Health and Safety Code, and Section 5068.5 of the Penal Code.

Institutions may use pre-doctoral psychology interns who are trained and supervised by a licensed psychologist according to regulations in Sections 1287, 1287.1, and 1287.2 of Title 16, Division 13.1 of the California Code of Regulations. Institutions may also use social work interns who are currently enrolled in a master's program in social work according to regulations in Section 4996.15 of the California Business and Professions Code.

All newly hired psychiatrists must meet minimum credentialing criteria as follows:

1. Current board certification from the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

OR

2. Satisfactorily completed specialized training requirements in psychiatry in programs that, for a psychiatrist, are accredited by the Accreditation Council for Graduate Medical Education (ACGME) or Bureau of Osteopathic Education of the American Osteopathic Association (AOA) or certified by the Royal College of Physicians and Surgeons of Canada.

a) Two patterns of training are acceptable:

**(i). Training Pattern One: A Three-Year Psychiatry Residency Program**

- A broad-based clinical year of ACGME or Bureau of Osteopathic Education of the AOA-accredited training in internal medicine, family practice, or pediatrics; or
- An ACGME or Bureau of Osteopathic Education of the AOA-accredited transitional year program that included a minimum of four months of primary care; or
- An ACGME or Bureau of Osteopathic Education of the AOA-accredited residency in a clinical specialty requiring comprehensive and continuous patient care.

**AND**

Three full years of postgraduate, specialized residency training in a psychiatry program accredited by the ACGME or Bureau of Osteopathic Education of the AOA.

OR

**(ii) Training Pattern Two: A Four-Year Psychiatry Residency Program**

Four years of training in an ACGME or Bureau of Osteopathic Education of the AOA-accredited program in psychiatry is acceptable. A psychiatry PGY-1 must include at least four months of internal medicine, family practice, and/or pediatrics. This training must be in a clinical setting that provides comprehensive and continuous patient care. No more than one month of this requirement may be fulfilled by an emergency medicine rotation, as long as the experience predominantly involves medical evaluation and treatment, rather than surgical procedure. Neurology rotations may NOT be used to fulfill this four-month requirement.

(Exception: Any applicant who completed a residency program in psychiatry that was accredited by the ACGME or Bureau of Osteopathic Education of the AOA or certified by the Royal College of Physicians and Surgeons of Canada at the time the applicant completed the residency will qualify under this pattern of training upon CDCR verification that all residency requirements were successfully completed and if all other requirements are met.)

If the candidate's training program(s) is not currently accredited by the ACGME or the Bureau of Osteopathic Education of the AOA, CDCR shall research the history of the program(s) to determine if it was accredited at the time the candidate attended and completed the training.

All osteopaths hired in the classification of psychiatrist before January, 2006, and presently in that classification must meet the above criteria or must undergo a court-mandated evaluation of their clinical competency for employment in the position of psychiatrist with the CDCR.

#### **H. PARAMETERS OF CONFIDENTIALITY OF INMATE-PATIENT COMMUNICATIONS AND GUIDELINES FOR DISCLOSURE**

CDCR has developed a detailed policy to ensure that confidentiality of inmate-patient communications with mental health clinicians is protected. This policy, issued in a memorandum dated April 18, 2007, is Attachment A to the MHSDS Program Guide. The policy is accompanied by examples for the purpose of staff training. Clinicians, including psychiatrists, physicians, psychologists, clinical social workers, nurse practitioners, registered nurses, licensed vocational nurses, licensed psychiatric technicians, and recreational therapists, shall be trained in this policy. In addition, all staff members who intentionally, accidentally, or inadvertently overhear confidential communications (arising from clinical contacts such as cell front visits) are responsible for maintaining confidentiality of the communication. Custody officers, correctional counselors, and other staff who are members of an IDTT are bound to not discuss health-related inmate-patient information with anyone other than the team members.

Clinicians are responsible for informing inmate-patients of the limits of confidentiality, or ensuring that prior documentation in the UHR indicates that this disclosure has occurred prior to commencement of a clinical encounter. CDCR 7448, *Informed Consent for Mental Health Care*, shall be used for this purpose.

#### **I. CLINICAL INPUT INTO THE DISCIPLINARY PROCESS**

Inmate-patients in the Mental Health program or any inmate showing signs of possible mental illness may require a CDCR 115-MH, *Rules Violation Report – Mental Health Assessment*, when they are charged with a disciplinary action.

All inmates in the EOP, MHCB, and DMH programs who receive a CDCR 115-MH, *Rules Violation Report – Mental Health Assessment*, shall be referred by the Reviewing Custody Supervisor to Mental Health Services for a Mental Health Assessment. All inmates in CCCMS or non-MHSDS inmates who receive a CDCR 115-MH, *Rules Violation Report* and who exhibit bizarre, unusual, or uncharacteristic behavior shall be referred for a CDCR 115-

*MH Rules Violation Report: Mental Health Assessment.* Inmates who receive a CDCR 115, *Rules Violation Report* for Indecent Exposure or Intentionally Sustained Masturbation Without Exposure shall be referred for a CDCR 115-MH *Rules Violation Report: Mental Health Assessment*.

A mental health clinician who is not the inmate's Primary Clinician shall review the relevant portions of the inmate's UHR and any other records deemed appropriate and shall evaluate the inmate in a non-confidential interview in a private setting. The findings shall be reported on a CDCR 115-MH, *Rules Violation Report: Mental Health Assessment*. The report must be returned to the Reviewing Custody Supervisor within 5 working days for non-MHSDS and CCCMS inmates (to allow time to assign a Staff Assistant) and within 15 calendar days for EOP, MHCB and DMH patients. The clinician shall determine the following:

1. Are there any mental health factors that would cause the inmate to experience difficulty in understanding the disciplinary process and representing his/her interests in the hearing that would indicate the need for the assignment of a Staff Assistant? **Note: All inmates in the EOP, MHCB, and DMH programs automatically have a Staff Assistant assigned.**
2. Did the inmate's mental disorder appear to contribute to the behavior that led to the Rules Violation Report?
3. If the inmate is found guilty of the offense, are there any mental health factors that the hearing officer should consider in assessing the penalty?

Refer to the "Inmate Disciplinary Process, Mental Health Assessment" manual (See Attachment B) and CDCR 115-MH, *Rules Violation Report: Mental Health Assessment*, for detailed instructions on completing this assessment and utilizing the information in the hearing process.

## **J. AUTOMATED TRACKING SYSTEM**

The Inmate Mental Health Identifier System (IMHIS) has been designed to track the movement of all inmate-patients receiving care in the MHSDS. The data entered into the system will be processed daily, so the system will maintain information regarding MHSDS inmate-patients current level of care as well as MHSDS inmate-patients transfers, discharges, and new cases. All institutions are to conduct a reconciliation of the inmate-patients housed in ASUs who require mental health treatment with the IMHIS codes for this specific population. It is very important that IMHIS information be as up to date as possible and daily updates to the IMHIS are mandatory.

**K. MENTAL HEALTH TRACKING SYSTEM**

The Mental Health Tracking System (MHTS) is an automated program designed to track and record all pertinent mental health information for inmate-patients from the time they enter the MHSDS until they are released, paroled, or transferred out of the MHSDS and return to the general population. This institutional information management program is capable of tracking an inmate-patient's medication history, level of care changes, mental health staff contacts, current and previous DSM psychiatric diagnoses, latest Abnormal Involuntary Movement Scale score, status and information regarding current or past Keyhea orders, as well as other key data related to an inmate-patient's mental health treatment history. In addition, the MHTS is used to produce the Inmate Profile which documents suicide risk data and accompanies inmates whenever they are transferred between institutions to provide the receiving institution with suicide risk data and other initial MHTS input data. The MHTS is designed to track and aggregate data which serves as a basis for quality assurance and improvement activities at the Institutional and Departmental levels.

**L. MENTAL HEALTH PLACEMENT CHRONO**

Each inmate who is assessed as having a serious mental disorder and is accepted into the MHSDS will have a CDCR 128-MH3, *Mental Health Placement Chrono* (MHPC) completed and entered into their UHR and Central File. This chrono indicates the inmate-patient's LOC, medication status, any behavioral alerts, and their GAF score. This information is entered daily into the IMHIS and the MHTS and is a critical component in the overall management of inmate-patients in the MHSDS. As long as an inmate-patient is in the MHSDS, they shall have a MHPC that reflects the inmate-patient's current status.

- At the RC, the MHPC shall be dated within 90 days of the Classification Staff Representative placement action. As inmate-patients usually spend less than 90 days in the RC, updates will not normally be required.
- In all other housing situations, no updates of the MHPC will be required unless there is a change in the level of care, or when the inmate-patient is being referred for transfer to another institution.

**M. LEVEL OF CARE CHANGE /TRANSFER TIMELINES**

The following table summarizes the time frames which CDCR must meet for the transfer of MHSDS inmate-patients between levels of care, whether within the same institution or to another institution. More detail on the level of care change/transfer process is provided in the individual level of care sections of the Program Guide.

The following definitions apply to the Transfer Timelines Table:

- **“Identification:”** The date that the inmate-patient is identified as requiring a higher LOC. The IDTT is responsible for identifying inmate-patients who are appropriate for discharge to a lower LOC, an increase from CCCMS to EOP LOC, or DMH intermediate care. An individual clinician may identify an inmate-patient as requiring initial admission into MHSDS at CCCMS or EOP LOC. A credentialed clinician may admit an inmate-patient to MHCB care. An individual clinician may refer an inmate-patient for DMH acute inpatient care.
- **“Referral”** within CDCR: The date the LOC change is documented on a Mental Health Placement Chrono, or the time the physician or clinical psychologist orders admission into a CTC.
- **“Referral”** to DMH: The date the completed referral packet is received by DMH by facsimile or overnight mail.
- **“Acceptance”** at DMH: The date the Clinical Assessment Team at DMH accepts the inmate-patient for placement at a DMH facility. Some inmate-patients may be placed on a waitlist pending bed availability after acceptance.
- **“Transfer:”** The date the inmate-patient is placed into the LOC and program to which s/he was referred.

<b>From:</b>	<b>To:</b>	
<b>Setting/Level of care</b>	<b>Setting/Level of Care</b>	<b>Timeline for Transfer</b>
RC/CCCMS	Mainline/ CCCMS	Within 90 days of referral; 60 days of referral if clinically indicated
RC/EOP	Mainline/EOP	Within 60 days of referral; 30 days of referral if clinically indicated
Any setting/level of care	MHCB	Within 24 hours of referral
Any institution/ level of care	Any Acute DMH placement	Within ten days of referral, if accepted to DMH. (Referral must be completed within two working days of identification. Transport must be completed within 72 hours of bed assignment)
Any institution/level of care	Any Intermediate Care DMH placement	Within 30 days of referral, if accepted to DMH. (Referral must be completed within five working days of identification by IDTT if inmate-patient consent is obtained, and within ten working days of identification if due process hearing is required. Transport must be completed within 72 hours of bed assignment).
Mainline (General Population)/ CCCMS	Mainline (General Population) /EOP	Within 60 days of referral; 30 days of referral if clinically indicated
Desert institutions (CAL, CEN, ISP, CVSP, CCC)/CCCMS	CCCMS	Within 30 days if inappropriately transferred; otherwise 90 days of referral or 60 days of referral if clinically indicated
Desert institutions (CAL, CEN, ISP, CVSP, CCC)/EOP	EOP	Within 21 days if inappropriately transferred; otherwise 60 days of referral or 30 days of referral if clinically indicated
EOP ASU	EOP ASU Hub	Within 30 days of ASU placement or referral to EOP level of care.
EOP ASU/ EOP ASU Hub	PSU	Within 60 days of endorsement to PSU
Outpatient Housing Unit	EOP	Within 30 days of endorsement to EOP



**N. PROGRAM GUIDE REVISION POLICY AND PROCEDURE**

The MHSDS Program Guide revisions shall occur annually. The revisions shall be presented to the Mental Health Program Subcommittee (MHPS) by January 31 of each year. The MHPS shall forward revisions to the appropriate authorities for approval.

All proposed revisions to the MHSDS Program Guide shall be submitted to the DCHCS Program Guide Coordinator (PGC). The PGC shall be designated by the DCHCS Chief of the Mental Health Program.

The PGC shall distribute proposed revisions to the Program Guide Focused Improvement Team (PG-FIT). The PG-FIT shall include at minimum:

- Program Guide Coordinator
- Chief Psychiatrist, Clinical Policy and Programs, DCHCS
- Chief Psychologist, Clinical Policy and Programs, DCHCS
- Assistant Deputy Director, or designee, DAI
- Supervising Attorney, or designee, Office of Legal Affairs

The PG-FIT shall be responsible for involving appropriate representatives from other CDCR Divisions and other appropriate consultants (e.g. representatives from field institutions) in decisions regarding any proposed revisions.

Where revisions may impact resources, the PG-FIT shall initiate evaluation of resource impact and/or request submission of a budget change proposal.

The PG-FIT shall meet as needed with the MHPS to make recommendations regarding revisions. The MHPS shall present the proposed revisions to the Quality Management Committee (QMC). The QMC will approve or disapprove each proposed revision. Approvals will be forwarded to the DCHCS Governing Body (GB). The PGC will record all changes approved by the GB.

Memoranda signed by the Deputy Director, DCHCS, shall implement emergent or court-ordered substantive changes to the MHSDS Program Guide throughout the year. These memoranda shall be integrated into the annual revision of the MHSDS Program Guide document.

The PGC shall maintain a project file to include original input submitted by those persons who provided review and or revisions of the MHSDS Program Guide, along with a tracking log of approved revisions of the MHSDS Program Guide. Revised portions of the MHSDS Program Guide shall be marked “SUPERCEDED” with the date it was superceded, and revised portions shall be filed by revision date.

This tracking log of approved revisions, along with revised MHSDS Program Guide pages shall be distributed to the Warden, Health Care Manager, Chief of Mental Health, and Correctional Health Services Administrator and/or Standards Compliance Coordinator at each institution no later than 30 days after final approval. The distribution shall include direction that copies of relevant sections are to be shared with appropriate staff. The Chief of the Mental Health Program at each institution shall ensure that the revisions are integrated into **ALL** existing copies of the MHSDS Program Guide according to Inmate Medical Services Policies and Procedures Chapter 8 “Implementation and Review of Health Care Policies and Procedures” section regarding Proof of Practice Documentation. Current DCHCS Policies and Procedures manuals shall be readily available to all mental health staff in each program and work area. The Chief of Mental Health shall be responsible to ensure that all staff are trained regarding revised Program Guide requirements.

## **CHAPTER 2**

### **Reception Center Mental Health Assessment**

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#### **A. INTRODUCTION**

The Reception Center (RC) program provides mental health assessment for all inmates committed to the California Department of Corrections and Rehabilitation (CDCR) and basic treatment for those inmates identified as having a serious mental disorder while awaiting transfer.

By enhancing and standardizing screening and evaluation efforts at the entry point into the institution system, the CDCR can best ensure that all inmates in need of mental health treatment are identified and provided necessary services at the earliest possible time. Early and easy access to care has been shown to have both therapeutic as well as fiscal benefits in managing mental illness at its lowest level of acuity. This is particularly true in the high stress environment of an institution setting.

This program utilizes clinical and clerical positions to achieve the following objectives:

1. Provide a standardized system for universal screening of all inmates received in the CDCR for possible symptoms of mental disorder or suicide risk.
2. Conduct in-depth clinical evaluations of individuals identified in the screening process for diagnosis of serious mental disorder, level of functioning, and necessary level of care.
3. Through the Inmate Mental Health Identifier System, CDCR is able to track inmate-patients who have been identified as seriously mentally disordered and enrolled in one of the Mental Health Services Delivery System (MHSDS) levels of care. This information provides a management tool and is utilized in program planning.

It is important to emphasize that the population this program seeks to identify is defined as those inmates who are dysfunctional in the prison environment as a result of a serious mental disorder. Specifically, these are inmates with a Diagnostic and Statistical Manual (DSM) Axis I diagnosis, with current symptoms, or evidence of medical necessity. Inmates who are prescribed psychotropic medications are also included in MHSDS. Inmates suffering suicidal

ideation shall also receive crisis care to protect life. Mental health intervention is also provided to treat significant disability/dysfunction in an individual diagnosed with or suspected of having a mental disorder.

Mental health issues which may be identified in the screening process, but which are not included in the treatment services provided by the CDCR's mental health treatment programs, are sexual and substance abuse disorders and personality disorders. However, if these mental health issues are also accompanied by an Axis I serious mental disorder or meet the requirements of medical necessity, treatment is provided by the CDCR's mental health treatment programs. While all inmates are screened in the RC for developmental disabilities, services for inmates with developmental disabilities, although provided by mental health staff in numerous institutions, are not addressed in this Program Guide, as they fall under the oversight of the Clark Remedial Plan. Inmates with developmental disabilities who also have an Axis I serious mental disorder are, of course, included in the MHSDS, and some inmates with developmental disabilities may be included in MHSDS programs under medical necessity criteria.

## **B. POLICIES AND PROCEDURES FOR ASSESSMENT OF MENTAL HEALTH NEEDS**

### Goal and Target Population

To identify and assign an appropriate level of care to inmates who are suicidal or are experiencing impaired functioning as a result of serious mental disorder.

### Policies to Achieve Goal

1. All inmates shall receive an Initial Health Screening by nursing staff within 24 hours of arrival to determine need for continuation of currently prescribed and used psychotropic medications, need for crisis psychiatric care, or other mental health intervention.
2. All inmates shall receive a Mental Health screening within the first seven calendar days of arrival to identify mental health concerns that may indicate a need for treatment.
3. All inmates with possible mental health treatment needs shall receive a standardized mental health evaluation within 18 calendar days of arrival, and prior to any placement decision.
4. All inmates who request a clinical interview shall receive one.
5. Any RC Staff may refer any inmate for clinical interview at any time.

6. All mental health screening and evaluation interviews shall be conducted in a private setting.
7. All psychological evaluations shall conclude with a provisional diagnosis, level of functioning, and recommended level of care placement, if required.
8. Mental health services shall be provided to inmates while awaiting transfer.
9. In order to facilitate long range planning, each RC shall accumulate and regularly report data on all inmates screened, evaluated, and determined to be in need of particular levels of treatment.

**C. PROCEDURES TO IMPLEMENT POLICIES**

1. Initial Health Screening of Inmates at Receiving and Release

All inmates arriving at a RC shall be interviewed utilizing a standard set of questions (CDCR 7277, *Initial Health Screening*) regarding their medication needs or need for immediate referral for crisis care under the supervision of a Registered Nurse (RN). Medical staff or equivalent staff trained in the procedures for the standardized health screening and mental health referrals, shall review available documentation from committing jurisdictions regarding mental health treatment. This includes a review of medications provided at County facilities or observed behavior that may indicate a need for mental health treatment.

This interview shall be conducted in an environment which is sufficiently private and confidential to encourage full disclosure and open, candid responses. Inmates who are unable to speak English shall be provided with necessary interpreters. Where a need for emergency or urgent psychiatric review is identified, a direct referral to a psychiatrist shall take place, utilizing a standard CDCR 128-MH5, *Mental Health Referral Chrono*. The original 128-MH5, *Mental Health Referral Chrono*, shall be sent to the psychiatrist and a copy to the mental health office for data entry and filing. These Chronos should be hand delivered or this information relayed by telephone, if necessary. Emergency referrals shall be made and responded to immediately. Urgent referrals, including medication assessment or review, shall be responded to within 24 hours. Observation of possible mental health symptoms not requiring emergency attention may also be documented on a staff referral chrono and forwarded to the mental health office within the next working day. Clinical evaluation and health transfer information from committing counties relating to a need for medical or mental health care or assessment are to be placed in the inmate's Unit Health Record (UHR).

2. Physical Exam

Within three working days of arrival, all inmates shall undergo a physical examination and evaluation of medical history. Any mental health issues that become apparent in the interviews by the physician, RN, or Licensed Vocational Nurse (LVN) conducting the reviews, shall be documented on staff referral chronos for subsequent mental health evaluation. Emergency or urgent cases requiring crisis care or medication review shall be immediately referred for psychiatric evaluation.

3. Mental Health Screening

Within seven calendar days of arrival at the RC, all inmates (new commitments and parole violators) shall receive a screening for possible mental health needs. They shall be individually interviewed by a psychologist or Clinical Social Worker using the standardized Mental Health Screening questionnaire. The screening clinician shall explain the purpose of the screening process, and assess the inmate's ability to complete the interview. Inmates who are unable to speak English shall be provided with necessary interpreters. Inmates who refuse to participate in the mental health screening interview shall be referred for a psychological evaluation to determine if they have a mental disorder. Individuals who are unable to participate in the screening interview due to possible acute psychiatric distress shall be immediately referred for crisis care. This will normally include a referral for an emergency psychiatric evaluation (see Section 5, *Psychiatric Evaluations*, below).

If a returning Parole Violator identifies himself or herself as a former MHSDS inmate-patient, the file review indicates such designation, or Distributed Data Processing System (DDPS) indicates such designation, he or she shall be automatically referred for further psychological evaluation.

Following completion of the screening interview, the completed screening form shall be forwarded to the mental health data processing station for analysis. The results of this screening shall be documented by mental health staff on a CDCR 128-MH1, *Mental Health Screening Chrono*. Refusals to participate and any need for an interpreter shall also be documented on this Chrono. Each case shall be either cleared for general population placement, scheduled for a full psychological evaluation within 18 calendar days, or immediately referred for crisis care, as needed.

Information from the standardized Mental Health Screening shall be retained in the automated system for future reference and data compilation.

4. Psychological Evaluations

Inmates referred for psychological evaluation who have been identified in the initial mental health screening as having a possible mental health need or who refused the screening, shall be scheduled for a full psychological evaluation to be completed by the 18 calendar day evaluation period after arrival. Preparatory to the evaluation, the inmate's UHR and Central Files shall be reviewed when available, by the clinician. The results of the clinical screening assessment, including working diagnosis, shall be reviewed, as will any information generated from staff or self-referrals to that point.

If the inmate states that he or she had significant prior treatment or the file review indicates history of such treatment, the clinician shall request that the inmate sign a *Release of Information* in an attempt to obtain previous records. The clinician shall immediately forward the signed *Release of Information* form to the Health Record Services staff. Health Record Services staff shall process all requests for information from external sources, and shall monitor the receipt of the requested information. All received health information shall be immediately incorporated into the appropriate UHR with simultaneous notification to the requesting health care personnel, consistent with the Health Record Services Policies and Procedures. If the inmate has been moved to another institution, the Health Record Services staff shall check the Offender Based Information System/DDPS to determine the inmate's current location and forward the information immediately to the Health Record Services supervisor at the current location.

The psychologist or psychiatrist shall conduct an individual interview with the inmate in a private and confidential setting. Where possible, the psychologist or psychiatrist will utilize a computer terminal for reference and input in completing the evaluation. Identifying information already available in the computer will be verified in the file review and inmate interview.

The psychological evaluation shall be recorded on the CDCR 7386, *Mental Health Evaluation*. The psychologist or psychiatrist shall obtain and input a brief narrative of the presenting problem and historical information of relevance from the files and interview. A mental status examination and assessment of level of functioning will be completed, with the results directly entered into the computer on pre-programmed screens (or hard copy forms, where automated systems are not available). A provisional

diagnosis shall be noted and, where this includes an Axis I condition, a level of functioning assessment shall also be provided.

After arriving at a diagnosis and functioning assessment, the psychologist or psychiatrist shall determine need for treatment and recommend a level of care, based upon the level of acuity and treatment program criteria. The psychologist's findings shall be documented on a CDCR 128-MH3, *Mental Health Placement Chrono*. Where possible needs for psychotropic medication are present, and no current prescription has been made, a referral to the psychiatrist shall be made, utilizing a standard CDCR 128 MH5, *Mental Health Referral Chrono*. A copy of the completed chrono requesting medication assessment shall be immediately provided to the psychiatrist. The psychiatrist's decision regarding the medication needs shall be documented in CDCR 128-MH6, *Psychiatric Evaluation Chrono* and the CDCR 7230-MH, *Interdisciplinary Progress Notes* in the inmate's UHR. Pending transfer of the inmate-patient to an appropriate level of care, an initial treatment plan shall also be provided by the psychologist or psychiatrist on a CDCR 7386, *Mental Health Evaluation*, and by the psychiatrist where medication or crisis care is necessary. Inmates who are acutely psychotic or suicidal shall be referred for placement in a mental health crisis bed (MHCB) or emergency transfer to the Department of Mental Health facility at the California Medical Facility or to Patton State Hospital for female inmates.

All inmates in a RC who are identified as requiring mental health services shall receive basic treatment as specified in the initial treatment plan. The initial treatment plan is an integral part of the psychological evaluation and formulated to meet individual inmate-patient's clinical needs while housed in the RC. The level of treatment provided during the transition period for these inmate-patients varies depending on the clinical needs and the length of stay in the RC as determined by the commitment status. The initial treatment plan is tailored to meet individual inmate-patient's clinical needs on a short-term basis and specifies the type of services, including orientation, medication needs assessment, or regular monitoring, crisis intervention as needed, and individual contact with a treating clinician as often as necessary.

Inmates who have no diagnosed mental illness, or whose current level of functioning is adequate without need for treatment (including psychotropic medications), shall be cleared for general population placement.

Inmates who are seen by the psychologist as a result of a staff or self-referral after the completed evaluation, shall be assessed for necessary adjustments to the original evaluation or treatment plan. Where such adjustments are indicated, new documentation will be generated.

Following entry of all elements of the psychological evaluation into the automated system, a CDCR 128-MH3, *Mental Health Placement Chrono*, shall be generated for the inmate's UHR. The chrono shall be provided for the Central File with copies to the Correctional Counselor (CC) and inmate. The 128-MH3, *Mental Health Placement*



*Chrono*, shall be completed whether the inmate requires treatment or is cleared for general population placement. The original document shall be dated and signed by the clinician completing the evaluation.

If an inmate refuses to participate in the psychological evaluation interview, the clinician shall review the Central File, UHR, and reports from housing officers and/or other staff, and make clinical observation of the inmate. Clinicians shall make an effort to resolve refusal cases by the end of the 18 calendar day evaluation period. In those rare situations where these cases cannot be resolved during the 18 calendar day evaluation period, the clinician shall document this on the inmate's CDCR 128-MH3, *Mental Health Placement Chrono*. The clinician shall include in a CDCR 7230-MH, *Interdisciplinary Progress Note*, a description of what efforts were made to complete the evaluation (e.g., review Central File and UHR, consult with housing officers, etc.) and a recommendation of how to proceed with the case. The Chief of Mental Health at the institution reviews all refusals and approves the clinician's recommendations. The results of the psychological evaluation shall be documented on a CDCR 128-MH3, *Mental Health Placement Chrono*. If the inmate is not transferred out of the RC within 90 days, a new CDCR 128-MH3, *Mental Health Placement Chrono*, shall be completed.

5. Psychiatric Evaluations

Psychiatric Evaluations will primarily address the issues of need for acute care and initiation or continuation of psychotropic medications. Review of need for continuation of medications prescribed prior to commitment to an institution will normally occur within 24 hours of intake. A medication specific informed consent with signatures of psychiatrist, inmate-patient, and a witness (health care staff) will be completed whenever a new medication is ordered. Psychiatric evaluations will be documented on a CDCR 7230, *Interdisciplinary Progress Note*, or CDCR 7386, *Mental Health Evaluation*, which will be placed in the inmate's UHR, and completion of a 128-MH6, *Psychiatric Evaluation Chrono*, for entry into the Central File. Inmate-patients requiring follow-up psychiatric care while awaiting transfer will be scheduled for that purpose, with documentation of clinical contacts recorded in the inmate-patient's UHR progress notes. Changes in mental status which impact placement decisions will also be documented on CDCR 128-MH6, *Psychiatric Evaluation Chrono*.

Psychiatrists are also responsible to review an inmate-patient's response to and side effects of psychiatric medications and to order and review appropriate laboratory testing. Where staffing permits, psychiatrists may also serve Primary Clinician (PC) functions.

6. Initial Treatment Planning and Treatment

Initial treatment planning must be developed and regular treatment must be provided for all inmate-patients who are identified as requiring mental health services. Mental Health needs of inmate-patients housed in a RC are often greater than those of inmate-patients in a general population setting, due to a variety of problems related to incarceration which often precipitate dysfunctional behavior or exacerbate pre-existing mental conditions. Treatment plans must address basic issues of adjustment, access to care, monitoring of medication continuity, and clinical pre-release or parole planning.

Without exception, mental health services are extended to all MHSDS designated inmate-patients while awaiting transfer to a mainline institution. Services include case management contacts, medication management, and monitoring pertinent to the level of functionality based on clinical judgment. In addition, crisis intervention, clinical pre-release or parole planning, and other case management services shall be provided consistent with the inmate's clinical needs. Services are provided through staff assigned to the RC.

Inmate-patients who require Correctional Clinical Case Management System (CCCMS) level of care shall be seen by the PC within 30 days of placement in CCCMS and at least every 90 days thereafter while at the RC, or more often if clinically indicated. These inmate-patients shall also be evaluated by a psychiatrist a minimum of every 90 days regarding psychiatric medication issues.

Inmate-patients who require Enhanced Outpatient Program (EOP) level of care shall be seen by the PC weekly and shall be evaluated by a psychiatrist at least monthly regarding psychiatric medication issues. Institutions that have both a RC and an established EOP may temporarily house and treat these inmate-patients in their regular EOP housing units until transfer.

Reception Centers housing inmate-patients requiring EOP level of care shall provide structured therapeutic activities. At the five reception centers with the preponderance of inmates (California Institution for Men, Richard J. Donovan Correctional Facility, North Kern State Prison, Wasco State Prison, and San Quentin State Prison), regularly scheduled therapy groups will be held on a daily basis. The remaining seven RCs with smaller populations will provide a less structured treatment array, but **all sites will provide opportunities for a minimum of one hour per day, five days per week, of out-of-cell therapeutic activities.** Inmate-patients will be enrolled into various group activities based upon PC assessment of individual needs, related to both individual symptoms as well as commitment status. The treatment activities delineated in the Program Guide will be augmented with the following options:

- Orientation to institution living – Individuals with impaired mental abilities who are placed into the institution environment require assistance in understanding and adapting to institutional rules and gaining access to available services. These individuals are also susceptible to being preyed upon by more aggressive inmates. This therapy group provides an orientation to prison life, offers coping mechanisms for personal safety, and allows for patients to ask questions and vent frustrations involved in their adaptation to their new environment.
- Assertiveness Training – Teaches ways to communicate assertively but non-aggressively. Didactic teaching techniques and practice sessions are utilized.

In addition to providing the above therapeutic activities (and the current provisions outlined in the EOP Clinical Pre-Release Program in 12-4-13 of the MHSDS Program Guide), additional clinical staff will provide individuals with imminent (60 to 120 days) release dates the following pre-release planning:

- Application for federal and state benefit entitlements, such as: Medi-Cal, Medicare, Supplemental Security Income, and Veterans Benefits. This will be accomplished by referring potentially eligible inmates to the Transitional Case Management Program under the rubric of the Division of Adult Parole Operations.
- Initiation of Conservatorship proceedings where the inmate-patient meets criteria.
- Liaison with Parole Outpatient Program staff with reporting instructions and planning for continuity of care.
- Liaison with family members and significant others who may provide living options to the individual upon release.
- Screening for need for inpatient placement per Penal Code 2962 (Mentally Disordered Offender).

#### 7. Transfer Timelines

Once an inmate-patient is evaluated and placed in the MHSDS program, the inmate-patient shall be processed by classification staff on a priority basis to ensure timely transfer to a treatment setting. All EOP designated inmate-patients shall be transferred to a treatment setting within 60 days of level of care designation, or 30 days of such designation, if clinically indicated. All CCCMS designated inmate-patients, with the

exception of parole violators with 90 days or fewer to parole, shall be transferred to a mainline institution within 90 days of level of care designation or 60 days of such designation, if clinically indicated. Inmate-patients with fewer than 30 days to parole shall receive mental health services as described above, consistent with their clinical needs. Refer to transfer timeline table in MHSDS Program Guide, Chapter 1, Program Guide Overview.

8. Staff and Self Referrals

At any time during the RC process, an inmate may self-refer, or be referred by any staff member for a review by a mental health clinician. Referrals will be made on standardized forms and forwarded to the mental health office. All referrals will be entered into the data system to ensure responses and facilitate scheduling.

Crisis cases identified by clinical and custody staff will be immediately referred to a psychologist or psychiatrist. Medication issues identified by clinical staff will be immediately referred to the psychiatrist.

- a) Staff referral: Any staff member who observes possible signs or symptoms of a serious mental disorder may refer an inmate for clinical evaluation by completing a CDCR 128-MH5, *Mental Health Referral Chrono*, and handle as self-referral process below. Any inmate who is observed to be a suicide risk, or in any other condition that requires crisis care, shall be immediately screened by a PC to assess the potential for suicide and, if appropriate, referral to the Mental Health Crisis Bed (MHCB) for admission. On weekends and holidays, refer to self-referral process below.
- b) Self referral: Inmates may request a clinical interview to discuss their mental health needs. These requests are made on a CDCR 7362, *Health Care Services Request*.

Mondays through Fridays, the following shall occur:

- a) A health care staff member shall collect all the CDCR 7362, *Health Care Services Request*, and CDCR 128-MH5, *Mental Health Referral Chrono*, each day from the designated areas.

- b) Upon receipt of the collected forms, nursing staff shall initial and date each CDCR 7362, *Health Care Services Request*, and CDCR 128-MH5, *Mental Health Referral Chrono*.
- c) The CDCR 7362, *Health Care Services Request*, and CDCR 128-MH5, *Mental Health Referral Chrono*, shall be delivered to the designated program representative in mental health services, dental services, or pharmacy services for same-day processing.

On weekends and holidays, the following shall occur:

- a) The Triage and Treatment Area RN shall review each mental health staff referral form and CDCR 7362, *Health Care Services Request*, for medical, dental, and mental health services, shall establish priorities on an emergent and non-emergent basis, and shall refer accordingly.
- b) If a mental health clinician is not available, the Medical Officer of the Day (MOD), physician on call or psychiatrist on call shall be contacted.

Inmates will be seen by a mental health clinician or on weekends by the MOD, physician or psychiatrist on call within the clinically determined time frame.

- a) Emergent – Emergency cases will be seen immediately or escorted to the Triage and Treatment Area
- b) Urgent – Urgent cases shall be seen within 24 hours
- c) Other cases will be seen within five working days. Copies of staff referral forms shall be placed in both the Central File and UHR for future reference. Staff members initiating referrals may be contacted directly, as necessary. Inmate self-referral forms shall be kept confidential, and the results of these interviews documented as deemed appropriate by the clinician.

9. Classification File Review

Correctional Counselors shall conduct a comprehensive Central File review for all inmates received into the CDCR. This shall include a review of current commitment offense records and parole violation reports. Other documentation (e.g., Mental Health Placement Chronos or Probation Officer's Reports) containing information about prior mental health issues, placement in mental health treatment programs, or criminal history

shall also be reviewed for indications of mental health needs, if applicable. A face-to-face interview shall also be conducted. The CC shall complete a staff referral when there are indications of a need for a mental health evaluation. The specific reason(s) for the mental health evaluation shall be noted on the CDCR 128-MH5, *Mental Health Referral Chrono.* Clinical recommendations for treatment shall be utilized in determining institutional placement.

10. Placement Decisions

The completed case file with results of mental health evaluations will be reviewed by Classification Staff Representatives for final placement decisions. Where treatment is required, the decision will necessitate placement in an institution with the availability of the recommended level of care (inpatient, MHCB, EOP, or CCCMS), consistent with the CDCR's policy on placements, based on security requirements.

11. Data Processing

A data processing station within mental health services at each RC will process screenings and assessments, receive all referrals for evaluation, schedule clinicians to conduct evaluations, process (type, record, distribute) completed evaluations, track inmates through the stages of assessment, and submit periodic summaries of required data to institutional administrative staff and headquarters. It is important to emphasize that, in order to ensure the accurate collection of data the system will be utilized by appropriately trained CDCR staff and will provide adequate safeguards to protect the security and confidentiality of the data. Inmate clerks are banned from having access to documents or records containing other inmates' mental health information (California Codes of Regulations, Title 15, Section 3354, (b), (6)).

## **CHAPTER 3**

### **Correctional Clinical Case Management System**

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#### **A. INTRODUCTION**

The California Department of Corrections and Rehabilitation's (CDCR) Mental Health Services Delivery System (MHSDS) serves the majority of inmates with serious mental disorders through the Correctional Clinical Case Management System (CCCMS) available at all institutions. For General Population (GP) outpatient services to be effective (e.g., sustain improved functioning and minimize the use of more intensive levels of care), inmates must know what services are available and how to access them. An effective clinical case management system ensures timely access to mental health care. Outpatient services delivered through a well-designed clinical case management system is the most cost-effective means of maintaining adequate institutional functioning among inmates with serious mental disorders.

1. The strength of well-coordinated clinical case management is its ability to systematically monitor the clinical needs and movement of MHSDS inmate-patients within and between CDCR institutions. With this service delivery mode, CDCR provides the best possible means of ensuring continuity of care while optimizing the use of available resources.
2. Clinical case management improves the quality of mental health services offered through timely therapeutic intervention, utilizing the CDCR-approved Mental Health Tracking System (MHTS). The MHTS fosters information sharing among staff who provide service to inmate-patients and the optimal utilization of professional time.

#### **The Correctional Clinical Case Management System**

Clinical case management facilitates care by linking inmate-patients to needed services and providing sustained support while accessing such services. Clinical case management adds to the usual functions of traditional case management a clinical component based on a therapeutic working relationship between inmate-patient and Primary Clinician (PC). This therapeutic relationship makes the PC a more effective agent in helping the inmate-patient achieve individualized treatment goals. The PC provides therapeutic intervention and coordinates other mental health treatment services required by the inmate-patient. This relationship ensures continuity of care.

The CCCMS services in CDCR are provided as outpatient services within the GP setting to promote inmate-patient integration and normalization. Inmate-patients requiring more

intensive services are referred to a higher level of care and are transferred to an appropriate institution/facility.

1. Through its universal availability and as the least restrictive level of care, CCCMS forms the foundation of the CDCR's MHSDS.
2. Ready access to treatment intervention increases the safety and security of the institution, and may also contribute to lowering the recidivism rate of inmate-patients released on parole or discharged to the community.

The CCCMS within the prison system is a different type of case management than one would find in the community. Within the CDCR, the fact that basic needs of inmate-patients are already provided allows PCs to concentrate on helping resolve mental health problems. Adjunct services which help maintain or improve functioning (e.g., education, substance abuse groups, and work training assignments), are available within the perimeter of the institution and are thus relatively easy for inmate-patients to physically access.

While the structure of correctional settings is conducive to facilitating clinical case management responsibilities, other factors including penological concerns that are inherent in correctional settings pose special problems for clinical practice. Institution inmates represent a specialized clientele in whom treatment of serious mental disorders are often complicated by dual diagnoses and behavior problems. Further, security considerations have to be appropriately considered in treatment plans and service delivery methods.

Psychiatrists, Clinical Social Workers (CSW), and psychologists can function as PCs. All institutions have clinical case management staff available to inmate-patients.

Using Correctional Counselors (CC), CDCR provides case management for institutional programming with which CCCMS shall interface. In effect, each CCCMS inmate-patient shall have both a PC and a CC working within the scope of their designated duties, as members of an Interdisciplinary Treatment Team (IDTT) to coordinate and deliver services.

CCCMS inmate-patients are a highly diversified population representing a broad spectrum of functional abilities. Treatment services must be tailored to adequately meet the clinical needs of each individual inmate-patient considering the functional level, readiness for treatment, insight into mental illness, and motivation for treatment. Individualized treatment plans specify measurable treatment goals and objectives, address problems, prescribe intervention modalities including treatment frequency/duration, and identify the staff member responsible for providing services. The treatment services are individualized by clinical need as described below:



1. For high-functioning inmate-patients, tracking and monitoring is often sufficient to meet this group's clinical needs. They are the most likely group to benefit from active involvement in institutional programming and require minimal contact with the PC. The primary treatment focus is on symptom management and medication monitoring.
2. For inmate-patients with significant psychological impairment, CCCMS provides, in addition to regular monitoring, more focused monitoring contacts with the PC, treating psychiatrist, and custody and correctional counseling staff to promote symptom management and prevent decompensation. Individual and group psychotherapy and other supportive services are provided as clinically indicated.
3. Although scheduled at different intervals according to clinical needs, CCCMS inmate-patient monitoring entails regular assessments and treatment plan updates.

**B. PROGRAM OBJECTIVES**

The goal of the CCCMS is to maintain and/or improve adequate functioning of mentally disordered inmate-patients in the least restrictive treatment setting possible within each correctional setting. Doing so enables CCCMS to prevent the use of more expensive, intensive level of care treatment services. The array of CCCMS services available to GP inmates extends to inmates in segregated housing units [Administrative Segregation Unit (ASU), Security Housing Units (SHU), and Condemned inmates]. The CCCMS also helps maintain adequate functioning among "nonpatients" by providing crisis intervention to those experiencing situational crises. To accomplish this goal the program provides:

1. Prompt access to mental health professionals for diagnostic evaluation and treatment.
2. Continuity of care by tracking inmate-patients' progress and by timely referral to appropriate level of care.
3. Linkage to available adjunct services when clinically and custodially appropriate (e.g., work assignments, academic and vocational education programs).
4. Linkage to existing prerelease programs and parole outpatient treatment services for inmate-patients about to parole.

**Treatment in CCCMS**

1. Ensures that inmate-patients participating in treatment address the following areas:

- a. Orientation and adjustment to the day-to-day requirements of institutional living.
  - b. The offense or crime itself and what, for the individual inmate, were precursors or contributing factors (including cognitive, behavioral, and emotional indicators).
  - c. The nature of the diagnosed mental disorder including symptom identification, coping strategies, medication compliance issues, and identification of high-risk situations that may lead to decompensation.
2. Minimizes crisis episodes and inpatient hospitalization through timely therapeutic intervention, regular assessments and treatment plan updates.
  3. Helps reduce recidivism upon release from CCCMS by providing clinical pre-release planning and coordinating the follow-up of mental health services with CCs and Parole Outpatient Clinic (POC Clinic) staff.

**C. POPULATION SERVED**

**Overall Treatment Criteria**

Overall treatment criteria have been developed for the MHSDS. An inmate must meet the criteria of 1, 2, or 3 below in order to receive MHSDS treatment at any level of care:

1. Treatment and monitoring are provided to any inmate who has **current** symptoms and/or requires treatment for the current Diagnostic and Statistical Manual diagnosed (may be provisional) Axis I serious mental disorders listed below:

**Schizophrenia (all subtypes)**

**Delusional Disorder**

**Schizophreniform Disorder**

**Schizoaffective Disorder**

**Brief Psychotic Disorder**

**Substance-Induced Psychotic Disorder (exclude intoxication and withdrawal)**

**Psychotic Disorder Due To A General Medical Condition**

**Psychotic Disorder Not Otherwise Specified**

**Major Depressive Disorders**

**Bipolar Disorders I and II**

2. Medical Necessity: Mental health treatment shall be provided as needed. Treatment is continued as needed, after review by an IDTT, for all cases in which:

**Mental health intervention is necessary to protect life and/or treat significant disability/dysfunction in an individual diagnosed with or suspected of having a mental disorder. Treatment is continued for these cases only upon reassessment and determination by the IDTT that the significant or life threatening disability/dysfunction continues or regularly recurs.**

3. Exhibitionism: Treatment is required when an inmate has had at least one episode of indecent exposure in the six month period prior to the IDTT consideration of the need for exhibitionism treatment, and the inmate-patient is either:
  - Diagnosed with Exhibitionism, or
  - Meets the alternate criteria. (*Alternate Criteria:* An inmate who meets all criteria for the diagnosis of Exhibitionism, except that the victim was not an “unsuspecting stranger” but was a staff member or inmate who did not consent to or encourage the behavior.)

(A diagnosis of Exhibitionism is not required for inmates who meet the alternate criteria.)

#### **Specific Treatment Criteria for CCCMS**

In addition to the overall treatment criteria above, an inmate must meet the following specific treatment criteria to receive treatment at the CCCMS level of care:

- Stable functioning in the GP, ASU, or SHU
- Criteria not met for higher levels of care
- Exhibits symptom control, or is in partial remission as a result of treatment
- These conditions usually result in Global Assessment Functioning scores of 50 and above.

All inmates, including those in SHU or ASU, needing crisis intervention and/or continued treatment also receive services from CCCMS staff. Details for provision of services in ASU and SHU are found in their respective chapters of the Program Guide.

Once entered in CCCMS, inmate-patients are tracked using the MHTS.

#### **D. TREATMENT AND ASSESSMENT SERVICES**

The CDCR's CCCMS relies on both mental health staff and custody staff, as members of an IDTT working within the scope of their credentials and job descriptions, to provide the prescribed services to an inmate-patient suffering from a serious mental disorder. The basic MHSDS treatment philosophy embraces the concept that mentally disordered inmate-patients need comprehensive services to maintain adequate functioning in the GP, ASU, or SHU. In addition to mental health treatment, institutional services such as academic and vocational education programs are therapeutic and integral elements in a comprehensive treatment plan for GP inmate-patients. For SHU inmate-patients, treatment plans are modified to take into account inmate security concerns and status. As noted, this correctional-clinical model of case management requires custody and clinical staff to work in tandem, from the beginning, to assess the treatment and programming needs of seriously mentally disordered inmate-patients and to ensure they receive the mental health and institutional services specified in their treatment plans.

### **Referral to CCCMS**

Inmates are referred to the program from a variety of sources. A large percentage come from Reception Centers (RC), identified as having a serious mental disorder in the routine process of screening and evaluation. Others are referred from Enhanced Outpatient Program (EOP), Mental Health Crisis Beds (MHCB) or, less frequently, Department of Mental Health (DMH) Inpatient Programs. Some may be identified at the time of inter-institutional transfer. Others are referred by institutional staff or through self-referrals. All referrals to CCCMS are processed in a timely manner and entered into the MHTS by clerical staff.

Inmates who receive a CDCR 115, *Rules Violation Report* for Indecent Exposure or Intentionally Sustained Masturbation Without Exposure shall be referred for all of the following:

- CDCR 115-MH, *Rules Violation Report: Mental Health Assessment*;
  - A mental health assessment shall be completed within 24 hours to rule-out decompensation and/or intoxication. The referral shall be made by telephone to the local Chief of Mental Health who shall arrange this assessment; and,
  - For inmate-patients included in the MHSDS, to the inmate-patient's PC.
1. Referrals are made on one of several forms, depending on referral source:
- Inmate Request for Interview
  - CDCR 7362, *Health Care Services Request Form*

- Staff Referral on CDCR 128-MH5, *Mental Health Referral Chrono*
- From RCs and other levels of care on a CDCR 7386, *Mental Health Evaluation*, and a corresponding CDCR 128-MH3, *Mental Health Placement Chrono*

NOTE: When an IDTT determines that an inmate-patient requires treatment of exhibitionism, that inmate-patient's level of care shall be changed to CCCMS, Medical Necessity (or higher if appropriate), bypassing the standard referral process.

2. The CCCMS Clinical Director shall appoint a staff member to coordinate and track referrals. A Clinical Intake Assessment shall be completed within ten working days of referral/arrival. If there is an adequate CDCR 7386, *Mental Health Evaluation*, available in the Unit Health Record (UHR) the PC may update it with documentation on a CDCR 7230, *Interdisciplinary Progress Note*, or on a CDCR 7389, *Brief Mental Health Evaluation*. If there is no CDCR 7386, *Mental Health Evaluation*, in the UHR, a new CDCR 7386, *Mental Health Evaluation*, must be done. The coordinator shall then arrange for the inmate to be seen immediately by a Staff Psychiatrist if an emergency psychiatric evaluation is needed. When disagreement exists between the evaluator at a reception center and the receiving institution IDTT regarding the need for the CCCMS services, the receiving institution clinician shall document the justification for removal from the program and complete a CDCR 128-MH4, *Mental Health Removal Chrono*, within 90 days of inmate transfer from that reception center. The CDCR 128-MH4, *Mental Health Removal Chrono*, requires approval from the Chief of Mental Health or designee.
3. Inmate-patients are continued on the same medication(s) without interruption pending further evaluation of psychotropic medications by a receiving psychiatrist.
4. Clinical case management staff are available for the initial screening of inmates referred for crisis episodes. In this initial screen the level of required clinical intervention is assessed and proper action taken.

### **Clinical Intake Assessment**

While the CDCR's MHSDS provides screening and assessment upon reception, a more comprehensive assessment is critical in formulating a treatment plan after placement in CCCMS. The assessment includes the inmate-patient's personal strengths, achievements and goals, and past responses to intervention. Inmate-patients placed in CCCMS directly from RCs have a psychological evaluation (CDCR 7386, *Mental Health Evaluation*) with at least a

provisional diagnosis and an initial treatment plan. In all cases, assessments and treatment plans are updated to include an evaluation of the inmate-patient's current readiness for institutional programming (e.g., work, substance abuse counseling, school, prerelease transition).

The PC completes a clinical intake assessment within ten working days of referral/arrival. If there is an adequate CDCR 7386, *Mental Health Evaluation*, available in the UHR the PC may update it with using page 13 of CDCR 7386, *Mental Health Evaluation* (Add-A-Page), or documentation on the CDCR 7230, *Progress Note*. If there is no CDCR 7386, *Mental Health Evaluation*, a new CDCR 7386, *Mental Health Evaluation* must be done. The clinical intake assessment shall include:

1. A review of the inmate-patient's Central File and UHR, a face-to-face interview with the inmate-patient, and interviews with other institutional staff when possible.
2. A review of previous mental health records. If the inmate-patient states that he or she had significant prior treatment or if the file review indicates history of such treatment, the clinician shall request that the inmate-patient sign a *Release of Information* form to obtain previous records. The clinician shall forward the signed *Release of Information* form to Health Records for immediate processing, in accordance with Health Record policies and procedures.
3. Evaluation of an inmate-patient's ability to program based on appropriate educational and vocational testing instruments that take into account the degree of psychiatric impairment, physical (medical) limitations, and custody and housing restrictions.
4. Multiaxial diagnoses (Axis I through V) from the current Diagnostic and Statistical Manual.
5. Evaluation of suicide and violence potential.

### **Treatment Planning**

#### **Interdisciplinary Treatment Team**

The responsibilities of overall treatment planning within the CCCMS program rests with an IDTT.

1. These responsibilities include:

- Admission decisions for individual cases
  - Formulation and approval of individualized treatment plans
  - Annual and special case reviews for the continuation or termination of services
  - Review of current treatment needs and response to past intervention efforts
2. The IDTT is composed of, at a minimum:
- Assigned Primary Clinician
  - Assigned Psychiatrist
  - Correctional Counselor
  - Inmate-patient
3. Other staff who have direct knowledge of the inmate-patient are encouraged to attend or provide information:
- Licensed Psychiatric Technicians
  - Custody Officers

The IDTT shall generally be responsible for developing and updating treatment plans. This process shall include input from the inmate-patient and other pertinent clinical information that may indicate the need for a different level of care. Referrals to higher levels of care shall be considered when the inmate-patient's clinical condition has worsened or the inmate-patient is not benefiting from treatment services available at the current level of care. Consideration of appropriate level of care shall be documented by the IDTT on a CDCR 7230-MH, *Interdisciplinary Progress Notes*, and shall include the justification for maintaining the current level of care or referral to a different level of care.

In consultation with the IDTT, the PC develops an individualized treatment plan for all CCCMS inmate-patients. Treatment plans are based on current assessments from all disciplines and with as much participation from the inmate-patient as possible. The inmate-patient shall be included in the IDTT, unless the inmate-patient refuses to participate. If the inmate-patient refuses to participate in the IDTT, the inmate-patient shall indicate the refusal, the reason for the refusal, and shall sign on the backside of the ducat. Inmate-patients shall

not be disciplined for not participating in IDTT. If the inmate-patient refuses to participate, the PC documents the reason for refusal in the CDCR 7230, *Interdisciplinary Progress Notes*.

The Treatment Plan specifies mental health and other institutional services that can facilitate the resolution of identified problems listed in the problem list. All activities including work, education, and recreation are potentially therapeutic and must be included in the total treatment plan. When activities are prescribed in the treatment plan, specific target behaviors that are expected to benefit from these activities must also be identified. The individualized treatment plan must be completed within 14 working days of referral/arrival by the PC in consultation with the other IDTT members. CDCR Form 7388, *Mental Health Treatment Plan*, is used for this purpose.

1. Selected information from the intake assessment and the treatment plan are shared with the CCs during IDTT for inclusion in the Classification Committee review.
2. The treatment plan includes:
  - a. Basic identifying data about the inmate-patient (age, race, committing county, commitment offense, current Earliest Possible Release Date or Minimum Eligible Parole Date, classification score/custody level, education, and work history);
  - b. A diagnosis, identified problems, and treatment objectives measurable in behavioral terms;
  - c. Treatment services and other institutional services designed to impact the identified problems and achieve individual treatment objectives;
  - d. Frequency and duration of services to be provided;
  - e. Documentation regarding the completion of appropriate forms such as a signed *Release of Information* necessary to obtain prior medical/mental health records,



- signed Medication Informed Consent to medicate, and heat warning forms for those inmate-patients prescribed psychotropic medication; and
- f. Aftercare and clinical pre-release plans.
3. The date of the treatment plan approval shall be entered into the MHTS.
  4. At the conclusion of the initial IDTT, if an inmate-patient is determined to be appropriate for inclusion in the CCCMS program, the PC shall send a CDCR-128 MH3, *Mental Health Placement Chrono*, to the appropriate staff to be entered in the Priority Level of Care List for inputting into the MHTS. That staff person forwards the CDCR 128-MH3, *Mental Health Placement Chrono*, to the Classification and Parole Representative.
  5. Treatment plans are updated at least annually, whenever a change in level of care occurs, or when clinical judgment indicates the need for an update.
  6. All services to inmate-patients shall be reflected in treatment plan updates.
  7. All updates shall be entered in the MHTS and a CDCR 128 MH3, *Mental Health Placement Chrono*, shall be produced with every change in level of care (see “Patient Monitoring and Clinical Case Review” in this section for more details).

### **Treatment Modalities**

Institutional programming is an essential component of the treatment regimen of most clinical case management participants. The PCs shall make specific recommendations for programs such as education, work, and substance abuse counseling and coordinate with CCs to ensure appropriate linkages to these programs. As noted earlier, a therapeutic working relationship between the inmate-patient and the PC is essential to the success of the treatment outcome.

Based on identified needs, treatment modalities may include:

- Orientation and supportive counseling for institutional adjustment
- Medication review and monitoring
- Individual counseling and crisis intervention
- Group therapy such as anger management and relapse prevention
- Social skills training

- Consultation services, such as to education and work programs
- Clinical discharge or clinical pre-release planning

**Medication Evaluation and Management**

1. Each CCCMS inmate-patient on psychiatric medication shall be reevaluated by a psychiatrist a minimum of every 90 days regarding psychiatric medication issues. The psychiatrist shall respond to inmate requests and staff referrals for medication issues according to the time frames established for inmate and staff responses (i.e., Emergent [immediately], Urgent [within 24 hours], or Routine [5 working days]).
2. Refer to Inmate Medical Services Policies and Procedures, Medication Management regarding procedures for administration of medication, medication refusals, Directly Observed Therapy (DOT), and other aspects of medication administration.
3. Refer to Chapter 5, *Mental Health Crisis Bed*, for information on involuntary medication administration.

**Transfer and Clinical Discharge**

Important functions of PC include:

- Making the clinical determination as to when and how to transfer inmate-patients to more intensive levels of care,
- Discharging those inmate-patients who no longer need services, and
- Coordinating pre-release planning for inmate-patients being paroled.

Clear and measurable criteria for both transfer to more intensive levels of care and clinical discharge are important (Chapter 1, Program Guide Overview, Section D). Equally important is coordination with units or programs which shall take over the care and/or monitoring of the inmate-patient and coordination of pre-release planning with correctional counseling staff, Parole and Community Services Division Transitional Case Management staff, and Parole Outpatient Clinic staff.

1. Prior to CCCMS termination (clinical discharge or program transfer), the PC must complete a CDCR 128-MH3, *Mental Health Placement Chrono*, or CDCR 128-MH4, *Mental Health Removal Chrono*, to notify custody.

2. Clinical discharges and/or program transfers shall be documented in the MHTS.
3. The PC shall present a recommendation for transfer to an EOP or clinical discharge in a clinical case review with the IDTT. If, after consultation, the IDTT approves recommendation for transfer to an EOP, the PC shall complete a CDCR 7386, *Mental Health Evaluation*, and a corresponding CDCR 128 MH3, *Mental Health Placement Chrono*. If the team approves recommendation for clinical discharge, the PC shall complete a CDCR 128 MH4, *Mental Health Removal Chrono*.
4. Inmate-patients requiring more intensive outpatient services within a structured setting shall be transferred to an EOP within 60 days of the EOP designation, or within 30 days if clinically indicated.
5. Inmate-patients awaiting EOP transfer shall have updated treatment plans, (CDCR 7388, *Mental Health Treatment Plan*). While awaiting EOP transfer, inmate-patients shall be seen on a weekly basis by the PC.
6. If a transfer occurs within the same institution, immediately before transfer to EOP the CCCMS PC shall contact the EOP Clinical Director or designee to ensure continuity of care and provide the most recent, relevant clinical information regarding the inmate-patient's clinical needs.
7. Inmate-patients shall be transferred to MHCB for crisis episodes requiring 24-hour nursing care. The transfer to a MHCB shall be accomplished within 24 hours of referral. While awaiting transfer, the inmate-patient shall be housed in a medical facility with at least an Outpatient Housing Unit (OHU) level of care. A psychiatrist, psychologist, or CSW shall provide clinically appropriate care, while the inmate-patient is awaiting transfer. This may include suicide observation, one to one counseling, medication management, and/or nursing care.
8. Inmate-patients with multiple admissions to MHCB (three or more within a six month period) shall be evaluated for referral to DMH or EOP.
9. Inmate-patients who:
  - attempt suicide,
  - currently have significant suicidal ideation or potential, or
  - pose a moderate to serious risk for suicide,

shall be admitted to MHCB and considered for referral to DMH. If an inmate-patient is accepted to DMH, the inmate-patient shall be transferred to DMH within 72 hours of bed assignment.

10. Inmate-patients may be clinically discharged from CCCMS if they have been in continuous remission and are functioning adequately in the mainline without treatment (including medication) for six-months. Inmates shall be seen for 90-day clinical contacts throughout the six-month period.
11. Inmate-patients admitted on the basis of medical necessity shall be discharged when the crisis or problem necessitating treatment is resolved. Discharge of inmate-patients, who were placed in the CCCMS program on a medical necessity, shall be determined by the IDTT and shall be approved by the Chief Psychiatrist, Chief Psychologist, Senior Psychologist or designee.
12. Clinical pre-release plans included as part of the Treatment Plan shall be updated as appropriate but at least at every annual clinical case review.
13. The Discharge/Transfer Summary shall include the diagnoses (current Diagnostic and Statistical Manual version), Axis I through Axis V, a brief summary of the inmate-patient's course of treatment in CCCMS, recommendations for follow-up care, and discharge medications (Pre-release planning).
14. The PC shall coordinate with the CC, staff from the Transitional Case Management program, and clinical staff from the POC Clinic regarding plans for release and follow-up of the inmate-patient to be paroled. Discharge/Transfer Summaries shall be forwarded to the POC Clinic or other pertinent clinical pre-release program providers after signed Releases of Information have been obtained. While necessary for record transactions with other agencies, a signed release is not needed within CDCR. Patients currently receiving medication, upon a physician's order, shall be provided a 30-day supply of essential medications when released on parole or discharged unless clinically contraindicated.
15. CCCMS inmate-patients who are inappropriately transferred to a non-CCCMS mainline institution shall be transferred to a defined treatment setting within 30 days of arrival at the non-CCCMS institution.
16. Inmate-patients who are determined to require CCCMS level of care while in a non-CCCMS institution shall be transferred to a treatment setting within 90 days of the level of care designation or 60 days of the level of care designation, if clinically indicated.

**E. INMATE-PATIENT MONITORING AND CLINICAL CASE REVIEW****Monitoring Contacts**

Inmate-patient progress is assessed by the PC during regularly scheduled contacts. The frequency of these contacts shall vary based on clinical needs. The majority of CCCMS inmate-patients who have been stabilized are capable of functioning adequately in the mainline while receiving maintenance care. Usually, they can manage the symptoms of their mental illness and report with little prompting for renewal of medication prescriptions. A certain percentage of inmate-patients will manifest greater needs and thus require more frequent contact.

1. Face-to-face individual contacts between the PC and the CCCMS inmate-patients in a GP setting shall occur as often as clinical needs dictate but at least once every 90 days.
2. Inmate-patients recently released from more intensive levels of care, admitted directly from RCs, or recently released from segregated housing units may initially require daily to weekly contacts.
3. Inmate-patients who were admitted to the MHCB for a suicide attempt or ideation, upon discharge from that program, shall be seen by the PC, or designee, daily for the first five calendar days following discharge, and as often as required thereafter. Custody staff shall also observe these inmate-patients a minimum of every hour for the first 24 hours after the discharge from the MHCB. At the end of the first 24 hours after discharge, the CCCMS clinical staff shall evaluate an inmate-patient to determine the need for extending the observation period (not to exceed 24 hours at a time). If the recommendation for an extension is justified, the inmate-patient shall be observed every two hours for the following 48 hours and every 4 hours thereafter. If, after a second evaluation, a mental health clinician feels additional hourly checks are required, the inmate-patient shall be returned to the MHCB for further stabilization. Custody staff shall maintain a log of their rounds on inmate-patients. Inmate-patients housed in OHUs for suicide observation, who do not require MHCB level of care and who were discharged from the OHU before 24-hours, may be seen by clinicians and custody staff for follow-up care. The process and timeframes for follow up care may be the same as is described for MHCB suicide discharges.
4. Monitoring contacts and attendance at treatment activities shall be entered into the inmate-patient contact file of the MHTS.

5. Significant inmate-patient contacts shall be documented on CDCR 7230, *Interdisciplinary Progress Notes*, in the UHR on the same day of occurrence. Group therapy sessions must be recorded in a monthly summary note and include the inmate-patient's attendance, behavior in the group, and the progress toward achieving treatment goals.

### **Clinical Case Review**

In consultation with the IDTT, a full review of outpatient progress, which includes clinical status and performance in work, educational and vocational training, social, and daily-living activities, shall be done to ascertain the appropriateness of current level of care placement. This review may or may not result in modifications of the Treatment Plan.

1. Clinical case reviews shall be done at least annually, prepared prior to, and included as applicable in Classification Committee hearings reviewing inmate-patient status. The first annual clinical review shall be scheduled in the month prior to a classification hearing and annually thereafter.
2. The annual review culminates in a CDCR 7388, *Mental Health Treatment Plan*, rejustification. This report shall include a description of current clinical status, participation in treatment and institutional programming, and reasons for continuation or termination of CCCMS services.
3. Clinical case reviews shall also be done every time placement in more intensive levels of care or change to nonpatient status is indicated. These case reviews are documented in the CDCR 7230, *Interdisciplinary Progress Notes*, CDCR 7386, *Mental Health Evaluation Form*, CDCR 7388, *Mental Health Treatment Plan*, a CDCR 128-MH-3, *Mental Health Placement Chrono*, or a CDCR 128-MH, *Mental Health Removal Chrono*. Clinical case review documentation shall include the printed names and signatures or initials of the clinical and custody staff present in the IDTT. The custody staff who manages the inmate-patient's day-to-day routine shall be included whenever possible in the IDTT. The PCs shall document the presence of the inmate-patient during the review and indicate reasons for the inmate-patient's absence.

## **F. STAFFING**

Staffing for CCCMS includes psychologists, CSWs, psychiatrists, and clerical support. CDCR may utilize contract staff as necessary to fulfill staffing requirements.

Staff training is crucial to the successful operation of the CCCMS. Training is essential because CCCMS, as a formalized systemwide approach to outpatient treatment in inmate-patients' regularly assigned living units, is relatively new, not only to CDCR, but to

correctional settings in general. Many clinical staff hired to work in CCCMS programs are new, not only to the institution setting, but also to forensic mental health. Training facilitates standardizing basic elements of CCCMS service delivery.

### **Clinical Director**

A Clinical Director is critical to the success of CCCMS. In addition to direct care responsibility, the Director takes the lead in developing and implementing local policies and procedures for clinical case management, oversees the MHTS, makes PC assignments, facilitates training, provides clinical and administrative supervision, and coordinates system monitoring functions contained in quality assessment and improvement activities. The Clinical Director can be any licensed mental health professional with experience running a complex case management system. In the standard staffing pattern, a Senior Psychologist is provided to serve as the CCCMS Clinical Director, although in some institutions this role is performed by the Chief of Mental Health or designee (see description in Chapter 1, *Program Guide Overview*).

### **Primary Clinician**

Under the direction of the Clinical Director, the PC performs the necessary case management functions for all outpatients in their caseloads. This includes assessment, treatment planning and treatment, clinical monitoring, and clinical case reviews. They coordinate with institutional services that are considered helpful in maintaining or improving inmate-patient functioning. The PCs shall screen institution referrals to the CCCMS, including those for crisis episodes. If an inmate-patient is referred for evaluation of medication related issues, the referral shall be routed directly to a psychiatrist for evaluation. CSWs, psychologists, and psychiatrists shall be assigned as PCs.

### **Clerical Support**

Medical Transcribers or Office Technicians shall provide clerical support to clinicians. Clerical support includes: record keeping; assisting with scheduling; transcribing and typing reports and forms used in referral, assessment, treatment planning, patient contacts, and clinical case reviews. Responsibilities of this position also include computer data entry, e.g. MATS.

## **G. MENTAL HEALTH QUALITY MANAGEMENT SYSTEM**

Ongoing assessment of the quality of clinical services shall follow the Mental Health Quality Management System procedures.

# **CHAPTER 4**

## **Enhanced Outpatient Program**

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### **A. INTRODUCTION**

The Enhanced Outpatient Program (EOP) provides the most intensive level of outpatient mental health care within the Mental Health Services Delivery System (MHSDS). The program is characterized by a separate housing unit and structured activities for mentally ill inmate-patients who, because of their illness, experience adjustment difficulties in a General Population (GP) setting, yet are not so impaired as to require 24-hour inpatient care. Inmate-patients who, because of a mental disorder, do not function well in EOP may be referred for higher levels of care including: Mental Health Crisis Bed (MHCB); or Department of Mental Health (DMH) Day Treatment Program, Intermediate Care Program, or Acute Psychiatric Program.

Critical components include:

1. A comprehensive array of mental health services delivered within the framework of an Interdisciplinary Treatment Team (IDTT), which is composed of representatives from a cross-section of clinical disciplines as well as prison custodial and counseling staff. Treatment is focused on resolution of institutional adjustment problems which impede functioning within the GP. Services include management of activities of daily living, group and individual psychotherapy, medication management, recreational therapy, and clinical pre-release planning.
2. A designated housing unit with restricted access and alternative educational, work, and recreational opportunities specifically provided for inmate-patients whose mental illness precludes their placement and participation in the GP programs.
3. Active interface with custodial staff, including Correctional Counselors (CC), which enhances the assessment and treatment process and optimizes the inmate-patient functioning within the prison environment.

### **B. PROGRAM OBJECTIVES**

The goal of the EOP is to provide focused evaluation and treatment of mental health conditions which are limiting an inmate's ability to adjust to a GP placement. The overall objective is to provide clinical intervention to return the individual to the least restrictive clinical and custodial environment.

More specific objectives include:



1. Provide short to intermediate term (a range of 3 to 12 months for most cases) focused care for inmate-patients who do not require 24-hour inpatient care. Short term treatment goals are primarily directed at developing constructive coping mechanisms, achieving treatment compliance, and further stabilization of psychiatric symptoms that are necessary for transition to the Correctional Clinical Case Management System (CCCMS) level of care.
2. Provide longer-term placement for inmate-patients with chronic mental illness whose symptoms have stabilized but whose level of functioning is insufficient to allow GP placement. Supportive care, assistance with activities of daily living, recreational therapy, anger management, reality therapy, and programs related to symptom management and clinical pre-release planning are offered.
3. Provide short-term secure custodial placements with clinical resources which address behavioral problems for mentally ill EOP inmate-patients who are transitioning from Security Housing Units or Psychiatric Services Units (PSU). Treatment for these inmate-patients focuses on achieving behavioral control and the development of socially acceptable behavior within the institution.

### **C. POPULATION SERVED**

#### **Overall Treatment Criteria**

Overall treatment criteria have been developed for the MHSDS. An inmate must meet the criteria in 1, 2, or 3 below in order to receive MHSDS treatment at any level of care:

1. Treatment and monitoring are provided to any inmate-patient who has **current** symptoms and/or requires treatment for the current Diagnostic and Statistical Manual diagnosed (may be provisional) Axis I serious mental disorders listed below:

**Schizophrenia (all subtypes)**

**Delusional Disorder**

**Schizophreniform Disorder**

**Schizoaffective Disorder**

**Brief Psychotic Disorder**

**Substance-Induced Psychotic Disorder (exclude intoxication and withdrawal)**

**Psychotic Disorder Due To A General Medical Condition**

**Psychotic Disorder Not Otherwise Specified**

**Major Depressive Disorders**

**Bipolar Disorders I and II**

2. Medical Necessity: Mental health treatment shall be provided as needed. Treatment is continued as needed, after review by an IDTT, for all cases in which:

**Mental health intervention is necessary to protect life and/or treat significant disability/dysfunction in an individual diagnosed with or suspected of having a mental disorder. Treatment is continued for these cases only upon reassessment and determination by the IDTT committee that the significant or life threatening disability/dysfunction continues or regularly recurs.**

3. Exhibitionism: Treatment is required when an inmate has had at least one episode of indecent exposure in the six-month period prior to the IDTT that considers the need for exhibitionism treatment, and the inmate-patient is either:

- Diagnosed with Exhibitionism, or
- Meets the alternate criteria (*Alternate Criteria*: An inmate who meets all criteria for the diagnosis of Exhibitionism, except that the victim was not an “unsuspecting stranger” but was a staff member or inmate who did not consent to or encourage the behavior.)

(A diagnosis of Exhibitionism is not required for inmates who meet the alternate criteria.)

#### Specific Treatment Criteria for EOP

In addition to the overall treatment criteria above, an inmate must meet the following specific treatment criteria to receive treatment at the EOP level of care:

- Acute Onset or Significant Decompensation of a serious mental disorder characterized by symptoms such as increased delusional thinking, hallucinatory experiences, marked changes in affect, and vegetative signs with definitive impairment of reality testing and/or judgment; and/or
- Inability to Function in General Population Based Upon:
  - a. A demonstrated inability to program in work or educational assignments, or other correctional activities such as religious services, self-help programming, canteen, recreational activities, visiting, etc. as a consequence of a serious mental disorder; or
  - b. The presence of dysfunctional or disruptive social interaction including withdrawal, bizarre or disruptive behavior, extreme argumentativeness, inability

to respond to staff directions, provocative behavior toward others, inappropriate sexual behavior, etc., as a consequence of a serious mental disorder; or

- c. An impairment in the activities of daily living including eating, grooming and personal hygiene, maintenance of housing area, and ambulation, as a consequence of a serious mental disorder.
- These conditions usually result in Global Assessment Functioning (GAF) Scores of less than 50.

#### Enhanced Outpatient Care (Designated Housing Unit)

Participants in the MHSDS EOP are placed in designated housing units that provide increased clinical and custodial support and limit contact with members of the institution's GP inmates.

### **D. ADMISSION TO PROGRAM**

#### Referral Process

1. Mental Health clinicians may initiate an EOP referral. This referral decision is documented on a CDCR 128-MH3, *Mental Health Placement Chrono*, and clinically supported in an original or updated CDCR 7386, *Mental Health Evaluation*. Both forms are placed in the Unit Health Record (UHR) and the CDCR 128-MH-3, *Mental Health Placement Chrono*, is placed in the Central File.
2. If the referral is generated for an inmate-patient at a GP institution without an EOP, the clinician at the referring institution may consult with the Chief of Mental Health at the closest EOP site regarding the need for EOP level of care, prior to initiating the referral process. In situations where there is a disagreement between the conferring clinicians, the inmate-patient will be referred to an EOP treatment setting for further onsite evaluation.
3. EOP placements do not require prior clinical approval from the receiving institution.
4. Referral documentation is prepared by the referring clinician. The documentation includes the chronological CDCR 7230, *Interdisciplinary Progress Note*, containing circumstances, symptoms, and behaviors justifying the need for EOP level of care. This document is placed in the UHR. The documentation also includes a CDCR 128-MH3, *Mental Health Placement Chrono*, containing a brief description of behavioral alerts. The original of this document is forwarded to classification staff for processing and

Classification Staff Representative (CSR) endorsement for institutional placement. A copy of the CDCR 128-MH3, *Mental Health Placement Chrono*, is placed in the UHR.

5. EOP placements from within the same institution are accomplished with the approval of the IDTT, placed in an available EOP bed, and documented on a CDCR 128-MH3, *Mental Health Placement Chrono*. For inmates not currently participating in the MHSDS program, the classification committee will refer the case to the CSR for EOP endorsement. For those currently participating in the MHSDS program, the classification committee will refer the case to the Classification and Parole Representative (C&PR) for EOP endorsement. Subsequent placements of the same individual into the EOP require only C&PR approval. A weekly count of filled and vacant EOP beds is provided to Division of Correctional Health Care Services (DCHCS) and Division of Adult Institutions to facilitate the use of available beds by population management staff.
6. The classification and transportation systems are designed to ensure placement within 60 days of level of care designation, or 30 days of level of care designation, if clinically indicated. Transfers within the same institution of inmate-patients previously identified and treated as EOP or from the institution's MHCB should occur on the same day, or within 24 hours of referral.
7. EOP inmate-patients who are inappropriately transferred via CSR endorsement action to a non-EOP institution shall be transferred to an EOP institution within 21 days of arrival.
8. Inmate-patients who are determined to require EOP level of care while in a non-EOP institution, shall be transferred to an appropriate EOP treatment setting within 60 days of the EOP designation, or 30 days of the designation, if clinically indicated.
9. Inmates who receive a CDCR 115, *Rules Violation Report* for Indecent Exposure or Intentionally Sustained Masturbation Without Exposure shall be referred for all of the following:
  - CDCR 115-MH *Rules Violation Report: Mental Health Assessment*;
  - A mental health assessment shall be completed within 24 hours to rule-out decompensation and/or intoxication. The referral shall be made by telephone to the local Chief of Mental Health who shall arrange this assessment; and,
  - For inmate-patients included in the MHSDS, to the inmate-patient's Primary Clinician (PC)

NOTE: When an IDTT determines that an inmate requires treatment of exhibitionism, that inmate's level of care shall be changed to CCCMS, Medical Necessity (or higher if appropriate), bypassing the standard referral process.

### Interdisciplinary Treatment Team

The responsibilities for overall treatment planning within the EOP rest with the IDTT. These responsibilities include:

- Program admission decisions for individual case
- Formulation and approval of initial and updated individual treatment plans
- Periodic case reviews and re-justifications of treatment
- Discharge decisions
- Overall utilization review of available beds
- Overall program quality improvement

The IDTT is composed of, at a minimum:

- Assigned Primary Clinician (PC)
- Assigned Psychiatrist
- Correctional Counselor
- Inmate-patient

Other staff who have direct knowledge of the inmate-patient are encouraged to attend or provide information:

- Licensed Psychiatric Technicians (LPT)
- Custody Officers

Recreation Therapists (RT), Registered Nurses (RN), Licensed Vocational Nurses, LPT, and the housing custody officer will also normally participate. Each member of the team will provide input into the overall treatment plan. Input from additional staff, including vocational and educational personnel, is strongly encouraged. A representative from the IDTT (the assigned PC or designee) should be present in all classification hearings regarding inmate-patients in treatment to provide mental health input into the classification decision-making process. The inmate-patient shall be included in the IDTT, unless the inmate-patient refuses to participate. If the inmate-patient refuses to

participate in the IDTT, the inmate-patient shall indicate the refusal and the reason for the refusal. The PC shall document this information on the treatment plan, CDCR 7388, *Mental Health Treatment Plan*, and in the progress notes, CDCR 7230-MH, *Mental Health Progress Note*. Inmate-patients shall not be disciplined for not participating in IDTT. The PC is responsible for presenting the inmate-patient's concerns to the IDTT.

The Chief of Mental Health shall designate the IDTT leader.

### **Initial Evaluation Process**

The initial clinical assessment involves an interview with the inmate-patient and a review of available clinical records, the Central File, the evaluation of the referring clinician, and records from prior institutional placements. A review of these evaluations and an observation period are utilized to establish a functional baseline and working clinical diagnosis. This process shall be completed within 14 calendar days from arrival at the EOP.

If the inmate-patient states that he or she had significant prior treatment or the file review indicates history of such treatment, the clinician shall obtain a signed *Release of Information* and forward it to the Institutional Health Record Services to obtain previous records. The referring clinician, custodial staff, work supervisors, teachers, chaplains, and family members are excellent sources of patient collateral information and should be utilized whenever possible (with appropriate release of information when required).

At the conclusion of the evaluation process and within 14 calendar days from arrival at the EOP, the IDTT will review all relevant clinical, institutional, and criminal history data, interview the inmate-patient and make one of the following determinations:

1. Admit to the program and develop a treatment plan on the CDCR 7388, *Mental Health Treatment Plan*.
2. Decline admission (indicate clinical options).
3. Extend evaluation process for an additional 14 calendar days.

All decisions regarding change of treatment level made by the IDTT shall be documented with a CDCR 128-MH3, *Mental Health Placement Chrono*. This chrono shall be forwarded to classification for review and central file update. One copy of the chrono is placed in the UHR and another copy forwarded for entry into the MHTS. An individualized treatment plan, CDCR 7388, *Mental Health Treatment Plan*, shall include the recommendations of the IDTT and specifics such as type of therapeutic activities (schedule, duration, outcome expectations) and anticipated length of stay. The

prescription of treatment activities should consider the commitment offenses and current institutional maladjustment.

Inmate-patients who are released from Administrative Segregation Unit (ASU) or the PSU to a GP EOP for continuing mental health treatment may require mental health services related to adjustment to the GP environment. The ASU or PSU PC shall document recommendations regarding the inmate-patient's specific treatment needs, including any concerns about facilitating the inmate-patient's successful transition to GP. The receiving EOP IDTT will consider documentation by the ASU or PSU clinician in developing the inmate-patient's treatment plan. The treatment plan for inmate-patients transferred from ASU or PSU to GP-EOP shall include services provided to aid in the transition to the GP environment. Inmate-patients referred from the ASU or PSU to a GP-EOP Unit shall be retained at EOP level of care for a minimum of 90 days.

#### **Release after Initial Evaluation**

If, at the conclusion of the initial evaluation process, the IDTT determines that EOP placement is inappropriate, documentation to this effect is placed in the UHR using CDCR 7388, *Mental Health Treatment Plan*. A CDCR 128-MH3, *Mental Health Placement Chrono*, noting the decision and recommending more appropriate placement shall be prepared for classification processing and transfer (if appropriate). If inpatient care is indicated, the assigned PC is responsible for initiating and completing the placement process.

### **E. EOP INMATE-PATIENT TREATMENT SERVICES**

Each EOP inmate-patient will have an individualized treatment plan that provides for treatment consistent with the inmate-patient's clinical needs. The treatment plan shall be documented on a CDCR 7388, *Mental Health Treatment Plan*. Each inmate-patient shall be offered at least ten hours per week of scheduled structured therapeutic activities as approved by the IDTT. It is recognized that not all inmate-patients can participate in and/or benefit from ten hours per week of treatment services. For some inmate-patients, ten hours per week may be clinically contraindicated. For those inmate-patients scheduled for less than ten hours per week of treatment services, the PC shall present the case and recommended treatment program to the IDTT for approval. The CDCR 7388, *Mental Health Treatment Plan*, must include a detailed description of the diagnosis, problems, level of functioning, medication compliance, and rationale for scheduling less than ten hours. For inmate-patients who are scheduled for less than ten hours of treatment activities per week, the IDTT shall meet at least monthly and be responsible to review and increase the treatment activities or refer to a higher level of care as clinically indicated.

**Categories of Treatment Services****REQUIRED TREATMENT**

1. Individual Treatment Planning involves a meeting of the IDTT and the inmate-patient at least every 90 days for the purpose of identifying treatment needs, developing treatment plans, assessing treatment progress, and updating/revising individual treatment plans in accordance with the inmate-patient's needs and progress.
2. Weekly clinical contact with PC either individually or in group psychotherapy; individual clinical contact at least every other week.
3. Medication Evaluation and Management
  - a) A psychiatrist shall evaluate each EOP inmate-patient at least monthly to address psychiatric medication issues.
  - b) Refer to Inmate Medical Services Policies and Procedures, Volume 4, Chapter 11, Medication Management, regarding procedures for administration of medication, medication refusals, Directly Observed Therapy, and other aspects of medication administration.
  - c) Refer to MHSDS Program Guide, Chapter 5, Mental Health Crisis Bed, for information on involuntary medication administration.
4. Ten hours per week of scheduled structured therapeutic activities. See below for list of treatment activities.

**OTHER TREATMENT ACTIVITIES**

1. Group therapy and psycho-educational groups provide inmate-patients with an opportunity to express, explore, and resolve issues with the assistance of clinical staff and other inmate-patient group participants who have similar problems or experiences. Psycho-educational groups focus on cognitive/behavioral skill building as a means of improving inmate-patient interpersonal skills and problem solving abilities.
2. Individual therapy provides inmate-patients with the opportunity to discuss personal problems that may not be adequately addressed in a group setting.
3. Recreational and occupational therapies provide inmate-patients with supervised recreational activities or exercise programs designed to reduce stress, improve self-esteem and physical health, foster positive interpersonal interactions, and promote the constructive use of leisure time. Occupational or recreational therapy is counted as



structured activity only if an appropriate clinician (an occupational therapist, recreational therapist, LPT, or other qualified professional) is present and supervising the activity. Unsupervised routine exercise is available for all inmate-patients and is not counted as a therapeutic activity.

4. Work and educational programs may provide rehabilitative services through institutional programming designed to help inmate-patients improve vocational and educational functioning. Work and education assignments can constitute up to four hours of structured activity per week if they are identified as such in the inmate-patient's treatment plan. The treatment plan must indicate how it is believed the inmate-patient benefits from particular vocational and/or educational activities.

### **Examples of Treatment Activities**

The EOP may offer some or all of the following treatment activities, depending on the needs of the inmate-patient population and the resources available.

1. Daily Living Skills - train and assist inmate-patients in developing or improving skills in maintaining appropriate personal hygiene and grooming habits. These activities include demonstrating and prompting inmate-patients in bathing, dressing, and the maintenance of a clean living environment. These activities promote personal responsibility and initiative for self-care, enhance self-esteem, and provide a predictable daily routine.
2. Medication Education - educate inmate-patients regarding the importance and benefits of regularly taking their prescribed medications. It discusses medication, interaction with alcohol and drugs, and teaches how to correctly take medication. It explains side effects and when they need to be brought to the attention of clinical staff. It stresses the importance of effective doctor/patient communication in obtaining and maintaining medication compliance.
3. Symptom Management - help inmate-patients with chronic mental disorders become more effective in managing their psychiatric symptoms by teaching them how to identify warning signs of relapse, persistent symptoms, and medication side effects. Inmates learn how to cope with symptoms and seek professional help.
4. Specific Mental Health Issues - provides focused clinical support for inmate-patients experiencing specific mental health issues, such as depression, or who have a history of being a victim.
5. Social Skills/Communication - focus on activities which allow inmate-patients to interact in a positive manner with other individuals, both staff and inmates. It promotes the development of communication skills that are appropriate and socially acceptable.

6. Anger Management - teaches inmate-patients the socially acceptable and appropriate ways of handling anger and expressing feelings. This module is geared towards reducing aggressive/assaultive behavior toward self or others or by developing self-control skills. It teaches inmate-patients processes that can be used within the institution setting to resolve conflicts and handle problems appropriately without resorting to violence.
7. Stress Management - teaches inmate-patients how to identify recurring prison stressors and provides specific stress reduction techniques to minimize the negative effects of stress on their behavior and mental health.
8. Substance Abuse Group - teaches inmate-patients about the relationship between substance abuse and criminality and emphasizes the effects of chemical abuse on inmate-patients with mental illness. The group offers supportive interactions and explores issues of chronic abuse and the development of alternatives.
9. Health Issues - provides education regarding basic physical, emotional, and mental health issues, including human sexuality and sexually transmitted diseases.
10. Offense Specific Therapy - provides clinical support for insight-oriented treatment related to causative factors in criminal behavior, emphasizing the development of alternative courses of conduct.
11. Rational Behavior/Reality and Decision-making - emphasizes the assumption of responsibility for one's actions, accepting the reality of their living environment, the development of more productive and pragmatic life scripts, as well as developing strategies to identify and achieve attainable goals.
12. Family Issues - focus on stressful experiences associated with spousal abuse, childhood physical and sexual abuse, separation from offspring and loved ones, dysfunctional relationships, pregnancy issues, etc.
13. Therapeutic Community Meeting - all inmate-patients in the program are involved in regularly scheduled community meetings to discuss issues that commonly affect their treatment and living environment. Inmate-patients learn through active interaction with peers and staff how to build a therapeutic community.
14. Clinical Pre-Release group - inmate-patients nearing parole to the community are seen weekly in group and discuss issues related to community living arrangements, continued outpatient care, financial, educational, and vocational needs. The skills necessary to successfully meet the general conditions of parole in the community are discussed. Clinical Pre-Release groups involve coordination with the Parole and Community

Services Division Transitional Case Management Program (TCMP) staff and Parole Outpatient Clinic (POC) clinical staff.

### **Daily Activity Schedules**

Utilizing the above treatment descriptions (and additional optional activities as may be developed at the institutional level), each inmate-patient has a weekly activity schedule incorporated into the individual treatment plan drawn from a schedule of treatment activities available on the unit. Development of, and adherence to, the schedule is the joint responsibility of the inmate-patient and PC. The establishment of additional unit activities, available to all inmate-patients, is the responsibility of EOP staff.

### **Nursing and Supportive Care**

Although 24-hour nursing care is not required for inmate-patients within the EOP, services expanded from those offered to GP inmate-patients are provided by RNs and/or LPTs. These services include:

1. Administration of all medications. Refer to the Inmate Medical Services Policies and Procedures, Volume 4, Chapter 11, Medication Management.
2. Regular monitoring of medication compliance, and notification of medication non-compliance to treating psychiatrist, consistent with DCHCS policy.
3. Provision of nursing services as ordered by a physician.
4. Supervision and assistance in the activities of daily living, including maintenance of living quarters, personal hygiene, and eating habits.
5. Coordination and support of out-of-cell activities with program staff.

### **Documentation**

Clinical staff shall document the progress of an inmate-patient on a CDCR 7230, *Interdisciplinary Progress Note*, at least monthly. Additionally, individual clinical contacts and significant changes in the inmate-patient's level of functioning shall be documented. The monthly progress note shall include:

- Record of attendance at treatment activities.
- Description of participation in treatment activities.

- Progress in resolving identified problems and symptoms.
- Current mental status.

**Aftercare Planning and Referral**

Planning for follow-up services is a critical component of care that inmate-patients need upon release from the EOP. The PC or the IDTT leader is responsible for ensuring that this is accomplished prior to an inmate-patient's discharge from the program. Such planning includes referrals to other levels of care, other programs, or other appropriate therapeutic placement to ensure continuity of care. Inmate-patients whose level of functioning has improved shall be referred to the CCCMS. Inmate-patients who require a higher level of care are referred to the MHCB or the DMH Inpatient Program.

Aftercare plans should describe:

1. The inmate-patient's diagnosis and the psychiatric problems continuing to require treatment.
2. Any other pertinent mental health or medical conditions (e.g., allergies, special dietary needs, chronic diseases), criminal and legal history, and cognitive or functional impairment (e.g., developmental problems, insufficient education and/or language barriers) that could affect adjustment and treatment.
3. Recommendations for follow-up treatment, including medications and recommendations for specific scheduled structured therapeutic activities.
4. Referrals to appropriate programs and other institutional services, including chaplain services, substance abuse programs, education, and job programs.

**Clinical Pre-Release Program**

This is designed to provide systematic planning, support and education to inmate-patients who are approaching their date of release/parole to the community and who are not expected to transition to another level of care before departure. This service is designed to maximize the inmate-patient's opportunities for successful transition into community living. The service coordinates its activities with the TCMP and POC staff to facilitate community outpatient care and support services. The PC shall prepare a discharge summary, which includes a diagnosis, current medications, and placement needs. The discharge summary shall be sent to the regional POC office prior to release.

**F. STAFFING AND CASE MANAGEMENT**

The EOP staffing structure is based on clinical needs for this level of care and the staffing ratios developed to meet these needs. EOP staff includes psychiatrists, psychologists, clinical social workers (CSW), RNs, LPTs, and RTs. In addition to interdisciplinary clinical staff, the EOP staffing provides enhanced correctional officer support.

**Chief of Mental Health**

The Chief of Mental Health (or designee) assigns the IDTT leaders and PCs, and reviews the overall quality of assessment and treatment plans, including aftercare plans for each inmate-patient.

**Primary Clinician**

One clinical staff member of the team (a psychiatrist, a psychologist, or a CSW) is identified as the PC for each inmate-patient. This individual assumes overall responsibilities for the treatment services provided to inmate-patients by maintaining active therapeutic involvement with the inmate-patient and coordinating services provided by other treatment providers involved in implementing the treatment plan. Specific responsibilities of the PC include:

1. Completion of initial clinical intake assessment (CDCR 7386, *Mental Health Evaluation*).
2. Documentation of:
  - All individual PC contacts;
  - Initial and updated treatment plans (CDCR 7388, *Mental Health Treatment Plan*);
  - Treatment progress or lack thereof, at least monthly (CDCR 7230-MH, *Mental Health Progress Note*);
  - Specific reasons when the inmate-patient is unable to attend or participate in group therapy;
  - Reasons for weekly individual PC contact when indicated;
  - Degree of participation in treatment activities;
  - Contact log for MHTS input.

3. Weekly clinical contacts (either individual or group psychotherapy) with assigned inmate-patients. Individual clinical contacts must occur at least every other week. Individual clinical contacts shall be held in a private setting out of cell, or cell-front if an inmate-patient refuses.
4. Provision of group therapy.
5. Scheduling for regular and special IDTT reviews. (Special IDTT reviews are held for inmate-patients who require a change in level of care or if otherwise clinically indicated.)
6. Response to inquiries regarding clinical status of inmate-patient.
7. When an inmate-patient is discharged to the CCCMS, notification to the PC at the receiving program/institution.

#### **G. CASE REVIEW**

The IDTT is responsible for conducting a structured process of case review. The review occurs quarterly or more often if clinically indicated. The purpose of the review is to ensure optimal progress toward achieving resolution of symptomatology sufficient for placement in the least restrictive clinical and custodial environment. Proper case review maximizes the utilization of the limited beds available for EOP placements.

The IDTT shall generally be responsible for developing and updating treatment plans. This process shall include input from the inmate-patient and other pertinent clinical information that may indicate the need for a different level of care. Referrals to higher levels of care shall be considered when the inmate-patient's clinical condition has worsened or the inmate-patient is not benefiting from treatment services available at the current level of care. Consideration of appropriate level of care shall be documented by the IDTT on a CDCR 7230-MH, *Interdisciplinary Progress Note*, and shall include the justification for maintaining the current level of care or referral to a different level of care.

The PC for each inmate-patient shall prepare a case summary on a CDCR 7230-MH, *Mental Health Progress Note*, for quarterly IDTT review, which will consist of the following:

1. Clinical diagnosis and brief history of previous clinical interventions with emphasis on interventions implemented since the last team review.
2. Current length of stay in EOP.
3. Assessment of current status and progress or lack of progress in achieving treatment goals.

4. Assessment of willingness and ability to participate in the program and description of attempts to improve treatment participation.
5. Recommendations for modifications to treatment plan, including diagnosis, level of care, problems, medications, and treatment intervention.
6. If applicable, input from the previous CCCMS PC when a reduction in level of care is considered.
7. Discharge planning, including a tentative discharge date, anticipated level of care, specific follow-up recommendations, and perceived impediments to discharge.

Pertinent information from IDTT reviews shall be documented on a CDCR 7230-MH, *Mental Health Progress Note*, and filed in the UHR. Any modifications to the individualized treatment plan shall be documented on an updated CDCR Form 7388, *Mental Health Treatment Plan*, and also filed in the UHR. A full case summary, with a recommendation for either continued placement or transfer to an alternative level of care, shall be completed on an annual basis, for placement in the UHR. If there is a change in the level of care, formal notification will be provided to the inmate-patient's Correctional Counselor via a CDCR 128-MH3, *Mental Health Placement Chrono*.

#### **H. DISCHARGE**

Discharge from the EOP will be based upon a decision utilizing the IDTT process when the inmate-patient satisfies any of the following conditions:

1. Is able to function in a GP setting with CCCMS support.
2. Has clinically decompensated to the extent that placement into 24-hour inpatient care (either MHCB or DMH hospitalization) is required.
3. Has reached his/her parole date, and clinical services will be transferred to a POC.

Note: Inmate-patients who are placed in ASU or SHU and continue to require EOP level of care shall not be discharged, but shall be transferred to the appropriate setting (see Chapters 7 and 9).

**I. ENHANCED OUTPATIENT PROGRAM FOR CONDEMNED INMATE-PATIENTS****1. EOP Housing for Condemned Inmate-Patients**

Per Penal Code Section 3600, male inmates who have received a death sentence are incarcerated at California State Prison - San Quentin (SQ). Female inmates who have received a death sentence are incarcerated at Central California Women's Facility (CCWF). Therefore, these two institutions are charged with the responsibility to provide mental health treatment services at the EOP level of care to condemned inmate-patients identified as needing this level of care.

Housing for condemned inmates is determined by the inmate's behavioral adaptation to the correctional setting. Upon arrival, each condemned inmate completes an orientation period. At SQ, the orientation period is generally completed in the Adjustment Center housing unit. During the orientation period, inmate-patients are identified as either a Grade A Condemned (housing and program closely related to a GP setting), or Grade B Condemned (housing and program closely related to an administrative segregation setting). Additionally, the initial medical evaluation identifies the inmate-patient's medical needs including any serious mental health needs that require treatment. Therefore, Grade A or Grade B Condemned inmates identified as requiring EOP level of care are housed according to institutional custody determination, and appropriate mental health treatment services are then provided. A condemned inmate's grade level determination is subject to review and change on an annual basis or more often if determined appropriate.

At CCWF, due to the few female inmates sentenced to the death penalty, all female condemned inmates are housed and programmed in a designated housing unit, separate from other GP inmates. The female condemned program at CCWF *does* currently classify condemned inmates into "grades" as referenced above. All programs including any required mental health treatment services for EOP female condemned inmate-patients are provided within this housing unit.

**2. Condemned EOP Inmate-Patient Treatment Plan**

All condemned EOP inmate-patients housed at SQ or CCWF shall have an individual treatment plan documented on a CDCR 7388, *Mental Health Treatment Plan*, that provides for treatment consistent with the inmate-patient's clinical needs.

The development of the individual treatment plan by the assigned IDTT must take into account the unique security operations and procedures necessary to effectively manage this condemned population during a period when the institution is locked down for an execution. At SQ, programs and services (excluding delivery of medication and



emergency services) are curtailed prior to, during, and after the actual execution of a condemned inmate, as determined by the Warden. Out-of-cell activities do not occur during the period that the institution is locked down pending or following an execution; however, LPTs shall continue daily rounds. These procedures are mandatory and are required due to the sensitive and potentially volatile atmosphere at the institution when carrying out an imposed death penalty.

Additionally, the recommended individualized treatment plan for Grade B Condemned EOP inmate-patients at SQ may require modification due to the heightened safety concerns associated with this population's required placement in the Adjustment Center. Out-of-cell activities for this population specifically require intensive staff resources to ensure the safety and security for all involved: inmates, clinical staff, as well as, correctional staff.

The individualized treatment plan for the condemned EOP inmate-patient, as for all EOP inmate-patients, provides the "blue print" for the course of mental health treatment that is intended to address the diagnosed condition. The initial plan provides the treatment foundation by prescribing services, activities, and medication that will be attempted and monitored. Frequent clinical and custody staff involvement provide ongoing assessment of progress and effectiveness of the applied plan. The ongoing assessment provides the impetus for the modification and/or change for the treatment services contained in the individualized treatment plan.

### **3. EOP Condemned Inmate-Patient Treatment Services**

The Condemned EOP Inmate-patient will receive treatment services commensurate with their demonstrated ability to safely participate in the offered services. All condemned EOP inmate-patients will be offered ten hours per week of scheduled structured therapeutic activities identified and approved by the IDTT as part of the individualized treatment plan. It is recognized that not all condemned EOP inmate-patients can or will participate in and/or would benefit from this amount of treatment time. The ten hours per week for certain diagnosed condemned EOP inmate-patients may be clinically contraindicated. However, for condemned EOP inmate-patients scheduled for less than ten hours, the PC shall present the case to the IDTT for approval. The CDCR 7388, *Mental Health Treatment Plan*, shall include a detailed description of the diagnoses, inmate-patient's problem list, level of functioning, medication compliance, and clinical reasons for scheduling less than ten hours. For inmate-patients who are scheduled for less than ten hours of treatment activities per week, the IDTT shall meet at least monthly to review and increase the treatment activities or refer to a higher level of care, as clinically indicated.

**REQUIRED TREATMENT ACTIVITIES**

The Condemned EOP inmate-patient shall be offered the following treatment services:

1. Individual Treatment Planning involves a meeting of the IDTT and the inmate-patient for the purpose of identifying treatment needs, developing treatment plans, assessing treatment progress, and updating/revising individual treatment plans in accordance with the inmate-patient's needs and progress. Refer to *Section D. Admission to Program, Interdisciplinary Treatment Team*, of this document for a complete description of the functions of the EOP IDTT and membership.
2. Weekly PC contact (either individual or group psychotherapy) with assigned inmate-patients. Individual clinical contacts must occur at least every other week.
3. Daily LPT contact for Grade B Condemned EOP inmate-patients.
4. Medication Evaluation and Management
  - a) A psychiatrist shall evaluate each Condemned EOP inmate-patient at least monthly to address psychiatric medication issues.
  - b) Refer to Inmate Medical Services Policies and Procedures, Volume 4, Chapter 11, Medication Management, regarding procedures for administration of medication, medication refusals, Directly Observed Therapy, and other aspects of medication administration.
  - c) Refer to MHSDS Program Guides, Chapter 5, Mental Health Crisis Bed, for information on involuntary medication administration.
5. Crisis Intervention
6. Ten hours per week of scheduled structured therapeutic activities. See below for list of treatment activities.

**TREATMENT ACTIVITIES**

Specific treatment services offered include the following:

1. Group Therapy provides inmate-patients with an opportunity to express, explore, and resolve issues with the assistance of clinical staff, as well as supportive interactions with inmate-patients who have similar problems or experiences.

2. Individual Therapy provides inmate-patients with the opportunity to discuss personal problems that may not be adequately addressed in a group setting.
3. Recreational Therapy provides inmate-patients with supervised recreational activities or exercise programs designed to reduce stress, improve self-esteem and physical health, foster positive interpersonal interactions, and promote constructive use of leisure time. Recreational therapy is counted as structured activity only if a recreational therapist is present and supervising the activity. Unsupervised routine exercise is available for all inmate-patients and is not counted as a therapeutic activity. No inmate-patient in SQ's Adjustment Center will be permitted out of his cell for the purposes of recreational therapy, but in-cell treatment activities (therapy) may be permitted, subject to the heightened safety and security concerns present in the Adjustment Center.
4. Monitoring and Assistance with daily living skills.
5. Nursing and Supportive Care: Although 24-hour nursing care is not required for inmate-patients within the EOP, expanded services from those offered to non-EOP Condemned inmate-patients are provided by RN and/or LPTs. These services include:
  - a) Administration of all medications. Refer to the Inmate Medical Services Policies and Procedures, Volume 4, Chapter 11, Medication Management.
  - b) Regular monitoring of medication compliance and notification of medication non-compliance to treating psychiatrist, consistent with DCHCS policy.
  - c) Provision of nursing procedures as ordered by a physician.
  - d) Supervision and assistance of activities of daily living, including maintenance of living quarters, personal hygiene, and eating habits.
  - e) Coordination and support of activities with recreational therapy staff.
  - f) Provision of clinical escorts, when needed.
6. Aftercare Planning and Referral: Planning for follow-up services is a critical component of care that inmate-patients need upon release from the EOP. The PC or the IDTT Leader is responsible for ensuring that this is accomplished prior to an inmate-patient's discharge from the program. It includes referrals to other levels of care, programs, or other appropriate therapeutic placement to ensure continuity of care. Inmate-patients whose level of functioning has improved significantly to the point where the structure of the EOP therapeutic and housing environment is no longer needed shall be referred to the CCCMS services available in Condemned Housing. Condemned male inmate-patients

who experience decompensation in the form of crisis shall be referred to the DMH Inpatient Program at CMF for a MHCB level of care or DMH inpatient level of care. Female inmate-patients shall be referred to Patton State Hospital.

**J. MENTAL HEALTH QUALITY MANAGEMENT SYSTEM**

Ongoing assessment of the quality of clinical services will follow the Mental Health Quality Management System procedures.

**K. TRACKING ATTENDANCE AT TREATMENT ACTIVITIES**

Attendance at treatment activities, psychiatrist and PC appointments, and scheduling of IDTTs, among other information, will be tracked by the MHTS.

**L. GROUP/PRIVILEGE GROUP A1A DESIGNATION**

All EOP inmate-patients who are actively participating in structured therapeutic activities as determined by the IDTT shall be assigned to work Group/Privilege Group A-1-A.

EOP inmates-patients may be assigned to established work or education programs if participation will be therapeutically beneficial. In these situations, a job description and timekeeping log shall be maintained by the work supervisor.

Inmates-patients not assigned to a credit qualifying work or education assignment, who refuse to participate in therapeutic activities and are returned to CCCMS level of care, shall be reassigned to Work Group/Privilege Group A-2-B.

# **CHAPTER 5**

## **Mental Health Crisis Bed**

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### **A. INTRODUCTION**

The goal of the Mental Health Crisis Bed (MHCB) program is to provide services for conditions which require an inpatient setting to ameliorate mental health symptoms in the least restrictive environment. MHCB programs are located in California Department of Corrections and Rehabilitation (CDCR) institutions with facilities licensed as a Correctional Treatment Center (CTC) [California Code of Regulations (CCR), Title XXII, Division 5, Chapter 12, Article 4, Section 79739, Mental Health Treatment Program], General Acute Care Hospital (GACH), or Skilled Nursing Facility (SNF). The MHCB program operates 24 hours a day, 7 days a week. An inmate-patient admitted to the MHCB for mental health treatment may have acute symptoms of a serious mental disorder or may be suffering from a significant or life threatening disability. Refer also to the Correctional Treatment Center Policy and Procedure Manual, Volume VIII, Mental Health, for more detailed procedures.

Many conditions may precipitate a mental health crisis during institution confinement. At reception, the loss of the existing support system the individual had on the outside and/or the stress of initial imprisonment may lead to suicidal behavior, self-harm, or other symptoms. In mainline settings within institutions, stress factors unique to imprisonment may cause a pronounced degree of emotional strain and/or physical and interactive tension, and often compound existing stress factors inherent in everyday life. Such factors as the restrictions of confinement, pressures to conform to the prison lifestyle, and fear of more predatory inmates may disrupt an inmate's coping abilities. An inmate with no known mental health history may suffer acute symptoms, while another with mental illness in remission may have recurring symptoms. Prior to release, fears of delayed release or inability to cope with the outside world or loss of the institution support system of food, shelter, clothing, and structure of time may lead to crisis reactions.

The MHCB has a length of stay of up to ten days. The Chief Psychiatrist or designee, must approve exceptions to the length of stay. Not all crises require admission to the MHCB. Crisis episodes for some inmate-patients may be handled on an outpatient basis. Other inmate-patients, even if stabilized on medications, may require placement in a structured therapeutic environment for ongoing treatment and monitoring. This may necessitate a referral to an Enhanced Outpatient Program (EOP), or if longer-term intensive care is needed, to an inpatient facility operated by the Department of Mental Health (DMH).

Presenting problems may require continuous observation or monitoring before an inmate-patient's treatment needs can be fully assessed or the crisis brought under control. Where 24-

hour care is needed, an inmate-patient shall be placed in a MHCB for continuous nursing care.

**B. PROGRAM OBJECTIVES**

The primary objective of the MHCB is to evaluate the symptoms associated with the crisis and provide initial stabilization and recommendations for follow-up care, post discharge. More specific objectives include:

1. To observe, monitor, and provide continuous nursing assistance to inmate-patients whose condition requires 24 hours or more to achieve stabilization.
2. To assess the inmate-patient's symptoms, formulate a provisional or differential diagnosis, and develop an initial treatment plan. This may include a medical/neurological evaluation or an initiation of referral for such.
3. To control symptoms of serious mental illness, using emergency medication when necessary.
4. To alleviate psychiatric distress with appropriate therapy or counseling.
5. To refer the inmate-patient for placement in an appropriate level of care.
6. To provide an alternative to hospitalization for inmate-patients whose condition allows placement within ten calendar days to a less intensive level of care.

**C. POPULATION SERVED****Overall Treatment Criteria**

Overall treatment criteria have been developed for the Mental Health Services Delivery System (MHSDS). An inmate must meet the criteria in either 1 or 2 below in order to receive MHSDS treatment at any level of care:

1. Treatment and monitoring are provided to any inmate who has **current** symptoms and/or requires treatment for the current Diagnostic and Statistical Manual (DSM) diagnosed (may be provisional) Axis I serious mental disorders listed below:

**Schizophrenia (all subtypes)**

**Delusional Disorder**

**Schizophreniform Disorder**

**Schizoaffective Disorder**

**Brief Psychotic Disorder****Substance-Induced Psychotic Disorder (exclude intoxication and withdrawal)****Psychotic Disorder Due To A General Medical Condition****Psychotic Disorder Not Otherwise Specified****Major Depressive Disorders****Bipolar Disorders I and II**

2. Medical Necessity: Mental health treatment shall be provided as needed. Treatment is continued as needed, after review by the Interdisciplinary Treatment Team (IDTT), for all cases in which:

**Mental health intervention is necessary to protect life and/or treat significant disability/dysfunction in an individual diagnosed with, or suspected of having, a mental disorder. Treatment is continued for these cases only upon reassessment and determination by the IDTT that the significant or life threatening disability/dysfunction continues or regularly recurs.**

**Specific Treatment Criteria for MHCB**

In addition to the overall treatment criteria above, an inmate must meet the following specific criteria to receive treatment at the MHCB level of care:

- Marked impairment and dysfunction in most areas (daily living activities, communication and social interaction) requiring 24-hour nursing care; and/or
- Dangerousness to Others as a consequence of a serious mental disorder/Dangerousness to Self.
- These conditions usually result in a Global Assessment of Functioning (GAF) score of less than 30.

**D. REFERRAL AND TRANSFER****Referrals**

An inmate-patient suffering from an acute, serious mental disorder resulting in serious functional disabilities, or who is dangerous to self or others, shall be referred to a MHCB.

**MHCB Transfer**

If the institution does not have a MHCB or there are no MHCB beds available in the institution where the inmate-patient is currently housed, the inmate-patient shall be

transferred to a designated MHCB institution. The inmate-patient shall be transferred within 24 hours of referral.

(See *Inmate Medical Services Policies and Procedures, Volume 4, Chapter 3, Health Care Transfer Process* and *Volume 6, Chapter 18, Transfer of Patient Health Records Within CDCR; Institution to Institution*, for specific requirements concerning transfers and Unit Health Records)

If the MHCB beds are not available at the designated hub institution, the inmate-patient shall be taken to an available MHCB bed that is able to provide MHCB care while simultaneously providing the commensurate level of custody and security. In most cases, movement from an institution to a MHCB bed shall be completed by institutional transportation staff via special transport within 24 hours. On weekends and after normal business hours, the mental health clinician on call or the physician on call at the referring institution shall contact the mental health clinician on call or the physician on call at other institutions to locate a vacant MHCB bed. **The Health Care Placement Oversight Program (HCPOP) may be contacted seven days a week to assist in locating a vacant MHCB bed.**

MHCB transfers shall be done under authority as "Emergency Medical Transfers" (Department Operations Manual [DOM] 62080.17). Since MHCB transfers are typically viewed as emergency moves, they do not require classification committee action or Classification Staff Representative (CSR) endorsement. MHCB transfers shall be done on a "Psychiatric and Return" basis.

Generally, the transfer process shall be initiated by the inmate-patient's psychiatrist, psychologist, or the Chief of Mental Health.

The transferring psychiatrist, psychologist, or Chief of Mental Health shall determine whether the inmate-patient is "medically cleared" to transfer. State law provides that, before a patient may be transferred to a health facility, the patient must be sufficiently stabilized to be safely transported. The transferring physician is responsible for determining whether the inmate-patient's condition will allow transfer. The CCR provides, in part, that a transfer or discharge may not be carried out if, in the opinion of the inmate-patient's physician, such transfer or discharge would create a medical hazard. The transferring physician must initially evaluate the relative benefits and risks associated with transporting the inmate-patient. The determination of whether the transfer creates an unacceptable risk or a "medical hazard" will depend upon the inmate-patient's condition, the expected benefits to the inmate-patient if he or she is transferred, and whether the risks to the inmate-patient's health are outweighed by the benefits.

The receiving facility must consent to the transfer. CCR, Title XXII, licensing standards provide that a patient shall not be transferred unless and until the receiving facility has



consented to accept the patient. Specifically, the CCR provides, in part, that no patient shall be transferred, or discharged for purposes of transferring, unless arrangements have been made in advance for admission to a health facility. Therefore, the transferring clinician must secure the receiving health facility's approval in advance for the inmate-patient's admission. The transferring clinician shall document in the inmate-patient's Unit Health Record (UHR) that approval was obtained and from whom.

Appropriate housing of inmate-patients pending MHCB transfer shall be determined by the sending institution and in the following order of preferred locations:

1. Inpatient beds
2. Outpatient Housing Unit
3. Outpatient Housing Unit overflow cells
4. Large holding cells with water/toilets including, but not limited to, “ZZ cells,” “wet cells,” and/or “clinic cells.” Many CTC buildings have holding cells located outside of the entrance to the licensed bed area. These are typically located in the Specialty Care Clinic area. These cells are permissible for temporary housing pending transfer without violating licensing restrictions of the licensed bed area of the CTC building.
5. Large holding cells without water/toilets such as “Contraband Cells” (not in a CTC licensed area)
6. Triage and Treatment Area or other clinic physical examining room
7. Other unit-housing where complete and constant visibility can be maintained
8. When none of the above are available, small holding cells (not in a CTC licensed bed area) that are designed for the inmate-patient to sit or stand may be used for up to four hours by which time consideration of a rotation to one of the above listed options shall have been considered and the outcome of such consideration documented. Inmate-patients shall be retained in sit/stand cells only with approval of the watch commander and notification of on-call clinical staff.
9. Holding cells within the licensed bed area of the CTC building (notification to Department of Health Services of an unusual occurrence is required)

All inmates-patients housed in one of the above sites while pending transfer to a MHCB shall be provided, at minimum, with a safety (no-tear) mattress, safety (no-tear) blanket, and safety (no-tear) smock. If the inmate-patient subsequently attempts to use any or all of these items

to harm him or herself, a clinician may then order that one or more of these items be removed. Inmate-patients who are subsequently returned to their housing units shall receive appropriate clinical follow-up, which may include five-day custody and clinical wellness checks.

When an inmate-patient, identified as requiring MHCB care, is housed in an Outpatient Housing Unit, Administrative Segregation Unit, or any of the above sites, the HCPOP shall be notified of the need for MHCB placement.

### **Procedure**

The Chief of Mental Health or designee at the sending institution shall contact the MHCB Clinical Director or designee at the receiving institution to obtain approval for the transfer.

In cases where the Clinical Director or designee at the receiving institution does not agree to the transfer, and the Chief of Mental Health at the sending institution believes the clinical need for transfer remains, the case shall be referred to the HCPOP and/or Mental Health Services at headquarters central office for assistance. If an agreement cannot be reached, the inmate shall be admitted and evaluated.

Upon receipt of approval to transfer, from the MHCB Clinical Director or designee at the receiving institution, the Chief of Mental Health or designee at the sending institution shall complete a CDCR 128-C, *Chrono – Medical/Psychiatric/Dental*, indicating acceptance. Copies of the completed CDCR 128-C, *Chrono – Medical/Psychiatric/Dental*, shall be forwarded to the MHCB Clinical Director or designee at the receiving institution and the Classification & Parole Representative (C&PR) at the sending institution.

The C&PR at the sending institution shall forward a copy of the completed CDCR 128-C, *Chrono – Medical/Psychiatric/Dental*, to the C&PR at the receiving institution.

The Chief of Mental Health or designee, MHCB Clinical Director or designee, and the C&PRs at both the sending and receiving institutions shall communicate to ensure all health care/classification/transportation aspects are addressed. The escort needs for each transport are different given the variation of custody and health care concerns that may arise. At times, the transportation may be accomplished with just custody staff. However, occasions do arise when a combination of custody and clinical staff are needed to accompany an escort. This may occur when the inmate-patient has highly sensitive and varying medication needs or when the presence of a clinical staff member may substantially reduce decompensating or disruptive inmate-patient behavior during transportation.

The C&PR at the receiving institution shall contact the Classification Services Unit (CSU) for teletype transfer approval. The transfer approval shall be obtained from a CSR if available on site.

Documentation and classification of inmate-patients accepted for transfer to another institution shall be consistent with procedures outlined in the DOM. The sending institution shall clearly indicate on CDCR 135, *Inmate Transfer Record*, that the purpose of the transfer is for psychiatric treatment.

The inmate-patient shall be informed of the reasons for and destination of the transfer.

The Receiving and Release sergeant at the receiving institution shall notify the MHCB when the inmate-patient arrives. An inmate-patient who arrives by special transport because of urgent acuity shall be screened by a physician. If immediate admission is not possible, an inmate-patient shall be housed in an appropriate medical setting until a bed is available (CCR, Title XXII, Section 79789).

#### **E. ADMISSION**

##### **Pre-admission Screening**

All inmate-patients referred to the MHCB shall receive a pre-admission screening for the purpose of determining the appropriateness of the admission to the MHCB program. During regular working hours, the screening shall be performed by a psychiatrist or a licensed psychologist privileged to practice in the MHCB, and documented in the Progress Notes. During weekends, holidays, and after normal business hours, the screening shall be performed by an on-site physician on duty or any other licensed health care staff. The pre-admission screening may be performed via telephone prior to transfer when the inmate-patient is at an institution without an available MHCB. An inmate-patient in crisis may be screened where the crisis occurs (such as in the cell), or in the emergency service area of the CTC/GACH/SNF, prior to admission to the MHCB.

All inmates attempting suicide and those having suicidal ideation or showing signs and symptoms of suicide potential will be evaluated by a mental health clinician (psychiatrist, psychologist, or Clinical Social Worker) on an emergency basis. Inmates referred to health care by custody because of suicide concerns, shall be immediately evaluated for suicide risk by a mental health clinician, which shall include a Suicide Risk Assessment Checklist (SRAC). On weekends, evenings, and holidays, the SRAC shall be performed by the Physician on Call (POC), Medical Officer of the Day (MOD), or Registered Nurse (RN) trained to administer the SRAC if mental health clinicians are not available. It is the responsibility of the Health Care Manager to establish procedures for suicide risk assessment by clinical staff outside of normal work hours. All SRACs shall be filed in the inmate-patient's UHR whether or not the inmate-patient is admitted to the MHCB. An inmate

showing suicidal potential cannot be refused admission until there is a face-to-face evaluation and SRAC completed by a clinician trained to conduct suicide risk assessments.

All inmates who are screened positive for possible admission to the MHCB on a weekend, holiday, or after normal business hours shall be referred to a MHCB psychiatrist or psychologist with admitting privileges (On Call or On Duty) for admission. The clinician facilitates the admission based on the admission criteria indicated in Section C above. The actual admission may be done by the MOD or POC in consultation with the psychiatrist or psychologist (On Call or On Duty). For all inmates not admitted, the psychiatrist or psychologist (On Call or On Duty) shall prepare a detailed Progress Note explaining the reason for the decision. A log shall be kept by the referring institution, and shall include the following information for all inmates referred to the MHCB and evaluated but not admitted:

- Date of referral
- Inmate-patient identification
- Reason for referral
- Reason for not being admitted
- Referring clinician

#### **Admission/Transfer Log**

Each mental health program with a MHCB unit shall develop and maintain a log of all MHCB admissions/transfers. This log shall include at least the following information:

- Date of referral
- Inmate identification
- Reason for referral to MHCB
- Current level of care
- Date of Admission to MHCB
- Whether a suicide risk assessment (including a SRAC) was performed upon admission (for suicidal inmates)
- Discharge diagnosis

- Whether a suicide risk assessment (including a SRAC) was performed upon discharge (for suicidal inmates)
- Date of clinical discharge from the MHCB
- Date of physical discharge from the MHCB
- Date of referral to new location/program
- Date of transfer to new location/program
- Location/program to which the inmate-patient has been transferred

All inmate-patients who receive a pre-admission evaluation for suicide potential, but who are not admitted, will be tracked in a separate log. The log shall be kept by the MHCB that did not admit the inmate-patient, and will include at least the following information:

- Date of referral
- Inmate-patient identification
- Reason for referral
- Reason for not being admitted
- Deciding clinician

### **Procedure**

The MHCB shall accept inmates who meet the criteria for care and treatment and shall continue to house only those inmates for whom care is appropriate. No inmate shall be admitted to the MHCB until a provisional diagnosis or valid reason for admission has been stated and the appropriateness determined. When clinical differences of opinion exist regarding the appropriateness for admission and the clinicians involved cannot reach an agreement at the institutional level, the cases shall be referred to the HCPOP and/or Mental Health Services at headquarters central office for assistance.

Admissions to the MHCB shall be made on a “Psychiatric and Return” basis. A psychiatrist or a psychologist with admitting privileges in the MHCB may admit an inmate to the MHCB. Inmates shall be admitted only upon the written or verbal order of a MHCB psychiatrist or a psychologist.

Occasionally, crisis referrals require emergency and involuntary admission to the MHCB. An inmate-patient may, because of a psychotic episode, be confused, disoriented, disorganized and/or gravely disabled, or because of acute depression, may be dangerously suicidal. An inmate-patient in crisis who is explosive and assaultive may also be admitted involuntarily if a serious mental disorder also exists. Assaultiveness that is assessed by the clinician as resulting from an antisocial behavior, and not as a result of a serious mental disorder, is more appropriately dealt with by custody staff, per general institution policies.

Any inmate-patient admitted to the MHCB program because of suicidal threats or behavior shall receive a suicide risk assessment (including a SRAC) from a clinician, upon admission and prior to discharge.

After hours, weekends, and holidays, the Administrative Officers of the Day, MODs, POCs, and Watch Commanders shall be notified of an inmate who makes a serious suicide attempt or engages in self-injurious behavior requiring medical treatment.

Inmate-patients with multiple admissions to MHCB (three or more within a six-month period) shall be evaluated for referral to DMH.

An admission note shall be completed within 24 hours of admission to the MHCB by the admitting clinician and shall include the inmate-patient's condition at the time of admission, provisional diagnosis, and an initial treatment plan. This shall be documented on a CDCR 7230, *Interdisciplinary Progress Notes*, and filed in the UHR.

### **MHCB Nursing Evaluation**

The nurse shall:

- a. Interview and give an orientation to the inmate-patient.
- b. Assess the inmate-patient and take vital signs.
- c. Notify the physician of admission status including any admission problems.
- d. Assemble the chart.
- e. Initiate the Patient Care Plan.
- f. Note and implement any admission orders, such as laboratory tests (for details refer to the Correctional Treatment Center Policy and Procedure Manual, Volume VIII, Mental Health), X-rays, medications, etc.

### **Physical Examination**

For immediate care planning, a history and physical examination, including neurological screening, shall be completed, to the extent clinically possible, immediately before or within 24 hours of admission. If the inmate-patient is uncooperative or otherwise cannot be fully examined, a description of all possible observations and findings of the physical examination shall be documented. The complete physical examination shall be conducted as soon as clinically possible and documented in the UHR.

## **F. ASSESSMENT AND TREATMENT SERVICES**

### **Intake Assessment**

Upon admission to the MHCB unit, an assessment shall immediately be made on how best to meet the critical needs of the seriously mentally disordered inmate-patient. This is accomplished by reviewing and updating the CDCR 7386, *Mental Health Evaluation*, completed by the referring clinician at the time of referral. At a minimum, a provisional diagnosis is determined and an initial plan in the “Recommended Follow Up/Initial Treatment Plan” section of the CDCR 7386, *Mental Health Evaluation*, shall be formulated within 24 hours for immediate care planning and to rule out medical conditions that may be a cause of presenting symptoms. Serious medical conditions that are a significant cause of the crisis may warrant acute care medical hospitalization.

### **Interdisciplinary Treatment Team and Individualized Treatment Planning**

The IDTT is composed of, at a minimum:

- Assigned MHCB psychiatrist
- Assigned MHCB Primary Clinician (PC)
- Nursing staff
- Correctional Counselor
- Inmate-patient (if clinically and custodially appropriate)

Other staff who have direct knowledge of the inmate-patient are encouraged to attend or provide information, such as:

- Custody officers
- RNs
- Licensed Vocational Nurses (LVN)

- Recreational Therapists

The IDTT is chaired by a licensed mental health clinician. The inmate-patient shall be included in the IDTT, if clinically and custodially appropriate as determined by the IDTT, unless the inmate-patient refuses to participate. If the inmate-patient refuses to participate, the PC shall document the reason for refusal on the CDCR 7230, *Interdisciplinary Progress Notes*. Inmate-patients shall not be disciplined for refusing to participate in IDTT. Attempts shall be made to gather input from the inmate-patient, such as talking to and observing the inmate-patient at the cell door.

The IDTT shall meet within 72 hours of an inmate-patient's admission and at least weekly thereafter. The IDTT shall begin discharge planning at the initial IDTT meeting.

An individual treatment plan shall be developed and implemented at the initial IDTT meeting. The treatment plan, which is to be filed in the inmate-patient's UHR, shall be individualized and based on a comprehensive assessment, including, at a minimum, a mental status exam and the inmate-patient's legal, criminal, psychiatric, medical, and developmental history, and psychosocial evaluations. Psychosocial evaluations shall include personal and family history, inmate-patient's strengths and weaknesses, and evaluation of support system.

The individualized treatment plan shall:

1. Provide a primary diagnosis and identify the main presenting problems targeted for treatment. The diagnosis may be provisional.
2. For every identified target problem, document the goals, interventions, and measurable objectives of treatment.
3. Specify the types, frequencies and providers of prescribed therapies and adjunct activities.
4. Document the success or failure in achieving stated objectives
5. Evaluate the factors contributing to the inmate-patient's progress or lack of progress toward recovery.
6. Document prescribed medication, dosage, and frequency of administration, as well as medication compliance.
7. Be reviewed at each IDTT meeting, at least weekly, and updated accordingly.
8. Designate appropriate medications, therapies, and custody follow-up in an aftercare plan to be followed after the inmate-patient's release from the MHCB. See MHSDS Program



Guide, Chapter 10, Suicide Prevention and Response, for specific follow-up requirements for inmate-patients admitted for suicide prevention.

**Case Reviews And Treatment Plan Update (CCR, Title XXII, Section 79747)**

An inmate-patient's condition shall be assessed and monitored daily by the treating clinician, either a psychiatrist or psychologist. On weekends or holidays, a mental health clinician on call or the MOD shall make daily rounds. The Chief of Mental Health is responsible to ensure that all physicians serving as MOD or POC are trained in the use of the SRAC.

Documentation of daily contacts shall be made within 24 hours in the UHR by the updating clinician.

The IDTT shall review each crisis case as often as necessary, but at least every seven days, and update the treatment plan accordingly. Each treatment plan update shall include the following:

1. Documentation of the inmate-patient's response to treatment and his/her progress or lack of progress towards the goals of treatment.
2. Evaluation of factors that hinder progress and the interventions planned by the team to facilitate progress.
3. The most recent diagnoses and descriptions of the main presenting problems.
4. Evaluation of risk factors.
5. Review of release or discharge plans.

**Treatment Services**

The MHCB Clinical Director or designee shall be responsible for the prompt care and treatment of each inmate-patient admitted to the MHCB, development and implementation of a treatment plan, completeness and accuracy of the UHR, necessary special instructions, and transmitting reports of the inmate-patient's condition. Whenever these responsibilities are delegated to another staff member, continuity shall be ensured [CCR, Title XXII, Section 79741 (b)] by the MHCB Clinical Director.

An inmate-patient admitted to the MHCB shall be provided the following services and treatment:

Medication Evaluation and Management

The assigned psychiatrist shall evaluate each MHCB inmate-patient individually at least twice weekly to address psychiatric medication issues.

Refer to Inmate Medical Services Policies and Procedures, Volume 4, Chapter 11, Medication Management, regarding procedures for administration of medication, medication refusals, Directly Observed Therapy, and other aspects of medication administration.

#### Nursing Care

Twenty-four hour nursing care is provided in the MHCB to administer and supervise medication, provide assistance for activities of daily living, observe and monitor inmate-patients, obtain all physician-ordered laboratory studies, and provide counseling or inmate-patient supervision as needed.

#### Therapy and Counseling

One-to-one intervention is often necessary in a crisis case. Usually, brief, intensive therapy is helpful if it focuses on issues that precipitated the admission and explores changes in behaviors, perceptions and expectations that facilitate coping with the crisis. Group therapy may be provided to MHCB inmate-patients, consistent with clinical needs.

#### Rehabilitation Therapy

Inmate-patients may participate in rehabilitation therapy activities, consistent with clinical needs. Rehabilitation therapy may include activities such as indoor or outdoor recreation. These activities provide a setting for additional observation of inmate-patients, allowing for the evaluation of exaggerated symptoms or severe symptoms that are masked [see CCR, Title XXII, Section 79749 (c) (1) for Rehabilitation Treatment Plan requirements].

Inmate-patients who are awaiting transfer to DMH and remain in a MHCB beyond ten days, shall be offered additional rehabilitation therapy and other treatment activities, as clinically indicated.

#### **Aftercare Planning and Referral**

Planning for follow-up services is a critical component of the care an inmate-patient needs upon release from the MHCB. This planning may lead to a referral to a program or other appropriate placement to ensure continuity of care. An inmate-patient who clearly requires longer-term hospital care may be referred and transferred to an inpatient hospital program operated by the DMH. Aftercare plans shall include:

1. The diagnosis and psychiatric problems continuing to require treatment.
2. Any other unique mental health or physical conditions that could affect treatment (e.g., allergies, special dietary needs, chronic diseases).
3. Recommendations for follow-up treatment, including medications and specific psychotherapies.
4. Referrals to other treatment programs and institutional services, including vocational or educational programs, substance abuse programs and job programs (CCR, Title XXII, Section 79749 [d]).
5. The aftercare plan shall consider the inmate-patient's potential in-custody housing, proximity to release from incarceration, probable need for community treatment and social services, and the need for continued mental health care. If an inmate-patient requires continued care upon paroling, the Parole Outpatient Clinic shall be contacted.

#### **G. INVOLUNTARY TREATMENT**

An inmate-patient in crisis who does not consent for treatment with medication may be involuntarily treated to control symptoms which constitute:

- A danger to self, or
- A danger to others, or
- Grave disability on the basis of a serious mental disorder.

Involuntary medication administration refers to the administration of any psychotropic or antipsychotic medication or drug by use of force, or restraint.

The reasoning for the determination that an inmate-patient is a danger to self or others, or is gravely disabled, and is incompetent to render an informed consent shall be documented in the inmate-patient's UHR.

If in the clinical judgment of a psychiatrist or other physician, an emergency exists, the physician or psychiatrist may order involuntary medication for a period not to exceed 72 hours. An emergency exists when there is a sudden marked change in the inmate-patient's condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to the inmate-patient or others and it is impractical to first obtain consent.

An inmate-patient shall be afforded due process rights if involuntary treatment is necessary beyond 72 hours.

Refer to Correctional Treatment Center Policy Manual, Volume VIII, Section 16, Involuntary Treatment, for detailed procedures.

## **H. CLINICAL RESTRAINT AND SECLUSION**

Restraint and/or seclusion are special treatment procedures used to protect the safety of inmate-patients who pose an immediate danger to themselves or others, by restricting their ability to inflict injury by limiting body movement or by containing them in a safe environment. While utilization of restraint and/or seclusion is clearly effective in saving lives and preventing serious injury, it is also a procedure with inherent risks. In rare cases inmate-patients who have been restrained or secluded have suffered injury or death as a result of improper procedure or monitoring.

Restraints and/or seclusion shall be used only as a last resort and in response to an emergency to protect the inmate-patient and/or others from imminent harm, after less-intrusive and non-physical interventions have been attempted or ruled out. Staff shall strive to minimize or eliminate the use of seclusion or restraint whenever possible, through proper training, thorough assessment, effective treatment planning, and continuous quality improvement efforts. This policy restricts the use of restraints for mental health purposes generally to MHCBs. The use of restraints, for mental health purposes, in areas other than a MHCB unit shall be restricted to the amount of time required for transfer to a MHCB unit. Inmate-patients in need of restraints shall be transferred, in an expedited timeframe, to a MHCB unit.

The form of restraint and/or seclusion selected shall be the least restrictive level necessary to contain the emerging crisis/dangerous behavior. The determination of the presence of an emergent situation rests upon the clinical judgment of staff. It does not require the staff to defer restraint or seclusion until dangerous behavior occurs but may be based upon knowledge of the inmate-patient and its predictive value.

Restraint and/or seclusion shall never be used as punishment or for the convenience of staff. Threatening inmate-patients with restraint and/or seclusion is considered psychological abuse and is prohibited. It may be appropriate to inform an inmate-patient when behavior may necessitate the use of restraints or placement into seclusion.

This policy expressly prohibits any form of as needed (PRN) or standing order for restraint or seclusion.

For the purpose of this policy, authorized clinician means a psychiatrist, licensed psychologist, (and at Pelican Bay State Prison only, a psychiatric nurse practitioner) or (on weekends or after normal business hours) the POC or psychiatrist on call, or the POD or MOD.

Per Title 22 Regulations, a “qualified RN” is a RN who has received training in the administration of restraints and placement into seclusion, and who has passed a competency examination, which includes assessment of clinical issues relevant to the use of restraint and/or seclusion.

## RESTRAINT

### Initial and Subsequent Orders

Restraints shall only be used on a written or verbal order of an authorized clinician. When an authorized clinician is present, the authorized clinician shall evaluate the need for restraints, and if appropriate, write an order and provide sufficient and adequate justification in the inmate-patient’s UHR.

In an emergency circumstance, when no authorized clinician is available, a qualified RN may authorize initiation of restraints. An emergency circumstance exists when there is a sudden marked change in the inmate-patient’s behavior so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to self or others, and it is impractical to first obtain an order from an authorized clinician.

When no authorized clinician is present, a qualified RN shall evaluate the need for restraints and implement restraints if appropriate. If a RN is not present, a RN shall be notified immediately and shall respond within 15 minutes of notification to evaluate the need for restraints and initiate restraints, if appropriate. When a RN initiates restraints, an authorized clinician shall immediately be notified. Within one hour of notification, an authorized clinician shall give a verbal or written orders (with justification) to either continue or discontinue restraints.

If the authorized clinician is not available for the initial assessment, a phone order will be secured to cover the restraint use and the nurse will do an initial assessment within one hour.

The initial order for restraint shall not exceed four hours. Subsequent orders for continuation of restraint shall not exceed four hours. Each order must specify the behavioral conduct requiring restraint and the type of restraint used. While a restraint order is valid for four hours, no inmate-patient shall be in restraint for longer than the time necessary to contain the dangerous behavior. Removal from restraints is an authorized clinician or RN determination, and does not require a physician’s order unless otherwise specified.

### Assessment by Authorized Clinicians and Qualified RNs

Prior to expiration of the initial order, an authorized clinician or qualified RN shall conduct a face-to-face evaluation to determine whether continued placement into restraints is clinically

justified. If the clinician performing the initial face-to-face assessment is not a psychiatrist/physician, within four hours of the initial order a psychiatrist/physician shall be contacted/consulted by the RN to review current medications and any contraindications to continued restraint.

An authorized clinician or a qualified RN shall conduct a face-to-face evaluation at least every 8 hours during the period an inmate-patient is in restraints. An authorized clinician shall evaluate the inmate-patient face-to-face at least every 24 after the first four hours. If the authorized clinician is not a physician, the authorized clinician should consult with a physician after the face-to-face assessment. A psychiatrist shall conduct a face-to face evaluation at least every 24 hours while the inmate-patient is in clinical restraint.

A physician or nurse practitioner shall perform a brief physical examination of the inmate-patient as soon as possible but no more than four hours after the initiation of restraint use and document the evaluation on a progress note in the UHR. The physician/nurse practitioner's assessment will include inquiring into any history of physical disability or any other condition which would place the inmate-patient at greater physical or psychological risk during the restraint procedure. If the use of restraints is discontinued prior to the physician's arrival, the physician shall conduct a brief physical examination no more than 24 hours after the episode of restraint use.

### **Documentation**

Documentation of an order for the use of restraints shall include the name of the authorized clinician giving the order, the time the order was received, the duration of the order, which is not to exceed four hours, the type of restraint to be used, and the name and signature of the RN receiving the order.

The Initial Telephone orders for restraint shall be received only by licensed nursing staff, who shall record them immediately. The ordering authorized clinician shall sign them within 24 hours. Likewise, subsequent telephone orders for restraint shall be signed within 24 hours of the time the orders were given.

This policy requires the clinician ordering the restraint to provide a written order authorizing the use of restraint even if such use is discontinued prior to the authorized clinician's arrival.

Each time a verbal order for restraint is written, the nurse shall complete a CDCR 7230, *Interdisciplinary Progress Note*, documenting the need for initiation/continuation of restraint and shall specify the elements for the emergency that necessitated the use of restraint and behavior changes that may indicate the inmate-patient no longer presents a danger to self or others. The note shall describe any less restrictive measures that were implemented prior to this order.

Results of face-to-face evaluations shall be documented on CDCR 7316, *Restraints/Seclusion Record*.

When a qualified RN initiates restraint, the RN shall document the need for the initiation of restraint on a CDCR 7316, *Restraint/Seclusion Record*. The documentation shall include a description of the inmate-patient's behavior including any precursor/antecedent behaviors and other relevant factors upon which the inmate-patient was determined to be a danger to self or others, staff actions taken to utilize alternatives to restraint, information given to the inmate-patient about the reasons for restraint, the conditions of release, the inmate-patient's response, and injuries to the inmate-patient.

The use of restraints requires the inmate-patient's treatment plan be modified to include a sufficiently detailed description of the emergency and the rationale for the use of the specific degree of restraint. The inmate-patient's nursing care plan shall be modified to provide for the special needs of the inmate-patient while in restraint and/or seclusion. The criteria for establishing termination should be described in operational, objective terms comprehensible to the inmate-patient.

### **Types of Restraint**

- Five-point: All four extremities and waist (note below on use of five-point restraints)
- Four-point: All four extremities
- Two-point: Upper extremities only

### **Application**

The inmate-patient shall be protected from injury during restraint application and use. Staff shall use the least physical force necessary to protect inmate-patient and yet exercise sufficient force to control the inmate-patient.

The dignity and well-being of the inmate-patient shall be preserved at all times during the period of restraint.

Inmate-patients shall be placed on their backs when restraints are applied unless clinically contraindicated. When an inmate-patient is medically compromised or disabled, all necessary steps to safeguard the inmate-patient during the procedure need to be taken. Inmate-patients who are considered medically compromised/disabled consist of, but are not limited to, the following: morbidly obese, known history of cardiac or respiratory disease, history of spinal injury, amputee, fractured or injured extremity, recent history of emesis,

pregnancy, or seizure disorder. RNs must contact a physician either prior to, or immediately after, the placement of a medically compromised inmate-patient in restraints to notify the physician of the restraint and the inmate-patient's medical condition. Upon notification of the restraint of a medically compromised/disabled inmate-patient, the physician will either order the RN to discontinue the restraint or order the restraint as well as any special measures/treatments that need to be taken to safeguard the inmate-patient's medical condition. If the inmate-patient is an amputee or otherwise lacks one or more limbs, two or three point restraints should be used. Generally, restraints should be applied to the upper extremities first.

Four-, five-, or two-point leather restraints shall be used by clinical staff when ordered by an authorized clinician. Inmate-patients shall only be restrained with the least amount of restraints necessary to contain the unsafe behavior. Each period of restraint must be assessed individually to determine the level of restraint required at the time of the application of the restraint. Five-point restraints will only be used after the inmate-patient has been unsuccessfully restrained in four-point restraints or a determination is made by the RN that a fifth restraint is needed to ensure the safety of the inmate-patient. The physician on-call and the Nursing Supervisor must be notified anytime five-point restraints are utilized. The restraint key shall be carried by nursing staff after restraints have been applied to an inmate-patient until the procedure is discontinued.

Generally, four-point restraints should be used unless there are compelling reasons to the contrary.

A soft cloth or bandage shall be applied to the extremity before applying the leather restraints to protect the skin.

Nursing staff shall notify the watch commander and Chief Psychiatrist or designee of an order to place an inmate-patient in restraints. When restraints are applied to an inmate-patient, CTC staff shall have at least three custody personnel present for the application of these restraints, but the RN shall be in charge of the actual application of restraints. The RN is responsible to ensure that the restraints are applied properly, and are not restricting the inmate-patient's circulation.

In emergency situations, custody staff may use metal restraints (handcuffs) on inmates in order to gain control. Metal restraints shall be replaced with leather restraints by the RN as soon as possible.

#### **Monitoring and Evaluation by Nursing Staff**



All inmate-patients placed into restraint shall remain under constant direct, in-person visual observation by trained nursing staff (CNA, psychiatric technician, LVN, or RN) until restraint is discontinued.

### **Immediate Nursing Evaluation**

A RN shall perform a mental status and physical assessment of the inmate-patient immediately upon the initiation of restraint use. The RN assessment will include the identification of techniques, methods and tools which can help the inmate-patient control their behavior, and will identify pre-existing medical conditions and physical disabilities that place the inmate-patient at greater risk during the restraint procedure.

#### **Assessment at 15 minute Intervals**

In order to continue adequate circulation, nursing staff monitoring the inmate-patient shall physically check each extremity every 15 minutes. Each 15 minute assessment period shall be documented on the CDCR 7316, *Restraint/Seclusion Record*.

The nursing staff shall provide fluids and nourishments every 15 minutes as needed and as practicable except during hours of sleep. The inmate-patient's head and shoulders shall be elevated, if needed, while being fed or receiving fluids to reduce the risk of aspiration. The nurse shall document meals and fluids on CDCR 7316, *Restraint/Seclusion Record*.

#### **Hourly Assessments**

The RN will conduct hourly assessments of the inmate-patient during the entire period of restraints. Subsequent to the initial assessment conducted by the RN, the hourly assessments will document current physical, mental, and behavioral status of the inmate-patient, any indicated interventions performed, and the inmate-patient's readiness for release from restraints. The assessment includes noting the condition of skin and circulation, need for toileting, personal hygiene procedures, and proper application of restraint. Documentation of the one hour evaluations shall summarize the inmate-patient's overall physical condition, general behavior, and response to counseling/interviews.

Every hour the nursing staff, with the assistance of custody staff, shall perform 2 minute range of motion exercises on each limb unless the inmate-patient is too agitated or assaultive to safely remove the restraints. For range of motion exercises, restraints on each extremity shall be removed, one at a time. Performance of range of motion exercises shall be clearly documented on the CDCR 7316, *Restraint/Seclusion Record*, and shall include the inmate-patient's behavior, respiration, and responsiveness. If range of motion exercises are not performed, nursing staff shall clearly document the reason on the CDCR 7316, *Restraint/Seclusion Record*.

A RN may suspend restraints for short periods of time in order to transfer inmate-patients from place to place to attend to necessary or personal needs (i.e., feeding, bathing, or other treatment needs as necessary). A RN shall decide whether release from restraint is necessary in order to attend to necessary nursing or personal needs. Custody staff shall provide adequate security to prevent assaults or self-injurious behavior during suspension of restraints. If an inmate-patient has been released from restraints for more than one hour, a new order shall be obtained. Inmate-patients shall not be returned to the previous, or any state of restraint without continuing evidence of dangerousness to self or others.

### **Restraint Renewal**

The RN shall contact an authorized clinician and provide a description of current behavior, attitudes, or other indicators of present dangerousness; PRN/emergency medication usage; change in vital signs, including pain assessment; changes in mental or physical status; and side effects (e.g., confusion, akathisia, or extrapyramidal) at least every four hours. The authorized clinician shall then either give an order to discontinue restraint or give an order to continue or modify restraint for a period not to exceed four hours.

### Termination

Restraint shall be terminated when:

1. The emergency or dangerous behavior no longer exists based on previously established criteria for release; or
2. The inmate-patient's identified precursor behaviors indicating imminent danger to self or others are not longer present; or
3. Due to the presence of medical contraindications, it would be harmful for the inmate-patient to remain in restraints.

Removal from restraints is an authorized clinician or RN determination that the inmate-patient has reached the behavioral criteria for release and no longer presents an imminent danger. Release does not require a physician's order unless otherwise specified.

Upon termination of the restraint use, an entry shall be made in the CDCR 7230, *Interdisciplinary Progress Note*, describing the condition and response of the inmate-patient.

In accordance with Health and Safety Code 1180, a clinical and quality review shall be conducted for each episode of the use of restraints.

**Seclusion**

Seclusion is a behavioral treatment procedure used to prevent injury to self or others by containment of the inmate-patient in a specially designed room. Seclusion will typically take place in safety cells in a MHCB facility. Seclusion rooms shall be designed or modified to: provide for sufficient space for freedom of movement of staff; be free from hazardous objects or fixtures; have adequate light and ventilation; be maintained at an appropriate temperature; have secure, lockable doors; and have windows that permit visual observation of the inmate-patient by staff. Each MHCB facility shall set aside and equip a specific room to be used for the purpose of seclusion.

Placement of inmate-patients in single cells located in housing units, CTC's, or MHCB's for custodial reasons does not constitute seclusion for the purposes of this section.

**Initial and Subsequent Orders**

Seclusion shall only be used on a written or verbal order of an authorized clinician. When an authorized clinician is present, the authorized clinician shall evaluate the need for seclusion and if appropriate, write an order and provide sufficient and adequate justification in the inmate-patient's UHR. The initial order for seclusion shall not exceed four hours.

In an emergency circumstance when there is no authorized clinician present, a qualified RN may authorize initiation of seclusion after evaluating the need for seclusion. An emergency circumstance exists when there is a sudden marked change in the inmate-patient's behavior so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to self or others, and it is impractical to first obtain an order from an authorized clinician. If a RN is not present, a RN shall be notified immediately and shall respond within 15 minutes of notification to evaluate the need for seclusion and initiate seclusion, if appropriate. When a RN initiates seclusion, an authorized clinician shall immediately be notified, and within one hour of notification write or give a verbal order with justification to either continue or discontinue seclusion.

Subsequent orders for continuation of seclusion shall not exceed four hours.

**Documentation**

Documentation of an order for seclusion shall include the name of the authorized clinician giving the order, the time the order was received, the duration of the order, and the name and signature of the RN receiving the order.

Telephone orders for seclusion shall be received only by licensed nursing staff, shall be recorded immediately, and shall be signed within 24 hours. Initial telephone orders for seclusion shall be followed with written orders within 24 hours of the time the seclusion was

first ordered. The ordering clinician will follow subsequent telephone orders for seclusion with written orders within 24 hours.

A written order authorizing the use of seclusion is required even if such use is discontinued prior to the authorized clinician's arrival.

Each time an order for seclusion is written, the authorized clinician or RN shall complete a CDCR 7230, *Interdisciplinary Progress Note*, documenting the need for initiation/continuation of seclusion and shall specify the elements of the emergency that necessitated the use of seclusion and behavior changes that may indicate the inmate-patient no longer presents a danger to self or others. The note shall describe what least restrictive measures were tried prior to this order.

Results of face-to-face evaluations shall be documented on CDCR 7316, *Restraint/Seclusion Record*.

When a qualified RN initiates seclusion, the RN shall document the need for the initiation of seclusion on a CDCR 7316, *Restraint/Seclusion Record*. The documentation shall include a description of the inmate-patient's behavior including any precursor/antecedent behaviors and other relevant factors upon which the inmate-patient was determined to be a danger to self or others, staff actions taken to utilize alternatives to seclusion, information given to the inmate-patient about the reasons for seclusion, the conditions of release, the inmate-patient's response, and injuries to the inmate-patient.

The inmate-patient's treatment plan must be modified to include a sufficiently detailed description of the emergency and the rationale for the use of seclusion. The inmate-patient's nursing care plan shall be modified to provide for the special needs of the inmate-patient while in seclusion. The criteria for establishing termination should be described in operational, objective terms comprehensible to the inmate-patient.

### **Monitoring and Evaluation by Nursing Staff**

During the entire period of seclusion, the inmate-patient shall remain on direct one on one nursing observation. Nursing staff will document their observations at least every 15 minutes on a CDCR 7316, *Restraints/Seclusion Record*. Nursing staff shall ensure that the inmate-patient is safely secluded. The direct one on one nursing observation shall also include verbal interaction when the inmate-patient is awake.

A RN shall perform a mental status and physical assessment of the inmate-patient within 15 minutes of the initiation of seclusion. A physician or nurse practitioner shall perform a brief physical examination of the inmate-patient as soon as possible but no more than four hours after the initiation of seclusion and document the evaluation in the patient's

UHR. If seclusion is discontinued prior to the physician's arrival, the physician shall conduct a brief physical examination no more than 24 hours after the episode of seclusion.

Prior to the expiration of the initial order an authorized clinician or qualified RN shall conduct a face-to-face evaluation to determine whether continued placement in seclusion is clinically justified. If the clinician performing the initial face-to-face assessment is not a psychiatrist/physician, within four hours of the initial order a psychiatrist/physician shall be consulted by the RN to review current medications and any contraindications to continued seclusion. The authorized clinician shall either give an order to discontinue seclusion or give an order to continue seclusion for a period not to exceed four hours.

After the initial face-to-face evaluation, an authorized clinician or a qualified RN shall conduct a face-to-face evaluation at least every eight hours during the period an inmate-patient is in seclusion and evaluated for continued dangerousness by an authorized clinician at least daily. The authorized clinician shall then either give an order to discontinue seclusion or give an order to continue seclusion for a period not to exceed four hours.

An authorized clinician shall evaluate the inmate-patient face-to-face at least every 24 after the first four hours. If the authorized clinician is not a physician, the authorized clinician should consult with a physician after the face-to-face assessment. A psychiatrist shall conduct a face-to-face evaluation at least every 24 hours while the inmate-patient is in clinical seclusion.

Every hour the RN will perform an assessment of the inmate-patient including need for toileting; exercise; personal hygiene procedures; and room environment, temperature, and cleanliness. Fluids and nourishment shall be offered every 15 minutes by the nursing staff assigned to the direct observation of the inmate-patient, except during hours of sleep. In documentation of hourly evaluations, the nurse shall summarize the inmate-patient's overall physical condition, general behavior, and response to counseling/interviews.

A RN may suspend seclusion for short periods of time in order to transfer inmate-patients from place to place to attend to necessary nursing or personal needs (i.e., feeding, bathing, or other treatment needs as necessary). A RN shall decide whether release from seclusion is necessary in order to attend to necessary nursing or personal needs. Custody staff shall provide adequate security to prevent assaults or self-injurious behavior during suspension of seclusion. If an inmate-patient has been released from seclusion for more than one hour, a new order shall be obtained. Inmate-patients shall not be returned to the previous, or any state of seclusion without continuing evidence of dangerousness to self or others.

#### Termination

Seclusion shall be terminated when:

1. The emergency or dangerous behavior no longer exists based on previously established criteria for release; or
2. The inmate-patient's identified precursor behaviors indicating imminent danger to self or others are no longer present; or
3. Due to the presence of medical contraindications, it would be harmful for the inmate-patient to remain in restraints.

Removal from the seclusion is an authorized clinician or RN determination that the inmate-patient has reached the behavioral criteria for release and no longer presents an imminent danger. Release does not require a physician's order unless otherwise specified.

Upon termination of the seclusion use, an entry shall be made on a CDCR 7230, *Interdisciplinary Progress Note*, describing the condition and response of the inmate-patient.

In accordance with Health and Safety Code 1180, a clinical and quality review shall be conducted for each episode of the use of seclusion.

## **I. DISCHARGE**

It is the responsibility of the MHCB to provide for continuity of inmate-patient care upon discharge to another level of care, another facility, or self-care.

The inmate-patient has a right to information regarding discharge on an ongoing basis during his or her stay in the MHCB.

### **Discharge Plan**

- a. The discharge plan is initiated at the time of admission.
- b. The IDTT shall assess the inmate-patient's need for further medical, psychiatric, psychological, social work, and rehabilitative services; nursing services; education services; and transportation when developing the discharge plan. The plan ensures that needed services are available at the appropriate level of care.
- c. The plan shall include participation by the inmate-patient to facilitate inmate-patient responsibility for his or her care and treatment.
- d. The plan reflects appropriate coordination with and utilization of MHCB custody staff.
- e. The plan includes documentation of contact with the Chief of Mental Health at the institution where the inmate-patient is being transferred.

- f. Once the discharge plan is completed, referrals for appropriate aftercare placement shall be documented by an MHCB clinical staff member in the inmate-patient's treatment plan.
- g. The assigned CCM or PC at the institution where the inmate-patient is being transferred is responsible for implementing the discharge plan.
- h. Treatment shall continue for all inmate-patients clinically discharged until transferred.

**Discharge Criteria**

Criteria for discharge from the MHCB to an EOP or CCCMS program include:

- stabilization of the crisis behavior; and
- the ability to function in a less clinically structured environment.

Discharge criteria do not necessarily include complete resolution of symptoms but a resolution sufficient to allow continuation of treatment at a less intensive level of care.

Discharge to DMH inpatient care requires the clinical need for inpatient services of a duration greater than ten days.

**Procedure**

- a. Upon completion of MHCB inpatient treatment, cases transferred to the MHCB as “Psychiatric and Return” shall be returned to the sending institution, unless the sending institution does not provide the level of care that the inmate-patient currently requires or the inmate-patient has any other case factor(s) that preclude return to the sending institution. In those cases, the MHCB will transfer the inmate-patient to an institution that provides the appropriate level of care and security.
- b. The MHCB discharge summary shall be completed by the attending psychiatrist or psychologist prior to release from the MHCB. This should include specific recommendations regarding follow-up visits with the CCM or PC and custody staff. The discharge summary, either handwritten or dictated, includes, but is not limited to, the MHCB course of treatment, current medications, response to treatment, condition at time of discharge, and detailed information regarding follow-up care needs. The inmate-patient’s participation, which supports inmate-patient responsibility, shall also be included.
- c. An inmate-patient shall be discharged only on the written order of the MHCB psychiatrist or psychologist.

- d. Each institution with an MHCB shall appoint a Discharge Coordinator who is responsible for notifying the Chief of Mental Health or designee at the institution where the inmate-patient is being transferred of the pending discharge. The notification shall occur prior to discharge and shall include the inmate-patient's discharge summary, custody level, treatment needs, and any significant medical conditions. The Discharge Coordinator shall document the notification in the inmate-patient's discharge plan.
- e. The Chief of Mental Health or designee at the institution where the inmate-patient is being transferred shall notify the assigned CCM or PC. If the inmate-patient does not have an assigned CCM or PC, one shall be assigned. If the inmate-patient was admitted to the MHCB for Suicide Precaution or Watch, the Chief of Mental Health shall also notify the mental health clerical staff responsible for the tracking system, clinical staff responsible for weekend or holiday coverage, and the Facility Captain of the housing unit to which the inmate-patient is being transferred so that the required clinical and custody evaluation can be scheduled.
- f. No inmate-patient shall be discharged from the MHCB without an IDTT review, or in the event a new IDTT cannot be convened, a consultation with an IDTT member, such as a nurse.
- g. At the time of discharge, the original inpatient record is retained at the MHCB institution. The inmate-patient's UHR shall be transferred to the receiving institution at the time of discharge. Certain documents from the Inpatient Record are copied and filed in the Inpatient section of the UHR. This includes copies of the Admission Record, History and Physical, Operative Reports, Physician Orders, Discharge Summary, Consultations, Progress Notes, and Diagnostic Reports.
- h. Prior to discharge from the MHCB, a nurse shall advise the inmate-patient regarding medications and follow-up visits, and clear the inmate-patient for MHCB discharge.
- i. Any inmate-patient admitted to the MHCB program because of suicidal threats or behavior shall not be discharged to their housing unit until a Suicide Risk Assessment Checklist has been completed and a follow-up plan developed.
  - The PC shall provide follow-up treatment on an outpatient basis. This shall include daily contact with the inmate-patient for five consecutive days following discharge. On weekends and holidays, a Licensed Psychiatric Technician or mental health clinician other than the PC may conduct the daily contact; however, the PC is responsible for ensuring the contacts occur. The daily contact shall be documented on a CDCR 7230, *Interdisciplinary Progress Note*, or a CDCR 7230B-MH, *Follow Up to MHCB/MH-OHU Discharge for Suicidal Issues* template. The note shall include the inmate-patient's current mental status and suicide risk.



- The contact shall occur in the inmate-patient's regular housing unit.
- Custody staff shall conduct an hourly check of inmate-patients admitted to the MHCB for suicidality for the first 24 hours after discharge. A mental health clinician shall then discuss the inmate-patient's behavior with the custody staff and evaluate the inmate-patient to determine if the custody checks should be continued or discontinued. If the custody checks are retained, the mental health clinician shall determine whether the checks are to be every hour, every 2 hours, or every 4 hours for the next 24 - 48 hours. Custody staff shall maintain a log of checks on inmates.
- If after any evaluation the mental health clinician believes the inmate-patient has not stabilized, the inmate-patient shall be returned to the MHCB for further treatment. Careful consideration by the IDTT should be given to releasing inmates on a Friday, during the weekend, or the day before a holiday. The mental status and stability of the inmate-patient should be documented in detail on a CDCR 7230, *Interdisciplinary Progress Note*. A mental health clinician must be available every day (including weekends and holidays), either on duty or on call, to monitor inmate-patients who are discharged from a MHCB.

### **Quality Management for Implementation of Discharge Planning**

Concurrent with the implementation of the discharge plan or within 21 days of the inmate-patient's discharge from the MHCB, the Chief of Mental Health at the institution where the inmate-patient was transferred will audit the implementation of the discharge plan and follow-up care.

For inmate-patients who were admitted to the MHCB for Suicide Precaution or Watch, the Chief of Mental Health shall review the SRAC that was completed prior to discharge from the MHCB to ensure the discharge plan is appropriate. The Chief of Mental Health shall document the review in the UHR and forward a copy of the SRAC to the local Suicide Prevention Committee. A copy will also be retained by the mental health clerical staff.

### **J. MENTAL HEALTH PATIENTS IN OUTPATIENT HOUSING UNITS**

When an inmate-patient requires observation and evaluation of behaviors that may be indicative of mental illness, a licensed mental health professional may document the need for placement of the inmate-patient into an Outpatient Housing Unit (OHU).

A physician, psychiatrist, or licensed psychologist shall order placement and release of inmate-patients into and out of the OHU for mental health care and shall be in charge of

the inmate-patients' care while housed there. The placement into the OHU shall be made using the CDCR 7221, *Physician's Order*.

Psychologists ordering placement of inmate-patients into the OHU shall refer the inmate-patient to a physician for a physical examination and to a psychiatrist for a medication evaluation.

The physician's or psychologist's placement orders may be transmitted verbally or by telephone to the RN or LVN. The ordering physician or psychologist shall sign all verbal placement orders within 24 hours.

A physician or psychologist shall document the need for placement on a CDCR 7230, *Interdisciplinary Progress Note*, within 24 hours of placement. Within 24 hours after placement each inmate-patient shall have an evaluation, including admission history and physical examination, for immediate care planning. The Mental Health Evaluation shall be documented on a CDCR 7386, *Mental Health Evaluation*.

The patient shall receive an additional face-to-face evaluation by a mental health clinician or other qualified medical staff within 48 hours. This contact shall be documented on a CDCR 7230, *Interdisciplinary Progress Note*. If at any time during this observation/evaluation period it is determined that the inmate-patient requires inpatient care, arrangements shall be made to transfer the inmate-patient within 24 hours of the determination to a MHCB. If evaluation of the inmate-patient's mental health need continues beyond 48 hours, arrangements shall be made to transfer the inmate-patient to a MHCB or inpatient facility. Inmate-patients shall not remain in OHU for more than 72 hours.

The only exception to this 72-hour limit shall occur, on a case-by-case basis, only if both of the following criteria are met:

1. The inmate-patient has been determined to need EOP level of care and is awaiting placement, and
2. An IDTT determines that the inmate-patient may be at risk if returned to any of the housing units available at that institution while awaiting transfer.

When both of the above criteria are met, the inmate-patient may be held in OHU until transferred to an EOP level of care program. The timeline for transfer from OHU to EOP shall not exceed 30 days from EOP endorsement. This timeline for transfer shall include any days that the inmate-patient is in a MHCB following endorsement, and shall not be restarted if the inmate-patient returns to the OHU.

When it is determined that inpatient care is necessary and the institution staff are unable to expeditiously find a MHCB, they will contact the HCPOP for assistance to ensure placement within the required timelines. If it is determined that an order for Suicide Precaution or Watch is necessary, observation by clinical and/or custody staff, consistent with the MHSDS Suicide Prevention policy (see Chapter 10 for details), shall be provided.

When an inmate is placed in the OHU for being potentially suicidal, a mental health clinician shall administer a SRAC at the times of placement and release. On weekends, holidays, or after hours, the SRAC shall be administered by the MOD, POD, or RN trained on administration of the SRAC. Inmate-patients housed in OHU for suicide observation, who do not require MHCB level of care and who were discharged from the OHU before 24-hours, may be seen by clinicians and custody staff for follow-up care utilizing the process and timeframes described for MHCB suicide discharges, if clinically indicated.

When emergency circumstances exist, clinical restraint or clinical seclusion may be applied in OHU, subject to the requirements for clinical restraint or clinical seclusion in the MHCB. Emergency circumstances exist when there is a sudden marked change in the inmate-patient's condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to the inmate-patient or others, and it is impractical to first transfer the inmate-patient to a MHCB. The MHCB transfer process (See Section D, *Referral and Transfer, MHCB Transfer*) shall be immediately initiated upon determination that an inmate-patient requires clinical restraint or clinical seclusion, and transported when clinically safe to do so.

HCPOP shall be notified when an inmate-patient has been placed in clinical restraint or clinical seclusion. HCPOP shall expedite MHCB placement of inmate-patients in clinical restraint or clinical seclusion.

**Mental Health Conditions Appropriate for Placement into an OHU**

1. Observation for Suicide Precaution or Suicide Watch consistent with the CDCR Suicide Prevention and Response Project.
2. Inmates who engage in behaviors that might be indicative of a mental disorder that interferes with daily living and requires further observation and evaluation.
3. Inmate-patients who have been referred to an EOP or MHCB who are too ill or too vulnerable to be placed in the general population while waiting for transfer.

If at any time the mental health clinician determines that the inmate-patient has improved and does not require a higher level of care, the clinician may discharge the inmate-patient back to the General Population at the appropriate level of care.

**K. STAFFING**

The MHCB is designed to provide 24-hour care and is subject to State licensing requirements (CCR, Title XXII, Section 79739). Consequently, it must comply with the staffing standards of the CTC license under which it operates. MHCB staff shall provide acute mental health services for inmate-patients admitted to MHCB. In programs with six or fewer beds, acute mental health services may be provided by the MHCB Clinical Director. Through contracts or temporary reassignment of mental health staff from other program areas, staffing shall be augmented as needed.

The MHCB shall have a Clinical Director who shall direct the clinical program and be responsible for the quality of clinical services (CCR, Title XXII, Section 79741 (b)). The Clinical Director shall be a psychiatrist, licensed clinical psychologist, licensed clinical social worker, or a psychiatric mental health nurse operating within his or her scope of licensure with at least three years of direct clinical experience with seriously mentally disordered individuals after completion of his or her last year of graduate education (CCR, Title XXII, Section 79755 (a)). Each inmate-patient admitted as a patient to the MHCB is under the treatment of Staff Psychiatrists, Psychologists and/or Licensed Clinical Social Workers. Nursing services are provided by RN, LVN, Recreational or Occupational Therapists or Licensed Psychiatric Technicians. Clerical services are provided by an Office Technician and a Medical Transcriber.

**Administrative Staff**

The MHCB is subject to the same medical staff organization, bylaws, and policies and procedures that govern the other licensed beds of the facility (CCR, Title XXII, Sections 79775, 79777). Staff serving in these positions shall meet the minimum qualifications specified in the CCR, Title XXII. All MHCB staff are responsible to the Clinical Director.

**Clinical Staff**

Individual therapy or counseling, aftercare planning and referral services, and the clinical lead role in treatment plan development and modification shall be performed by the Staff Psychiatrist, Staff Psychologist, or Licensed Clinical Social Worker. A Chief or Senior Psychiatrist or a Chief or Senior Psychologist may also provide these clinical services in addition to his or her other supervisory or management responsibilities, as directed. Supervising clinical staff may assist in these services if required by workload, staffing considerations or unusual complexity of an individual case. Staff Psychiatrists, Staff

Psychologists, Licensed Clinical Social Workers, Senior Psychiatrists and Senior Psychologists serve as PCs and report to the Clinical Director.

**Nursing Staff** (CCR, Title XXII, Section 79629)

Two Supervising RNs positions oversee all nursing services delivered in the CTC: one for medical services and one for mental health services (CCR, Title XXII, Section 79755 (d)). Although the latter includes the MHCB, the use of one Supervising RN per shift may mean that MHCB nursing functions may be supervised by the medical Supervising RN for part of each 24-hour day.

Supervising RN are responsible for functional supervision of CTC line nursing staff and nursing administration, which includes the MHCB. Twenty-four hour registered nursing coverage and availability of a Supervising Psychiatric RN forty hours a week are necessary in the MHCB. There are sufficient nurses within a 24-hour period to provide at least 2.5 hours per inmate-patient (CCR, Title XXII, Section 79759). An inmate-patient with higher acuity needs receives additional nursing and professional care as symptoms require. RNs may co-manage selected inmate-patients assisting PCs with group therapies but will not function independently as PCs.

**Mental Health Rehabilitation Services Staff**

Mental health rehabilitation therapy services shall evaluate social, recreational, and vocational needs in accordance with the interests, abilities and needs of the inmate-patient; shall develop and prepare related therapies; and shall include such evaluation, and documentation of therapy development and preparation, in the inmate-patient's treatment plan (CCR, Title XXII, Section 79749).

Mental health rehabilitation therapy services shall be designed by and provided under the direction of a licensed mental health professional, a Recreational Therapist, an Occupational Therapist, or a Licensed Psychiatric Technician (CCR, Title XXII, Section 79749 (c) (2)).

In the Department, appropriately trained Correctional Officers (COs) and Correctional Counselors may be counted to meet licensing ratios. COs also assist in managing, observing and escorting the assaultive or suicidal inmate-patients.

**Clerical Staff**

Clerical support in the MHCB is provided by an Office Technician, who reports to the Clinical Director, and a Medical Transcriber, who is placed in the institutional transcriber pool and reports to the pool's Supervising Medical Transcriber.

**L. UNIT HEALTH RECORDS****1. Confidentiality**

Mental health records generally have a higher standard of confidentiality than other medical records. All staff with possible access to such records shall sign an oath of confidentiality to keep any information they learn from the records strictly confidential (CCR, Title XXII, Section 79807).

**2. Access**

All MHCB clinicians and nursing staff must have access to the inmate-patient's records 24 hours per day. Records shall be brought as needed from the records storage area, kept in the MHCB treatment area or clinician offices while needed, and returned to the storage area when no longer needed. If records are required outside the MHCB treatment area or clinician's offices, the records shall be hand carried by escorting staff and returned to the MHCB with escorting staff as soon as the outside business is completed (CCR, Title XXII, Section 79807).

**3. The Clinical Director shall:**

- a. Ensure the History and Physical is transcribed and delivered to the MHCB as soon as possible.
- b. Ensure that previous medical records are provided to the MHCB [Title XXII, Section 79803 (d)].

**M. MENTAL HEALTH QUALITY MANAGEMENT SYSTEM**

Ongoing assessment of the quality of clinical services will follow the Mental Health Quality Management System procedures.

## **CHAPTER 6**

### **Department of Mental Health Inpatient Program**

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#### **A. INTRODUCTION**

The California Department of Corrections and Rehabilitation (CDCR) is responsible for providing acute and intermediate inpatient care, in a timely manner, to those CDCR inmates clinically determined to be in need of such care. CDCR currently maintains a contract with the California Department of Mental Health (DMH) to provide acute and long-term intermediate inpatient mental health care to inmate-patients. Referrals to a DMH facility may be made by CDCR clinicians for inmate-patients who are so severely disturbed or suicidal that their treatment needs cannot be met in a CDCR treatment program or who may require a comprehensive psychiatric assessment.

1. Inmate-patients who have had repeated admissions to a CDCR Mental Health Crisis Bed (MHCB) or have been in an MHCB for longer than ten days shall be considered for such a referral.
2. The following DMH institutions are available for referrals for the indicated level of care:

Acute Psychiatric Care: Vacaville Psychiatric Program (VPP), Acute Psychiatric Program (APP) (males only);

Emergency Acute Psychiatric care: (Mental Health Crisis Beds) ASH and VPP under the conditions prescribed in the acute Memorandum of Understanding (MOU);

Intermediate Care: Atascadero State Hospital (ASH) (males only); Coalinga State Hospital (CSH) (males only); Patton State Hospital (PSH), (females only); Salinas Valley Psychiatric Program (SVPP), (high security males only); Vacaville Psychiatric Program (VPP); and

Day Treatment: Vacaville Psychiatric Program, Day Treatment Program (DTP) (males only).

#### **B. OVERALL TREATMENT CRITERIA**

**Inpatient Placement General Requirements**

The inmate-patient to be referred must have a Serious Mental Disorder (See Mental Health Services Delivery System [MHSDS] Program Guides, Chapter 1, Program Guide Overview) and:

1. Have marked impairment and dysfunction in most areas (daily living activities, communication and social interaction) requiring 24-hour inpatient care, or
2. Is a danger to self or others as a consequence of a serious mental disorder, or
3. Meets admission criteria for any of the DMH programs.

**C. DMH ACUTE PSYCHIATRIC PROGRAM (APP)**

The APP is a short-term, intensive-treatment program with stays usually up to 30 calendar days to 45 calendar days provided. Actual length of stay shall be determined by the Interdisciplinary Treatment Team on a case-by-case basis. Inmate-patients in the APP who are determined to need long-term mental health inpatient care shall be referred to an appropriate DMH intermediate care program.

Referral to the APP is considered when, in the judgment of the CDCR treating clinician, the inmate-patient meets the following DMH admission criteria:

**Admission Criteria**

1. Any inmate-patient (age 18 or older) who suffers impairment of functioning with signs and symptoms that may be attributed to either an acute major mental disorder or an acute exacerbation of a chronic major mental illness, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM). Such signs and symptoms of illness may render the inmate-patient:
  - Unable to carry out adequately the normal routines of the institution,
  - Unable to provide for his basic needs or use the supportive treatment resources available to him, or
  - A significant risk of harming himself or others.
2. Any inmate-patient who has been assessed as a severe suicidal risk.



3. Additional factors that justify consideration for referring an inmate to the APP include:
  - The inmate-patient has symptoms or secondary conditions that require inpatient mental health treatment.
  - The inmate-patient engages in self-injurious behavior that has not responded to treatment in a CDCR facility. Without mental health treatment, the inmate is likely to develop serious medical complications or present a threat to his life.
4. Each inmate-patient referred from another CDCR institution who is not accepted for direct placement-evaluation to the APP due to lack of an available bed shall be retained at the sending institution until a bed is available.
5. Inmate-patients admitted to the APP shall be inmates anticipated to be stabilized sufficiently for release from DMH within 30 to 45 days.

**Referral Procedure**

1. Each referral to the APP is the responsibility of CDCR clinical staff. Referrals shall be made whenever in the judgment of the treating clinician the inmate-patient's condition warrants inpatient care and meets the admission criteria for APP. Referrals generally are made by a clinician working in a CDCR MHCB Program or Enhanced Outpatient Program (EOP). Referrals must be completed within two working days of identification.
2. CDCR shall transmit standardized referral information to the appropriate DMH program on the DMH Referral Form/Acute Psychiatric Care. The referral packet shall be sent to the APP Admission and Discharge Coordinator.
3. DMH shall review the referral packet within one working day of receipt. DMH staff shall immediately notify the referring institution on the DMH Referral Decision Form by fax of their decision. The decision shall provide the detailed reasons for any rejections.
4. An inmate-patient considered for transfer to the APP must sign a consent to treatment at DMH or is entitled to a hearing in accordance with Title 15, Section 3369.1 (a) unless the inmate waives the hearing. Documentation of the hearing shall be processed in accordance with Department Operations Manual Section 62030.4.2. Written consent shall be obtained, or the hearing shall be conducted by the prison prior to transfer.

5. The referral packet shall be completed fully and include all required information as follows:

- If the inmate-patient is referred from a **Mental Health Crisis Bed (MHCB)**, then the referral packet shall only include the following three items with their sub-components:
  - a. Written consent OR documentation of the required due process hearing, or a valid waiver of the due process hearing if the inmate-patient refuses to sign consent to transfer;
  - b. Custody Case Factor Sheet; and
  - c. Mental Health Crisis Bed Inpatient Record including but not limited to:

**Admission summary**

**Progress Notes**

**Orders and lab orders**

**Interdisciplinary treatment plan**

**Interdisciplinary Treatment Team notes**

**Discharge summary**

- If the inmate-patient is referred from **any other level of care (EOP, Correctional Clinical Case Management System [CCCMS]) or other location**, then the referral packet shall include:
  - a. Written consent OR documentation of the required due process hearing (CDCR 128-MH6), or a valid waiver of the due process hearing if the inmate-patient refuses to sign consent to transfer;
  - b. Custody Case Factor Sheet;
  - c. CDCR suicide risk assessment including a Suicide Risk Assessment Checklist (SRAC);
  - d. Current Treatment Plan – CDCR 7388-MH, *Mental Health Treatment Plan*
  - e. Transfer Medical Summary or Health and Physical (H&P);
  - f. Pharmacy Profile or Medication Administration Record (MAR);

- g. Supporting Keyhea documentation or Keyhea Order (when relevant for involuntary medications); and
- h. TB chrono from the referring institution.

**Admission Procedure**

1. The APP shall notify the referring institution in writing of the decision on a referral (accept, deny, defer) within one (1) calendar day of the referral including, if accepted, the APP bed number. Inter-institutional endorsements for transfer of inmate-patients accepted into the APP are processed by the Classification and Parole Representative (C&PR) at California Medical Facility (CMF).
2. Inmate-patients who have been accepted shall be moved via special transport to DMH within 72 hours of bed assignment. In any event all transfers shall be accomplished within 10 days of the date of the referral.
3. Referred inmate-patients who are accepted into the APP are transferred from the referring institution as “psych and return” cases (i.e., in most circumstances the inmate-patient will be returned to the referring institution provided that institution can provide appropriate treatment and custody). Inmate-patients referred to the APP, who are accepted but are deferred for lack of bed availability, are retained at the referring institution pending a bed assignment.
4. APP staff and the CMF Chief Deputy, Clinical Services, or designees, shall prioritize, on a daily basis, any inmate-patient awaiting transfer into the APP. Prioritization for admission is based upon the clinical acuity of the inmate-patient, the length of time the inmate-patient has been on the waiting list, and the availability of mental health staff at the referring institution. APP staff shall separately review, on a weekly basis, APP inmate-patients who are clinically ready to be discharged to a CDCR institution.
5. DMH is responsible for completing any referral of an APP inmate-patient to any other DMH program.

**Discharge Procedures**

1. The APP will contact the receiving institution’s designated “DMH Contact” and fax the clinical discharge summary with continuing care recommendations to the designated clinician at the institution. The discharging clinician shall also telephone the designated clinician at the receiving institution to notify that institution of the impending discharge of the inmate-patient and describe the inmate-patient’s recommended aftercare plan.

2. For each inmate-patient returning to CDCR from the APP the following documents shall be transferred with the inmate-patient to the respective CDCR institution:

- Psychiatric Discharge Summary or Recommended Continuing Care Plan (RCCP);
- Nursing Assessment or Discharge Summary;
- Current physician's orders and/or MAR;
- Current Treatment Plan; and
- Keyhea Order (if applicable).

The inmate-patient shall not be placed in the transport vehicle without the above documents.

In addition, a discharge packet will be faxed by DMH within two weeks of discharge. The discharge packet shall include:

- Interdisciplinary Notes for past 15 days;
- Physician Progress Notes for past 15 days;
- Relevant Consults; and
- If applicable, forms specific to psych and return, mental health placement and transfer information for parolees.

All DMH programs shall provide written copies of the aforementioned cited materials. Due to its proximity to CMF, VPP shall provide the entire Inpatient Medical Record for review by the CMF Chief of Mental Health instead of the materials cited above.

**D. DMH INTERMEDIATE CARE FACILITIES: ASH, CSH, PSH, SVPP, and VPP**

The Intermediate Care Programs (ICF) at ASH, CSH, SVPP and VPP are for male inmate-patients; the program at PSH is for female inmate-patients. These programs provide longer-term mental health intermediate and non-acute inpatient treatment for inmate-patients who have a serious mental disorder requiring treatment that is not available within CDCR. There will not be direct admissions from CDCR to CSH at this time.

Male inmate-patients who require close or high custody shall be referred only to SVPP.

Custody Level IV male inmates that do not require close or high custody may be referred to ASH or VPP.

The ICF programs have a full complement of mental health staff including psychiatrists, psychologists, clinical social workers, rehabilitation therapists, psychiatric technicians, and registered nurses. Most housing is dormitory-type rooms. The inmate-patients have access to the day room, supervised yard access and are fed in a dining room. The inmate-patients receive a multidisciplinary assessment. From this information an individualized treatment program is developed from a wide variety of treatment modalities including group and individual psychotherapy, medication management, depression and crisis management, training in daily living skills and interpersonal skills, substance abuse, management of assaultive behavior, supportive counseling, modification of maladaptive behaviors, and educational and vocational programs.

### **Admission Criteria**

Referral to an ICF is considered when in the judgment of the CDCR treating clinician the inmate-patient meets the following DMH admission criteria:

1. An Axis I major (serious) mental disorder with active symptoms and any one of the following:
  - As a result of the major mental disorder, the inmate-patient is unable to adequately function within the structure of the CDCR EOP level of care.
  - The inmate-patient requires highly structured inpatient psychiatric care with 24-hour nursing supervision due to a major mental disorder, serious to major impairment of functioning in most life areas, stabilization or elimination of ritualistic or repetitive self-injurious/suicidal behavior, or stabilization of refractory psychiatric symptoms.
  - The inmate-patient requires a neurological/neuropsychological consultation.
  - The inmate-patient requires an inpatient diagnostic evaluation.
  - The inmate-patient would benefit from a comprehensive treatment program with an emphasis on skill (i.e., coping, daily living, medication compliance) development with increased programming and structured treatment environment.
  - The inmate-patient's psychiatric medication history indicates that a clozapine trial might be useful.

- Inmate-patients, who are deemed a significant assault risk, have a history of victimizing other inmate-patients (including inciting others to act in a dangerous manner) or present a high escape risk, shall be referred to the SVPP Intermediate Program. CDCR refers to these inmate-patients as high custody inmate-patients.
  - The inmate-patient's Global Assessment of Functioning indicates behavior that is considerably influenced by psychotic symptoms; OR serious impairment in communication or judgment; OR inability to function in almost all areas.
  - For SVPP only, the inmate-patient is medically appropriate as determined by the receiving prison medical staff. The program psychiatrist will determine mental health suitability. If agreement is not reached refer to the Coordinated Clinical Assessment Team (CCAT) process in Section VI. Any denial for medical reasons will be immediately referred to the, Assistant Deputy Director, CDCR, Division of Correctional Health Care Services (DCHCS).
2. In addition to a primary Axis I disorder, admission to VPP and SVPP shall be considered when:
- The patient engages in ritualistic or repetitive self-injurious/suicidal behavior that has not responded to treatment in a CDCR facility. Without inpatient mental health treatment, the inmate-patient is likely to develop serious medical complications or present a threat to his life.
  - The patient is chronically suicidal and has had repeated admissions to a Mental Health Crisis Bed (MHCB).
3. Inmate-patient committed to DMH by the courts as being incompetent to stand trial per Penal Code, Section 1370.

Inmate-patients who commit an offense while in CDCR, are referred to the District Attorney for prosecution, and are found by the court to be incompetent to stand trial per Penal Code, Section 1370 will first be considered for the SVPP. If there are no custodial or clinical reasons for admission to SVPP, they will then be considered for other DMH programs.

4. Whenever the CDCR institution referring clinician is in doubt concerning the appropriateness of referring a particular patient, or the appropriate DMH program to meet the inmate-patient's custody needs, the referring clinician will discuss the case with the

interdisciplinary treatment team (IDTT). If the IDTT does not reach consensus, or does not agree regarding the appropriate DMH program, a case conference shall be scheduled with a clinical facilitator from the headquarters DCHCS office. Case conference calls can be requested by calling the Mental Health Program Specialist at DCHCS headquarters.

5. Inmate-patients shall be eligible for admission to a DMH program regardless of parole date. CDCR will provide all discharge and community planning. CDCR will transfer the inmate-patient from the DMH program to a CDCR institution for release at least one calendar day prior to the release date.
6. Inmate-patients who are serving a Security Housing Unit (SHU) term and are clinically appropriate for placement in an ICF, shall be referred to the sending institution's Institutional Classification Committee (ICC). The IDTT/ICC shall consider suspension of the SHU term.
  - When the sending institution's IDTT/ICC decides to suspended the SHU term, the inmate-patient shall be eligible to participate in the entire ICF program upon arrival at the receiving institution.
  - It is not necessary for the sending institution's ICC to suspend a determinate or indeterminate SHU term prior to transferring the inmate-patient if the ICC is disinclined to take such action due to safety and/or security concerns. The inmate-patient shall be transferred to DMH with the SHU term in place
  - In cases where the sending institution's IDTT/ICC elects not to suspend the SHU term, the inmate-patient may participate in only Phase I of the ICF program. The inmate-patient will be evaluated in Phase I and a decision regarding suspension of the SHU term will be made by the receiving institution's IDTT/ICC.

### **Referral Procedure**

Referrals must be completed within five working days of identification by IDTT if inmate-patient consent is obtained and within ten working days of identification if due process hearing is required.

The following CDCR institutions retain Unit Health Records (UHR) for inmate-patients referred to ASH/PSH. California Men's Colony (CMC) shall retain records of inmate-patients referred to ASH. California Institution for Women (CIW) shall retain records for female inmate-patients referred to PSH.

1. All referrals shall be made on the required referral form – Department of Mental Health

Referral Form-Intermediate Care Program. The referral packet shall be sent to the DMH Forensic Coordinator or the Admission and Discharge Coordinator. The form shall be fully completed and include all required information as follows:

- Transfer Medical Summary or History & Physical for Transfer to DMH. The H&P is required for SVPP and must have been completed within the last 30 days;

**Current Treatment Plan – CDCR 7388-MH, *Mental Health Treatment Plan*;**

- Due Process documentation of the hearing OR Written consent (Use CDCR 128C until CDCR 128-MH6 is implemented), or a valid waiver of the due process hearing is required for referral if the patient refuses to sign consent to transfer;

**Pharmacy Profile;**

**Supporting Keyhea documentation or a Keyhea Order (when relevant);**

**Interdisciplinary Progress Notes for past 15 days (May be less for new arrival to reception center);**

**TB chrono from the referring institution;**

**Abstract of Judgment (For State Hospitals only);**

**Legal Status Summary (For State Hospitals only);**

**Chrono History (For State Hospitals only);**

**Custody Case Factor Sheet;**

**CDCR Suicide Risk Assessment.**

2. Any CDCR clinical concerns regarding the referral shall be discussed with the Chief of Mental Health, or designee, at DCHCS, prior to completion of the referral form. Questions regarding the transfer process shall be discussed with Health Care Placement Oversight Program (HCPOP), or designated Central Office Staff. (See also CCAT below).
3. DMH shall review the referral packet within three working days of receipt, and shall immediately notify the referring institution by fax of the decision to accept or reject. The decision shall provide detailed reasons for any rejections.

**Transfer Procedure**

1. The CDCR institution shall provide for transportation of a patient between a DMH program and a CDCR institution or DMH psychiatric program. The parole unit or region shall provide for transportation of a parolee between a DMH program and a local detention facility or community placement. Transfer must take place within 30 days of referral if accepted at DMH.



2. A transfer schedule shall be established by the CDCR referring institution and the respective DMH program.
3. Inmate-patients who have been accepted shall be transported to DMH within 72 hours of bed assignment.
4. Each patient or parolee admitted to a DMH program shall have with him/her, unless already sent, all documentation listed in Section V. B. 4. If, following the patient's admission, it is determined by assessments of the DMH staff that the patient does not meet admission criteria for the inpatient mental health program CDCR will transport the inmate-patient back to an institution on expedited basis but no more than 72 hours.

If the admission was based on a 5150 evaluation by the state hospital and the patient does not meet criteria for continued hospitalization or conservatorship. CDCR/Parole will transport the patient back to prison or the inmate-patients county of residence within 24 hours. The state hospital cannot retain a patient beyond 24 hours and if the inmate-patient is not picked up within this time period, it may become necessary for the state hospital to discharge the inmate-patient to the street.

5. A patient who has been found to pose an unusual and severe security risk to the DMH program in which he/she is housed shall be transferred by CDCR to a CDCR institution within 24 hours. However, if the security risk is on the basis of mental disorder rather than criminality or personality disorder, DMH shall make every effort to retain and treat the patient or parolee in the DMH hospital.
6. A patient or parolee's personal property and funds are to accompany him/her at the time of delivery to and from the DMH hospital.
  - Property, other than legal materials, shall be limited to no more than can be stored within six cubic feet.
  - The property box from CDCR shall be inventoried and sealed. Any Board of Control Claim resulting from items missing from a patient or parolee's property upon admission to the DMH hospital is the responsibility of CDCR.
  - CDCR shall ensure that items on the DMH Hospital Contraband List (see Attachment # 1-Contraband List) are not transferred to a DMH hospital with the patient or parolee's personal property.
7. Each patient or parolee shall be subject to TB evaluation by DMH upon admittance.

**Utilization Management (UM)**

1. CDCR reserves the right to inspect, monitor, and perform utilization reviews prospectively, concurrently, or retrospectively regarding the courses of treatment or inpatient care provided to CDCR's inmate-patient. Such reviews shall be undertaken to determine whether the course of treatment or services was prior authorized, medically necessary and performed in accordance with CDCR rules and guidelines. DMH agrees to make available, upon request by CDCR, for purposes of utilization review, an individual patient's medical record and any committee reviews and recommendations related to a CDCR patient.
2. DMH acknowledges and agrees that concurrent utilization management review shall not operate to prevent or delay the delivery of emergency treatment.
3. DMH acknowledges that the care of a patient at DMH shall be reviewed by CDCR Utilization Management (UM) nurses or designated party and by a Joint CDCR/DMH Review Process.
4. CDCR UM nurses or designated party will gather data and review cases of CDCR inmate-patients in DMH programs. CDCR UM nurses or designated party will report their findings and make recommendations to the CDCR Health Care Manager and CDCR Chief Psychiatrist or their designee(s). CDCR and DMH managers or their designees will meet monthly to review the data. Each DMH program also will have a joint CDCR/DMH UM process that will review individual cases.

If there is a disagreement about discharge, the UM nurse will review the patient's record and forward a recommendation to the Joint CDCR/DMH UM Review Process. If there continues to be disagreement, the recommendation will be conveyed to the CCAT.

**Discharge Criteria**

1. The inmate-patient has improved to a degree that further hospitalization is unnecessary, or the primary illness or problem for which hospitalization was required is in substantial remission, and the remaining symptoms are those of a disorder for which continued DMH inpatient care is not necessary, the inmate-patient will be returned to CDCR for ongoing treatment; or
2. Evaluation during hospitalization has resulted in a change of diagnoses such that continued hospitalization is not appropriate or necessary.
3. If requested by DMH, an inmate-patient who has withdrawn informed consent for mental health treatment or psychiatric medication, but for whom continued treatment is

otherwise recommended, may be returned to CDCR after all other clinical and legal avenues to obtain authorization to treat have been exhausted, if the following two criteria have been met:

- Withdrawal of informed consent shall be demonstrated by seven calendar days of continuous refusal to take oral medication or 30 calendar days of continuous refusal to accept scheduled depo-injectable medication, and documentation of discussions between treating DMH psychiatrists and other team members and the patient regarding the risks and benefits of continuing medication.
- Documentation that the patient has not met criteria for involuntary treatment for at least the last seven calendar days.

**Discharge Procedure**

1. Inmate-patients will be returned to the institution from which they came per the “psych and return” policy provided that institution can meet the level of care and security needs of the inmate-patient. Generally most inmate-patients will be returned to an institution that has an EOP. The EOP IDTT may decide to discharge the inmate-patient to a lower level of care after the initial 14-28 day evaluation period.
2. Inmates who are paroling and require ongoing treatment will be referred to the Parole and Community Services Division (P&CSD) Transition Case Management Program and to a Parole Outpatient Clinic or to a State hospital per Penal Code 2974.
3. DMH shall fax a copy of the Discharge Summary to the designated “DMH contact”, of the receiving institution at the time of notification of discharge. DMH shall also call the receiving institution. The inmate-patient shall then be returned to the CDCR institution within five working days after the time of notification, or resolution of any appeal, whichever occurs later.
4. Appeals for denial of return to CDCR will be reviewed by the Coordinated Clinical Assessment Team (CCAT), Part V of this document.
5. Emergency returns to CDCR, shall be accomplished within twenty-four hours. Such returns will be with prior notification and approval by telephone of the CDCR institution’s C&PR staff and Mental Health Program Director, or designee. DMH shall call the receiving institution to provide continuity of care including medication.

A dictated, typed discharge summary shall follow as soon as practicable, but not more than fourteen days after return.

6. Discharge Information: For each inmate-patient returning to CDCR from a DMH program, DMH shall ensure that the following documents be shall be transferred with the inmate-patient to the respective CDCR institution:

- Psychiatric Discharge Summary;
- Nursing Assessment or Discharge Summary;
- Current Physicians orders and/or MAR;
- Current Treatment Plan;
- Keyhea Order (if applicable).

The inmate-patient shall not be placed in the transport vehicle without the above documents. For each parolee returning to (P&CSD) supervision, DMH shall ensure that the parolee's documents shall be forwarded to the Chief Psychiatrist of the respective Parole Region.

In addition, a DMH discharge packet will be faxed within two weeks of discharge. The discharge packet shall include but not be limited to (see Attachment #2-DMH Discharge Checklist:

- Interdisciplinary Notes for past 15 days;
- Physician Progress Notes for past 15 days;
- Relevant Consults;
- If applicable, forms specific to psych and return, mental health placement and transfer information for parolees.

The DMH psychiatric programs will include in their discharge packets, the forms specific to psych and return, mental health placement and transfer information for parolees.

All DMH programs shall provide written copies of the aforementioned cited materials. For VPP and SVPP, due to their close proximity to CMF and SVSP, shall provide the entire UHR for review by the CMF and SVSP Chief of Mental Health instead of the above.

7. When an inmate returns to a prison from DMH, the Receiving & Release nurse shall notify Mental Health Service upon arrival. The inmate shall be evaluated by a mental health clinician within 24 hours of arrival. Medications shall be continued according to Inmate Medical Services Policies and Procedures, Volume 4, Chapter 11, Medication Management.

**E. DMH DAY TREATMENT PROGRAM (DTP) at CMF**

The DTP is a comprehensive treatment program with an emphasis on skill development. This program provides treatment for inmate-patients who require a higher LEVEL OF CARE than is provided in EOP but do not require 24-hour nursing care. The program includes increased programming and supervision to improve level-of-functioning, reduce further need for inpatient treatment and promote successful adjustment to the EOP, CCCMS, GP or parole environment.

**Admission Criteria**

To be accepted the inmate-patient:

1. Has an Axis I major (serious) mental disorder with active symptoms.
2. Does not require 24-hour nursing supervision.
3. Suffers from mild to moderate impairment of functioning in most life areas that would benefit from focused and comprehensive skill development to improve functioning within the prison setting or in preparation for parole, and/or requires continuing stabilization of psychiatric symptoms in a more structured setting.
4. Is able to function in a structured therapeutic setting with minimal staff prompting.
5. Is able to participate in own treatment planning.
6. Has had no serious suicide attempts in the past 30 days.
7. Has no acute medical issues.

**Referral Process**

All referrals shall include a completed DTP referral form and a referral packet, which consists of:

1. Medical H&P for Transfer to DMH;
2. Current Treatment Plan – CDCR 7388;
3. Due process or written consent;
4. Pharmacy profile;
5. Interdisciplinary Progress Notes for past 15 days;
6. TB chrono from the referring institution;
7. Custody Case Factor Sheet; and
8. CDCR Suicide Risk Assessment (including a SRAC).

DMH psychiatric programs (VPP and SVPP) shall require only a transfer form (see Attachment #3-DMH Referral/Transfer Form) and case factor sheet for DMH-to-DMH transfers.

All male CDCR institutions shall provide written copies of the aforementioned cited materials except for CMF where due to their proximity they shall provide the entire UHR for review by the DTP Admission and Discharge Coordinator or designee.

### **Discharge Process**

DTP options for return to CDCR:

1. Return to the sending institution provided that institution can meet the treatment needs.
2. If the inmate-patient requires continued mental health care, transfer to an appropriate LEVEL OF CARE (see Chapter 3, CCCMS, and Chapter 4, EOP, for inclusion criteria).
3. Discharge to parole with a referral to a Parole Outpatient Clinic as needed.
4. The inmate-patient shall be returned to the CDCR institution on an expedited basis but no later than 5 working days after the time of notification.

### **Discharge Procedure**

1. For each inmate-patient returning to CDCR from the DTP, the DTP shall ensure that the

following documents be shall be transferred with the inmate-patient to the CDCR institution (see Attachment #2-DMH Discharge Checklist):

- Psychiatric Discharge Summary;
- Nursing Assessment or Discharge Summary;
- Current Physicians orders and/or MAR;
- Current Treatment Plan; and
- Keyhea Order (if applicable).

The inmate-patient shall not be placed in the transport vehicle without the above documents. For each parolee returning to P&CSD supervision, the DTP shall ensure that the parolee's documents shall be forwarded to the Chief Psychiatrist of the Parole Region.

In addition, a discharge packet will be faxed within two weeks of discharge. The discharge packet shall include but not be limited to:

- Interdisciplinary Notes for past 15 days;
- Physician Progress Notes for past 15 days;
- Relevant Consults;
- If applicable, forms specific to psych and return, mental health placement and transfer information for parolees.

The DTP shall provide written copies of the aforementioned cited materials except for CMF where due to their proximity; they shall provide the entire UHR for review by the CMF Chief of Mental Health or designee.

**F. PROCESS FOR CENTRALIZED DECISION MAKING FOR REJECTIONS AND INCOMPLETE PACKETS-CCAT**

The Coordinated Clinical Assessment Team (CCAT) shall review referrals of CDCR inmate-patients that were rejected by DMH, and referrals where incomplete items were not resolved within two working days. Conducted by members of both the DMH and CDCR DCHCS,

CCAT provides a centralized approach to expedite the review and decision making process for inmate-patients referred to DMH.

When any DMH program rejects an inmate-patient for admission, or is unable to resolve incomplete referral items within two days after referral, a designee from DMH Long Term Care shall contact a designee from CDCR DCHCS to initiate the CCAT process. The CDCR, DCHCS designee shall facilitate a telephone or videoconference to discuss the case with involved clinical and custody staff.

The CCAT shall include (but not be limited to):

- Senior mental health clinician(s) from DCHCS
- CDCR HCPOP representative(s)
- CDCR Classifications Services Unit representative(s)
- The referring clinician and supervising clinician(s) from the referring CDCR institution, and
- Senior clinician(s) from the relevant DMH programs.

When reviewing a rejection, a senior clinician from each potentially relevant DMH program shall participate in the review. When reviewing an incomplete packet, only the DMH senior clinician from the affected state hospital or psychiatric program shall be required to participate.

Case Conferences: The CDCR, DCHCS designee shall schedule case conferences upon request by DMH and/or CDCR clinicians regarding a difficult or perplexing inmate-patient case, including repeated admissions of the same inmate-patient in a short time frame.

#### **G. HEALTH CARE PLACEMENT OVERSIGHT PROGRAM**

The HCPOP shall assist institution staff in referring and placing an inmate-patient in a DMH facility in the following ways:

1. Assist field staff with DMH intermediate or acute LEVEL OF CARE referrals
  - Coordinate with mental health staff at DCHCS headquarters for proper determination of appropriate DMH LEVEL OF CARE and subsequent placement determination.
  - Assist field staff concerning the referral process for the different DMH placement



- settings.
- Assist field staff regarding Program Guide and MOU placement requirements such as timelines and means of transportation.
2. HCPOP staff shall assist field staff with appeals of referrals denied by DMH for clinical and custody reasons
- Assist field staff regarding the DMH appeal process as appropriate (e.g., DMH contact persons, obtain written denial).
  - Coordinate with headquarters DCHCS mental health staff for determination of appealing referrals denied by DMH for clinical and/or custody reasons.

# **CHAPTER 7**

## **Administrative Segregation**

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### **A. INTRODUCTION**

The Administrative Segregation Unit (ASU) Mental Health Services (MHS) program is part of the California Department of Corrections and Rehabilitation (CDCR) Mental Health Services Delivery System (MHSDS). This Program Guide outlines program policies and provides basic institutional operational procedures to ensure the effective delivery of clinical services to inmates with serious mental disorders who, for custodial reasons, require housing in ASU.

### **B. RESPONSIBILITY**

1. Overall institutional responsibility for the program shall rest jointly with the Health Care Manager and the Warden.
2. Institutional operational oversight of the ASU MHS shall be the responsibility of the Chief of Mental Health at each institution.
3. Custodial responsibilities, including initial placement, disciplinary actions, correctional counseling services, classification, inmate-patient movement, and daily management shall rest with the Warden or designee. The assigned psychiatrist or Primary Clinician (PC) shall attend all Institutional Classification Committee (ICC) meetings to provide mental health input.
4. Individual clinical case management, including treatment planning, level of care determination and placement recommendations, are performed by the assigned PC and approved by the institution Interdisciplinary Treatment Team (IDTT).

### **C. PROGRAM GOALS AND OBJECTIVES**

The goal of the ASU MHS program is to provide necessary mental health services for the population of seriously mentally disordered inmates who, for custodial reasons outlined in California Code of Regulations Title 15, Section 3335, require placement in ASU.

*Specific program objectives include:*

1. Continuation of care for inmate-patients with identified mental health treatment needs through regular case management activities and medication monitoring to enable inmate-patients to maintain adequate levels of functioning and avoid decompensation.
2. Daily clinical rounds of ALL inmates.
3. Mental Health screening of inmates who are not currently in the MHSDS caseload to identify mental health needs, and referral for further mental health evaluation as indicated.
4. Referral to a more intensive level of care for inmate-patients whose mental health needs cannot be met in the ASU, including expeditious placement into Mental Health Crisis Beds (MHCB) for inmate-patients requiring inpatient mental health care.
5. Mental health assessments and input into the classification decision-making process during ICC meetings, including the inmate-patient's current participation in treatment, medication compliance, suitability of single celling or double celling, risk assessment of self-injurious or assaultive behavior, status of Activities of Daily Living (ADL), ability to understand Due Process proceedings, likelihood of decompensation if retained in ASU, recommendations for alternative placement, and any other custodial and clinical issues that have impact on inmate-patients' mental health treatment.
6. Mental health assessments and input into the adjudication of Rules Violation Report (RVR) hearing proceedings involving MHSDS inmate-patients. Mental health information includes the quality of the inmate-patients' participation in their current MHSDS treatment plan, mental condition that may have been a contributing factor in the alleged misbehavior, and the ability to comprehend the nature of the charges or participate meaningfully in the disciplinary process. Final housing decisions are made by the ICC after considering all relevant clinical and custody factors.

#### **D. TREATMENT POPULATION**

Refer to the Treatment Criteria for the level of care in the MHSDS, Chapter 1, Overview Program Guide.

##### **Referral for Mental Health Services**

1. **Pre-placement mental health screening:** All inmates are screened by medical personnel for possible suicide risk, safety concerns, and mental health problems before placement in ASU (see Inmate Medical Services Policy and Procedure, Volume 4, Chapter 14: CDCR 7219). If an inmate screens positive on the CDCR 128-MH7, *ASU Pre-Placement Chrono*, they are referred for a mental health evaluation on an Emergent, Urgent, or

Routine basis, depending on their answers to the screening questions. After completion, the CDCR Form 128-MH7, *ASU Pre-Placement Chrono*, shall be placed in the mental health chrono section of the Unit Health Record (UHR). For Urgent and Routine referrals, the medical staff conducting the screening shall complete a CDCR 128-MH5, *Mental Health Referral Chrono*, and follow the referral process below.

2. Current MHSDS inmate-patients: All inmates placed into ASU shall be reviewed for identification of current MHSDS treatment status by the time of the initial CDCR-114D, *Order and Hearing on Segregated Housing*, review. This shall occur on the first work day following an inmate's placement. Current MHSDS inmate-patients are identified by checking the ASU placements reported on the Institutional Daily Movement Sheet with the treatment identifier code in the Distributed Data Processing System (DDPS) or the Mental Health Tracking System (MHTS) for inmate-patient treatment cases. During the initial review, mental health staff will ensure the continuity of mental health care, including the delivery of prescribed medications. Upon inmate's placement into ASU, nursing staff shall transfer the inmate's Medication Administration Record to ASU, consistent with the post orders.
3. Staff referral: Any staff member who observes possible signs or symptoms of a serious mental disorder shall refer an inmate for clinical evaluation by completing a CDCR 128-MH5, *Mental Health Referral Chrono*. The Referral Chrono shall be processed by following the referral process below. Any inmate who is observed to be a suicide risk, or in any other condition that requires crisis care, shall be immediately screened by the PC to assess the potential for suicide and, if appropriate, referral to the MHCB for admission.
4. Inmates who receive a CDCR 115, *Rules Violation Report*, for Indecent Exposure or Intentionally Sustained Masturbation Without Exposure shall be referred for all of the following:
  - CDCR 115-MH *Rules Violation Report: Mental Health Assessment*;
  - A mental health assessment shall be completed within 24 hours to rule-out decompensation and/or intoxication. The referral shall be made by telephone to the local Chief of Mental Health who shall arrange this assessment; and,
  - For inmate-patients included in the MHSDS, to the inmate-patient's Primary Clinician
5. Self referral: Inmates in ASU may request a clinical interview to discuss their mental health needs. These requests are made on a CDCR 7362, *Health Care Services Request*. Inmates shall receive the attached pamphlet, "*Administrative Segregation Inmate*

*Orientation Mental Health Guide*” (available in Spanish), within 24 hours of placement into ASU.

NOTE: When an IDTT determines that an inmate-patient requires treatment of exhibitionism, that inmate-patient’s level of care shall be changed to CCCMS, Medical Necessity (or higher if appropriate), bypassing the standard referral process.

### **Referral process**

Mondays through Fridays, the following shall occur:

1. A health care staff member shall collect the CDCR 7362, *Health Care Services Request*, and staff referral forms each day from the designated areas.
2. Upon receipt of the collected forms, a Registered Nurse (RN)/Licensed Vocational Nurse shall initial and date each CDCR 7362, *Health Care Services Request*, and the CDCR 128-MH5, *Mental Health Referral Chrono*.
3. The CDCR 7362, *Health Care Services Request*, and the CDCR 128-MH5, *Mental Health Staff Referral*, shall be delivered to the designated program representative in mental health services, dental services, or pharmacy services for same-day processing.

On weekends and holidays, the following shall occur:

1. The Triage and Treatment Area RN shall review each CDCR 128-MH5, *Mental Health Staff Referral*, and CDCR 7362, *Health Care Services Request*, for medical, dental, and mental health services, shall establish priorities on an emergent and non-emergent basis, and shall refer accordingly.
2. If a mental health clinician is not available, the medical officer of the day (MOD), physician on call or psychiatrist on call shall be contacted.

Inmates will be seen by a mental health clinician, or on weekends, by the MOD, physician, or psychiatrist on-call within the clinically determined time frame.

- Emergent: Emergency cases will be seen immediately or escorted to the Triage and Treatment area
- Urgent: Urgent cases will be seen within 24 hours
- Routine: Other cases will be seen within five working days

## **E. CLINICAL ROUNDS AND SCREENING**

**Clinical rounds**

A mental health staff member, usually a Licensed Psychiatric Technician (LPT), shall conduct rounds seven days per week in all ASUs to attend to the mental health needs of all inmates. The LPT shall make initial contact with each inmate placed into ASU within 24 hours of placement.

A morning “check-in” meeting between custody and clinical staff shall be held each day. At minimum, an ASU Sergeant and an assigned ASU Mental Health clinician (psychologist or social worker) shall attend the morning meeting. During the meeting, involved personnel shall identify new arrivals, discuss current behavioral issues and concerns, and share any pertinent information regarding new arrivals and/or at-risk inmates. Pertinent suicide risk information from the MHTS Suicide Tracking Report will be discussed. This meeting shall be documented in the ASU Log book and salient clinical information shall be documented in the UHR and, if necessary, a referral for mental health services shall be made at the appropriate level of urgency.

In order to establish contact and provide information, mental health staff shall attend to developing rapport with new inmates on the first day of mental health rounds.

Each institution is to ensure that effective communication is observed when inmates have limited ability to speak English or are hearing impaired. Interpreter services information shall be posted in all areas where phones may be used for that purpose, and all staff assigned to ASU shall be provided documented training regarding access and use of services and available translation equipment.

Those inmates not previously identified as having mental health treatment needs who exhibit possible signs and symptoms of serious mental disorders are referred, via CDCR 128-MH5, *Mental Health Staff Referral*, for clinical evaluation. Interaction shall be sufficient to ascertain the inmate’s mental condition particularly during the first ten days. The LPT shall maintain an individual record of clinical rounds on both MHSDS and non-patients by initialing next to the inmate's name on the CDCR 114, *Isolation Log Book*, each time the inmate is seen. Any unusual findings that may require closer observation by custody shall be documented on the CDCR 114-A, *Daily Log*, on the same day of occurrence. For identified MHSDS inmate-patients, the LPT shall document a summary of daily clinical rounds on a CDCR 7230, *Interdisciplinary Progress Notes*, in the UHR on a weekly basis. Notes will be

clearly labeled as “Weekly Summary of LPT Clinical Rounds.” If clinically indicated, the LPT may provide additional documentation.

**Screening Questionnaire**

All inmates who are not in the MHSDS and who are retained in ASU shall receive, within 72 hours of placement in ASU, a mental health screening interview utilizing the 31-question mental health screening questionnaire also used in the Reception Centers. The interview shall be conducted by a mental health clinician or trained nursing staff in private and confidential settings that afford confidentiality of sight and sound from other inmates, and confidentiality of sound from staff. Screening interview appointments shall be announced by custody staff as “health appointments” to avoid stigmatization and possible retribution by other inmates. Every effort shall be made to encourage inmates to attend these appointments.

The results of the questionnaire are evaluated either by hand-scoring or on an approved automated scoring system to determine the need for further evaluation. The scoring sheet shall be filed in the UHR. All inmates scoring positive on the questionnaire shall be referred to a mental health clinician to be seen within the clinically appropriate time frame. Emergent cases shall be seen immediately, Urgent cases shall be seen within 24 hours, all others shall be seen within 5 working days.

All referrals and results of evaluations are documented in individual inmates’ UHR on approved forms and entered into the institutional MHTS. Decisions to provide treatment via placement into an outpatient program or MHCB shall be entered into DDPS.

#### **F. CLINICAL EVALUATION**

Referral evaluations will be completed within the time frames listed above and consist of the following:

1. A review of the UHR and, if necessary, the Central File, shall be completed and documented on approved forms as a part of the assessment process. Past treatment needs, medications, and program placements shall be noted.
2. An individual clinical interview to determine the nature of the problem and a full mental status examination. The examination is documented on a CDCR 7386, *Mental Health Evaluation*, and placed into the UHR.
3. When necessary, as determined by the evaluating clinician in consultation with the IDTT, psychological and neuropsychological testing may be conducted as a part of the diagnostic assessment of all cases not previously identified as having mental health treatment needs (testing is discretionary for inmate-patients currently receiving care who have not previously undergone such testing). When suicidality is an issue, a suicide risk assessment shall be conducted using the Suicide Risk Assessment Checklist (SRAC).
4. All assessments shall conclude with a five axis Diagnostic and Statistical Manual clinical diagnosis, be documented on CDCR approved forms, and placed in the inmate’s UHR.

5. Inmates who are identified as a result of the above process as meeting the clinical criteria for MHSDS placement may be referred to a psychiatrist for possible medication needs and other interventions as deemed appropriate (including placement into a MHCB for initiation of involuntary medication). These referrals shall be made on a CDCR 128-MH5, *Mental Health Referral*.

**G. CORRECTIONAL CLINICAL CASE MANAGEMENT SYSTEM (CCCMS) CARE**

Inmate-patients who were receiving treatment at the CCCMS level of care prior to ASU placement and those who are newly identified as requiring treatment at this level of care are assigned a PC. The IDTT shall include the inmate-patient's Correctional Counselor who shall present case factors of the ASU placement for consideration in development of the treatment plan and initiation of an aftercare plan.

The treatment intervention shall meet the guidelines set forth in the MHSDS Program Guide, *CCCMS, Chapter 3*, and may include the following:

**Required Treatment**

1. Regular monitoring of symptoms by LPTs through daily rounds.
2. Individual contact every week by the PC, or more frequently as clinically indicated.
3. Medication treatment and monitoring of compliance by psychiatric and nursing staff

**Other Treatment Activities**

1. Group therapy when deemed clinically appropriate
2. Self-help therapeutic activities such as reading and writing
3. When necessary, supportive care for Activities of Daily Living.

**H. ENHANCED OUTPATIENT PROGRAM CARE**

1. The Chief of Mental Health or designee, or the Health Care Manager or designee, shall present the IDTT's recommendation for the Enhanced Outpatient Program (EOP) level of



care to the ICC and provide clinical input regarding mental health placement options based on the inmate-patient's clinical needs. Placement options include:

- a. Referral to an EOP for inmate-patients who are involved in non-violent incidents and determined to not be a risk to others.
  - b. Transfer to an appropriate ASU EOP hub institution treatment setting within 30 days of placement at the EOP level of care designation. Inmate-patients who are involved in serious rule violations and whose propensity for threat to others and/or the security of the institution is so high that no other alternative placement is considered appropriate shall be retained in ASU. These inmate-patients shall receive the EOP level of care as described below.
  - c. Referral to a Psychiatric Services Unit for inmate-patients who are serving an established and endorsed SHU term (placement of these cases requires ICC referral and Classification Staff Representative endorsement).
2. Once identified as requiring EOP level of care, an inmate-patient shall be processed through investigations and disciplinary hearings on a priority basis. Where court proceedings are required, staff will make every effort to expeditiously support the Court's adjudicative process. In no event shall a pending CDCR 115, *Rules Violation Report*, impede or delay the transfer of these inmate-patients to a hub ASU institution.
3. Intake Assessment
- a. Within a maximum of five calendar days of the time of placement, an ASU Primary Clinician (PC) will be assigned who shall complete a brief evaluation of the inmate-patient including a review of the inmate-patient's mental health history and interview.
  - b. A comprehensive mental health clinical assessment shall be done by the PC and other IDTT members prior to the initial IDTT. If this evaluation is completed within five days, the brief evaluation referenced above need not be completed. This assessment shall include at minimum:
    - Comprehensive review of Central File and UHR of mental health treatment needs, including prior placements and medications.
    - Current mental status examination, including diagnosis and level of functioning.
    - Daily observation by mental health and custody staff to assess ADL and social interactions.

- Review of medication history and adjustments to current prescriptions (including involuntary medications as necessary) by staff psychiatrist.
- The assigned Correctional Counselor shall be prepared to discuss significant disciplinary history and custodial placements.
- Review with inmate-patient specific risk factors for violence toward self and others.

4. Interdisciplinary Treatment Team

- a. All EOP inmate-patients will appear at the initial IDTT.
- b. All inmate-patients referred for EOP will be seen by the IDTT prior to the initial ICC or within 14 calendar days.
- c. The IDTT will develop a treatment plan on CDCR 7388, *Mental Health Treatment Plan*.

5. Length of Stay More Than 90 Days

- a. Inmate-patients housed in ASU for more than 90 days shall be reviewed every 30 days outside of the ICC process, by the Facility Captain and Correctional Counselor II. The status of each case, with detailed information regarding reasons for delays in the referral, disciplinary, classification, and/or transfer process, shall be compiled and reviewed by the Warden or designee (Chief Deputy Warden, or Associate Warden for Health Care). The Warden shall ensure that reviewers take action to resolve any issues that impact length of stay in ASU.
- b. Inmate-patients housed in ASU for more than 90 days who postpone a RVR hearing pending referral to the District Attorney, shall be reviewed for alternate housing. If the time housed in ASU is equivalent to the projected SHU term (if the inmate-patient has been found guilty of the RVR), the inmate-patient shall be released to a general population setting. The Warden or designee shall contact the District Attorney to discuss expediting pending cases.

6. EOP Treatment in ASU Hubs

To avoid premature returns of inmate-patients and provide adequate time for observation and evaluation, inmate-patients transferred to EOP ASU hub institutions for treatment shall be held at the hub institution for no less than 60 days from the date of reception. Inmate-patients placed into general population housing during the initial 60-days after transfer to an ASU EOP hub shall be maintained at the EOP level of care for the duration of the 60-day period

Inmate-patients housed in ASU EOP hubs shall be provided care consistent with their clinical needs. Each inmate-patient shall have an individualized treatment plan for ten hours per week of scheduled structured therapeutic activities, using standardized therapeutic materials, with the following services:

**REQUIRED TREATMENT**

- a. Medication Management including a psychiatric evaluation by the psychiatrist at least every 30 days
- b. Daily LPT rounds seven days per week
- c. Weekly PC contact
- d. Crisis intervention

**OTHER TREATMENT ACTIVITIES**

- a. Medication Education
- b. Group Therapy including Anger Management, Stress Management, Substance Abuse (where clinically appropriate)
- c. Monitoring and assistance with daily living skills
- d. Recreation therapy both within cell and out of cell; this may include music therapy, art therapy, current events

Inmate-patients who are released from ASU to a general population EOP for continuing mental health treatment may require mental health services related to adjustment to the general population environment. The ASU primary clinician shall document recommendations regarding the inmate-patient's specific treatment needs, including any concerns about facilitating the inmate-patient's successful transition to general population. The receiving EOP IDTT will consider documentation by the ASU clinician in developing the inmate-patient's treatment plan. The treatment plan for inmate-patients transferred from ASU to general population-EOP shall include services provided to aid in the transition to the general population environment.

**7. Treatment Refusals**

For inmate-patients who refuse more than 50% of offered treatment during a one-week period, the PC shall:

- Interact with these inmate-patients daily on scheduled work days (instead of weekly)
- Include in the treatment plan efforts to reduce resistance to participation in group therapy
- Discuss these inmate-patients during the ASU morning meeting with custody
- Consider referral of inmate-patients to higher levels of care and document the results of this consideration.

**I. INPATIENT PLACEMENT**

Inmates who are found to meet the clinical criteria for referral to the MHCB for inpatient care shall immediately be transferred for such treatment, upon authorization by the Chief of Mental Health of the sending institution. (Refer to Section 5, Mental Health Crisis Bed, for transfer procedure)

If an ASU inmate-patient in an MHCB is determined to meet the clinical criteria for referral to the Department of Mental Health (DMH) program, the Chief of Mental Health or designee, of the sending institution shall initiate the referral process following established procedures to facilitate the admission to a DMH program.

**J. STAND-ALONE ADMINISTRATIVE SEGREGATION UNITS**

1. No participant in the MHSDS shall be housed in a stand-alone ASU. Any inmate-patient included in the MHSDS, who is inadvertently placed in a stand-alone ASU, shall be transferred out within 24 hours.
2. LPTs shall make rounds seven days a week.
3. A mental health clinician shall conduct an assessment of any inmate in a stand-alone ASU identified and referred by the LPT or any staff immediately or within 24 hours, depending on urgency of the referral. Any inmate who meets criteria for MHSDS shall be transferred to another ASU as soon as possible but no longer than 24 hours following identification.

**K. PLACEMENT REVIEW AND CLINICAL INPUT IN CLASSIFICATION COMMITTEE**

1. The initial IDTT is held prior to the initial ICC and as often as needed thereafter, at a minimum, once every 90 days. The PC and the Correctional Counselor assigned to the case shall present relevant clinical and custody case factors with recommendations concerning treatment and placement needs. The PC shall document the results of the IDTT reviews and decisions on the CDCR 7388, *Mental Health Treatment Plan*.

A CDCR 128-MH3, *Mental Health Placement Chrono*, shall be completed by the PC and forwarded to correctional counseling staff for necessary classification actions when there is a change in the level of care.

2. The Chief of Mental Health or designee, or in institutions without such a position, the Health Care Manager or designee, shall attend the ICC to provide clinical input at the committee meeting.

**L. INTERDISCIPLINARY TREATMENT TEAM**

The responsibilities for overall treatment planning within the ASU rest with the IDTT. These responsibilities include:

1. Placement decisions for individual cases.
2. Review of relevant clinical data for diagnostic formulation.
3. Review of relevant case factors.
4. Formulation and approval of treatment plans.
5. Annual and special reviews for continuation or termination of services
6. Review of treatment response.
7. Discharge planning.

The IDTT shall generally be responsible for developing and updating treatment plans. This process shall include input from the inmate-patient and other pertinent clinical information that may indicate the need for a different level of care. Referrals to higher levels of care shall be considered when the inmate-patient's clinical condition has worsened or the inmate-patient is not benefiting from treatment services available at the current level of care. Consideration of appropriate level of care shall be documented by the IDTT on a

CDCR 7230-MH, *Interdisciplinary Progress Note*, and shall include the justification for maintaining the current level of care or referral to a different level of care

The ASU MHS IDTT is composed of, at a minimum:

**The assigned PC**

**The assigned psychiatrist**

**The LPT**

**The assigned Correctional Counselor**

Correctional housing officer or any other mental health and custodial staff members who have specific information or knowledge relevant to cases under review are encouraged to attend. The inmate-patient shall be included in the IDTT, if clinically and custodially appropriate, unless the inmate-patient refuses to participate. If the inmate-patient refuses to participate, the clinician must document the reason for refusal on a CDCR 7230-MH, *Mental Health Progress Notes*.

#### **M. DUTIES OF CLINICAL CASE MANAGER OR PRIMARY CLINICIAN**

Each inmate-patient within the treatment component of the ASU MHS shall be assigned a PC or PC, typically a Clinical Social Worker (CSW) or psychologist. This individual shall maintain clinical involvement with the inmate-patient, as well as performing casework functions, including the following:

1. Documentation of initial and updates to the Mental Health Assessment.
2. In consultation with the IDTT, develop and document initial and updated treatment plans that also address security concerns and status.
3. Weekly individual contact for CCCMS and EOP inmate-patients.
4. Scheduling for regular or special IDTT reviews.
5. Response to inquiries regarding clinical status of the inmate-patient.
6. Attendance at initial IDTT reviews of the inmate-patient, prior to the initial ICC, and at subsequent IDTTs, at least every 90 days.
7. Participation in ICC to provide mental health input.

8. Liaison with custody and correctional counseling staff regarding overall management of inmate-patients.
9. Group therapy as defined in the inmate-patient's treatment plan.
10. Crisis intervention and referral for inpatient care as needed.
11. Review of the weekly summary of clinical rounds and documentation of this review in the UHR.

**N. UNIT HEALTH RECORD**

1. A current record of all treatment plans and progress notes shall be maintained on departmentally approved forms within the individual UHR. Only designated staff shall have access to this record. All staff shall adhere to the confidentiality requirements.
2. There are many legitimate exceptions to confidentiality requirements (e.g., institutional security). However, every member of the ASU MHS, including correctional staff, shall treat all clinical information with professional discretion. No information shall be divulged without clinical or correctional necessity.

**O. AUTOMATED TRACKING SYSTEM**

The Inmate Mental Health Identifier System (IMHIS) has been designed to track the movement of all inmate-patients receiving care in the MHSDS. The data entered into the system will be processed daily, so the system will maintain current information regarding MHSDS inmate-patients' current level of care, as well as MHSDS transfers, discharges and new cases. All institutions are to conduct a reconciliation of the inmate-patients housed in ASU who require mental health treatment with the IMHIS codes for this specific population. Daily updates to the IMHIS are mandatory for every ASU.

All mental health contacts shall be tracked in the MHTS.

**P. CUSTODIAL OPERATIONS**

Inmate-patients within the ASU MHS are subject to all rules, custodial requirements, activities, and privileges of other ASU inmates.

**Q. PHYSICAL PLANT**

Interviews of inmates will be held in a private setting unless the security of the institution or the safety of staff will be compromised. Screening and evaluation interviews and treatment activities are accomplished in existing interview rooms and exercise areas within current ASU units. The IDTT interviews may require inmate-patient escorts to

classification/interview rooms. Clinical monitoring and routine interviews, including clinical staff daily rounds, may be provided through cell-front contacts as clinically appropriate and depending on the cooperation of the inmate. While some therapeutic activities may take place within the cell, whenever possible treatment activities should take place out of cell.

Mental health treatment in ASU may be provided using mental health programming booths. All mental health programming booths procured after March 2007, shall conform to design specifications available through the Prison Industry Authority. Booths are available through the Prison Industry Authority's online product catalog at: <http://catalog.pia.ca.gov/> using the search term "Mental Health Programming Booth."



# **CHAPTER 8**

## **Security Housing Unit**

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### **A. INTRODUCTION**

It is the policy of the Department of Corrections and Rehabilitation (CDCR) to provide inmates in a prison setting with prompt access to mental health services, regardless of their housing designation. Provision of mental health services within a Security Housing Unit (SHU) is part of the Mental Health Services Delivery System (MHSDS). Mental health services within a SHU are provided to all SHU inmate-patients in accordance with the inmate-patient's treatment needs and level of care. Services are designed to achieve symptom management through regular case management activities, medication administration and monitoring, crisis intervention, continuous monitoring for signs or symptoms of a serious mental disorder, and referral to a more intensive as needed.

The CDCR currently has four SHUs located at the institutions listed below. Inmates in the MHSDS receive services as indicated.

- Valley State Prison for Women (females only) – Inmates in this unit receive mental health services in conjunction with inmates in the Administrative Segregation Unit (ASU).
- California Correctional Institution – Inmates are provided Correctional Clinical Case Management Services (CCCMS). Inmates requiring the Enhanced Outpatient Program (EOP) are referred to a Psychiatric Services Unit (PSU) and transferred to an ASU EOP hub while awaiting PSU placement.
- California State Prison, Corcoran – Inmates are provided CCCMS in the SHU. Inmates requiring EOP services are referred to a PSU and transferred to the ASU EOP hub while awaiting PSU placement.
- California State Prison, Sacramento – Inmates are provided CCCMS in the SHU. Inmates requiring EOP services are referred to a PSU.
- Pelican Bay State Prison (PBSP) – Per exclusionary criteria from the federal court, inmates with one of the conditions listed below shall not be admitted to the PBSP SHU.

1. Documented diagnosis or evidence of any of the following Diagnostic and Statistical Manual IV – Axis 1 conditions currently in existence or within the preceding three months:

**Schizophrenia (all sub-types);**

**Delusional Disorder;**

**Schizophreniform Disorder;**

**Schizoaffective Disorder;**

**Brief Psychotic Disorder**

**Substance-Induced Psychotic Disorder (excluding intoxication and withdrawal);**

**Psychotic Disorder Not Otherwise Specified;**

**Major Depressive Disorders;**

**Bipolar Disorder I and II**

2. A diagnosed mental disorder that includes being actively suicidal.
3. A diagnosis of a serious mental illness that is frequently characterized by breaks with reality, or perceptions of reality that leads to significant functional impairment.
4. A diagnosis of “organic brain syndrome” that results in a significant functional impairment if not treated.
5. A diagnosis of a severe personality disorder that is manifested by frequent episodes of psychosis or depression and results in significant functional impairment.
6. A diagnosis of mental retardation.
7. A prior history, which suggests that the inmate will do poorly in the SHU. This includes inmates who have experienced psychotic symptoms that appear to be attributable to incarcerations in a SHU environment. These inmates are those for whom evidence exists of a deterioration in mental health which correlates with placement in SHU or SHU-like environments. Such diagnoses as “Brief Psychotic Episode,” “Psychosis NOS,” and “Major Depression” which have been assigned during periods of placement in SHU may, for example, be indicative of deterioration of mental health which accompanies SHU placement. Inmates whose history suggests such a causal relationship should be excluded from SHU.
8. A history which includes any of the following within the preceding three months:
  - a. Medication prescribed to address any of the “at risk” mental health categories listed above.

- b. Therapy and/or supportive services to address any of the “at risk” mental health categories listed above.
- c. Frequent (e.g. at least weekly) monitoring for deterioration in mental health condition. This does not include situations in which repeated visits by mental health staff are attributable to repeated referral from the inmate or from custody staff but where no mental health condition is noted.
- d. A history which includes a recurrent or “cyclic” mental health condition (e.g. Bipolar Disorder) where the inmate has not currently been symptom free for a period of time that is at least **twice as long** as the longest known period of active symptoms or known to demonstrate recurrent symptoms at intervals of approximately 6 months, would be considered as “positive” on this indicator until they had been symptom free for a continuous period of at least 12 months.

Where the results of the Unit Health Record (UHR) review reveal that any of the above conditions exist, the inmate must be removed from SHU within 96 hours of his arrival on that unit.

Where the results of the UHR review **do not** reveal the existence of any of the above conditions **and** there is evidence that the inmate has been evaluated with the existing 31 item mental health screen or other evaluation (documented on a CDCR 7386, *Mental Health Evaluation*) within the preceding 12 month period, the inmate may be housed in SHU.

Where the results of the UHR are equivocal (as where no clear diagnosis is established but where mental health contact and observations have suggested that symptoms consistent with one or more of the above conditions have been observed) or when no mental health evaluation (a 31 item mental health screen or completion of an evaluation documented on a CDCR 7386, *Mental Health Evaluation*) has occurred the preceding 12 month period, a mental health evaluation shall be conducted.

## **B. PURPOSE**

This chapter outlines program policies and provides institutional operational procedures to assure the effective delivery of mental health services to inmate-patients with serious mental disorders who, for custodial reasons, require housing in a SHU, according to California Code of Regulations, Title 15.

**C. RESPONSIBILITY**

1. Overall institutional responsibility for the program shall rest jointly with the Health Care Manager and the Warden.
2. Institutional operational oversight of the Mental Health Services in a SHU shall be the responsibility of the Chief of Mental Health. The assigned Psychiatrist or Primary Clinician (PC) shall attend all Institutional Classification Committee (ICC) meetings in the SHU to provide mental health input.
3. Custodial responsibilities, including initial placement, correctional counseling services, classification, inmate movement, and daily management shall rest with the Warden or designee.
4. Clinical case management, including treatment planning and placement recommendations, shall be performed by an assigned PC and approved by the SHU Interdisciplinary Treatment Team (IDTT).

**D. PROGRAM GOALS AND OBJECTIVES**

The goal of the mental health services in the SHU is to provide evaluation and treatment of serious mental disorders that are limiting the ability of inmates with high security needs to adjust to appropriate institutional placements. Inmate-patients with clinical needs that cannot be met within the SHU mental health program, as determined by the IDTT, shall be referred to the SHU ICC for consideration of alternative treatment programs.

**The program objectives are to:**

1. Provide regular case management, treatment activities, and medication monitoring, to enable inmate-patients to maintain their current level of functioning and avoid decompensation.
2. Ensure that inmate-patients whose clinical mental health needs cannot be met in SHU and require a change in level of care are referred for alternative treatment programs by mental health clinicians.
3. Provide clinical rounds every other week by Licensed Psychiatric Technicians (LPT) or other clinicians to identify mental health needs for all inmates who are not currently in MHSDS. Rounds are provided by PCs at PBSP and by LPTs in other SHUs.
4. Provide weekly clinical rounds by LPTs or other clinicians of inmates in the MHSDS.

5. Conduct mental health assessments to provide input into ICC proceedings concerning the inmate-patients' current participation in the MHSDS program. This includes medication compliance, suitability for single or double celling, risk assessment for self injurious or assaultive behavior, status of Activities of Daily Living (ADL), ability to understand Due Process, likelihood of decompensation if retained in SHU, and recommendations for alternative placement.
6. Conduct mental health assessments to provide input into the adjudication of Rules Violation Reports (RVR) hearing proceedings on MHSDS caseload inmate-patients according to current policy. Mental health information includes the inmate-patient's participation in the current MHSDS level of care, any mental condition that may have been a contributing factor in the alleged behavior, the inmate-patient's ability to comprehend the nature of the charges or the disciplinary process, and any mental health factor that the hearing officer should consider in assessing the penalty. Final decisions are made in ICC meetings or hearings after considering all relevant clinical and custody factors, consistent with Department Operations Manual, Section 62050.13.23 (ICC/Suspension of SHU terms).

#### **E. TREATMENT POPULATION**

Refer to the Treatment Criteria for the levels of care in the MHSDS Program Guide, Chapter 1, Program Guide Overview.

#### **F. SOURCES OF REFERRAL FOR MENTAL HEALTH SERVICES**

1. Current MHSDS treatment cases: Current MHSDS inmate-patients are identified by checking the SHU placements reported on the Institutional Daily Movement Sheet to ensure the continuity of mental health care including prescribed medications. Upon an inmate-patient's placement into the SHU, the nursing staff from the originating unit shall transfer the inmate-patient's Medication Administration Record (MAR) to the SHU, consistent with their post orders.
2. Staff referral: Any staff member who observes possible signs or symptoms of a serious mental disorder may refer an inmate for clinical evaluation by completing a CDCR 128-MH5, *Mental Health Referral Chrono*, and follow the self-referral process below. Any inmate who is observed to be a suicide risk, or in any other condition that requires crisis care, shall be immediately screened by a PC to assess their potential for suicide and, if appropriate, referred to the MHCb for admission. On weekends and holidays, follow the self-referral process below.

3. Inmates who receive a CDCR 115, *Rules Violation Report*, for Indecent Exposure or Intentionally Sustained Masturbation Without Exposure shall be referred for all of the following:
  - CDCR 115-MH *Rules Violation Report: Mental Health Assessment*;
  - A mental health assessment shall be completed within 24 hours to rule-out decompensation and/or intoxication. The referral shall be made by telephone to the local Chief of Mental Health who shall arrange this assessment; and,
  - For inmate-patients included in the MHSDS, to the inmate-patient's PC.
4. Self referral: Inmates in SHU may request a clinical interview to discuss their mental health needs. These requests are made on a CDCR 7362, *Health Care Services Request*. Mondays through Fridays, the following shall occur:
  - a. A health care staff member shall collect the CDCR 7362, *Health Care Services Request*, and staff referral forms, 128-MH5, *Mental Health Referral Chrono*, each day from the designated areas.
  - b. Upon receipt of the collected forms, an nursing staff shall initial and date each CDCR Form 7362, *Health Care Services Request*, and/or staff referral forms, 128-MH5, *Mental Health Referral Chrono*.
  - c. The CDCR Forms 7362, *Health Care Services Request*, and/or mental health staff referrals forms, 128-MH5, *Mental Health Referral Chrono*, shall be delivered to the designated program representative in mental health services for same-day processing.

On weekends and holidays, the following shall occur:

- a. The Treatment and Triage Area (TTA) registered nurse (RN) shall review each mental health staff referral form, 128-MH5, *Mental Health Referral Chrono*, and each CDCR 7362, *Health Care Services Request*, for the need for medical, dental, and mental health services, establish priorities on an emergent and non-emergent basis, and refer accordingly.
  - b. If a mental health clinician is not available, the medical officer of the day (MOD), physician on call or psychiatrist on call shall be contacted.
5. Inmates will be seen by a mental health clinician, or on weekends by the physician or psychiatrist on call within the clinically determined time frame.
    - Emergent: Emergency cases will be seen immediately or escorted to the TTA

- Urgent: Urgent cases will be seen within 24 hours
  - Other: Other cases will be seen within five working days
6. Clinical rounds: A mental health staff member, usually a LPT or at PBSP, a PC, shall conduct rounds weekly unless clinically needed more often in the SHU to attend to the mental health needs of all MHSDS inmates. The LPT shall make rounds of non-MHSDS inmates every other week. If an inmate refuses to talk to the LPTs, the LPT will discuss the inmate's functioning with custody staff. The LPT shall maintain an individual record of clinical rounds by making a check mark next to the inmate's name on the SHU Inmate Roster each time they are checked. Those inmates who have not been previously identified as having mental health treatment needs but exhibit possible signs and symptoms of a serious mental disorder shall be referred, via CDCR 128-MH5, *Mental Health Referral Chrono*, to a PC for clinical evaluation. Any unusual findings that may require closer observation by custody shall be documented on the 114-A, *Isolation Log*, on the same day of occurrence. The LPT shall document a summary of the status of MHSDS inmate-patients in a weekly progress note in the UHR.
7. All referrals and evaluations shall be documented on approved forms, filed in individual inmate UHR, and entered into the Mental Health Tracking System.

NOTE: When an IDTT determines that an inmate-patient requires treatment of exhibitionism, that inmate-patient's level of care shall be changed to CCCMS (or higher if appropriate), bypassing the standard referral process.

#### **G. CORRECTIONAL CLINICAL CASE MANAGEMENT SYSTEM (CCCMS)**

The mental health staff shall continue to provide mental health services to inmate-patients with the CCCMS level of care designation after they are placed in SHU. Inmate-patients who meet the clinical criteria of MHSDS resulting from staff referrals, self-referrals, or clinical rounds shall also receive mental health evaluation and ongoing services, if determined appropriate. Each MHSDS inmate-patient is assigned a PC.

##### **1. Interdisciplinary Treatment Team**

- a. The responsibilities for overall treatment planning within the CCCMS program rest with an IDTT. These responsibilities include:
- Placement decisions for individual cases
  - Review of relevant clinical data for diagnostic formulation

- Review of relevant case factors
  - Formulation and approval of treatment plans
  - Annual and special reviews for continuation or termination of services
  - Review of treatment response
  - Discharge planning
- b. The IDTT is composed of, at a minimum:
- The assigned PC (either a psychologist or a Clinical Social Worker).
  - The LPT
  - The SHU Senior Psychologist or designee
  - The assigned psychiatrist
  - The assigned Correctional Counselor
  - The inmate-patient (if clinically and custodially appropriate). The inmate-patient shall be included in the IDTT, unless the inmate-patient refuses to participate. If the inmate-patient refuses to participate, the clinician must document the reason for refusal in the CDCR 7230, *Mental Health Progress Notes*. Inmate-patients shall not be disciplined for not participating in IDTT.
  - The housing custody officer or any other staff member who has direct knowledge of the inmate-patient under review is encouraged to attend. As the staff involved in day-to-day interactions with inmate-patients, custody officers can provide input in assessing clinical status and continuing needs, and support in implementing treatment programs.
- c. All CCCMS inmate-patients are seen in the initial IDTT that is held prior to the initial ICC hearing (within 14 calendar days of arrival in SHU) and quarterly thereafter. Some inmate-patients may be seen more frequently by the IDTT in special reviews at the request of the assigned PC or psychiatrist whenever changes in the level of care or treatment plans are indicated. The results of the IDTT reviews and decisions shall be documented by the PC in the interdisciplinary progress notes and filed in the UHR. These notes shall include the following:



- Names of all IDTT members present
  - Inmate-patient's participation
  - Inmate-patient's suitability for single or double celling
  - Risk assessment for self injurious or assaultive behavior
  - Current medication regimen
  - Compliance with treatment, including medication
  - Status of ADL
  - Treatment goals and objectives, progress or lack of progress in treatment
  - Recommendations for placement options
  - Need for staff assistance
  - ICC action
- d. CDCR 128-MH3, *Mental Health Placement Chrono*, shall be completed by the PC and forwarded to correctional counseling staff for necessary classification actions when there is a change in the level of care.
2. Functions of the PC in SHU may include the following:
- a. Complete mental health evaluation on new cases. If an inmate-patient is an active CCCMS case and the Mental Health Assessment has been completed by a previous clinician, the PC shall update the assessment.
  - b. In consultation with the IDTT, develop and document initial and updated CDCR 7388, *Treatment Plans*, that also address security concerns and status.
  - c. Provide individual monitoring contact once every 30 days at a minimum for CCCMS inmate-patients, or more frequently as clinically indicated.
  - d. Participate in IDTT meetings.
  - e. Participate in ICC to provide mental health input.

- f. Provide crisis intervention and referral for a more intensive level of care as needed.
  - g. Perform as liaison with custody and correctional counseling staff regarding overall management of inmates.
3. Treatment Modalities: Based on identified needs, the following treatment modalities are available:

**REQUIRED TREATMENT**

- Individual meeting with PC at least every 30 days or more frequently as clinically indicated.
- Quarterly IDTT update of treatment plan.
- Medication evaluation, review, and monitoring of compliance by psychiatric and nursing staff for those inmate-patients receiving medication.
- Regular monitoring of symptoms by LPTs through weekly rounds of all MHSDS inmate-patients and rounds every other week of all non-MHSDS inmates.

**OTHER TREATMENT ACTIVITIES**

- Orientation and supportive counseling for institutional adjustment
- Individual counseling and crisis intervention
- Group therapy such as anger management and relapse prevention
- Social skills training
- Consultation services, such as to education and work programs
- Clinical discharge or clinical pre-release planning

**H. ENHANCED OUTPATIENT PROGRAM**

Inmate-patients who are serving an established and approved SHU term and require an EOP level of care shall be referred to a PSU. While awaiting placement for a PSU, these inmate-patients shall be transferred to an EOP ASU hub within 30 days of being designated as requiring EOP care. EOP mental health services shall be provided in the EOP ASU Hubs.

**I. PLACEMENT REVIEW AND CLINICAL INPUT INTO ICC**

1. The appropriateness of an inmate-patient's placement in SHU shall be reviewed in regularly scheduled ICC meetings. The Chief of Mental Health or designee, is a member of the ICC. In that capacity, he/she shall present the IDTT's recommendations regarding placement recommendations, based on the inmate-patient's clinical needs. Designees shall be a psychiatrist, a licensed psychologist, or a Licensed Clinical Social Worker.
2. All identified CCCMS and EOP inmate-patients in SHU shall receive continued mental health services managed by the assigned PC. An exception to this policy will occur at PBSP when an inmate-patient meets the exclusionary criteria at which time the inmate-patient shall be transferred to an appropriate treatment setting such as the PSU for EOPs or a SHU with CCCMS care. Any inmate in the PBSP SHU who is identified as having one of these diagnoses and requiring EOP level of care shall be transferred within 96 hours out of the PBSP SHU to the PSU, EOP or Correctional Treatment Center (CTC).
3. Inmate-patients in the PBSP PSU recommended by the IDTT for CCCMS are scheduled for the next available ICC and referred for transfer to the COR SHU. They are housed in ASU pending transfer.
4. An inmate-patient whose clinical needs cannot be adequately met through regular case management activities shall be referred to ICC for consideration of alternative clinical placement, including placement in a Level IV EOP. Inmate-patients who are determined to meet the clinical criteria for referral to the MHCB shall immediately be transferred to MHCB. Upon approval by the Chief of Mental Health, or designee, the PC shall initiate such referrals, based on the direct observation and assessment.
5. The ICC shall review all referrals for alternative placement and may recommend one of the following placement options, based on the clinician's input and Correctional Counselor review of case factors:
  - a. Transfer to the MHCB program. This option is for inmate-patients who require 24-hour crisis care and do not require ICC review.
  - b. Transfer to an appropriate inpatient program through Department of Mental Health (DMH).
  - c. Transfer to a PSU. This option is for male inmate-patients who require both maximum custodial controls and EOP level of care. Female inmate-patients will continue to be treated in SHU, consistent with updated individualized treatment plans and LOC, until a PSU for female inmate-patients is established.

- d. Suspension of SHU term and placement in the Level IV EOP: This option is for inmate-patients who are determined by the ICC to no longer require the maximum custodial controls of SHU.
- e. All inmate-patients requiring EOP care shall be transferred to either a PSU or EOP, as determined by the ICC, within 60 days or 30 days, if clinically indicated.

**J. UNIT HEALTH RECORD**

A current record of all CDCR 7386, *Mental Health Evaluations*, CDCR 7388, *Treatment Plans*, and CDCR 7230, *Interdisciplinary Progress Notes*, shall be maintained in the UHR. Records shall include documentation regarding modifications to an inmate-patient's treatment plan for developmental and other disabilities. Only designated staff shall have access to this record. All staff shall adhere to the confidentiality requirements. No information shall be divulged without clinical or correctional necessity.

**K. AUTOMATED TRACKING SYSTEM**

The Inmate Mental Health Identifier System (IMHIS) has been designed to track the movement of all inmate-patients receiving care in the MHSDS. The data entered into the system shall be processed daily, so the system will maintain current information regarding MHSDS inmate-patients' current level of care as well as MHSDS inmate-patient transfers, discharges, and new cases. All institutions shall conduct a reconciliation of the inmate-patients housed in ASU and SHU who require mental health treatment with the IMHIS codes for this specific population. Daily updates to the IMHIS are mandatory for every SHU.

Inmate-patients clinical contacts shall be tracked in the Mental Health Tracking System .

**L. CUSTODIAL OPERATIONS**

Inmate-patients with a serious mental disorder within the SHU are subject to all rules, custodial requirements, activities, and privileges of other SHU inmates.

**M. PHYSICAL PLANT**

Screening and evaluation interviews and treatment of inmates shall be held in a private setting unless the security of the institution or the safety of staff will be compromised. The IDTT interviews may require inmate-patient escorts to classification/interview rooms. Clinical monitoring and routine interviews, including clinical staff rounds, may be provided through cell-front contacts as clinically appropriate and depending on the cooperation of the

inmate. While some therapeutic activities may take place within the cell, whenever possible treatment activities should take place out of cell.

Mental health treatment in SHU may be provided using mental health programming booths. All mental health programming booths procured after March 2007, shall conform to design specifications available through the Prison Industry Authority. Booths are available through the Prison Industry Authority's online product catalog at: <http://catalog.pia.ca.gov/> using the search term "Mental Health Programming Booth."

# **CHAPTER 9**

## **Psychiatric Services Unit**

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### **A. INTRODUCTION**

The Psychiatric Services Units (PSU) were developed to deliver mental health services to inmates who have been diagnosed as having a serious mental disorder and are serving a Security Housing Unit (SHU) term. The purpose of the PSU is to assure the effective delivery of Enhanced Outpatient Program (EOP) services to inmate-patients in a maximum-security setting. The PSUs are currently located at the Pelican Bay State Prison, California State Prison, Sacramento, and for female inmates at the California Institute for Women.

### **B. PROGRAM GOALS AND OBJECTIVES**

1. The goal of the PSU is to provide evaluation and treatment of serious mental disorders that are limiting the ability of inmates with high security needs to adjust to appropriate institutional placements. The overall objective is to provide clinical intervention to return the individual to the least restrictive clinical and custodial environment.
2. More specific program objectives for individual cases may include:
  - a. Providing comprehensive mental health assessment of inmates to determine their need for treatment and appropriate clinical placement.
  - b. Providing alternative housing for inmate-patients whose mental health needs limit their ability to adjust to placement within the SHU.
  - c. Providing clinical interventions that reduce the inmate-patients' behavioral problems and allow re-integration into less restrictive clinical and custodial placements, or, for inmate-patients approaching release dates, transition to parole status.
  - d. Assisting inmate-patients in acquiring skills to function more appropriately and successfully in an institutional setting.

**C. PROGRAM RESPONSIBILITY**

1. The overall institutional responsibility for the program rests jointly with the Health Care Manager (HCM) and the Warden.
2. The coordination of clinical activities within the PSU is the responsibility of the PSU Senior Psychologist. The PSU Senior Psychologist is responsible for ensuring that the PSU Mental Health Program is in compliance with the Mental Health Services Delivery System (MHSDS).
3. The PSU Facility Captain will oversee custodial responsibilities, correctional counseling services, and classification actions.
4. Decisions on inmate-patient treatment plans, individual inmate-patient program activities, and level of care are made by the Interdisciplinary Treatment Team (IDTT).

**D. POPULATION TO BE SERVED**

Any California Department of Corrections and Rehabilitation (CDCR) inmate-patient with a SHU classification who requires an EOP level of care will be housed in the PSU. Refer to the Treatment Criteria for the levels of care in the MHSDS Program Guide, Chapter 1, Overview Program Guide.

**E. REFERRAL AND ENDORSEMENT**

SHU inmates shall be placed into PSU when a mental health evaluation determines that EOP level of care is indicated or when an EOP inmate receives an established and approved SHU term. Staff shall not postpone a referral to the Classification Services Representative (CSR) for any unresolved disciplinary infractions or District Attorney referral determinations. In cases where restrictions may apply (e.g., parole violators returned to custody who are awaiting a parole revocation extension hearing), the inmate-patient will be referred to the CSR for PSU endorsement and retained at the ASU hub until the revocation process is complete, then transferred to the PSU if still appropriate.

1. When an inmate-patient has both an active SHU Term and EOP level of care, he will be referred for placement in a PSU. The referring source must complete a CDCR 128-MH3, *MHSDS Placement Chrono*, outlining the need for PSU placement. This CDCR 128-MH3, *MHSDS Placement Chrono*, must be signed by the referring institution's Chief of Mental Health or designee.
2. The Institutional Classification Committee (ICC) at the referring institution shall make a referral to the CSR for endorsement.

3. Once endorsement is obtained, the inmate-patient shall be transferred to a PSU.
4. EOP inmate-patients with an established and approved SHU term shall be transferred within 30 days of designation to an EOP ASU hub and will be provided EOP care while awaiting PSU placement.
5. Per exclusionary criteria from the federal court, inmate-patients with one of the diagnoses listed below shall not be admitted to the PBSP SHU. SHU EOP inmate-patients with one of the diagnoses shall be placed in a PSU. Any inmate already in a SHU who is identified as having one of these diagnoses and requiring EOP level of care shall be transferred within 96 hours out of the PBSP SHU to the PSU, EOP or Correctional Treatment Center (CTC).
6. If an inmate in the PBSP SHU is diagnosed with one of the exclusionary diagnoses and requires Correctional Clinical Case Management System (CCCMS) level of care, he shall be moved within 96 hours to ASU, the PSU, or the CTC. The inmate shall be reviewed by the ICC and referred for transfer to the California State Prison, Corcoran SHU. If the inmate-patient's diagnosis does not meet exclusion criteria, he shall be retained in the SHU and reviewed weekly by clinical staff. The exclusionary diagnostic criteria are:
  - Schizophrenia (any subtype)
  - Delusional Disorder
  - Schizophreniform Disorder
  - Schizoaffective Disorder
  - Substance Induced Psychotic Disorder (excluding intoxication and withdrawal)
  - Psychotic Disorder Not Otherwise Specified
  - Any mental illness characterized by breaks with reality or perceptions of reality leading to significant functional impairment
  - Major Depressive Disorder
  - Bipolar Disorder I or II
  - Brief Psychotic Disorder
  - Mental retardation
  - Any mental disorder which includes inmate being actively suicidal
  - Organic Brain Syndrome consistent with significant functional impairment
  - Severe personality disorder manifested by frequent episodes of psychosis or depression and resulting in significant functional impairment



**F. CLINICAL SERVICES****Intake Assessment**

1. The Senior Psychologist or designee shall appoint a Primary Clinician (PC) for each inmate-patient admitted to the PSU. The PC shall complete a brief evaluation of the inmate-patient including a review of the inmate-patient's mental health history and an interview in a timeframe clinically determined appropriate but not more than five calendar days after arrival in the PSU.
2. All inmate-patients will be evaluated by the IDTT prior to the initial ICC but not later than 14 calendar days after arrival in the PSU.
3. A comprehensive mental health clinical assessment shall be done by the PC and other IDTT members prior to the initial IDTT. This assessment shall include at minimum:
  - a. Comprehensive review of the central file and unit health record (UHR) of mental health treatment needs, including prior placements and medications.
  - b. Current mental status examination, including diagnosis and level of functioning.
  - c. Daily observation by mental health and custody staff to assess Activities of Daily Living and social interactions.
  - d. Review of medication history and adjustments to current prescriptions (including involuntary medications as necessary) by staff psychiatrist.
  - e. Review of disciplinary history and custodial placements by the assigned Correctional Counselor or Lieutenant.
  - f. Review specific risk factors for violence toward self and others. This includes a suicide risk assessment if indicated.
4. The IDTT will make a decision regarding appropriate placement. This decision includes the following options:
  - a. Retention for an additional 14 calendar days to determine the inmate-patient's appropriateness for PSU placement.
  - b. Referral to the Department of Mental Health (DMH) for inpatient care. Inmate-patients shall be referred to the DMH Acute Psychiatric Program (APP) at the California Medical Facility (CMF) for acute care.

Inmate-patients requiring intermediate care shall be referred to the DMH Salinas Valley Psychiatric Program. All female inmate-patients requiring Department of Mental Health level of care shall be referred to Patton State Hospital.

- c. Placement in Mental Health Crisis Beds (short term crisis stabilization, including initiation of involuntary medications when required).
- d. Retention in the PSU Treatment Program if the inmate-patient requires EOP level of care.
- e. Referral to classification committee recommending SHU placement if the inmate qualifies for CCCMS care or has been discharged from the MHSDS. Inmate-patients with any of the exclusionary diagnoses listed in Section E, *Referral and Endorsement*, Paragraph 6 above, shall not be placed in the PBSP SHU.
- f. If the SHU term has been served, general population placement at the appropriate level of care including EOP.

**Interdisciplinary Treatment Team**

1. The PSU IDTT shall be chaired by the PSU Senior Psychologist. All clinical decisions regarding intake, treatment planning, re-justification of level of care, and discharge, are made by the PSU IDTT. The IDTT is composed of, at minimum:

- Senior Psychologist
- Assigned Psychiatrist
- PSU Facility Captain
- Correctional Counselor II
- Assigned Primary Clinician
- Inmate-patient

Other PSU staff such as a Recreation Therapist (RT), Nursing staff, Licensed Psychiatric Technician (LPT), Sergeant and Correctional Officers, and/or custody representatives may attend. A representative from the IDTT (the assigned PC or designee) shall be present in all classification hearings regarding inmate-patients to provide mental health input into the classification decision-making process. The inmate-patient shall be included in the IDTT, unless the inmate-patient refuses to participate. Inmate-patients

shall not receive a CDCR 115, *Rules Violation Report*, for not participating in IDTT. The PC documents the reason for refusal on the CDCR 7230-MH, *Mental Health Progress Notes*, in the UHR. The PC is responsible for presenting the inmate-patient's concerns to the IDTT.

2. After the initial IDTT, inmate-patients will be evaluated by the IDTT minimally at 60 and 120 days after admission and at least every 90 days thereafter or sooner, whenever there is a significant change in level of functioning. The IDTT will evaluate treatment progress, update the treatment plan and review the discharge goals. The PC assigned to the case will present a case summary with recommendations for continued treatment or discharge. The results of all IDTT reviews, decisions and recommendations will be documented in the UHR. Initial and level of care changes are documented on a CDCR 128-MH-3, *Mental Health Placement Chrono*, and forwarded to the Correctional Counselor II.
3. The responsibility for mental health treatment planning for inmate-patients in the PSU rests with the IDTT. These responsibilities include:
  - a. Admission decisions
  - b. Treatment planning
  - c. Periodic case reviews and re-justifications of treatment at 60, 120 and at least every 90 days thereafter, or whenever there is a significant change in the inmate-patient's functioning that requires a change in the treatment plan.
  - d. Discharge recommendations – The initial treatment plan and all subsequent treatment plans shall include a discharge plan and behavioral goals to discharge the inmate-patient from the PSU to a less intensive level of care.

### **Primary Clinician**

Each inmate-patient in the PSU shall be assigned a PC, usually a Clinical Social Worker (CSW) or psychologist, although other clinicians may be assigned to cases with special needs. The PC will maintain active clinical involvement with the inmate-patient, as well as performing casework functions, including the following:

- Documentation of initial treatment plan and updates
- Regular clinical contacts with assigned inmate-patients
- Ensuring scheduling of periodic IDTT reviews

- Attendance at IDTT reviews of the inmate-patient
- Referral to, and coordination with, the assigned staff psychiatrist
- Response to CDCR inquiries regarding clinical status of the inmate-patient

**G. TREATMENT PROGRAM**

1. Each PSU shall have an Operational Plan that describes its treatment program. Each PSU shall have a behavioral incentive program with criteria for achieving and retaining each level. Every level has certain privileges. See the Operational Plan at each institution for a complete description.
2. Treatment Plan
  - a. Each inmate-patient in the PSU shall have a current individual treatment plan on CDCR 7388, *Mental Health Treatment Plan*.
  - b. The treatment plan shall be reviewed by the IDTT at 60 and 120 days after admission, at least every 90 days thereafter, or whenever there is a significant change in the inmate-patient's functioning requiring a change in the treatment plan.
  - c. There shall be a CDCR 7230-MH, *Mental Health Progress Note*, documenting the IDTT meeting that includes a list of members in attendance.
  - d. Each treatment intervention shall be directed to a problem on the inmate-patient's Problem List.
  - e. Each treatment intervention shall indicate the provider, type of intervention (e.g. individual or group therapy), frequency of intervention, outcome objectives, and specific measurable behavioral goals.
  - f. Discharge from the EOP or transfer to another level of care will be documented on a CDCR 128-MH3, *Mental Health Placement Chrono*.
3. Within the PSU, each inmate-patient shall have an individualized treatment plan that provides for treatment consistent with the inmate-patient's clinical needs. Each inmate-patient will be offered at least ten hours per week of scheduled structured therapeutic activities as approved by the IDTT. It is recognized that not all inmate-patients can participate in and/or benefit from ten hours per week of treatment services. For some inmate-patients, ten hours per week may be clinically contraindicated. For those inmate-

patients scheduled for fewer than ten hours per week of treatment services, the PC shall present the case and recommended treatment program to the IDTT for approval. The CDCR 7388, *Mental Health Treatment Plan*, must include a detailed description of the diagnosis, problems, level of functioning, medication compliance, and rationale for scheduling fewer than ten hours. For inmate-patients who are scheduled for fewer than ten hours of treatment activities per week, the IDTT shall meet at least monthly and be responsible to review and increase the treatment activities, and consider higher level of care as appropriate.

#### REQUIRED TREATMENT

- Individual treatment planning involves a meeting of the IDTT and the inmate-patient at least every 90 days for the purpose of identifying treatment needs, developing treatment plans, assessing treatment progress, and updating/revising individual treatment plans in accordance with the inmate-patient's needs and progress.
- Weekly PC contact (either individually or in group psychotherapy) with assigned inmate-patients. Individual clinical contacts shall occur at least every other week.
- Medication evaluation and management
- A psychiatrist shall evaluate each EOP inmate-patient at least monthly to address psychiatric medication issues.
- Refer to Inmate Medical Services Policies and Procedures, Volume 4, Chapter 11, Medication Management, regarding procedures for administration of medication, medication refusals, Directly Observed Therapy, and other aspects of medication administration.
- Refer to MHSDS Program Guide, Chapter 5, Mental Health Crisis Bed, for information on involuntary medication administration (*Keyhea*).

#### OTHER TREATMENT ACTIVITIES

- Individual psychotherapy
- Group therapy such as Anger Management, Stress Management, Offense-related Issues, Current Events
- Medication education
- Crisis intervention

- Pre-release planning
- Monitoring and assistance with daily living skills
- Cognitive Behavioral Therapy directed to specific behaviors or symptoms
- Recreational activities
- Vocational and pre-vocational training as available
- Education as available
- 12-Step Program and other substance abuse treatment

4. CCCMS – Pelican Bay State Prison

PSU inmate-patients identified as requiring CCCMS level of care shall be transferred as soon as possible to a SHU that provides CCCMS care. Inmate-patients with any of the exclusionary diagnoses listed in Section E, *Referral and Endorsement*, Paragraph 6 above, shall not be placed in the PBSP SHU. Pending transfer, inmate-patients will receive the following services within the PSU:

- a. Assignment of a PC for the purposes of regular monitoring and program review. The PC shall see the inmate-patient at least every other week or more often if clinically indicated.
- b. Monitoring of symptoms by clinical staff
- c. Development or review of an individualized treatment plan
- d. Medication, treatment and monitoring
- e. Monitoring of daily living skills
- f. Pre-release planning
- g. Consultation regarding behavior deterioration or other contingency management procedures

**H. DOCUMENTATION**

1. Clinical documentation will occur as required. This includes but is not limited to:
  - a. Initial assessment on CDCR 7386, *Mental Health Evaluation*, and initial treatment plan and updates on CDCR 7388, *Mental Health Treatment Plan*, by the PC.
  - b. CDCR 7230-MH, *Mental Health Progress Notes*, documenting weekly contacts and any other treatment interventions done by all staff. Group therapy shall be documented monthly. This documentation shall include time attended and a description of the inmate-patient's level of participation.
  - c. Completion of CDCR 128 MH3, *Mental Health Placement Chrono*, whenever there is a change in level of care.

**Documentation on CDCR 114-A, Detention/Segregation Record**

The CDCR 114-A, *Detention/Segregation Record* (commonly referred to as the Isolation Log), is a daily record of the inmate-patient's activities and is used to note the inmate-patient's behavior as well as to document services provided. The activities report shall record the inmate-patient's daily activities such as showers, yard, meals, visits, clothing/linen exchange and supplies. This form shall be used to record attendance at treatment activities such as individual and group therapy, and recreational therapy. The CDCR 114-A, *Detention/Segregation Record*, shall also include a list of approved scheduled structured therapeutic activities. All relevant chronos shall be attached. Staff may also document their observations and comments regarding the inmate-patient and his program. Significant events affecting the inmate-patient's treatment program should be recorded on this form such as those listed below.

1. Unit staff shall initiate a CDCR 114-A, *Detention/Segregation Record*, for all inmate-patients housed in the unit.
2. Unit officers on every shift shall fill out the CDCR 114A, *Detention/Segregation Record*, noting the inmate-patient's activities during their shift. The correct date and time are critical factors. When a CDCR 114-A, *Detention/Segregation Record*, is completely filled out, the last officer making the entry will prepare and begin a new form.
3. A daily chronological report of each PSU inmate-patient will be kept on the CDCR 114A *Detention/Segregation Record*, which will include meals, showers, yard, visits, law library, supplies, clothing and linen issue, or other pertinent information.

4. When an inmate-patient is escorted to a CDCR 115, *Rules Violation Report* disciplinary hearing, the CDCR 114-A, *Detention/Segregation Record*, will be taken to the hearing. The Hearing Officer or Senior Hearing Officer, will note the CDCR 115, *Rules Violation Report* log number, findings, and disposition on the CDCR 114-A, *Detention/Segregation Record*.
5. When an inmate-patient is seen or his/her case is heard by ICC, the CDCR 114-A Form will be taken with the inmate-patient and given to the Committee. The Correctional Counselor II will note on the CDCR 114-A, *Detention/Segregation Record*, whether the inmate-patient attended or refused to attend the Classification meeting and the action taken.
6. A classification disposition such as “Confined to Quarters”, loss of privileges, or a restriction, will be noted on the CDCR 114-A, *Detention/Segregation Record*, and continued on successive CDCR 114-A, *Detention/Segregation Record*, until the action has expired.
7. Other possible entries may include canteen, legal mail, packages, and issuance of property or cell moves/searches.
8. Staff making the entry on the CDCR 114-A, *Detention/Segregation Record*, will clearly and legibly sign their first initial and last name.
9. All of the CDCR 114-A, *Detention/Segregation Record*, are to be kept in a folder(s) that are maintained within the housing unit and are available to all staff who interact with the inmate-patient. On Sunday of each week, First Watch staff will perform an audit of each inmate-patient’s CDCR 114-A, *Detention/Segregation Record*, and prepare a unit compliance report. These reports will be forwarded to the PSU Facility Captain for review and retention.

### **Unit Activity Log**

Custody staff must record and share with the clinical staff any observations that may impact an inmate-patient’s treatment plan or provide insight into the success or ineffectiveness of the current treatment plan. This is particularly critical for First Watch staff. Each housing unit shall maintain a logbook reflecting daily activities and information of interest to all staff. All unusual activities will be recorded in the logbook. Observations of unusual or aberrant behavior shall be recorded via a CDCR 128-B, *Informational Chrono*. Behavior that constitutes an infraction of institutional rules or policies may be recorded via a CDCR 115, *Rules Violation Report*.



**I. CUSTODIAL OPERATIONS****Classification**

The Operational Plan of each PSU will contain a detailed description of applicable custody procedures. These procedures shall be in compliance with relevant California Code of Regulations, Title 15, and Department Operational Manual requirements.

**Removal from a Cell**

1. Escorts – Inmate-patients housed in the PSU shall be assigned escorts and program status at the ICC review. All inmate-patients shall be escorted at all times when they are outside their respective housing unit sections. Individual escorts shall be performed by a minimum of two custody officers, and the inmate-patient shall be secured with mechanical wrist restraints at all times during the escort.
2. The inmate-patient may be recommended for additional escort status by the IDTT or through the disciplinary process. This shall be approved by the PSU Facility Captain.

**Out-of-Cell Exercise**

All inmate-patients assigned to the PSU shall be offered a minimum of ten hours of out-of-cell exercise each week, which may include supervised recreational therapy. An inmate-patient's yard designation shall be established by the ICC with input from the IDTT as part of the individual treatment plan.

**J. PHYSICAL PLANT**

Mental health treatment in Psychiatric Services Units may be provided using secure modular treatment units. All modular treatment units procured after March 2007, shall conform to design specifications available through the Prison Industry Authority (See Attachment 7: Mental Health Modular Treatment Unit Schematic Design and Photo)

**K. SICK AND DENTAL CALL AND MENTAL HEALTH REFERRALS**

1. The PSU shall have mental health staff on duty during Second Watch. Each day, the assigned physician, Registered Nurse (RN) or LPT will tour the unit and assess any inmate-patient with medical/dental needs.
2. During Second Watch, inmate-patients requiring medical attention will be referred to the PSU RN.

3. Staff Referral: Referrals may be made on CDCR 128 MH5, *Mental Health Referral Chrono*.
4. Inmates who receive a CDCR 115, *Rules Violation Report* for Indecent Exposure or Intentionally Sustained Masturbation Without Exposure shall be referred for all of the following:
  - CDCR 115-MH *Rules Violation Report: Mental Health Assessment*;
  - A mental health assessment shall be completed within 24 hours to rule-out decompensation and/or intoxication. The referral shall be made by telephone to the local Chief of Mental Health who shall arrange this assessment; and,
  - To the inmate-patient's PC.
5. Self referral: These requests are made on a CDCR 7362, *Health Care Services Request*. Mondays through Fridays, the following shall occur:
  - a. A health care staff member shall collect all the CDCR 7362, *Health Care Services Request*, each day from the designated areas.
  - b. Upon receipt of the collected forms, nursing staff shall initial and date each CDCR 7362, *Health Care Services Request*.
  - c. The CDCR 7362, *Health Care Services Requests*, shall be delivered to the designated program representative in mental health services, dental services, or pharmacy services for same-day processing.
6. On weekends and holidays, the following shall occur:
  - a. The Triage and Treatment Area (TTA) RN shall review each CDCR 7362, *Health Care Services Request*, for medical, dental, and mental health services, shall establish priorities on an emergent and non-emergent basis, and shall refer accordingly.
  - b. If a physician, mental health clinician, or dentist is not available, the physician on call or psychiatrist on call shall be contacted.
7. Inmates shall be seen by a mental health clinician or on weekends by the physician or psychiatrist on call within the clinically determined time frame.
  - Emergent: Emergency cases shall be seen immediately or escorted to TTA.

- Urgent: Urgent cases shall be seen within 24 hours.
- Routine: Other cases shall be seen within five calendar days.

NOTE: When an IDTT determines that an inmate-patient requires treatment of exhibitionism, that inmate-patient's level of care shall be changed to CCCMS (or higher if appropriate), bypassing the standard referral process.

#### **L. DISCHARGE PROCEDURES**

1. At the time of admission to the PSU, a preliminary discharge plan shall be developed based on the clinical and security needs of the inmate-patient as well as the inmate-patient's SHU term.
2. Inmate-patients admitted to the PSU may be discharged to the SHU to complete their term when they no longer require an EOP level of care. They will be transferred to a CCCMS level of care in a SHU for at least six months if they no longer require EOP level of care. Inmate-patients with one of the exclusionary diagnoses listed in Section E, *Referral and Endorsement*, Paragraph 6 above, shall not be placed in the PBSP SHU. Inmate-patients in the PBSP PSU recommended by the IDTT for CCCMS are scheduled for the next available ICC and referred for transfer to the COR SHU. Pending transfer, inmate-patients are housed in the ASU.
3. Inmate-patients who complete their SHU term and still require EOP care will be discharged to a general population EOP for continuing mental health treatment. The PSU primary clinician will document recommendations regarding the inmate-patient's specific treatment needs, including any concerns about facilitating the inmate-patient's successful transition to general population. The receiving EOP IDTT will consider documentation by the PSU clinician in developing the inmate-patient's treatment plan. The treatment plan for inmate-patients transferred from PSU to GP-EOP shall include services provided to aid in the transition to the general population environment.
4. Inmate-patients may be referred to a DMH program as clinically indicated. Generally, given the security requirements of PSU inmate-patients, this will be to the Salinas Valley Psychiatric Program for intermediate inpatient care for inmate-patients with a history of being highly assaultive, predatory, or a high escape risk. Inmate-patients who do not present these security risks may be referred to Atascadero State Hospital. Inmate-patients requiring acute inpatient care should be referred to the DMH APP at CMF.
5. Treatment recommendations upon discharge from the PSU shall be made by the IDTT and documented on a CDCR 128 MH3, *Mental Health Placement Chrono*.

6. The ICC shall review the discharge recommendations of the IDTT with the PSU Senior Psychologist or designee present considering both the clinical and custody needs of the inmate-patient. The decision of the ICC shall be documented on a CDCR 128-G Chrono.

# **CHAPTER 10**

## **Suicide Prevention and Response**

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### **A. INTRODUCTION**

It is the goal of the California Department of Corrections and Rehabilitation (CDCR) Suicide Prevention and Response Focused Improvement Team (SPR FIT) to prevent inmate deaths due to suicide. Suicide is defined as an intentional self-injurious behavior that causes or leads to one's own death. CDCR recognizes that prevention of suicide involves a team effort by every employee regardless of professional discipline or job title.

To accomplish this goal, each institution shall implement CDCR Division of Correctional Health Care Services (DCHCS) policies, described herein, regarding suicide prevention and response, via written operating procedures. The purpose of the policies is to:

- Establish standards of intervention and care
- Establish ongoing education and training for clinical, custodial, and administrative staff.
- Provide instructions and guidance for establishment and maintenance of the SPR FIT.
- Review suicide deaths regarding systems issues, clinical care issues, and custody response.
- Ensure that quality improvement (also known as corrective action) plans are drafted and implemented, when indicated, to reduce the incidence of preventable suicides, improve the delivery of quality care, improve the involvement of non-healthcare staff, and contribute to the ongoing education and training.

This chapter of the Mental Health Services Delivery System (MHSDS) Program Guide is divided into the following subsections:

### **B. Suicide Prevention and Response Project**

### **C. Training for Staff**

### **D. Clinical Care Services**

#### **1. Suicide Risk Assessment**

2. Interventions for Suicidal Ideation and Threats, Self-Injurious Behaviors and Suicide Attempts
  - a. Procedures for Suicide Precautions
  - b. Procedures for Suicide Watch
  - c. Response to Self-Injurious Behaviors and Suicide Attempts

**E. Suicide Reporting****F. Suicide Death Review****G. Mental Health Evaluation Component for a Rules Violation Report****B. SUICIDE PREVENTION AND RESPONSE PROJECT***Policy*CDCR DCHCS

The CDCR DCHCS Quality Management Committee (QMC) shall maintain a DCHCS Mental Health Program (MHP) Subcommittee that provides oversight to and coordination of the statewide mental health program to achieve statewide strategic objectives. The DCHCS MHP Subcommittee shall plan, develop, manage and improve timely access to and effectiveness of clinical services related to the mental health program. The DCHCS MHP Subcommittee shall also cooperate with, and respond in a timely manner to, any requests from the DCHCS Emergency Response & Death Review (ERDR) Subcommittee following a suicide.

The DCHCS MHP Subcommittee shall establish and maintain a statewide SPR FIT. The DCHCS MHP Subcommittee shall appoint a DCHCS SPR FIT Coordinator. The Coordinator shall be a licensed physician, psychologist, social worker, nurse practitioner, or registered nurse (RN).

Local Institutions

Each Local QMC shall maintain a Local MHP Subcommittee that provides oversight to and coordination of the local mental health program to achieve statewide strategic objectives. Each Local MHP Subcommittee shall plan, develop, manage and improve timely access to and effectiveness of clinical services related to the mental health program. Each Local MHP Subcommittee shall also cooperate with, and respond in a timely manner to, any requests from the Local ERDR Subcommittee following a suicide.

Each Local MHP Subcommittee shall establish and maintain a Local SPR FIT. Each Local MHP Subcommittee shall appoint a Local SPR FIT Coordinator. The Coordinator shall be a licensed physician, psychologist, social worker, nurse practitioner, or RN.

### ***Purpose***

The DCHCS SPR FIT and each Local SPR FIT shall provide employees with training and guidance with regard to suicide prevention, response, reporting, and review for the purpose of reducing the risk of inmate suicides.

### ***Procedure***

#### **1. Reporting Relationships**

The DCHCS SPR FIT shall:

- Send a management report, at least once a month, to the DCHCS MHP Subcommittee.
- Receive formal communication, at least once a month, from the DCHCS MHP Subcommittee.
- Each local SPR FIT shall:
  - Send a management report, at least once a month, to the local MHP Subcommittee.
  - Receive formal communication, at least once a month, from the local MHP Subcommittee.

#### **2. Responsibilities**

##### **a. The DCHCS SPR FIT shall:**

- 1). Provide oversight and guidance for each Local SPR FIT regarding time sensitive due dates.
- 2). Monitor implementation and compliance with all CDCR policies and procedures relating to suicide prevention and response.
- 3). Provide for the planning, development, and implementation of statewide training, in collaboration with the DCHCS Training Department, regarding the issue of suicide prevention and response.
- 4). Monitor and track all suicides statewide.
- 5). Provide for the selection and dispatch of a mental health suicide reviewer (MHSR) after a suicide occurs.

- 6). Provide oversight, assistance, coordination, and supervision of MHSR activities and reports.
- 7). Track and analyze demographic and clinical information received from the DCHCS ERDR Subcommittee for improving suicide prevention and response processes.

**b. Each Local SPR FIT shall:**

- 1). Ensure implementation and compliance with all CDCR policies and procedures, relating to suicide prevention and response, at their institution.
- 2). Be responsible for updating local operating procedures (LOP) to ensure consistency with DCHCS policies regarding suicide prevention and response. The institution's Suicide Prevention and Response LOP shall be updated at least annually and sent to the DCHCS through the standard Quality Management process for review and approval.
- 3). Implement training, in collaboration with the local In-Service Training (IST) unit, regarding the issue of suicide prevention and response.
- 4). Review Suicide Watch and precaution procedures, including use of video cameras (used as a supplement to direct visual observation), to ensure they are being carried out consistent with operating procedures.
- 5). Work with the Local ERDR Subcommittee to review all suicides and those suicide attempts, in which Cardiopulmonary Resuscitation (CPR) and/or other medical procedures were performed, as well as custody cell entry and cut-down procedures.
- 6). Monitor and track all suicide gestures, suicide attempts, self-mutilations, and deaths. Monitoring and tracking of suicide attempts should include a review of the appropriateness of treatment plans and five-day follow-ups.
- 7). Review and track all 5-day clinical follow-up treatment plans and custody wellness check procedures. The Mental Health Tracking System (MHTS) shall be used to track all clinical five-day follow-ups.
- 8). Ensure all required documentation for suicide death reporting is forwarded to DCHCS in adherence with time-sensitive due dates.
- 9). Provide assistance for the activities of the visiting MHSR.
- 10). Provide oversight for the implementation of DCHCS-issued quality improvement plans (QIP) with input and assistance from the Local MHP and Local ERDR Subcommittees.

**3. SPR FIT Membership**

DCHCS shall include:

Local shall include:



- SPR FIT Coordinator (Chairperson)
- Chief Psychiatrist
- Chief Psychologist
- Nurse Consultant
- Designated Facility Captain

- SPR FIT Coordinator (Chairperson)
- Chief Psychiatrist\*
- Chief Psychologist\*
- Supervising RN
- Sr. Licensed Psychiatric Technician (LPT) or LPT (preferably from Administrative Segregated Unit (ASU))
- Health Program Coordinator
- Correctional Health Services Administrator
- DMH Coordinator

DCHCS may also include, but is not limited to:

- Senior Psychiatrist
- Senior Psychologist
- Administrative/Clerical Support
- Analyst Support

Local may also include, but is not limited to:

- Senior Psychiatrist
- Senior Psychologists
- Staff Psychiatrist: Mental Health Crisis Bed (MHCB)/Outpatient Housing Unit (OHU)
- Staff Psychologist: MHCB/OHU
- Standards and Compliance Coordinator
- Litigation Coordinator
- Facility Captain
- ASU Lieutenant/Sergeant
- Reception Center Lieutenant/Sergeant
- Classification and Parole Representative
- In Service Training Lieutenant
- Administrative/Clerical Support
- Keyhea Coordinator

\*Senior Psychiatrist/Senior Psychologist attendance shall meet quorum requirement in institutions without Chief Psychiatrist/Chief Psychologist positions.

#### **4. Frequency of Meetings**

The DCHCS SPR FIT shall meet at least, but is not limited to, once a month.

Each Local SPR FIT shall meet at least, but is not limited to, once a month.

#### **5. Attendance Requirements**

A quorum consists of the above listed mandatory members.

## **6. Management Reports**

The DCHCS SPR FIT shall submit a complete, standardized management report to the DCHCS MHP Subcommittee by the 5<sup>th</sup> day of each month.

Each Local SPR FIT shall submit a complete, standardized management report to the Local MHP Subcommittee by the 5<sup>th</sup> day of each month.

## **C. TRAINING FOR STAFF**

### ***Definitions***

Suicidal ideation:	Thoughts of suicide or death, which can be specific or vague, and can include active thoughts of committing suicide or the passive desire to be dead.
Suicidal intent:	The intention to deliberately end one's own life.
Self-injurious behavior:	A behavior that causes, or is likely to cause, physical self-injury.
Self-mutilation:	An intentional self-injurious behavior without suicidal intent. The purpose of the behavior may be to gain attention, relieve stress, or experience pain. Self-mutilation can result in serious injury or accidental death.
Suicide gesture:	An intentional self-injurious behavior, accompanied by suicidal ideation and/or intent, which is unlikely to cause death. The purpose of the behavior may be to gain attention and/or experiment with the possibility of suicide. Suicide gestures may indicate increased suicide risk.
Suicide attempt:	An intentional self-injurious behavior, which is apparently designed to deliberately end one's life, and may require medical and/or custody intervention to reduce the likelihood of death or serious injury.
Suicide:	An intentional self-injurious behavior that causes or leads to one's own death.

All CDCR health care and custodial employees at the local institutions shall attend updated training on suicide prevention and response at least once annually. Suicide Prevention and Response training shall be part of the new employee orientation provided by mental health

staff in collaboration with the IST unit at each local institution. New correctional officers shall receive this training at the Basic Correctional Officer Academy.

The suicide prevention and response training shall include the following elements:

- Suicide risk assessment
- Suicide methods awareness
- Interventions for suicidal ideation, threats, gestures, and attempts
- Suicide reporting and reviews
- Mental health evaluations for rules violation reports

Clinical and custody staff shall receive specialized training with respect to their particular roles in responding to self-injurious behaviors, suicide attempts, and suicides.

#### **D. CLINICAL CARE SERVICES**

This subsection addresses the various clinical care services for inmates regarding suicide prevention and response. Included are the assessment of risk for suicide, the utilization of a form for documenting the risk factors, and clinical interventions such as procedures for Suicide Precaution and Suicide Watch, and responses to suicide attempts and to suicide.

Education regarding the methods utilized by inmates when attempting suicide shall be taught as part of the suicide prevention and response training.

Employee strategies for maintaining a safe environment, and for ensuring that other policies and procedures relative to suicide prevention and response, such as regarding medication distribution and inmate-patient compliance, are detailed in the relevant chapters and sections of the complete Inmate Medical Services Program Policies & Procedures.

**Any CDCR employee who becomes aware of an inmate's current suicidal ideation, threats, gestures, self-injurious behaviors or suicide attempts shall immediately notify a member of the health care staff. The inmate shall be placed under direct observation, per local custody operating procedure, until a clinician trained to perform a suicide risk assessment (psychiatrist, psychologist, clinical social worker, primary care physician, nurse practitioner, or RN) conducts a face-to-face evaluation.**

##### **1. Suicide Risk Assessment**

All inmates are observed for suicide risk. Suicide risk assessment is critical to successful suicide prevention. Inmate-patients enrolled in the MHSDS shall be regularly monitored for risk of suicide as clinically appropriate. When an inmate expresses current suicidal ideation, or makes threats or attempts, a suicide risk assessment shall be made by collecting, analyzing, and documenting data. Documentation is achieved by utilizing the CDCR standardized Suicide Risk Assessment Checklist (SRAC) and by clinician notation in the Unit Health Record (UHR). When an inmate expresses chronic suicidal ideation without intent or plan, the clinician may document that no change in suicide risk has occurred since completion of the prior SRAC, instead of completing a new SRAC.

**These clinicians shall be trained to perform a suicide risk assessment and complete the SRAC:**

- psychiatrists
- psychologists
- clinical social workers
- primary care physicians
- nurse practitioners
- RNs

This shall occur during the specialized training provided for clinical staff who are receiving either the new employee orientation or completing the required annual training module, or when determined necessary by supervisory and/or management staff.

When a primary clinician is scheduled to be available on-site, he or she shall be responsible for completing a SRAC. When a mental health clinician is not available, any other staff member who has been trained by CDCR in suicide risk assessment may complete the SRAC.

A RN completing the SRAC shall collect data related to suicide risk and protective factors and refer the patient and data collected to a mental health clinician for further evaluation to determine level of risk.

**At a minimum, a written suicide risk assessment using a SRAC shall be completed:**

- Every time an inmate has an initial face-to-face evaluation for suicidal ideation, gestures, threats, or attempts, by a clinician trained to complete the SRAC.
- By the referring clinician prior to placement of an inmate-patient into an OHU for continued suicide risk assessment or into a MHCB for suicidal ideation, threats, or attempt.
- After hours, on weekends and holidays, on call clinicians shall conduct a face-to-face assessment of suicide risk prior to releasing an inmate to any housing without suicide watch or precaution.

- After hours, on weekends and holidays, when the referring clinician has not completed an SRAC, by the clinician providing coverage, by the next day, for those inmate-patients placed into an OHU or MHCB.
- By the associated Interdisciplinary Treatment Team (IDTT) and/or clinician for all inmate-patients placed into an OHU, for mental health reasons, or MHCB, for any reason, upon decision to release or discharge.
- Subsequent to release from an OHU placement that was for the purpose of continued suicide risk assessment, or a MHCB placement for the reason of suicidal ideation, threats, or attempts, at a minimum of every 90 days for a twelve month period, by a mental health clinician.
- Within 72 hours of return from a Department of Mental Health (DMH) facility, or within 24 hours if clinically indicated based on new arrival screening.
- Any time the medical and mental health screening of a new arrival to an institution indicates a current or significant history, over the past year, of suicide risk factors, ideation, threats, or attempts.
- Pursuant to Department Operating Manual (DOM), Article 41, Prison Rape Elimination Act Policy, for victims of sexual assault, within four hours after the required sexual assault forensic examination.

**The clinician shall use the SRAC when documenting a suicide risk assessment, in addition to making a notation in the UHR. At a minimum, the following categories shall be used to assess potential risk:**

a. Static Risk Factors (unchanging, historical):

- Ethnicity
- History of lewd and lascivious acts with a child and/or killed a child
- History of violence
- History of substance abuse
- Suicide ideation and/or threats in past (when and method)
- Previous suicide attempts (when and method)
- Family history of suicide
- History of mental illness with Axis I diagnosis
- High profile case

b. Slowly Changing Risk Factors (long-term risk factors):

- First prison term
- Long or life sentence; three strikes
- History of poor impulse control and/or poor coping skills
- Early in prison term
- Known new court proceedings and/or disciplinary actions
- Current term in ASU, Security Housing Unit, or Psychiatric Services Unit
- Level IV custody score
- Chronic, serious or terminal illness

c. Dynamic Risk Factors (short-term risk factors that require ongoing assessment):

- |   |  |
|---|--|
| • Recent suicidal ideation - acute or chronic | • Recent rejection and/or loss                     |
| • Recent release from psychiatric hospital    | • Single-cell placement                            |
| • Sudden calm following ideation or attempt   | • Significant current impulsivity                  |
| • Anxious and/or agitated and/or fearful      | • Recent suicide attempt or self-injury            |
| • Disturbance of mood (depression or mania)   | • Well-planned, highly lethal, attempt or ideation |
| • Unstable or labile affect                   | • Hoarding and/or checking medication              |
| • Current insomnia and/or poor appetite       | • Poor compliance with treatment and/or medication |
| • Lack of perceived support system            | • Recent trauma and/or threat to self-esteem       |
| • Hopelessness and/or helplessness            | • Recently assaultive or violent                   |
| • Feelings of guilt and/or worthlessness      | • Pre-death behavior: note, gives things away      |
| • Fearful for safety                          | • Disclosure of adverse court hearings             |
| • Anniversary of important loss               |  |

d. Protective Factors:

- Family support
- Children at home
- Religious support
- Spousal support
- Supportive friends
- Helping others
- Adequate insight
- Realistic life plan
- Exercises regularly
- Group activities
- Job assignment
- Other noted protective factors

Clinicians shall utilize their best clinical judgment and make a summary of the relative risk for suicide via an appropriate descriptor, such as “No apparent significant risk, Low Risk, Moderate Risk, High Risk, or Conditional Risk” based on a combination of the above factors, an interview of the inmate, and all other relevant information available to them. Peer consultation is encouraged when information collected for making a suicide risk assessment is ambiguous. The clinician shall then make a recommendation regarding the appropriate level of care required. They shall document their summary, recommendations, and plan on the SRAC and with appropriate notation in UHR. Treatment recommendations should be as specific as possible, leaving as little room as possible for misinterpretation or confusion. A brief rationale for each recommendation shall be provided. They shall also address how the treatment plan will be implemented and any required follow-up procedures.

Peer Consultation

Peer consultation can be one of the most important clinical and legal safeguards a practitioner has at his or her disposal, especially when dealing with ambiguous cases.

Sources of peer consultation include, but are not limited to:

- Other clinical members of an IDTT
- Other colleagues working at the institution
- Clinical supervisors

When evaluating for suicide risk, peer consultation is not always necessary. However, in those cases where there is clinical uncertainty about ambiguous issues, it can be of benefit for validating or challenging ideas and assumptions. Another clinician’s opinion may also uncover important additional information. Peer consultation does not absolve a clinician of responsibility for any decision that he or she ultimately makes, nor does it require the

clinician to change his or her initial opinion. It is to the clinician's advantage to consult with peers. It demonstrates that the clinician cared enough about the case to seek another opinion and that he or she utilized prudent and reasonable judgment.

### Suicide History Tracking

In order to ensure quality and continuity of care for high-risk mental health inmate-patients, all institutions shall track the suicidal history of inmate-patients using MHTS.

## **2. Interventions for Suicidal Ideation, Threats, and Attempts**

Any CDCR employee who becomes aware of inmate suicidal ideation, threats, or attempt shall immediately notify a member of the health care staff. The inmate shall be placed under direct observation, per local custody operating procedure, until a clinician trained to perform a suicide risk assessment (psychiatrist, psychologist, clinical social worker, primary care physician, nurse practitioner, or RN) conducts a face-to-face evaluation.

### Recommendation for placement or admission

Health care staff who assess a patient as a significant suicide risk shall initiate procedures to admit the patient into a MHCB.

A physician, licensed psychologist, or nurse practitioner may place an inmate-patient into an OHU for continued suicide risk assessment. Custody staff shall inspect the cell to ensure that there are no known or obvious safety hazards present. When an inmate-patient in the OHU is determined to require MHCB level of care, including Suicide Precaution and/or Watch, he or she shall be recommended for admission to that higher level of care. The established timeframe for MHCB transfers is 24 hours from the time a physician or licensed psychologist determines the need for a MHCB.

When an inmate-patient verbalizes suicidal ideation without other signs and symptoms of increased risk of suicide, the mental health clinician is responsible for evaluating any contributing environmental stressors and communicating with custody staff and supervisors regarding any potentially solvable custody issues.

Pending transfer out of the OHU direct observation by clinical and/or custody staff shall be provided, consistent with requirements for Suicide Precaution or Watch, until the inmate-patient is transferred.

If there is a difference of opinion, between the clinician who makes the recommendation and the receiving/admitting clinician, regarding admission into a MHCB or placement into an OHU, then



- a. A third opinion and final decision shall be obtained by consultation with a Chief or Senior Psychiatrist, or a Chief or Senior Psychologist.
- b. When a Chief or Senior Psychiatrist, or a Chief or Senior Psychologist is not available, the third opinion and final decision shall be obtained from Chief Medical Officer or Chief Physician and Surgeon.
- c. The default shall be to place the inmate into the MHCB or OHU in the event that there is not a Chief, Senior, or Chief Medical Officer (CMO) available to supply the third opinion and final decision.

#### Required Documentation

The clinician who recommends an inmate for placement into an OHU for continued suicide risk assessment or into a MHCB for active suicidal ideation, or suicide threats or attempts, shall provide to the accepting clinician both a completed SRAC, the patient's medication administration record, and a written transfer summary that contains:

- Date and time of referral
- Identifying information: inmate name, CDCR number, date of birth, age, and race
- Current level of care and housing location
- Current diagnosis: all five Diagnostic and Statistical Manual (DSM) axes
- Reason for referral: suicidal ideation and/or threat and/or attempt
- History of present illness
- Mental status examination
- Brief psychiatric history including previous OHU, MHCB, or DMH placements
- History of previous suicidal ideation, threats, and/or attempts
- Treatment recommendations
- Contact information for the referring clinician

After hours and on weekends and holidays, the clinician providing coverage shall complete the required documentation by the next day.

#### Health Care Cost and Utilization Program

As an integral part of the DCHCS, the Health Care Cost and Utilization Program provides timely and accurate information, and analysis of health care service delivery data to assist in the provision of cost effective, quality health care. To facilitate this effort, the clinician

who admits an inmate-patient to a MHCB shall record two codes for the diagnosis on the CDCR 7388, *Mental Health Treatment Plan*. One code shall be from the most current edition of the Diagnostic and Statistical Manual of Mental Disorders and the other shall be from the most current edition of the World Health Organization's International Classification of Diseases Code.

#### Additional Treatment Options

In addition to inpatient care, the clinician may recommend another type of treatment such as daily or weekly contact by a mental health clinician, intensive individual psychotherapy, resolution of a stressful environmental issue or interpersonal conflict, or other clinically appropriate intervention. Other interventions may be considered such as notifying a correctional counselor of the inmate-patient's desire or need to contact a family member. Alternative interventions, such as a housing change, may be considered in consultation with custody staff. Clinical and custody staff shall work together to develop an intervention to address the inmate's concerns and reduce the risk of suicide.

#### Physical Restraints and Seclusion

Physical restraints or placement in seclusion may be utilized to protect an inmate-patient from imminent self-harm, if clinically indicated, and other treatment measures are ineffective. A staff member shall be assigned to provide one-on-one direct visual observation of all inmate-patients in physical restraints. Refer to MHSDS Program Guide, Chapter 5, *Mental Health Crisis Bed*, for complete descriptions of procedures. In accordance with Health and Safety Code 1180, a clinical and quality review shall be conducted for each episode of the use of seclusion or restraints.

#### Inmate and Cell Search

Before placing an inmate-patient in a room for Suicide Precaution or watch, a custody officer shall conduct a complete body search.

Call-light cords, nightstands, bed frames, and sheets shall be removed, by order of a clinician, from the room unless the inmate is in physical restraints. Only a safety (no-tear) mattress, a safety (no-tear) blanket, and a safety (no-tear) smock/gown shall be provided and placed directly on the floor.

Additional inmate-patient clothing and furnishing items, while on Suicide Watch or Precaution, shall be allowable by a clinician's order.

Custody staff shall conduct a complete cell search before placing an inmate in a cell.

#### Suicide Precaution and Suicide Watch

When clinically indicated, an inmate with active suicidal ideation, threats, or attempt shall be placed in an MHCB on Suicide Precaution or Suicide Watch. These are methods used to provide a safe environment and prevent the inmate from harming him or herself or others. Suicide Watch and Suicide Precaution procedures shall be a joint responsibility of custody and health care staff. A close working relationship shall be maintained between custody and health care staff to ensure the safety and security of the inmate.

The preferred location to place an inmate on Suicide Precaution or Watch status is in the MHCB, or in the OHU pending transfer to MHCB. The use of Suicide Precaution or Suicide Watch in any non-medical location shall be a temporary, short-term approach until an inmate can be moved to an OHU or MHCB, and shall require constant direct visual observation.

A psychiatrist, licensed psychologist, physician, or nurse practitioner shall review, modify, and/or renew the order for Suicide Precaution and/or Watch at a minimum of every 24 hours with input from at least one other member of the IDTT, such as the RN on duty.

Inmate-patients that are placed in an OHU for continued assessment of suicide risk, or in an MHCB for active suicidal ideation, threats, or attempt, shall have a note regarding progress toward the treatment plan goals and objectives recorded *daily* by a treating clinician in the Interdisciplinary Progress Notes section of the UHR.

a. **Suicide Precaution**

When an inmate is in an MHCB because of high risk of attempting self-injurious behavior, but is not in immediate danger, he or she shall be placed on Suicide Precaution.

These inmate-patient management procedures require an order from a psychiatrist, licensed psychologist, physician or nurse practitioner. Additional details of requirements and procedures are located in Chapter 5, *Mental Health Crisis Bed*.

**Guidelines for clinician-ordered Suicide Precaution:**

<b><u>STATUS</u></b>	<b>CLOTHING</b>	<b>FURNITURE AND OTHER MATERIALS</b>	<b>BEHAVIORAL CHECKS</b>
SAFE CELL STATUS	Safety (no-tear) smock/gown, no	Remove all furniture. Safety	Staggered intervals not to exceed 15-

	ID band on wrist	(no-tear) mattress, safety (no-tear) blanket	minute staff checks
PARTIAL ISSUE	Shorts, t-shirt, socks	Remove all furniture. Safety (no-tear) mattress, safety (no-tear) blanket, one book	Staggered intervals not to exceed 15-minute staff checks
FULL ISSUE	Shorts, t-shirt, socks	Safety (no-tear) mattress or furniture. Reading and writing materials. Toiletries.	Staggered intervals not to exceed 15-minute staff checks

A clinician, when writing orders, can utilize these guidelines for furniture and clothing and/or make modifications based on clinical judgment, with documentation of justification. The IDTT shall review all decisions regarding furniture, clothing, and other materials. No modification is allowed for the interval of staff checks for Suicide Precaution.

b. **Suicide Watch**

When an inmate is in an MHCB because of suicide risk *and* is in immediate danger of self-injurious behavior, he or she shall be placed on Suicide Watch.

These inmate-patient management procedures require an order from a psychiatrist, licensed psychologist, physician or nurse practitioner. Additional details of requirements and procedures are located in Chapter 5, *Mental Health Crisis Bed*.

**Guidelines for clinician-ordered Suicide Watch:**

<b><u>STATUS</u></b>	<b>CLOTHING</b>	<b>FURNITURE AND OTHER MATERIALS</b>	<b>BEHAVIORAL CHECKS</b>
SUICIDE WATCH	Safety (no-tear) smock/gown, no ID band on wrist	Remove all furniture. Safety (no-tear) mattress,	Continuous observation 15 minute nursing

		safety (no-tear) blanket	checks
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All institutions shall conduct Suicide Watch observation by direct visual observation. The staff member shall be stationed at the cell door with direct line-of-sight from the observer to the patient. One observer may be responsible for observation of two inmate-patients on Suicide Watch when the staff member can maintain direct line-of-sight observation of both inmate-patients. The staff-observer to inmate-patient ratio shall not exceed one-to-two. Video-monitoring shall never be used as the sole method for observation of any inmate-patient housed on Suicide Watch status, but may be used to supplement direct visual observation.

Some institutions have been approved via memoranda signed by the Directors of the Division of Adult Institutions (DAI) and the DCHCS, to provide one-on-two direct cell-front observation of inmate-patients on Suicide Watch, when the staff member can maintain direct line-of-sight observation of both inmate-patients, unless one-on-one monitoring is ordered by the psychiatrist or psychologist. All other institutions shall provide one-on-one direct cell-front observation.

The assigned observer shall assume a position where continuous direct visual contact with the inmate-patient can be maintained, including when the inmate uses the shower, sink, or toilet.

Suicide Watch posts will be filled using the following order of job classifications:

1. Hospital Aide
2. Certified Nursing Assistant
3. Licensed Psychiatric Technician
4. Licensed Vocational Nurse
5. RN
6. Correctional Officer

It is the responsibility of the Health Care Manager and Warden to ensure that all hiring efforts be exhausted, including offering voluntary overtime and assigning involuntary overtime of the medical classifications on the list above, prior to filling these positions with a Correctional Officer.

The employee assigned to provide direct observation shall be appropriately trained regarding this post and the performance of duties related to Suicide Watch.

#### Observation Documentation

The custody and/or health care staff employee assigned to provide continuous observation during Suicide Watch shall document such observation every 15 minutes on a log sheet.

Custody and health care staff shall document behaviors and activities on a CDCR 114A, *Detention/Segregation Record*.

Nursing staff shall document behavioral checks and the inmate-patients' affect at least every 15 minutes during both Suicide Precaution and Suicide Watch. Nursing checks shall always include visual observation and, when the inmate-patient is awake, shall also include verbal interaction. Nursing staff shall document using CDCR 7212, *Nursing Care Record* (for non-acute care settings), or CDCR 7212A, *Nursing Care Record-Acute Hospital*, (for acute care settings) in the UHR.

#### Leaving a Post Assignment

- The observer assigned to Suicide Watch shall only vacate the post if immediate attention or assistance is needed in a life-threatening situation, and no other alternative exists.
- A life-threatening situation is defined as a situation in which staff's failure to immediately respond will likely result in serious morbidity or mortality.
- In the event of a life-threatening situation, the staff shall activate a personal alarm in order to summon additional staff to the MHCB area.
- If it becomes necessary for staff assigned to Suicide Watch to leave their post due to a life-threatening situation, they shall request other staff in the vicinity, whenever possible, to provide direct observation coverage of the inmate-patients while away. If no other staff is available, and there is sufficient time, the officer shall contact the Watch Office before responding to the life-threatening situation.
- Any vacating of the post under these circumstances shall be for the minimal time necessary. Once the life-threatening situation has been contained, or there is sufficient staff at the scene to handle the situation, the officer shall immediately return to the Suicide Watch post.
- Upon return to post, the staff shall document his or her departure and return on the CDCR 114A, *Detention/Segregation Record*. The officer shall also ensure that the staff that covered the post in his or her absence also documents that on the CDCR 114A, *Detention/Segregation Record*.
- For the purpose of this procedure, a minimum of one custody officer and one health care professional shall respond to a life-threatening situation involving a general population or reception center inmate.

- For the purpose of this procedure, a minimum of one peace officer and one nursing staff member shall respond to a life-threatening situation involving an ASU inmate. Responding staff shall obtain and wear a protective vest while responding in the ASU areas. The ASU Sergeant shall also be notified as soon as possible.
- Staff will use universal precautions when responding to medical emergencies and utilize Personal Protective Equipment kits, available in the MHCB unit.

#### Discharge or Return

Inmates sent to a MHCB because of active suicidal ideation, threats, or attempt shall be returned to their housing unit only after the IDTT and/or a clinician has completed a SRAC and has determined that the inmate-patient is no longer at imminent risk. The inmate-patient shall be placed on the 5-day clinical follow-up treatment plan and custody wellness check procedure as detailed below.

Inmates sent to an OHU for continued suicide risk assessment shall be returned to their housing unit only after the IDTT and/or a clinician has completed a SRAC and has determined that the inmate-patient is not at significant risk. The inmate-patient may, depending on clinical determination, be placed on the 5-day clinical follow-up treatment plan and custody wellness check procedure as detailed below.

#### MHCB Discharge

- A psychiatrist or licensed psychologist, in consultation with the IDTT, shall write the order to discontinue an inmate-patient from Suicide Precaution or Suicide Watch when the inmate is no longer in imminent danger of self-harm. After hours, on weekends and holidays, the Medical Officer of the Day (MOD) or psychiatrist, licensed psychologist, or primary care physician on call may write an order to discontinue Suicide Precaution or Suicide Watch.
- A psychiatrist or licensed psychologist shall complete the MHCB discharge summary.
- Before discharge, the IDTT shall develop a detailed and complete follow-up treatment plan, which shall be documented in the inmate's UHR on CDCR 7221, *Physician's Orders*. The plan shall include prescribed housing, medication, type and frequency of outpatient therapy, and an explicit recommendation on 5-day clinical follow-up treatment plan and custody wellness check procedure.
- The primary clinician (PC) (or in their absence, the senior mental health clinician) shall be notified person-to-person of the pending discharge of the inmate-patient and the discharge plan.

- Inmates with multiple MHCB admissions (three or more within a six-month period) shall be evaluated by the IDTT for referral to the DMH. The results of this evaluation, decision of the IDTT, and outcome of the referral shall be documented on a CDCR 7230-MH, *Mental Health Progress Note*, in the UHR.
- Careful consideration should be given by the IDTT when discharging from an MHCB an inmate-patient who was admitted for reasons of suicidal ideation, threats, or attempt, on a Friday, over the weekend, or the day before a holiday. Inmate-patients will only be released over a weekend if the IDTT has determined such and only after an updated face-to-face evaluation by a mental health clinician. That clinician will establish the 5-day clinical follow-up treatment plan and custody wellness check procedure. The mental status, stability, and risk factors of the inmate-patient should be documented in detail on a CDCR 7230-MH, *Mental Health Progress Note*. A mental health clinician must be available on weekends and holidays, either on duty or on call. **In the event that there is no mental health clinician on call in an institution, no discharges shall be accepted by that institution on, or the day before, a weekend or holiday.**
- A mental health clinician, usually the inmate-patient's PC, shall provide follow up treatment on an outpatient basis. This shall include daily contact with the inmate in their housing unit for five consecutive days following discharge. A psychiatric technician or other mental health clinician may conduct the contacts on weekends and holidays. The PC is responsible for ensuring that the contacts occur. The frequency of visits may then be reassessed. Housing unit custody officers and mental health staff shall communicate regarding the inmate-patient's status.
- Custody shall conduct an hourly check of inmate-patients discharged from the MHCB (admitted for suicidal ideations, threats, or attempt) for the first 24 hours after discharge. A mental health clinician shall then discuss the inmate-patient's behavior with the custody staff and evaluate the inmate-patient to determine if the custody checks should be continued or discontinued. If the custody checks are continued, the mental health clinician shall determine whether the checks are to be every hour, every two hours, or every four hours for the next 24-48 hours. If after a second evaluation, mental health clinical staff feel additional hourly checks are required, the inmate shall be readmitted to the MHCB for further stabilization. Custody staff shall maintain a log on CDCR 114A, *Detention/Segregation Record*, of rounds on inmate-patients.
- The local SPR FIT shall regularly audit compliance with the 5-day clinical follow-up and custody wellness check procedure. Audit findings shall be forwarded monthly to the Local MHP Subcommittee.

c. **Response to Self-Injurious Behaviors and Suicide Attempts**



Self-injurious behaviors cause, or are likely to cause, physical self-injury. A suicide attempt is an intentional act that is deliberately designed to end one's own life. Both are medical emergencies that require immediate and appropriate responses.

#### Custody Protocol

**In medical emergencies, the primary objective is to preserve life.** All peace officers who respond to a medical emergency are mandated, pursuant to court order, to provide immediate life support, if trained to do so, until medical staff arrives to continue life support measures. All peace officers must carry a personal CPR mouth shield at all times.

The officer must assess and ensure it is reasonably safe to perform life support by effecting the following actions:

- Sound an alarm (a personal alarm or, if one is not issued, an alarm based on local procedures must be used) to summon necessary personnel and/or additional custody personnel.
- Determine and respond appropriately to any exposed bloodborne pathogens.
- Determine and neutralize any significant security threats to self or others including any circumstances causing harm to the involved inmate.
- Initiate life saving measures consistent with training.

The responding peace officer will be required to articulate the decision made regarding immediate life support and actions taken or not taken, including cases where life support is not initiated consistent with training and/or situations which pose a significant threat to the officer or others.

#### Clinical and Custody Combined Efforts

**Upon arrival, responding medical personnel shall relieve the correctional peace officer and assume primary responsibility for the provision of medical attention and life saving efforts. Custody and medical personnel together are responsible for the continuance of life saving efforts for as long as necessary.**

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**Preservation of life shall take priority over preservation of a crime scene.**

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#### Emergency Response

The following first aid procedures shall be implemented when an inmate attempts suicide by hanging, laceration, or other methods:

#### Hanging

Medical and custodial staff shall be informed of the nature of the emergency by the most expedient method available. The cut-down kit shall be transported to the location immediately by custody staff. Clearing the obstruction to the airway as quickly as possible is critical to saving the life of the inmate who has attempted suicide by hanging. When it appears safe, a minimum of two staff shall enter the area where the inmate is located, relieve pressure on the airway by using a stable object for support of the inmate's body or by physically lifting the inmate's weight off the noose. The inmate shall be cut down by cutting above the knot and then loosening the noose. Custody staff shall preserve any item of evidentiary value.

Once the inmate is cut down, custody staff shall provide immediate life support, if trained to do so, until medical staff arrives to continue life support measures.

Medical staff, upon arrival, shall assume responsibility for medical care, as outlined in the institution's local operating procedures for emergencies, including any decisions regarding initiating or continuing CPR.

If possible, the inmate shall also be transported to a triage and treatment area.

#### Laceration

General guidelines:

- Use impervious latex gloves and/or appropriate, personal protective equipment
- Utilize whatever clean material is available to apply pressure to the wound site
- Elevate extremities if they are bleeding
- Transport to a triage and treatment area or an emergency room

#### Other Methods (overdosing, trauma, swallowing dangerous objects):

- Provide assistance to medical staff and obtain as much information as possible.
- Staff shall perform the Heimlich maneuver if choking is evident.

#### Cut-down Kit Availability

Each warden shall ensure that cut-down kits:

- Are maintained within each housing unit
- Are inventoried and inspected on a daily basis with problems immediately reported to a supervisor
- Consist of a lockable metal box containing:
  - a. One inventory list affixed to the inside of the box door
  - b. One emergency cut-down tool
  - c. One single-patient-use resuscitator (e.g., AMBU Single-Patient-Use Resuscitator)
  - d. One CPR mask (e.g., Lardell CPR Mask, for use by CPR-certified staff only)
  - e. Minimum of ten latex gloves
  - f. Disposable oral airway

#### **E. SUICIDE REPORTING**

All reports of death shall be in accordance with DOM, Section 51070, Deaths.

If at any point during the review of the case, questions arise regarding any circumstances surrounding or leading up to the suicide that may be attributed to employee misconduct, the MHSR, the Health Care Manager (HCM), or other responsible individuals may request a misconduct investigation. In this event, the MHSR shall immediately consult with the DCHCS SPR FIT Coordinator to determine further action. Requests for further misconduct inquiry and/or investigation shall be referred in accordance with DOM, Chapter 3, Article 14, Employee Misconduct Investigations/Inquiries. Even if the matter is referred, all other aspects of the suicide review shall continue.

##### **Local Institution Responsibilities**

- In the case of an inmate suicide death, the watch commander or senior custody officer shall be notified immediately, and shall subsequently notify the Warden, or evenings, weekends and holidays, the Administrative Officer of the Day. Upon notification of a possible death, the senior custody officer or the watch commander shall determine the need to secure the death scene and initiate investigation or other custody measures as indicated in accordance with DOM, Section 51070.7.
- The institution's CMO or physician designee shall have primary responsibility for reporting the death within eight hours to the DCHCS Death Notification Coordinator (DNC).
- The initial reporting procedures and submission of the CDCR 7229 A, *Initial Inmate Death Report*, shall be completed and submitted in accordance with the procedures set

forth in DOM, 51070.9, Deaths. The CDCR 7229 B, *Initial Inmate Suicide Report*, shall be completed by the Local SPR FIT Coordinator or designee, and shall be reviewed, signed and dated by the HCM/CMO. It shall be submitted to the DNC at Central Office by the close of the second business day following the date of death. This form shall contain relevant information including the method of suicide, mental health level of care, psychiatric diagnoses (if applicable), behavioral problems observed, recent history of suicidal ideations or attempts, medication, and recent stressors.

#### **F. SUICIDE DEATH REVIEW**

- Within one business day of receipt of the initial data including CDCR 7229 A, *Initial Inmate Death Report*, and 7229 B, *Initial Inmate Suicide Report*, the DCHCS Death Notification Coordinator (DNC) shall forward the death review folder to the DCHCS SPR FIT Coordinator.
- Within two business days of receipt of the death review folder, the DCHCS SPR FIT Coordinator shall appoint a MHSR from a pool of qualified mental health staff at DCHCS, or regionally from an institution other than where the suicide occurred.
- Within one week, seven calendar days, of being appointed, the MHSR shall begin reviewing the suicide case for compliance with the CDCR SPR FIT policies and procedures. The MHSR shall also review all related documentation including the UHR; Central File; Inmate Death Reports, CDCR 7229 A, *Initial Inmate Death Report*, 7229 B, *Initial Inmate Suicide Report*; CDCR 837 A and B, *Crime/Incident Report*; and any other appropriate documentation. The MHSR shall have access to the inmate's cell, visiting log, recorded telephone conversations, and other information as required. The institution's SPR FIT Coordinator may assist the MHSR in his or her efforts. The assistance may include making available the UHR, the Central File, and any other appropriate information as well as arranging interviews if required. The MHSR may conduct interviews with clinical staff, custody staff, and inmates. However, should there be any indication an employee misconduct investigation may be warranted, the MHSR shall immediately consult with the DCHCS SPR FIT Coordinator, who shall provide guidance in proceeding with the review. Generally, the MHSR shall discontinue interviews with any employees who may be associated with or implicated in the employee misconduct investigation, but shall continue with all other aspects of the suicide review process.
- In cases where there are concerns with clinical care, the case shall be referred to the local Clinical Performance Enhancement and Review Subcommittee.
- Within 30 calendar days of the inmate suicide, the MHSR shall complete a preliminary Suicide Report containing the following information: Inmate name, CDCR number, age, date and time of discovery, time of death, institution, housing, mental health level of care (if applicable), method, cause of death, findings of coroner (if available), brief summary and preliminary findings including recommendations for quality improvement. The report

shall also indicate whether further investigation/inquiry is recommended (if one has not already been initiated). This report shall be immediately forwarded to the DCHCS SPR FIT Coordinator who will then schedule discussion of the report at the DCHCS Suicide Case Review (SCR) Subcommittee. The MHSR will present the case to the SCR Subcommittee.

- The DCHCS SCR Subcommittee is the body that reviews the documentation and reports submitted by the institution and MHSR, determines compliance with the statewide SPR FIT policies and procedures, reviews the QIP (also known as corrective action), and continues its review, in collaboration with the DCHCS MHP Subcommittee, until the QIPs are completed and the cases are closed.
- Within 45 days from the date of death, the DCHCS ERDR Subcommittee shall complete its review of the preliminary suicide report, review the QIP on the preliminary suicide report, and forward the report to the MHSR for completion of the Suicide Report and the accompanying Executive Summary.

#### Quality Improvement Plan

When warranted, the MHSR shall recommend a QIP (also known as corrective action), based on the findings from the review of the case, which shall address and make recommendations to improve identified problems with clinical care and compliance with policy and procedure. The QIP shall address problems identified, recommended actions, due dates for recommended actions, and supporting documents required from the institution.

The DCHCS SCR Subcommittee shall review the QIP and may take the following actions:

- Ensure consistency with policy and procedure
- Recommend remedial action, documentation, and monitoring
- Refer for further action in accordance with DOM, Chapter 3, Article 14, Employee Misconduct Investigations/Inquiries, when appropriate. When individual conduct of custody staff requires further investigation, a memorandum shall be forwarded to the Director, Adult Institutions Division, who shall initiate a CDCR 989, *Request for Investigation*, to the Office of Internal Affairs.
- Prepare a memorandum to refer the case to the DCHCS Professional Practice Executive Committee (PPEC) for review of individual practice of licensed psychologists, psychiatrist, and/or physicians when appropriate. The DCHCS PPEC shall report to the appropriate professional licensing board for investigation, when appropriate

When approved by the DCHCS SCR Subcommittee, the Suicide Report shall be signed by the Director, DCHCS, or designee.

The Suicide Report by the MHSR shall incorporate the QIP approved by the DCHCS SCR Subcommittee. The DCHCS SPR FIT Coordinator shall include with this report the Inmate Death Reports, CDCR 7229 A, *Initial Inmate Death Report*, and CDCR 7229 B, *Initial Inmate Suicide Report*, CDCR 837 A and B, *Crime/Incident Report*, Movement History and Offense History, and the Executive Summary serving as the cover page to complete the Final Suicide Report. The report shall then be forwarded to the Director of the CDCR DCHCS and the Director, DAI. The report shall be signed by both Directors, and copied to Regional Administrators of DCHCS and DAI; Legal Affairs Division; and to the reporting institutions' Warden; Health Care Manager/Chief Medical Officer; Mental Health Program Manager, Chief/Senior Psychiatrist and Chief/Senior Psychologist; and, other appropriate interested and legally designated persons within 60 days of date of death.

When an investigation is required, the Office of Internal Affairs (OIA) shall track progress until the investigation is complete. The OIA shall forward a memorandum with a summary description of the methods and outcome of the investigation to the DCHCS SPR FIT Coordinator, who shall forward the results to the *Coleman* Special Master through DCHCS routing procedures.

For QIP items focused on institutional compliance, the Warden and HCM/CMO are responsible for ensuring the implementation of the QIP within the specified time frame, which is not greater than 60 days of receipt of the finalized Executive Summary of the Suicide Report with signature approval from the Director, DCHCS (120 days following the date of death). QIP items focused on system-wide policy or training shall be referred to the SPR FIT at DCHCS. The SPR FIT Coordinator shall maintain a master list of QIP problems, corrective action, supporting documentation required, and completion dates. A proof-of-practice binder shall be maintained by the SPR FIT coordinator in order to track and record the progress of policy revisions and system-wide training.

The QIP shall be monitored by the Warden, HCM/CMO, Mental Health Program Manager, Chief Psychiatrist, Chief Psychologist, and SPR FIT Coordinator at the institution of occurrence. DCHCS may require ongoing documentation of compliance.

The Local SPR FIT Coordinator shall prepare a follow up report of implementation addressing action taken on the recommendations of the QIP. All appropriate supporting documentation confirming that these actions have been taken shall be attached to this report. See table below for list of suggested supporting documentation. The Warden and HCM/CMO, or institution Mental Health Program Manager shall sign this report. The institution shall retain a copy of the report and forward the original to the DCHCS ERDR for review. The report is due within 30 days following the implementation of the QIP (90 days following receipt of the Executive Suicide Report). Additional follow up monitoring shall occur as necessary as dictated in the QIP.

**Action, Documentation, & Monitoring for Suicide Quality Improvement Plans**

<b>ACTION</b>	<b>DOCUMENTATION/MONITORING</b>
Training	Copy of training agenda and sign-in sheet
Required appointments with clinicians are held	List of appointments from MHTS
Changes in operating procedure	Copy of procedure or memos
Develop Quality Improvement Team	Copy of recommendations or change in procedures
Missing medication due to transfer to a different housing unit	Ongoing monitoring of Medication Administration Records in the UHR Provide sample audit
Proper Documentation	Provide plan to audit UHR and a sample audit
Five Day Follow-up of suicidal inmates released from MHC B	Audit of documentation in UHR; provide a sample audit
Rounds and evaluations done in ASU by psychiatric technicians	Audit UHR, CDCR 114 Isolation log and CDCR 114-A, <i>Daily Log</i> ; provide sample audit
Inmates on Keyhea are identified	Review UHR
Conduct suicide risk assessment	Review UHR
Statewide policy issues	Review new policy
Investigation of individual practitioners	Provide status or completion date of investigation
Audit of records per specified length of time to be sure that quality improvement is being consistently followed	Periodic reports of audit findings to DCHCS SPR FIT and DCHCS MHP

The DCHCS SCR Subcommittee shall continue to review all open suicide cases until the QIP is approved and each case is closed. The QIP shall be incorporated into the final Suicide Report. All decisions made by the DCHCS SPR FIT regarding compliance and quality improvement shall be documented in the final Suicide Report.

The follow-up report on implementation of the QIP shall be reviewed by the DCHCS SPR FIT Coordinator. In cases where the QIP is not sufficiently completed by the institution within the required time frame, the SPR FIT coordinator shall send a memorandum indicating non-compliance to the institution and to the Regional Administrator at DCHCS and DAI. Appropriate follow-up shall be conducted by the Regional Administrator in order to ensure the completion of the QIP item. In cases where a system-wide QIP is not sufficiently completed by the SPR FIT within the required time frame, a report of progress and any barriers to completion shall be forwarded from the SPR FIT to the Director of the appropriate CDCR division. The CDCR Division Director shall take appropriate action to ensure

completion of the QIP. When complete, the QIP shall be distributed by the SPR FIT Coordinator according to legal mandates.

If, during the suicide review process, other death related information arrives, such as CDCR 837 C, CDCR 7229 C, or Coroner's report, the DNC will locate the death review folder and place these documents inside. The DNC shall update the routing sheet and notify the SPR FIT Coordinator of the new information. Upon completion of the suicide review, the death review folder containing the Suicide Report and other related information shall be returned to the DNC for final data entry. The DNC shall ensure that all documentation is complete and then return the folder for final storage in a designated locked cabinet at DCHCS.

The DCHCS SPR FIT Coordinator appointed to oversee suicide-related activities shall coordinate analysis and review of each suicide, and compile and forward annual suicide statistics to: Secretary, Youth and Adult Correctional Agency; Director, DAI; Director, DCHCS; Deputy Director, DCHCS; Chief of Clinical Policies and Programs, DCHCS; Institution Wardens; Institution HCM/CMOs; and, other appropriate senior DCHCS staff.

#### **G. MENTAL HEALTH EVALUATION COMPONENT FOR A RULES VIOLATION REPORT**

Per California Code of Regulations, Title 15, Section 3317 "An inmate shall be referred for a mental health evaluation prior to documenting misbehavior on a CDCR 115, in any case where the inmate is suspected of self-mutilation or attempted suicide."

Staff are to utilize the Request for CDCR 128B, when requesting this mental health evaluation.

Subsequent to the mental health evaluation, the mental health clinician's determination will be documented on a CDCR 128C. A copy of this CDCR 128C shall be forwarded to the custody staff who requested the mental health evaluation.

In order to preserve an inmate's due process rights, any decision that a suicide attempt was not genuine must be supported by the following:

1. A thorough review of the UHR and Central File
2. A complete mental health evaluation including a complete history, current mental status examination, and current Diagnostic and Statistical Manual diagnosis
3. Appropriate psychological testing to include both objective and projective testing
4. A detailed summary supporting the conclusion that the suicide attempt was not genuine
5. The clinician's summary must be approved and co-signed by the institution's Chief of Mental Health before issuance of a CDCR 115.



If the mental health clinician determines the inmate's actions were an attempt to manipulate staff, the inmate may be charged under CCR Section 3005(a) for the specific act of "Attempted Manipulation of Staff." The specific act of "Attempted Suicide" or "Self Mutilation" is not an appropriate charge for a CDCR 115 and shall not be used. In cases where a self-injurious behavior is found to be intended to manipulate staff, a copy of the completed mental health evaluation shall be sent to the local SPR FIT coordinator and the mental health program director.

If a mental health clinician determines that, the inmate's action was an "actual suicide attempt," or cannot make a clear determination that the inmate's action was an actual suicide attempt, a CDCR 115 shall not be written. In both these instances the behavior and/or the inability of mental health staff to make a clear determination shall be documented by custody staff on a CDCR 128B, *Mental Health Services Staff Referral, General Chrono*, for inclusion in the inmate's Central File and UHR.