



**POLICY STATEMENT**  
Commonwealth of Pennsylvania • Department of Corrections

<b>Policy Subject:</b> <b>Access to Mental Health Care</b>		<b>Policy Number:</b> <b>13.8.1</b>
<b>Date of Issue:</b> <b>March 2, 2015</b>	<b>Authority:</b> <b>Signature on File</b> <b>John E. Wetzel</b>	<b>Effective Date:</b> <b>March 9, 2015</b>

**I. AUTHORITY**

The Authority of the Secretary of Corrections to direct the operation of the Department of Corrections is established by Sections 201, 206, 506, and 901-B of the Administrative Code of 1929, 71 P.S. §§61, 66, 186, and 310-1, Act of April 9, 1929, P.L. 177, No. 175, as amended.

**II. APPLICABILITY**

This policy is applicable to all facilities operated under the jurisdiction of, or conducting business with the Department of Corrections, Department employees, volunteers, contract personnel, visitors and inmates.

**III. POLICY**

It is the policy of the Department to deliver a broad continuum of mental health services to ensure that regardless of how major or minor the emotional disturbance, services are available to every inmate in the Department.<sup>1</sup>

- A. screening for mental health problems on intake as approved by the mental health professional (refer to **Section 2 - Delivery of Mental Health Services** of this procedures manual);
- B. outpatient services for the detection, diagnosis, and treatment of mental illness (refer to **Section 2** of this procedures manual);

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<sup>1</sup> 4-4368

- C. crisis intervention and the management of acute psychiatric episodes (refer to **Section 2** and **Section 3 - Delivery of Psychiatric Services** of this procedures manual);
- D. stabilization of the mentally ill and the prevention of psychiatric deterioration in the correctional setting (refer to **Section 2**, **Section 3**, and **Section 5 - Residential Treatment Units [RTUs]** of this procedures manual);
- E. preventive treatment (refer to **Section 1** and **Section 2** of this procedures manual);
- F. provision for referral and admission to a licensed mental health unit/facility (refer to **Section 2** and **Section 4 - Temporary Transfer of Mental Health Commitments** of this procedures manual);
- G. facilities for an offender whose psychiatric needs exceed the treatment capability of the facility (refer to **Section 5**, **Section 7 – Special Assessment Unit**, **Section 10 – Intermediate Care Unit** of this procedures manual); and
- H. procedures for obtaining and documenting informed consent (refer to **Section 2** of this procedures manual).

#### IV. PROCEDURES

- A. The systematic method of delivering psychological services to every inmate includes, but is not limited to, the below listed vehicles.

- 1. Intellectual, Academic and Mental Health Assessment

The Department provides psychological and psychiatric assessments of levels of intellectual functioning, academic achievement, personality dynamics, and mental health needs to identify each inmate's strengths and weaknesses in order to make prescriptive program and treatment recommendations to help him/her develop the necessary skills for successful adjustment while incarcerated and upon release in the community.<sup>2</sup>

- 2. Individual Treatment and Program Planning

The mental health treatment service needs of each inmate are addressed via his/her **DC-43, Integrated Correctional Plan (ICP)**, which is developed with participation of the inmate and is updated annually. In addition, the special needs of an inmate with mental illness are further addressed via the Individual Recovery Plan (IRP).

- 3. Mental Health Tracking

An inmate with mental health problems is tracked on the automated Mental Health/Intellectual Disability (MH/ID) tracking system to ensure continuity of care.

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<sup>2</sup> 4-4305

#### 4. Outpatient Treatment Services

Outpatient psychiatric and psychological services are provided upon an inmate's initial intake and as needed throughout his/her period of incarceration at every facility. Individual and group treatment services are developed to assist an inmate in emotional growth and/or prevention/management of mental illness, managing the behaviors that lead to his/her offense(s), coping with the prison environment and external stressors, and preparing for reentry into the community as law abiding citizens.

#### 5. Inpatient Treatment Mental Health Services

Inpatient psychiatric services are provided in Mental Health Units (MHUs) and the Forensic Treatment Center (FTC) at Waymart. The MHUs are small inpatient units that are licensed by the Department of Human Service's Office of Mental Health and Substance Abuse Services (OMHSAS) and provide short-term treatment. The FTC is a psychiatric hospital licensed by OMHSAS, which provides long-term inpatient psychiatric services.

#### 6. Special Needs Housing

Specialized housing is available for inmates that require that level of care in a Special Needs Unit (SNU), Intermediate Care Unit (ICU), Special Assessment Unit (SAU), Residential Treatment Unit (RTU), Secure Residential Treatment Unit (SRTU), Behavior Management Unit (BMU), Diversionary Treatment Unit (DTU) and Special Observation Unit (SOU). SNUs are non-licensed living areas or blocks located where an inmate with special mental health or medical needs can receive additional or more intense treatment services, support and/or protection. The ICU at Waymart is a 93-bed living unit that accepts an inmate who has a history of serious mental illness, psychiatric hospitalizations, and SNU/RTU placements. The ICU prepares an inmate for living in a SNU/RTU. The SAU provides additional diagnostic and assessment services for an inmate with mental illness who displays serious behavioral problems. The SOU is an observation and assessment unit for newly committed inmates who are experiencing stress and are suspected of having mental health problems.<sup>3</sup>

#### 7. Community Based Residential and Treatment Services

CCCs for a mentally ill inmate are located in Philadelphia and Allegheny Counties to help these men and women transition back into community life.

B. All pertinent procedures for staff are contained in the procedures manual for this policy.

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<sup>3</sup> 4-4305

## **V. SUSPENSION DURING AN EMERGENCY**

In an emergency or extended disruption of normal facility operation, the Secretary/designee may suspend any provision or section of this policy for a specific period.

## **VI. RIGHTS UNDER THIS POLICY**

This policy does not create rights in any person nor should it be interpreted or applied in such a manner as to abridge the rights of any individual. This policy should be interpreted to have sufficient flexibility to be consistent with law and to permit the accomplishment of the purpose(s) of the policies of the Department of Corrections.

## **VII. RELEASE OF INFORMATION AND DISSEMINATION OF POLICY**

### **A. Release of Information**

#### **1. Policy**

This policy document is public information and may be released upon request.

#### **2. Confidential Procedures (if applicable)**

Confidential procedures for this document, if any, are not public information and may not be released in its entirety or in part, without the approval of the Secretary of Corrections/designee. Confidential procedures may be released to any Department of Corrections employee on an as needed basis.

### **B. Distribution of Policy**

#### **1. General Distribution**

The Department of Corrections' policy and procedures shall be distributed to the members of the Central Office Executive Staff, all Facility Managers, and Community Corrections Regional Directors on a routine basis. Distribution of confidential procedures to other individuals and/or agencies is subject to the approval of the Secretary of Corrections/designee.

#### **2. Distribution to Staff**

It is the responsibility of those individuals receiving policies and procedures, as indicated in the "General Distribution" section above, to ensure that each employee expected or required to perform the necessary procedures/duties is issued a copy of the policy and procedures either in hard copy or via email, whichever is most appropriate.

## VIII. SUPERSEDED POLICY AND CROSS REFERENCE

### A. Superseded Policy

#### 1. Department Policy

13.8.1, Access to Health Care, issued May 24, 2004 by Secretary Jeffrey A. Beard, Ph.D.

#### 2. Facility Policy and Procedures

This document supersedes all facility policy and procedures on this subject.

### B. Cross Reference(s)

#### 1. Administrative Manuals

- a. DC-ADM 003, Release of Information;
- b. DC-ADM 201, Use of Force;
- c. DC-ADM 801, Inmate Discipline;
- d. DC-ADM 802, Administrative Custody Procedures;
- e. 2.1.1, Planning, Research, Statistics and Grants;
- f. 4.1.1, Human Resources and Labor Relations;
- g. 5.1.1, Staff Development and Training;
- h. 6.3.1, Facility Security;
- i. 6.5.1, Administration of Security Level 5 Housing Units;
- j. 6.5.8, Capital Case Administration;
- k. 6.7.2, Special Response Teams;
- l. 11.2.1, Reception and Classification;
- m. 11.4.1, Case Summary;
- n. 11.5.1, Records Office Operations;
- o. 13.1.1, Management and Administration of Health Care; and
- p. 13.2.1, Access to Health Care

2. ACA Standards

- a. Adult Correctional Institutions: 4-4191, 4-4257, 4-4258, 4-4286, 4-4305, 4-4350, 4-4351, 4-4366, 4-4368, 4-4369, 4-4371, 4-4372, 4-4373, 4-4374, 4-4399, 4-4401, 4-4404, 4-4411, 4-4416
- b. Adult Community Residential Services: None
- c. Correctional Training Academies: None

3. PREA Standards

None



PROCEDURES MANUAL  
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**Authority:**

**Signature on File  
John E. Wetzel**

**Effective Date:**

**March 9, 2015**

Release of Information:

**Policy Document:** The Department of Corrections policy document on this subject is public information and may be released to members of the public, staff, legislative, judicial, law enforcement, and correctional agencies and/or inmates upon request.

**Procedure Manual:** The procedures manual for this policy may be released in its entirety or in part, with the prior approval of the Secretary/designee. Unless prior approval of the Secretary/designee has been obtained, this manual or parts thereof may be released to any Department employee on an as needed basis only.

**Procedure Development:** All required procedures will be developed in compliance with the standards set forth in this manual and/or the governing policy. These standards may be exceeded, but in all cases these standards are the minimum standard that must be achieved. In the event a deviation or variance is required, a written request is to be submitted to the appropriate Regional Deputy Secretary and the Standards and Practices Unit for review and approval prior to implementation. Absent such approval, all procedures set forth in this manual must be met.

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## Section 1 – Psychological Services

### A. Diagnostic Center

1. Every inmate entering the Department shall be given a psychological evaluation conducted at the Diagnostic and Classification Center (DCC).<sup>1</sup> The DCC shall administer basic psychometric testing and interview the inmate upon reception. DCC will provide further assessments only for an inmate who evidences a need for more comprehensive evaluation, e.g., those inmates scoring 70 or below on the intellectual screening to rule out intellectual deficiency.
2. The purpose of this psychometric testing is to provide screening in the areas of intelligence, achievement, personality, and emotional stability. Whenever screening indicates a need for more in-depth study, such shall be provided. Basic Assessment will be conducted with results and recommendations made available to appropriate staff for the purpose of initial classification in accordance with Department policy **11.2.1, “Reception and Classification.”**
  - a. Personality Assessment Inventory (PAI)
    - (1) The psychology staff will administer the PAI.
    - (2) PAIs will be administered in an appropriate testing environment without interruption.
    - (3) A recorded version of the PAI will be administered to an illiterate inmate.
    - (4) The complete protocol and computer narrative will be reviewed the same day it is administered and forwarded to the receiving facility along with a completed clinical interview form and the **Pennsylvania Clinical Risk Assessment (PCRA)**. If the initial review reveals clinically indicated concerns, an interview will be conducted the next working day.
  - b. **DCC-PCRA**: the psychology staff will complete the **DCC-PCRA** form and forward it to the receiving facility.
  - c. Revised Beta III
    - (1) The psychology staff will administer the Beta III to every inmate.
    - (2) An inmate who scores 70 or below will receive additional assessment at the DCC to “rule out intellectual disability (ID)/development disabilities (DD).” ID/DD assessment will include intelligence testing on the Wechsler Abbreviated Scale of Intelligence (WASI), the Wechsler Adult Intelligence Scale, adaptive behavior

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<sup>1</sup> 4-4286

testing measured by the Vineland and research to determine whether the condition occurred before the age of 18.

d. More Comprehensive Assessments

- (1) Mental Illness: An inmate with evidence of mental illness will receive a more comprehensive assessment. The Psychiatrist/Certified Registered Nurse Practitioner – Psychiatric Services (PCRNP) will conduct a comprehensive psychiatric evaluation in each case of serious mental illness (SMI) and the Psychiatric Review Team (PRT) will generate an **Individual Recovery Plan (IRP)** within 20 days of determination that the inmate has an SMI. This **IRP** will accompany the inmate to the receiving facility. The inmate shall be offered an opportunity to attend this meeting and the **IRP** will include goals in the inmate's own words, the PRT's unique plan for the inmate addressing his/her goals including sentinel behaviors, e.g. self-injurious behavior (SIB) and interventions utilized to achieve goals. Inmates that are not identified immediately at reception, but demonstrate evidence of mental illness, will be referred to psychiatry via the **DC-97, Mental Health Referral Form (Attachment 1-A)** for non-emergent referrals and this process must occur within 14 days of the referral.
- (2) Other cases: Assessment procedures will not be modified for juveniles adjudicated as adults, for capital cases, or for boot camp cases.

**B. Facility Functions and Procedures**

1. The functions of the psychology staff are to provide diagnostic, therapeutic, mental health, and consultative services. The facility psychology staff shall provide group and individual therapy, as well as supervision and training in counseling and treatment for other staff members who need or request it, serve as a resource and consultant for administrative, custodial and other staff, participate in the development of individualized treatment programs, and participate in various staffings. Social workers may perform duties consistent with their licensure. The facility psychology staff shall evaluate mental health cases for potential commitment to the mental health system, arrange and coordinate mental health commitment hearings, and provide appropriate testimony at such hearings, as required. Psychology staff may serve as the point of contact with the courts and mental health facilities and make appropriate arrangements for the transfer to and/or return of an inmate from a mental health facility. The psychology staff are responsible for advising the Regional Licensed Psychology Manager (RLPM) and the Central Office Chief of Psychology, of any problems, difficulties, or unusual occurrences involving mental health cases and/or the transfer procedures, and for keeping records of every transfer to/from the mental health system. The psychology staff also provides follow-up treatment and monitors every mental health case returned to the facility from one of the Mental Health Units (MHU), State Correctional Institution (SCI) Waymart Forensic Treatment Center (FTC), or a Department of Human Services facility.<sup>2</sup>

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<sup>2</sup> 4-4368, 4-4369



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2. Designated psychology staff members in the facility shall function as Mental Health Coordinators (MHC), coordinating treatment services for particular inmates, arranging mental health commitments, tracing of mental health commitments, and crisis intervention until needed services can be coordinated.<sup>3</sup>

a. Diagnostic Evaluations for Program Planning

Counselors and other staff members make frequent referrals to the psychology department for the following reasons:

- (1) consideration for Community Work Program (CWP);
- (2) consideration for outside clearance;
- (3) difficulty adjusting to program and/or facility life;
- (4) frequent or serious disciplinary infractions;
- (5) offer of an in-person, out-of-cell assessment, of every active mental health roster inmate involved in the disciplinary process prior to appearing before the decision maker;
- (6) potential mental health commitments;
- (7) guilty but mentally ill (GBMI) commitments, including an annual psychological evaluation in PCRA format;
- (8) parole evaluations in PCRA format for active mental health roster inmates (C and D Roster) or those convicted of violent offenses; and/or
- (9) psychosocial evaluations for use by local and Central Office Gender Review Committee (GRC).

b. Procedures

The counselor or other staff member shall refer cases to the psychology department for comprehensive evaluation and treatment on the **DC-97**. Ideally, such referrals shall be discussed with the referring party. If this is not possible, it may be necessary to proceed on the basis of the written referral only. It may also be necessary for the psychology staff to train other facility staff on the appropriate way to ask referral questions and what types of cases are appropriate for referral. Once the psychology staff receives the referral, he/she shall review the request and determine what procedures are necessary to answer the referral question. A diagnostic interview may be sufficient or additional testing may be necessary. The appropriate procedures necessary to reach responsible conclusions shall be determined by the nature of the

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<sup>3</sup> 4-4368, 4-4369

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request, the information available in the record, and the psychology staff's own skills. Generally, some additional testing shall be necessary, employing objective and/or projective techniques. The psychology staff performing the evaluation shall select the instruments used, except where policy may specify instruments to be used. The evaluation will be completed within 14 days of the referral request date and include the following:<sup>4</sup>

- (1) review of mental health screening and appraisal data to include requesting community treatment data with the **DC-108, Authorization for Release of Information** and the **DC-484, Mental Health Informed Consent Form** signed;
- (2) direct observations of behavior;
- (3) collection and review of additional data from individual diagnostic interviews and tests assessing personality, intellect, and coping abilities;
- (4) compilation of the individual's mental health history; and
- (5) development of an IRP/management plan with appropriate referral to include transfer to a mental health facility for inmates whose psychiatric needs exceed the treatment capability of the facility.

c. Specialized Evaluations

- (1) Psychology staff frequently are called upon to perform specialized evaluations. These cases, which may be sent to outside agencies, require sophisticated and intensive evaluations. General guidelines for the completion of these reports are presented in the **Guidelines for Department Psychological Evaluations for Parole and Other Assessments Required by Policy or Referral (Attachment 1-B)**.
- (2) The psychologist shall employ appropriate interview procedures and test instruments, which may include objective measures (Minnesota Multiphasic Personality Inventory [MMPI-2], PAI, and PCRA), mental status exam, the Montreal Cognitive Assessment and one or more projective tests, to provide the required information. When possible, these evaluations shall be performed by a licensed psychologist (LP). Only under exceptional circumstances shall the following reports be prepared by anyone at a level less than the Psychological Services Specialist (PSS). Reports prepared by unlicensed staff must be reviewed and signed by a LP. The examiner and/or the reviewer's PA license number and signature shall be affixed to the report.

(a) Commutation

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<sup>4</sup> 4-4372

When possible, commutation evaluations shall be performed by a LP. If any commutation reports are prepared by other than a LP, the reports must be reviewed and signed by a LP, preferably the Licensed Psychologist Manager (LPM). The reviewing psychologist shall include his/her license number and signature. For further information on the preparation of commutation psychological evaluations, please refer to **Procedure for Preparation of Commutation Psychological Evaluations (Attachment 1-C)** and to Department policy **11.4.1, “Case Summary.”**

(b) Court Requests for Special Evaluations

Occasionally the committing court requests a special psychological evaluation on an individual. These requests shall be honored as rapidly as possible.

(c) Parole Board Requests

Psychological evaluations for parole shall include a clinical interview, review of the relevant files, and administration of the **PCRA and Psychological Evaluation for Parole (Attachment 1-D)**. The PCRA is a list of risk factors that research suggests are related to re-offending. Specific directions for administration of the PCRA and format for the PCRA are presented in **Psychological Evaluation and Clinical Risk Assessment (Attachment 1-E)**.

(d) Evaluations for Mental Health Facility Placement

The psychologist may be requested to perform an evaluation on an inmate being considered for transfer to a Department MHU or state hospital. The psychologist shall choose the appropriate clinical instruments that provide the information needed to assist in such determinations.

(e) Evaluations Requested by Facility Psychiatrist/PCRNP

The facility Psychiatrist/PCRNP may occasionally refer an inmate for psychological evaluation. When possible, the psychologist shall discuss the referral with the Psychiatrist/PCRNP prior to performing the evaluation. It is also helpful if the findings of the psychological evaluation can be discussed with the referring Psychiatrist/PCRNP.

(f) Psychological Evaluation of Inmates Confined in a Security Level 5 (SL5) Unit

These units include the Restricted Housing Unit (RHU), Special Management Unit (SMU), and Security Threat Group Management Unit (STGMU).

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- i. Psychology staff shall visit the SL5 Unit five times per week.<sup>5</sup> All psychology staff entering the unit shall sign in/out on the **DC-702, SL5 Unit Log Book**.
- ii. Psychology and/or nursing staff will assess every inmate placed in a SL5 Unit for suicide potential and review the **DC-510, Suicide Indicators Checklist (Attachment 1-F)**. These procedures are outlined in **Section 2** of this procedures manual.
- iii. All assessments and written reports of SL5 inmates shall address suitability for continued placement in the SL5 and assess mental deterioration or lack thereof. It is expected that all assessments will also include risk for suicidality and include consideration of protective factors.
- iv. The treating Psychiatrist/PCRNP shall continue to see inmates on the C Roster out-of-cell a minimum of every 90 days or more frequently based on their clinical discretion, and shall make recommendations to the Program Review Committee (PRC) regarding inmates in Administrative Custody (AC)/Disciplinary Custody (DC) status who may be released.
- v. Psychology staff shall personally interview, assess, and make a written report utilizing the **DC-560, Mental Health Contact Note (Attachment 1-G)** to be filed in the medical record for all A and B Roster status inmates monthly. A brief **Inmate Cumulative Adjustment Record (ICAR)** entry indicating the contact occurred shall also be made. Psychology staff shall make recommendations to the PRC regarding inmates in AC/DC status who may be released.
- vi. Psychology staff shall personally interview, assess, and make written reports utilizing the **DC-560** to be filed in the medical record for every C Roster inmate monthly. A brief **ICAR** entry indicating the contact occurred will also be made. Psychology staff shall make recommendations to the PRC regarding inmates in AC/DC status who may be released. C Roster inmates shall be offered out-of-cell contacts with psychology/Psychiatry/PCRNP on the unit at least every 90 days. The refusal and/or acceptance of these offers shall be documented in the **ICAR** and on the **DC-560** in the medical record. These out-of-cell contacts are contingent on behavioral compliance from the inmate. If behavior is demonstrated that would contraindicate out-of-cell contact, this shall be documented in the **DC-17X, Adjustment Record for SL5 Inmates, ICAR**, and the **DC-560**. The inmate shall be seen at the next available visit if behavior permits.

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<sup>5</sup> 4-4258

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- vii. Psychology staff shall assess an inmate referred and/or approved for Secure Residential Treatment Unit (SRTU) or Behavioral Management Unit (BMU) programming (whether on transfer waiting list or time-out) at least every seven days and shall make recommendations to the PRC regarding the inmate. These assessments shall be documented as brief **ICAR** entries with a more detailed **DC-560** filed in the medical record. SRTU and BMU approved inmates shall be offered out-of-cell contacts with Psychiatry/PCRNP at least every 30 days on the unit and shall be reviewed by PRT on a monthly basis.
- viii. An inmate continuously confined in a SL5 Unit for a period of one year shall be given, at a minimum, an annual psychological, and if indicated, psychiatric examination during his/her confinement addressing the suitability of continued confinement in the SL5 Unit, regardless of current Mental Health (MH)/ID roster status. It is the responsibility of the psychology staff to see that such an evaluation is conducted. These shall be documented as brief **ICAR** entries with a PCRA evaluation filed in the medical record. If the inmate refuses to submit to assessment, procedures in accordance with Department policy **13.1.1, “Management & Administration of Health Care,”** shall be followed.
- ix. Psychology staff shall make recommendations to the PRC regarding inmates in long-term AC/DC status who may be released or possibly transferred to a SRTU, BMU, SMU, STGMU, or other specialized program.
- x. Unless a specific need exists that the inmate must be removed from the unit, the inmate shall be visited in the unit. This is to restrict traffic and to avoid possible problems during escort or time out of the unit. The Shift Commander/designee must approve any move from the unit for a psychological/psychiatric visit or interview.
- xi. The LPM/MHC will provide the Commissioned Officer-in-Charge of the SL5 Unit weekly with a listing of all inmates on the active mental health roster and those considered to display risk factors for suicidal behavior. This list is to be utilized by security staff to assist in their day-to-day interactions and decision-making processes. These postings should stay in the secured control bubble.
- xii. The Unit Manager/Officer-in-Charge is responsible for coordinating visit/interview dates and times to ensure that security is provided during meetings between inmates and psychology/psychiatric staff. Any requests by mental health staff to interview an inmate out-of-cell shall be accommodated by security staff if possible, as they are to have unrestricted full access to inmates. At the same time, mental health staff should be sensitive to the activities on the unit and

whenever possible, attempt to coordinate in advance times that are convenient for security for out-of-cell contacts. For example, psychiatry and psychology are permitted to interview the same inmate together.

- xiii. The **RHU C & D Roster Inmate Review Tracking Sheet (Attachment 1-H)** is to be utilized for tracking contacts with C Roster inmates housed in the RHU. It is intended to serve as a mechanism to ensure compliance with the required psychology/psychiatry contacts in accordance with **B.2.c.(2)(f)i.-xiii. above**. The Facility Manager shall designate a staff member to maintain the **RHU C & D Roster Inmate Review Tracking Sheet**. The tracking sheet shall be forwarded to the Facility Manager on a weekly basis and shall be reviewed during the quarterly inspection process.

(g) Psychological Evaluation of Inmates Housed in Specialized Housing Units

These units include Diversionary Treatment Units (DTUs), SRTUs, and BMUs.

- i. Psychological services provided in the DTUs will be in accordance with **Section 14** of this procedures manual.
- ii. Psychological services provided in the SRTUs will be in accordance with **Section 10** of this procedures manual.
- iii. Psychological services provided in the BMUs will be in accordance with **Section 12** of this procedures manual.

(h) Gender Dysphoria Evaluation

This psychological evaluation should follow the below guidelines.

A psychological evaluation will be scheduled and completed by a LPM or LP, if available, and recommendations made for treatment or referral (i.e., this psychological evaluation shall not be completed by a psychological services associate [PSA]). A PSS may complete this report if an LPM or LP is not available. The purpose of this assessment is to gather a complete psychosocial and developmental history of this individual and to determine how this individual has adjusted to prison since arriving in the Department. This psychological assessment will include an assessment of the individual's need for psychological and psychiatric treatment. The psychology staff member completing this assessment will attempt to retrieve any existing prior psychological and psychiatric treatment records utilizing the **DC-108, Authorization for Release of Information**. This report will be utilized by Central Office Administrative GRC to make informed recommendations. Further information on the Central Office GRC

can be found in Department policy **DC-ADM 008, “Prison Rape Elimination Act (PREA).”**

These records may include treatment prior to incarceration (i.e., including hormone therapy, completed or currently in process, surgical interventions, and ongoing counseling).

This comprehensive evaluation will specifically review and address:

- i. the individual’s developmental history (especially with reference to gender identity), history and development of gender dysphoric feelings, history of sexual behavior, mental health history, the impact of stigma associated with gender nonconformity on one’s mental health history, and family and social support currently available and anticipated upon release, if applicable. Additionally, consideration of diagnoses and treatment of comorbid conditions, such as anxiety disorders, depressive disorders, and autism spectrum disorder should be addressed, as well. If during this assessment, information is gleaned to suggest comorbid conditions not previously identified, appropriate referrals to psychiatry should be made utilizing the **DC-97**;
- ii. institutional adjustment, including a review of sexual behavior in prison (e.g., misconducts for sexual behavior), current relations with inmate peers, level of identification with subpopulations in the correctional environment, any current or anticipated safety concerns in the institution, history of sexual victimization in prison (and otherwise, anywhere else);
- iii. a thorough mental status examination; this examination should focus on the dysphoria currently being reported by the individual. Areas to address should include, but not be limited to, specifics about why the individual is currently dysphoric; what accommodations might improve the individual’s dysphoria and why/how; what accommodations have improved the individual’s dysphoria (if applicable) and why/how; what current circumstances in the individual’s life are causing or leading to the dysphoria; what is the individual’s current level of dysphoria; and
- iv. completion of the PAI, with specific attention given to relevant subscales.

Once completed, a licensed professional must sign off this psychological evaluation, if a licensed professional does not conduct the evaluation. In addition to the above information, we would like to have “any and all available psychological and psychiatric records” from the referring SCI. This would include the entire psychology and psychiatry portions of the medical file.

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- (3) The LPM shall ensure that a psychology staff member assesses each newly received inmate transferred from another correctional or mental health system (county prison, the Federal Bureau of Prisons, parole supervision, or a State Hospital). The assessment shall be completed within 14 days of admission to the facility. If there is documented evidence of a mental health evaluation within the previous 90 days, a new evaluation is not required, unless the inmate is placed on the MH/ID roster, or the inmate had demonstrated some behavior or made some statement which makes correctional staff believe that further assessment is needed. Mental health assessments shall include, but are not limited to:<sup>6</sup>
- (a) review of available historical records of inpatient and outpatient psychiatric treatment;
  - (b) review of history of treatment with psychotropic medication;
  - (c) review of history of psychotherapy, psycho-educational groups, and classes or support groups;
  - (d) review of history of drug and alcohol treatment;
  - (e) review of education history;
  - (f) review of sexual abuse-victimization and predatory behavior;
  - (g) assessment of current mental status and condition;
  - (h) assessment of current suicide potential and person specific circumstances that increase suicide potential;
  - (i) assessment of violence potential and person-specific potential circumstances that increase violence potential;
  - (j) assessment of drug and alcohol abuse and addiction;
  - (k) use of additional assessment tools as indicated;
  - (l) referral to treatment as indicated; and
  - (m) development and implementation of a treatment plan, including recommendations concerning housing, job assignment, and program participation.

**NOTE:** Psychology staff can collect much of this information through participating in the Initial Reception Committee (IRC) and completing the **DC-**

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<sup>6</sup> 4-4371



**560 and DC-560A, Initial Reception Mental Health Questionnaire (Attachment 1-I).**

d. Reporting and Distribution of Specialized Psychological and Psychiatric Reports and Evaluations

Every evaluation performed in the permanent facility shall be maintained as noted below.

- (1) Psychological Evaluations – The original psychological evaluation shall be filed in the Integrated Medical Record, Psychiatric/Mental section, and copies of the report placed in the **DC-15, Inmate Record**. A notation of the fact that an evaluation was performed, the purpose, and date shall be entered in the **ICAR**. Additionally, the psychology staff responsible for producing the report may maintain a copy of the evaluation in his/her own records. In addition to Health Care and Corrections Counseling staff, access to these evaluations shall be permitted to the Treatment Team, which is generally composed of Unit Management staff (including Unit Manager, Drug and Alcohol Treatment Specialists [DATS], and Corrections Officers), Centralized Services staff, Corrections Classification and Program Manager (CCPM), Deputy Superintendents, and the Facility Manager. Each report shall contain a statement that the contents are confidential and that the document shall not be reviewed by, nor the information shared with, persons who are not members of the Treatment Team.
- (2) Psychology contacts with inmates shall be recorded employing the Subjective Objective Assessment Plan (SOAP) note format and with date and time on the **DC-560**. A notation of the fact that a contact occurred and the date shall be entered in the **ICAR**. It is the responsibility of the treating psychology staff member to ensure that continuity of care is provided and that important information is forwarded to the counselor. Information may be summarized on the **ICAR**, or copies of the **DC-560**.
- (3) Psychiatric Reports
  - (a) Notes of specialized, ongoing mental health treatment, including infirmary visits by psychiatry staff, shall be entered in the medical record using the **DC-472** and maintained in the Integrated Medical Record, Psychiatric/Mental Health section. Assessment shall be written in SOAP format.
  - (b) Each report shall contain a statement that the contents are confidential and that the document shall not be reviewed by, nor the information shared with, persons who are not members of the Treatment Team.

e. Psychology Response to PREA Events

- (1) Psychology staff are responsible for interviewing all reported victims and alleged inmate perpetrators of sexual abuse within 24 hours of the allegation being made. If the report is made during the timeframe when psychology staff are not on shift, such as a weekend or holiday, then this interview will take place the next business day.
- (2) If no mental health staff are on duty at the time a report of abuse is made, security staff first responders shall take preliminary steps to protect the victim as outlined in Department policy **DC-ADM 008**.
- (3) Prior to conducting the interview, the psychology staff member will explain that, if indicated for the inmate's protection, information disclosed will be shared only on a need-to-know basis with indicated staff (i.e., Security Office, PREA Compliance Manager [PCM], Unit Manager, Counselor, Sexual Abuse Review Team, Pennsylvania State Police [PSP], etc.). The psychology staff member will then have the inmate sign a **DC-484**.
- (4) The purpose of the interview is to evaluate and assess the current level of cognitive, mental, and emotional functioning as well as to determine overall inmate safety (the current risk of self-harm or harm to others or the fear of harm by others). In addition, crisis intervention, education about expected reactions to stressful events, and the normalization of worrisome thoughts and emotions are provided. This interview and the report are neither conducted for the purposes of an investigation nor for the purpose of documenting and illuminating the inmate's account of events and circumstances that allegedly took place as part of the incident.
- (5) This interview should be conducted in a private area to ensure confidentiality, with no security staff present during the interview, unless there are documented security concerns.
- (6) If indicated, a referral to psychiatry for evaluation and possible treatment shall be initiated.
- (7) The facility shall provide alleged victims with mental health services consistent with the community level of care.
- (8) The results of this interview shall be documented on the **DC-575, Post Sexual Assault Interview** in accordance with Department policy **DC-ADM 008**.
- (9) Contacts with alleged victim and alleged perpetrator should continue after the initial assessment monthly for at least 90 days and may occur more frequently and last longer due to clinical judgment and inmate's roster status.

f. Monthly Report

The psychology staff shall keep an accurate record of the number of psychological evaluations (testing), number of psychological interviews for information gathering (other than testing), and any group testing sessions conducted. These records shall be submitted to the facility State Corrections Analysis Network (SCAN) Coordinator at the end of each month for inclusion in the facility's monthly SCAN report.

g. Mental Health Roster Status

- (1) The mental health needs of an inmate shall be rated on a four-point nominal scale system according to the following:
  - (a) "A" Roster - inmate has no identified psychiatric/ID needs or history of psychiatric treatment.
  - (b) "B" Roster - inmate has identified history of psychiatric treatment, but no current need for psychiatric treatment; inmate is placed on inactive MH/ID roster.
  - (c) "C" Roster - inmate is currently receiving psychiatric treatment, but is not currently diagnosed with a SMI or functional impairment, and does not have an ID or is not GBMI.
  - (d) "D" Roster – inmate is currently diagnosed with a SMI, ID, credible functional impairment, or is GBMI. The PRT shall generate an IRP for him/her. An IRP for a newly incarcerated inmate shall be developed within 30 days of intake and updated every 120 days, or more frequently if clinically indicated. The Treatment Team shall generate a new IRP annually. The psychology staff shall coordinate with the education department to ensure that any inmate with an ID who is 21 years of age or younger receives an Individual Education Plan (IEP).
- (2) The MHC (or other psychology staff member who enters data into the mainframe system) is required to enter any mental health roster status change within one working day of the change by the PRT.

h. Reclassification Summary Psychological Report – Prior Commitment-Parole Violation Cases Classification Summaries for Parole Violators (PVs) must be completed as quickly as possible after the inmate returns to the permanent facility. The primary purpose is to identify special risk factors for violence against self or others in order to help the facility make critical decisions about housing and treatment. In addition, facility staff may desire information that would be useful in making employment decisions. In many cases, the psychology staff can gather sufficient data to complete the summary by conducting a clinical interview, administering a Mental Status Exam, and reviewing the inmate's file.

### **C. Treatment**

Each psychology staff member will engage in both individual and group therapy commensurate with his/her level of skill and training. Social workers will provide services consistent with their licenses. PSA personnel shall seek supervision from a LP or the facility Psychiatrist/PCRNP when conducting therapy, unless they are licensed and/or are able to document specialized supervised training and experience in therapy. Every unlicensed psychology staff member engaged in ongoing psychotherapy must arrange for supervision by a LP. This constraint does not apply to routine counseling, but rather to sustained in-depth, therapeutic endeavors. The psychologist shall, if qualified and if requested to do so, make himself/herself available to serve as a consultant and/or supervisor for Corrections Counselors who are engaged in counseling or leading groups.

#### **1. Procedures**

- a. When establishing therapeutic programs, the psychology staff member should take into account facility routines and appropriate custodial needs. However, all therapeutic programs should be driven by inmate need and reflected on individual inmate IRPs. The psychology staff are free to use the standard therapeutic techniques of his/her choice, unless the Department mandates a particular type of treatment model. However, if he/she elects to use some highly unusual or radical therapeutic approach, such plans shall be discussed with his/her supervisor, RLPM, and the Central Office Chief of Psychology prior to implementation.
- b. Psychology staff members shall conduct or co-facilitate a variety of different types of treatment groups. These include, but are not limited to, sex offender treatment, mental health related treatment and support, and standardized program groups. Each psychology staff member shall conduct at least four hours of group treatment per week.

#### **2. Reporting of Therapeutic Contacts and Progress**

Each therapeutic contact and the date of the contact shall be recorded in the **ICAR**. A periodic, brief summary of progress in therapy shall be prepared and placed in the inmate's medical file, psychology section. Periodic conferences and review of progress should be held with the inmate's counselor. Contacts shall be recorded on the **DC-560** using the SOAP format and filed in the psychology section of the medical record.

#### **3. Monthly Reports on Treatment**

The DCC psychology staff shall maintain accurate records of the number of individual psychological interviews, the number of individual psychological evaluations (testing), and the number of individual psychological counseling sessions held each month. The number of inmates seen in each activity shall be recorded. In addition, every group testing session shall be recorded, including the number of inmates and the number of hours involved. Any group counseling session conducted by the psychology staff shall be recorded in a similar manner. The data collected shall be submitted at the end of each

month for inclusion in the Monthly SCAN Report in accordance with Department policy 2.1.1, “Planning, Research, and Statistics.”

#### **D. Procedure for Preparation of Commutation Psychological Evaluations**

The Board of Pardons is charged with making critical decisions on the basis of the information they receive. Refer to the **Procedures for Preparation of Commutation Psychological Evaluations**. The Format for Commutation Psychological Reports is outlined in the **Format for Commutation Psychological Reports (Attachment 1-J)**.

#### **E. Training, Consultation, and Peer Review**

1. The facility psychology staff shall conduct a variety of training, consultation, and other supportive services for other staff members in the facility. For example, the corrections school principal may coordinate a training during break week, conducted by psychology staff after discussing with the LPM/designee at the monthly Deputy Superintendent for Centralized Services (DSCS) department head meeting.
2. ***Psychology staff members and/or other mental health staff members may be required to teach suicide prevention classes to contact staff members in each facility in accordance with Department policy 5.1.1, “Staff Development and Training.” The recommended delivery of this program is that it is team taught with security and treatment staff. It is acceptable to teach with just one instructor if the other is unavailable. This is not intended to mean that it is the sole responsibility of psychology/mental health staff to teach every suicide prevention class. Other treatment staff may co-teach with security staff based on the treatment staff member’s experience, interest in training, and the administration’s belief that they are capable of teaching. Examples of treatment staff include CCPMs, Unit Managers, counselors, DATS, nurses, etc. In addition, psychology staff are frequently asked to conduct training in mental health services and communication skills.***
3. Psychology staff members and other mental health staff may be requested to provide consultation in areas where they possess specialized information or expertise. For example, the psychology staff may consult with the Facility Manager regarding the impact of new programs upon the inmate population. During emergencies and extraordinary occurrences in the facility (riots, hostage takings, or work stoppages), the psychology staff may advise the crisis team. A mental health staff member who has received special training may coordinate the Critical Incident Stress Management (CISM) services in the facility and supervise the delivery of stress defusing and debriefings for any facility employee and/or inmate who has been exposed to traumatic events in accordance with Department policy 6.7.2, “**Special Response Teams.**”
4. Psychology staff members are frequently asked to perform other professional duties in the facility that may not relate to the inmate population.

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- a. A LP reviews the personnel packages of Correctional Officer Trainee Candidates, and completes the **Psychological Screening Report Form (Attachment 1-K)** in accordance with the instructions found in the **Role of Psychologist in Personnel Selection of Corrections Officer Trainees (Attachment 1-L)**.
  - b. A LP is required to evaluate a correctional officer who has worked in a SL5 Unit for longer than 12 months to judge whether he/she is suited to continue working in these units in accordance with Department policy **6.5.1**.
  - c. Psychology staff members may assist other staff members and make referrals in accordance with Department policy **4.1.1, “Human Resources and Labor Relations.”**
  - d. During facility emergencies, psychology staff may be required to perform unusual non-professional duties. For example, during crises that involve “lock-downs,” psychology staff members will support food services in food preparation and delivery of food trays to the blocks, assist in cell searches, and other duties as assigned.
5. Peer reviews for LPMs shall be completed as specified in Department policy **13.1.1**, and may include the below listed types.
- a. Scheduled Peer Review – all LPMs shall have a scheduled peer review performed every two years. Scheduled peer reviews may be completed as part of the annual Psychology Office mental health services review.
  - b. Exceptional Peer Review – may also be initiated in response to patient complaints or patient care issues identified by health service providers, the Psychology Office, Contracted Health Care Provider staff, or non-medical personnel including facility staff.<sup>7</sup>

**F. Central Office Oversight, Quality Improvement, and Quality Assurance Activities**

1. Central Office Special Needs Psychiatric Review Team (COSNPRT)
  - a. This interdisciplinary team meets monthly and is composed of all Regional Deputy Secretaries, Major of Security, Director of the Office of Population Management, Chief Data Analyst from Planning, Research, and Statistics, Chief of Psychiatry, Licensed Psychologist Director (LPD), and the Mental Health Program Manager from the Central Office Psychology Office.
  - b. Topics for discussion are to centrally track and capture trends and reach back out to the field through action items and the distribution of a report.
    - (1) Review of waiting lists for specialized programs requiring referrals (Special Assessment Unit [SAU], Intermediate Care Unit [ICU], BMU, SRTU, and SMU).

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<sup>7</sup> 4-4411

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- (2) Trends in regard to facility referrals to include consideration of capacities.
- (3) Use of force and restraint chair trends and totals by region and year-to-date.
- (4) Review of DTU, MHU, SRTU, and BMU populations.
- (5) Appropriate plans for SMI/ID in DTU for greater than 30 days.
- (6) Review of suicides, serious attempts, and SIB for the month and year-to-date.
- (7) Trending in regard to regions considering location, most frequent self-injurers, etc.
- (8) Review of MHU commitments.
- (9) Review of cases due to sentinel events, difficult placements, or referral.
- (10) Distribution of COSNPRT packet to members, Facility Managers, Regional LPMs, and the contract service provider for psychiatric services.
- (11) The Central Office Chief of Psychology will elevate to the Executive Deputy Secretary issues that are significant or cannot be resolved.

**2. RLPM Oversight**

- a. RLPMs provide clinical oversight and monitoring of their assigned facilities. They review referral packets and monitor trending in operations through visits and discussion with appropriate staff. Any issues of significance or those that cannot be resolved are elevated to the LPD at Central Office.
- b. At least once per quarter the RLPM will visit their assigned sites and complete a compliance report. These reports shall be submitted to the Secretary, Executive Deputy Secretary, respective Regional Deputy Secretary, and the Chief of Psychology at Central Office. The first report is due by April each year and will be due by the tenth day following the end of each quarter. Reports are due by April 10, July 10, October 10, and January 10. The annual psychology operations audit is an additional visit, unless the annual audit is conducted the same day as a compliance report. These dates do not limit visits if, in the clinical opinion of the RLPM, they need to be on-site more frequently than this schedule.
- c. Quarterly reports will be submitted in a narrative format and cover all measurable areas of the Technical Compliance Consultant Matrix.

## Section 2 – Delivery of Mental Health Services

### A. Identifying Mental Health Needs of Inmates

Good treatment begins with the appropriate identification of the needs of each inmate. Thus, early and appropriate identification of needs for mental health services is the foundation for the appropriate handling of these individuals.

#### 1. Automated Tracking System

Tracking of an inmate with mental illness is accomplished via the Automated Mental Health/Intellectual Disability (MH/ID) Tracking System. This tracking system is a mechanism through which the Department seeks to ensure that an inmate with mental illness is identified and receives treatment, and that he/she receives continuity of care. The automated MH/ID tracking program is a system that ensures that mental health staff in the Department have access to the most up-to-date information available concerning an inmate. The tracking system is composed of the **Active** MH/ID Roster and Inactive MH/ID Roster.

##### a. Distinctions between the **Active and Inactive** MH/ID rosters

- (1) The **Active** MH/ID Roster includes every inmate who is being tracked by the Psychology Department; many of these individuals may be medically compliant and psychiatrically stable.
- (2) Some of these individuals may earlier have been diagnosed **with** a "Serious Mental Illness" ("A substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or cope with the ordinary demands of life."), but may be in remission and/or displaying adequate adjustment to facility life.
- (3) The Inactive MH/ID Roster includes any inmate who has a history of mental health treatment or was previously followed by the Psychiatric Review Team (PRT) until the team determined that he/she no longer needed mental health monitoring.
- (4) The inmate's status on the MH/ID Roster is communicated to other Department staff by means of the Mental Health **Roster** in the following manner:
  - (a) "A" **Roster** – inmate has no identified psychiatric/Intellectual Disability needs or history of psychiatric treatment;
  - (b) "B" **Roster** – inmate **has identified history of psychiatric treatment, but no current need for psychiatric treatment. Inmate** is placed on Inactive MH/ID Roster;



- (c) **“C” Roster – inmate is currently receiving psychiatric treatment, but is not currently diagnosed with a serious mental illness or functional impairment and does not have an intellectual disability or is not Guilty But Mentally Ill (GBMI). An Individual Recovery Plan (IRP) for a newly incarcerated C-Roster inmate shall be developed within 30 days of intake and updated annually, or more frequently if clinically indicated; and**
- (d) **“D” Roster – inmate is currently diagnosed with a serious mental illness, intellectual disability, credible functional impairment, or is GBMI. The PRT shall generate an IRP for him/her. An IRP for a newly incarcerated inmate shall be developed within 30 days of intake and updated every 120 days. The treatment team shall generate a new IRP annually.<sup>1</sup> The psychologist shall coordinate with the education department to ensure that any inmate with Intellectual Disability who is 21 years of age or younger receives an Individual Education Plan (IEP).**

**B. Definition of Serious Mental Illness**

**1. Inmates determined by the PRT to have a current diagnosis or a recent significant history of any of the DSM5 diagnoses (using ICD10 codes and letter tags):**

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

**F10.159, Alcohol-Induced Psychotic Disorder, with mild use disorder,  
F10.259, Alcohol-Induced Psychotic Disorder, with moderate-severe use disorder,  
F10.959, Alcohol-Induced Psychotic Disorder, without use disorder**

**Substance-Induced Psychotic Disorders employ the same specifiers (.159; .259; .959)**

**With cannabis F12; sedative, hypnotic, anxiolytic F13; cocaine F14;  
amphetamine F15;  
other hallucinogen/ phencyclidine F16; inhalant F18;  
and other substance/unknown substance F19**

**b. Schizophreniform Disorder F20.81**

**c. Schizophrenia F20.9**

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<sup>1</sup> 4-4350

- d. **Delusional Disorder**                      **F22a, Erotomanic type**
  - F22b, Grandiose type**
  - F22c, Jealous type**
  - F22d, Persecutory type**
  - F22e, Somatic type**
  - F22f, Mixed type**
  - F22g, Unspecified type**
  
- e. **Brief Psychotic Disorder**                      **F23**
  
- f. **Schizoaffective Disorder**                      **F25.0, BIP type**
  - F25.1, DEP type**
  
- g. **Other Psychotic Disorders**
  - F06.0, Psychosis due med condition w/ delusions**
  - F06.2 Psychosis due med condition w/ hallucinations**
  - F28 Other specified schizophrenia spectrum and other Psychotic Disorder**
  - F29 Unspecified schizophrenia spectrum and other Psychotic Disorder**
  
- h. **Bipolar I and II**
  - F31.0, BIP I, current or most recent episode hypomanic**
  - F31.11, BIP I, current or most recent episode manic, mild**
  - F31.12, BIP I, current or most recent episode manic, moderate**
  - F31.13, BIP I, current or most recent episode manic, severe**
  - F31.2, BIP I, current or most recent episode manic, w/psychotic features**
  - F31.31, BIP I, current or most recent episode depressed, mild**
  - F31.32, BIP I, current or most recent episode depressed, moderate**
  - F31.4 BIP I, current or most recent episode depressed, severe**
  - F31.5 BIP I, current or most recent episode depressed, w/psychotic features**
  - F31.71, BIP I, current or most recent episode hypomanic, in partial remission**
  - F31.72, BIP I, current or most recent episode hypomanic, in full remission**
  - F31.73, BIP I, current or most recent episode manic, in partial remission**
  - F31.74, BIP I, current or most recent episode manic, in full remission**
  - F31.75, BIP I, current or most recent episode depressed, in partial remission**
  - F31.76, BIP I, current or most recent episode depressed, in full remission**
  - F31.81, BIP II disorder**
  - F31.9a, BIP I, current or most recent depressed, unspecified**
  - F31.9b, BIP I, current or most recent episode hypomanic, unspecified**
  - F31.9c, BIP I, current or most recent episode manic, unspecified**
  - F31.9d, BIP I, current most recent episode unspecified**

i. **Major Depressive Disorder**

- F32.0, MDD, single episode, mild**
- F32.1, MDD, single episode, moderate**
- F32.2, MDD, single episode, severe**
- F32.3, MDD, single episode, w/psychotic features**
- F32.4, MDD, single episode, in partial remission**
- F32.5, MDD, single episode, in full remission**
- F32.9a, MDD, single episode, unspecified**
- F33.0, MDD, recurrent, mild**
- F33.1, MDD, recurrent, moderate**
- F33.2, MDD, recurrent, severe**
- F33.3, MDD, recurrent, w/psychotic features**
- F33.41, MDD, recurrent, in partial remission**
- F33.42, MDD, recurrent, in full remission**
- F33.9, MDD, recurrent, unspecified**

**NOTE: For the purpose of this definition, the term “recent significant history” shall be defined as “currently in existence or within the preceding three months.”**

- 2. Inmates diagnosed by PRT with DSM5 disorders that are commonly characterized by breaks with reality, or perceptions of reality, that lead the individual to experience significant functional impairment involving acts of self-harm or other behaviors that have a seriously adverse effect on life or on mental or physical health.**
- 3. Inmates diagnosed by PRT with Intellectual Disability, a dementia, or other cognitive disorders that result in a significant impairment involving acts of self-harm or other behaviors that have seriously adverse effect on life or on mental or physical health.**
- 4. Any inmate sentenced GBMI.**

**C. Clinical Guidelines for Functional Impairment**

**Factors for consideration when assessing significant functional impairment shall include the following:**

- 1. whether the inmate has engaged in self-harm which shall be defined as a “deliberate, intentional, direct injury of body tissue with or without suicidal intent.” Such acts include, but are not limited to the following behaviors: hanging, self-strangulation, asphyxiation, cutting, self-mutilation, ingestion of a foreign body, insertion of a foreign body, head banging, drug overdose, jumping, and biting themselves;**

2. *the inmate has demonstrated significant difficulty in his or her ability to engage in activities of daily living, including eating, grooming and personal hygiene, maintenance of housing area, participation in recreation, and ambulation; and*
3. *the inmate has demonstrated a pervasive pattern of dysfunctional or disruptive social interactions including withdrawal, bizarre or disruptive behavior.*

**D. Intellectual Disability**

*Inmates scoring 70 or below on the BETA-III will be administered an individual IQ test (WASI-II or WAIS-IV) at the parent facility. If their WASI-II IQ is 70 or below then a full WAIS-IV will be administered. If this WAIS-IV comes out to 70 or below, a measurement of adaptive behavior including the following will be assessed:*

1. *conceptual skills – language and literacy; money, time and number concepts; and self-direction;*
2. *social skills – interpersonal skills, social responsibility, self-esteem, gullibility, naiveté, social problem solving, the ability to follow rules/obey laws and to avoid being victimized; and*
3. *practical skills – activities of daily living (personal care), occupational skills, healthcare, travel/transportation, schedules/routines, safety, use of money, and use of telephone.*

**NOTE:** *An assessment to determine if the disability originated during the developmental period should be conducted to establish if the intellectual and adaptive deficits were present during childhood or adolescence. This assessment should include corroborative information obtained from complementary reliable and valid sources, which reflect functioning outside of the prison setting. Additional factors to take into account include the community environment typical of the individual's peers and culture, linguistic diversity, cultural differences in the way people communicate, move, and behave. Assessments must also assume that limitations often coexist with strengths, and that a person's level of life functioning will improve if appropriate personalized supports are provided over a sustained period.*

**F70, Intellectual Disability (Intellectual Developmental Disorder) mild = 50/55-70**  
**F71, IDD, moderate =35/40-50/55**  
**F72, IDD, severe =20/25-35/40**  
**F73, IDD, profound =<20/25**  
**F74, IDD, severity unspecified**

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- a. Decision rules for placement of inmates on the **Active and Inactive** MH/ID Rosters

An asterisk (\*) identifies each criterion that requires **consideration of** placement upon the **Active MH/ID** Roster. An inmate meeting the non-asterisk criteria may not necessarily be placed on a roster; however, his/her case shall be reviewed.

- (1\*) History of outpatient treatment or inpatient psychiatric hospitalization - Hospitalization in the past year shall be an automatic MH/ID Roster addition; treatment within the last five years shall be reviewed for possible roster addition.
- (2\*) Receiving psychotropic medication - An inmate who receives **or is prescribed** psychotropic medication shall be placed on the Active MH/ID Roster.
- (3\*) History of **serious** suicide attempt within the last two years - Recent suicide attempts shall trigger **review of** roster placement.
- (4\*) An inmate who is **on the Active MH/ID Roster and is** non-compliant with psychotropic medication for a period of seven days, has a history of violence, and has a current pattern of facility infractions shall be **reviewed by** the PRT. **The purpose of the PRT review should be to review the inmate's IRP, consider enrollment into a medication compliance group, etc.**
- b. The PRT shall review the case of an inmate with serious mental illness and/or who is housed on a **Residential Treatment Unit (RTU)** every 120 days **or more frequently if clinically indicated**. **C Roster** MH/ID cases shall be reviewed at least annually. The scheduling of the yearly review may coincide with the inmate's annual unit review so that the Unit Management Team may be as involved as possible in the treatment.
- c. The PRT shall meet at least weekly, and the session shall be documented on the **appropriate IRP (Initial – IRP [Attachment 2-A], Change of Status – IRP [Attachment 2-B], or Review – IRP [Attachment 2-C])**. The **IRP** and documentation of the PRT meetings shall be filed in the psychiatric section of the Medical Record. The **IRP** documentation must show clearly that the ***inmate was invited to attend PRT and that the unit team, to include Corrections Officers, were present or had input*** at the meetings, and were actively involved in development and/or review of the **recovery** plan. The **IRP** must also show that the inmate was involved in the development of the plan, and the inmate shall **be offered the opportunity to** sign the **IRP**. **If the inmate opts not to sign the IRP, refusals shall be noted.**
- d. In order to maintain confidentiality required by patient/client ethical standards and applicable laws, staff approved to make inquiry and maintain records shall be limited. Staff must obtain a User ID through Computer Services and security clearance through the **Central Office, Psychology Office**.

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- e. The PRT must approve removal of an inmate from the **Active** MH/ID Roster. The rationale for the removal and the date shall be recorded in the psychiatric section of the Medical Record. An inmate removed from the Active Rosters shall automatically be placed on the Inactive MH/ID Roster and the change noted on the tracking system.
  
  - f. Information which is available in the tracking system and is automatically included on the MH/ID Roster includes:
    - (1) name, Department number, offense, and dates of minimum and maximum sentence;
    - (2) facility, custody level, block/cell location;
    - (3) history of problem areas including inpatient/outpatient hospitalization (Y/N), GBMI (Y/N), “S” score (*i.e. Roster status*), and program codes (“Z” and “O”); and
    - (4) Beta IQ score *or appropriate individual intelligence test* score.
  
  - g. Information which is not available in the system and must be entered by the mental health staff:
    - (1) International Classification of Diseases (ICD) code;
    - (2) **WHODAS** score; and
    - (3) suicide attempt history – means, dates, and severity of attempts.
4. Reception Officer<sup>2</sup>

The first point of contact with a new reception, whether it is in the Diagnostic and Classification Center (DCC) or in a permanent facility, is the receiving officer. Therefore, every receiving officer shall receive training in the recognition of the signs and symptoms of mental illness and intellectual disability. Each facility shall develop an appropriate system for the immediate referral of any new reception identified as potentially mentally ill, suicidal, **intellectually disabled**, etc., to the appropriate staff for close observation and further evaluation. An inmate who is currently receiving medication for mental health treatment shall be scheduled for the psychiatrist/Certified Registered Nurse Practitioner-Psychiatric Services (PCRNP) as soon as possible and be seen by the psychiatrist no later than 72 hours after arrival.

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<sup>2</sup> 4-4372

5. Diagnostic and Classification Center<sup>3</sup>

- a. Observations or concerns about any inmate reporting or displaying mental health issues shall be relayed to appropriate treatment staff for evaluation and follow-up using the **DC-97, Mental Health Referral Form (refer to Attachment 1-A in Section 1 of this procedures manual), in non-urgent cases**. Under supervision of the Licensed Psychology Manager (LPM), Psychology staff will interview the inmate as soon as possible after receipt of the referral, but no later than one week.<sup>4</sup> This interview will be documented using a **DC-560, Mental Health Contact Note**. The LPM will evaluate the need for immediate psychiatric evaluation and/or Psychiatric Observation Cell (POC) placement. If the LPM/designee determines psychiatric evaluation is warranted but not an emergency, a **DC-97** along with a copy of the **DC-560** shall be forwarded to the psychiatry provider the same day. The inmate shall be seen by the psychiatry provider within two weeks of this referral from psychology staff or sooner if *clinically indicated*. ***In urgent cases, a phone call shall be made to the psychology department (or the infirmary if after hours), or the inmate shall be escorted to the infirmary area.***
- b. DCC psychology staff shall be alert and search for indications of previous psychiatric/psychological treatment, current or prior suicidality, use of psychotropic medications, hospitalizations or outpatient treatment and/or evaluations, Intellectual Disability placements, or history of drug or alcohol abuse. Every effort shall be made to obtain prior records of hospitalizations, treatment programs, or specialized placements.
- c. Prior to transfer, when suicidality, assault potential, or other special treatment needs are identified during the classification process, appropriate notification via case conference shall be made by DCC psychology staff either by email or phone call to the receiving LPM/designee. A corresponding **Inmate Cumulative Adjustment Record (ICAR)** entry shall be made by DCC staff documenting the case conference as previous treatment recommendations, **ICAR** entries, and psychological reports are not sufficient means of communicating about unstable, potentially suicidal, or violent mental health transfers.

6. Permanent Facilities<sup>5</sup>

a. Receptions<sup>6</sup>

Every permanent facility shall have procedures for reviewing the records and holding a personal interview with every new reception. In this review of records and interview, staff shall explore with the inmate the possible need for mental health services. When such needs are identified, every appropriate staff shall be alerted to these needs and

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<sup>3</sup> 4-4366, 4-4368

<sup>4</sup> 4-4372

<sup>5</sup> 4-4372

<sup>6</sup> 4-4368

appropriate referrals made for follow-up by treatment staff. Under supervision of the LPM, the initial record review and interview by psychology staff shall take place as soon after reception as possible, but no later than one week. Every C and D **Roster** inmate shall be scheduled for PRT review within two weeks of arrival and a new **IRP** must be completed by the receiving facility PRT staff and placed in the medical file within four weeks of the inmate's arrival.

b. General Population

Since any inmate may report or demonstrate mental health issues whether or not they are currently receiving mental health treatment, all contact staff must be trained and able to recognize signs of potential mental illness, suicidality, or elevated risk of violence. Observations or concerns about any inmate with such issues shall be relayed to the appropriate treatment staff for evaluation and follow-up using the **DC-97**. In urgent cases, a phone call shall be made to the psychology department (or the infirmary if after hours) or the inmate shall be escorted to the infirmary area. Under supervision of the LPM, Psychology staff will interview the inmate as soon as possible after receipt of the referral, but no later than one week.<sup>7</sup> This interview will be documented on a **DC-560**. The LPM will evaluate the need for immediate psychiatric evaluation and/or POC placement. If the LPM/designee determines psychiatric evaluation is warranted but not an emergency, a **DC-97** along with a copy of the **DC-560** shall be forwarded to psychiatry the same day. The inmate shall be seen by the psychiatry provider within two weeks of receipt of this referral from psychology staff or sooner if **clinically indicated**.

**E. Processing**

Each facility shall provide mental health services needed by an inmate in its population.

1. Mental Health Services

a. Psychiatric Services – Each facility in the Department shall have psychiatric services available through contracted services.

- (1) The treating psychiatrist/PCRNP shall see the inmate on the **C or D Roster** a minimum of once every 90 days. The psychiatrist/PCRNP is encouraged to see the inmate more frequently than 90 days **if clinically indicated**. However, frequency of contacts is driven by clinician discretion, clinical presentation, and acuity of illness. Frequency of psychiatry and psychology contacts shall be noted in the inmate's **IRP**.
- (2) If an inmate diagnosed with a Serious Mental Illness is placed in a **Diversionsary Treatment Unit (DTU)**, the treating psychiatrist/PCRNP must see the inmate **out of cell** once every 30 days.

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<sup>7</sup> 4-4372



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- b. Psychological Services - Each facility shall provide sufficient psychological staff to provide evaluation, monitoring, and treatment to those inmates in need of such services.

**NOTE:** The treating psychologist (LPM/Psychological Services Specialist [PSS]/Psychological Services Associate [PSA]/Mental Health Coordinator [MHC]) shall see inmates on the **Active MH/ID Roster** a minimum of once every 30 days. The psychologist has the discretion to see the inmate more frequently, if clinically indicated. These contacts can be completed in group settings. **All mental health contacts will be recorded on a DC-560 and a corresponding ICAR entry. If these contacts occur in a group setting, each inmate is required to speak and be spoken to by the mental health staff.**

- c. Counselors - Each facility shall have available Corrections Counselors trained to work with an inmate who is in need of mental health services. Counselors working with an inmate in need of **residential** mental health services (*i.e. RTUs, Secure Residential Treatment Units [SRTUs], Behavior Management Units [BMUs], DTUs, etc.*) shall meet with him/her at least monthly. The frequency of such contacts shall be determined by the severity of the need and the personnel available.
- d. MHC - Every facility shall have a MHC on the psychology staff and shall make appropriate use of the coordinator to assist an inmate in receiving each of the mental health services he/she is scheduled to receive.

2. Internal Mental Health Facilities<sup>8</sup>

- a. Short term **inpatient** Regional Mental Health Units (MHU) are available at State Correctional Institution (SCI) Graterford, **Pittsburgh**, Rockview, and Muncy to provide mental health care for an inmate who needs the service.
- b. The Forensic Treatment Center (FTC) at Waymart is available to provide long-term inpatient care for those individuals who need the service. Procedures for referring inmates to the FTC and MHUs are presented in **Section 4** of this procedures manual.
- c. SRTUs are available at SCI Muncy, Retreat, Rockview, Smithfield, **Graterford**, and Pittsburgh. Procedures for referring an inmate to the SRTU are contained in **Section 10** of this procedures manual.
- d. **BMUs are located at SCI Muncy and SCI Frackville. Procedures for referring an inmate to the BMU are contained in Section 12 of this procedures manual.**

3. Information Flow

- a. Each facility shall provide for the flow of information and observations of behavior from all levels of staff (particularly from Corrections Officers and trades instructors) to

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<sup>8</sup> 4-4368

appropriate treatment personnel concerning an inmate in need of mental health services. The treatment staff member receiving it shall acknowledge receipt of this information and, when possible, feedback shall be provided to the originator of the information. The **DC-97** shall be used to refer mental health related matters to the counselor, psychologist, and psychiatrist and to provide information feedback to the referral sources.

- b. Treatment staff shall share with Corrections Officers, trades instructors, and other staff the goals and direction of **recovery** plans developed for inmates in need of mental health services.

#### 4. **Recovery** Plans

- a. The PRT shall develop **IRPs** for inmates on the **Active** MH/ID Roster, and the inmates shall **be given the opportunity to provide input**, review, and sign the plan. **IRPs** for inmates on the **D** Roster shall be updated a minimum of every 120 days and **IRPs** for inmates on the **C** Roster shall be updated at least annually. The treating psychiatrist/PCRNP shall **participate and** approve the development, modification, and discontinuance of each treatment plan.<sup>9</sup>
- b. **Recovery** plans shall include the goals the team **and inmate** intends to achieve, **including** symptom stabilization and elimination, and recommendations regarding how staff shall interact in dealing with the inmate. The inmate shall be involved in the development of his/her **recovery** plan, shall **be given the opportunity to** sign-off on the completed plan, and shall receive a copy of the **IRP**. These procedures are more fully described under **Subsection G. below**.<sup>10</sup>
- c. A **DC-551, Continuity of Care and Transfer Individual Treatment Plan (Attachment 2-D)** shall be generated. Items indicated by an asterisk must be completed for an inmate who is being petitioned for transfer to another facility.

## F. Mental Health Commitments

### 1. General

- a. An inmate who becomes mentally ill and in need of mental health treatment beyond interim, community type care is to be considered for commitment to an approved mental health facility.<sup>11</sup> Every such commitment shall be governed by the Mental Health Procedures Acts 143 of 1976 and 324 of 1978, and it is expected that all staff dealing with mental health commitments shall be thoroughly familiar with these acts. When it is determined that an inmate is in need of a mental health commitment, the facility shall move as expeditiously as possible to obtain such a commitment.<sup>12</sup>

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<sup>9</sup> 4-4372

<sup>10</sup> 4-4372

<sup>11</sup> 4-4372

<sup>12</sup> 4-4374

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- b. In general, §201 voluntary admissions and §302 and §303 involuntary emergency commitments governed by the Mental Health Procedures Act, Acts 143 of 1976 and 324 of 1978, shall be treated in the MHUs. Longer-term §304 involuntary commitments shall be placed in the FTC at Waymart or a Department of Human Services (DHS) Forensic Unit. A female inmate requiring a longer-term §304 involuntary commitment shall be placed in a DHS Forensic Unit.<sup>13</sup> Appropriate forms for each type of commitment are:
- (1) **Application for Involuntary Emergency Examination and Treatment, MH 783 (Attachment 2-E);**
  - (2) explanation of **Patient’s Bill of Rights, MH 783-A (Attachment 2-F);**
  - (3) **Application for Extended Involuntary Treatment, MH 784 (Attachment 2-G);**
  - (4) **Voluntary Application for Mental Health Treatment (Section 201) (Attachment 2-H);**
  - (5) **Explanation of Voluntary Admission Rights, MH 781-Z (Attachment 2-I);**  
and
  - (6) **Initial Evaluation, MH 781-A (Attachment 2-J).**
- c. Facilities are encouraged to use the certified MHUs for emergency and acute care commitments that are acceptable within the criteria of the specific unit. Commitments to the MHU are governed by the Mental Health Procedures Act and completion of appropriate petitions is required. Consent for Voluntary Inpatient Treatment, 201 petition, is acceptable and preferred for admission to a Department in-house MHU.
- d. Only psychiatrists or other facility physicians can be **the** examining physicians for the purposes of a mental health commitment documentation. A PCRNP cannot take the role of **an** examining physician.

2. Non-Emergency Commitment to a Mental Health Facility

- a. When an inmate is observed behaving in a way that is dangerous to himself/herself or to others, is suicidal or self-mutilating, or so disturbed that he/she is unable to care for himself/herself without assistance, a psychiatric evaluation for possible 304 Mental Health Commitment shall be requested.<sup>14</sup>
- b. Upon referral for evaluation for possible commitment, the inmate shall be seen by the psychiatrist as soon as possible, but no later than the next working day.<sup>15</sup>

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<sup>13</sup> 4-4374

<sup>14</sup> 4-4374

<sup>15</sup> 4-4374

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- c. The psychiatrist shall evaluate the inmate in accordance with the criteria for commitment contained in the Mental Health Procedures Act.<sup>16</sup>
- d. If upon evaluation by the psychiatrist, the inmate is found committable, the designated facility staff member shall prepare the petitions (**Application for Involuntary Emergency Examination and Treatment, MH 783**), obtain the necessary signatures, see that the inmate is advised of the forthcoming hearing, and read the inmate's rights to him/her (**Patient's Bill of Rights, MH 783-A**).
- e. The designated staff member shall submit copies of the petition to the committing court and notify the county MH/ID Administrator of the committing county and the county MH/ID Administrator of the inmate's home county, if the home county is known and is different than the committing county. Local county mental health services shall be contacted, when appropriate, for their involvement since they may require a delegate to be involved in the involuntary commitment process.
- f. When approval has been obtained from the committing county, the local mental health reviewing officer or local court shall be contacted and a hearing date established. If the committing county wishes to conduct the hearing, appropriate arrangements shall be made.
- g. When possible, mental health commitment hearings will be conducted in the facility.
- h. If the hearing is to be held outside the facility, appropriate arrangements for custody and transportation shall be made as far in advance as practical. A day or two before the hearing, a follow-up check shall be made to be certain all transportation and security plans are ready. Necessary staff shall also be advised of the date, time, and place of the hearing so he/she may be available to testify if needed.
- i. When a commitment hearing has been completed, the designated staff member shall make appropriate arrangements for transportation of the inmate to the mental health facility. The procedures for a male inmate are fully described in **Section 4** of this procedures manual. Such transfer shall occur as expeditiously as possible.
- j. Following transfer of an inmate to a mental health facility for treatment, either the MHC or another designated staff member shall routinely contact the mental health facility every 90 days to determine the status of the inmate. Such contacts shall be logged on the **ICAR** and forwarded to the counselor for filing or recorded on the **DC-472, Progress Notes** and copies forwarded for filing in the Psychiatric Section of the medical record.

**3. Emergency Commitments to a Mental Health Facility**

- a. In accordance with Acts 143 of 1976 and 324 of 1978, §302 emergency commitment is available, but shall only be used in genuine emergency situations. When properly

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<sup>16</sup> 4-4374

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handled, emergency commitments can be effected in less than eight hours and rarely take more than 12 hours. Psychology staff at each facility shall make certain that §302 emergency commitment forms are available and staff shall familiarize themselves with the process.<sup>17</sup>

- b. In most cases, the MHC shall initiate the §302 emergency commitments and serve as the petitioner. The consulting psychiatrist shall serve as the examining physician. However, in some facilities, a staff member who has been appointed as a delegate by the local county mental health administrator may initiate the §302 petition. In a few facilities, either the ranking officer on duty or the staff member who observed the behavior may sign the §302 petition or emergency commitment.<sup>18</sup>
- c. Any staff member who has observed the behavior on which the petition is based shall be prepared to testify to and document his/her observations in accordance with the Mental Health Act and the requirements of the county administrator conducting the extension §303 hearing.<sup>19</sup>
- d. If a DHS mental health facility accepts the female inmate on an emergency commitment, the MHC or other designated staff member shall maintain contact with the mental health facility to determine if the mental health facility will proceed with a §303 commitment at the end of the five day emergency commitment or whether the mental health facility plans to discharge the inmate at the end of the five days.<sup>20</sup>
- e. In a Department MHU, the MHU staff are responsible to notify the sending facility of changes in the inmate's treatment status. If the inmate is to be discharged, appropriate arrangements shall be made for the inmate's return to the facility from which he/she was committed.

4. Information Provided to the Treating Mental Health Facility

The complete medical record shall accompany the inmate as well as the documents listed in **Application for Involuntary Emergency Examination and Treatment, MH 783** and **Patient's Bill of Rights, MH 783-A**.

5. Voluntary Commitment to a Department MHU

- a. An inmate who believes he/she is experiencing symptoms of a mental illness, is a danger to himself/herself or others, or is suicidal or self-mutilating may request a psychiatric evaluation and voluntary commitment to the MHU.<sup>21</sup>

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<sup>17</sup> 4-4351

<sup>18</sup> 4-4351

<sup>19</sup> 4-4351

<sup>20</sup> 4-4351

<sup>21</sup> 4-4351

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- b. If upon evaluation by the psychiatrist, the inmate is found in need of treatment, the designated facility or MHU staff member shall prepare the petition, obtain the necessary signatures, see that the inmate is advised of his/her rights and forthcoming hearing, if applicable (**Patient's Bill of Rights, MH 783-A**). A psychiatrist or physician shall complete a **Voluntary Application for Mental Health Treatment** petition.
- c. The designated staff member shall submit the original copy of the petition and history of the inmate, including treatment program, and any special needs to the MHU staff.
- d. An inmate who is a §201 voluntary admission, who wishes to sign out prior to discharge, but presents a threat to self/others or is debilitated, shall be processed as an emergency commitment, 302 petition, by MHU staff.<sup>22</sup> If deemed necessary, the MHU staff shall process extension of emergency commitment, 303 petition, and involuntary treatment, 304 petition.
- e. Upon discharge of the inmate from the MHU or FTC, the treatment unit staff shall provide the referring facility staff with a discharge summary including treatment recommendations. The discharge conferencing and treatment recommendations procedures are discussed more thoroughly in **Subsection G. 4. below**.

**G. Continuity of Care Procedures for Inmates with Mental Illness Being Transferred**

Continuity of care between State Correctional Facilities, DHS State Hospital Regional Forensic Centers, and the Department's MHUs shall be as follows:

1. General

- a. The Department provides a continuum of mental health services for every inmate in the system; this continuum ranges from outpatient services offered to an inmate in the general population, to temporary crisis beds, short term psychiatric treatment in a Department MHU, or long term hospitalization at the FTC at Waymart, or at a DHS Regional Forensic Center. It is the policy of the Department to provide continuity of care for an inmate with mental illness who is transferred from:
  - (1) one facility to another;
  - (2) between the facilities and the FTC;
  - (3) between the facilities and the Department MHUs; and
  - (4) from the facilities into mental health services in the community (continuity of care procedures for inmates being discharged into the community are described in **Subsection H. below**).

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- b. The mechanisms which have been developed to ensure this continuity of care include the MH/ID Automated Tracking System, enhanced teleconferencing between mental health staffs who work with these inmates, and the sharing of treatment plans between service providers in the interfacing facilities, hospitals, and agencies.
2. Tracking of an Inmate with Mental Illness Moving from One Facility to Another
    - a. The automated tracking system shall ensure that an inmate with mental illness who was being tracked in the sending facility shall appear on the MH/ID roster of the receiving facility immediately after his/her arrival. Mental health and medical staff in every facility shall review the automated MH/ID roster daily to see if any new cases have been entered into the facility's population.
    - b. When a facility requests to transfer an inmate with mental illness to another facility, the mental health staff of the sending facility shall generate an **IRP** to guide the inmate's treatment in the receiving facility. These procedures shall be in accordance with Department policy **11.2.1, "Reception and Classification."**
    - c. The LPM/designee at the sending facility shall initiate a teleconference or email correspondence with the mental health staff at the receiving facility to discuss the inmate and his/her special needs.
    - d. Any additional critical clinical information shall be forwarded to the receiving facility as soon as possible via facility courier in an envelope marked confidential and placed in the medical file.
  3. Tracking of Inmates Returning from the FTC, Department Regional MHUs, and DHS Regional Forensic Centers returning to other Department facilities
    - a. Shortly before the inmate is to be discharged from the FTC, Department Regional MHU, or DHS Regional Forensic Center, the treatment team at the unit and the PRT at the sending facility shall conduct a videoconference or a teleconference to discuss the patient's progress and develop an **IRP** to guide his/her reintegration into the facility population.
      - (1) At a minimum, the multi-disciplinary treatment team at the facility shall consist of the following members:
        - (a) LPM/MHC;
        - (b) Psychiatrist/PCRNP;
        - (c) Corrections Health Care Administrator (CHCA) and/or psychiatric nurse;
        - (d) Corrections Counselor, Drug and Alcohol Treatment Specialist (DATS), and/or Unit Manager; and

- (e) Lieutenant from the area.
  - (2) During the videoconference or teleconference, the FTC, DHS Regional Forensic Center, or MHU team shall summarize the inmate's response to treatment at the forensic facility and offer any insights he/she might have concerning the inmate's treatment needs and potential readjustment problems upon return to the facility.
  - (3) The MHU and FTC treatment teams shall document their discharge treatment recommendations on the **DC-551**, and the facility team shall document the teleconference on the **DC-97** to ensure that the inmate is evaluated by mental health staff immediately upon return to the facility. The treatment facility shall fax the completed **DC-551** to the LPM/MHC at the receiving facility immediately following the videoconference or teleconference so that the updated treatment plan can be attached to the **DC-97**.
  - (4) It is likely that the DHS Regional Forensic Centers may use different forms to document videoconference or teleconference treatment recommendations. DHS, FTC, and MHU teams may attach additional information on the **DC-551**.
  - (5) The treatment teams in the FTC, DHS Regional Forensic Center, and MHU shall make recommendations for the inmate's facility placement. This is a key component of the videoconference or teleconference.
- b. Upon return to the facility, the inmate shall be placed in an infirmary observation cell or other appropriate setting until he/she can be evaluated by the facility psychiatrist/PCRNP or licensed psychologist who shall make placement recommendations within the facility, based on the evaluation results and the recommendations in the **DC-551**. An inmate returning from the FTC, MHU, or DHS unit who is on Administrative Custody (AC) or Disciplinary Custody (DC) status shall not be placed in the Restricted Housing Unit (RHU) until his/her case has been reviewed by the PRT. The Program Review Committee (PRC) shall be notified immediately of the inmate's return so that the committee can review the inmate's AC/DC status. Insofar as possible, an inmate with a **serious** mental illness shall be diverted from RHU placement **to DTU, if appropriate**.
  - c. The FTC, DHS Regional Forensic Center, MHU, and facility treatment teams shall schedule the inmate's return to the facility to ensure that he/she will receive a mental health evaluation immediately following his/her return. The PRC shall be informed immediately of the return of any Capital Case inmate from the FTC, DHS Regional Forensic Center, SRTU, or MHU.
  - d. The PRT shall review the inmate's case monthly for four months to monitor the success of the **IRP** to reintegrate the inmate into prison life.
  - e. Several weeks after the inmate's return to the facility from the FTC, DHS Regional Forensic Center, or MHU treatment staff from those units may request information



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concerning the inmate's readjustment in the facility. This data shall be useful for FTC/DHS/MHU program development.

- f. The FTC, DHS Regional Forensic Center, or MHU shall send a discharge summary to the facility within 30 days following the inmate's discharge.
4. Tracking of Inmates Following Placement in an MHU Housed on the Grounds of the Same Facility
    - a. If the MHU is housed on the grounds of the same facility, the general procedures described in **Subsection G.3. above** shall apply.
    - b. In these cases, it is likely the PRC will be more involved in the placement of the inmate in the facility.
    - c. The PRT should work closely with the MHU staff and PRC to ensure appropriate placement in the facility.

#### **H. Continuity of Care Procedures for an Inmate with Mental Illness Being Discharged**

These procedures provide direction to staff in developing continuity of care services for an inmate with mental illness following his/her release from incarceration into the community following Sentence Complete or parole.

1. Sentence Completes Inmates on the MH/ID Roster
  - a. The Psychology Department shall maintain automated procedures for **Active MH/ID Roster inmates**. Lists of the names and Department numbers of each roster inmate shall be updated monthly and sent to the unit staff so that the RHU Lieutenant, Unit Manager, Corrections Counselor, and/or DATS can be aware of inmates with mental illness who are housed on his/her unit.
  - b. The LPM shall schedule special PRT reviews for an inmate on the MH/ID roster 12 months prior and again six months prior to the Sentence Complete to update the inmate's **IRP** on the **DC-551**. The updated **IRP** shall address continuity of care service needs and actions required to transition the inmate into the community.
    - (1) Participants in the meeting shall include, but are not limited to, the LPM, MHC, psychiatrist/PCRNP, CHCA, DATS, and Corrections Counselor or Unit Manager. It is desirable that the inmate attend the meeting.
    - (2) The **IRP** shall address the inmate's anticipated community needs including mental health, medical treatment, substance abuse and/or sex offender specific treatment, Medical Assistance (MA), Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and housing. If additional assessments are necessary, this shall be addressed in the **IRP**.

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- (3) If the inmate did not attend the PRT meeting, this will be documented on the **DC-551**, and the staff shall meet with the offender to discuss the planning process. Staff shall determine where the inmate plans/wishes to reside, ascertain his/her view of treatment and benefit needs, and secure the offender's participation in the planning process.
  - (4) Staff shall request that the inmate sign the **DC-108, Authorization for Release of Information**, in accordance with Department policy **DC-ADM-003, "Release of Information,"** so that the Department staff can share treatment information including the inmate's Social Security number, physical/medical health diagnoses, and psychiatric diagnosis, with outside agencies. Staff shall advise the inmate that the **DC-108** will expire in 30 days for physical/mental health information and 90 days for non-physical/non-mental health information, and it may be necessary to sign several releases of information.
- c. The **Central Office Psychology Office** shall monitor the MH/ID Roster to identify each roster inmate who is within 12 months of Sentence Complete. The **Central Office Psychology Office** shall forward this information quarterly to the DHS Office of Mental Health and Substance Abuse Services (OMHSAS) Forensic Liaison so that the OMHSAS can be aware of each inmate with mental illness who will be returning to the community in the upcoming year, dates he/she is leaving, the facility from which he/she is being discharged, and the county to which he/she will be returning. The OMHSAS will forward this information to the appropriate county **MH/ID** administrators.
- d. The LPM/MHC shall contact the MH/ID Administrator in the inmate's county of origin to advise the county staff of the inmate's impending Sentence Complete and obtain assistance locating community resources. A list of MH/ID administrators can be obtained from the OMHSAS Forensic Liaison or **Central Office Psychology Office**.
- (1) The LPM/MHC shall document all contact with the MH/ID Administrator in the medical record on the **DC-472**, and shall follow-up this contact with a collaborating letter to the MH/ID administrator, copied to the correspondence section of the medical record and the OMHSAS Forensic Liaison.
  - (2) If the inmate has signed the **DC-108**, the LPM/MHC shall provide the county MH/ID agency with the inmate's Social Security number, current ICD diagnosis, **WHODAS** score, treatment being provided, and other pertinent data. The information shall be included on/attached to the **DC-551**.
  - (3) If the inmate refused to sign the **DC-108**, the LPM/MHC shall provide the **MH/ID** agency with information regarding the inmate's date of release and number of MHU/FTC commitments while incarcerated. If the inmate refused to sign the **DC-108**, the LPM/MHC will not provide to the OMHSAS the inmate's current ICD diagnosis, **WHODAS** score, **level of** treatment being provided, and other pertinent data. This confidential information shall not be included on/attached to

the **DC-551** until the inmate has signed a **DC-484, Mental Health Informed Consent Document (Attachment 2-K)**.

- (4) The LPM/MHC shall invite the County MH/**ID** staff to visit the correctional facility and/or participate in the PRT meetings. The county MH/**ID** staff and/or OMHSAS may request to attend the PRT meetings.
  - (5) The Department has made special continuity of care arrangements with Philadelphia County and the four surrounding counties (Bucks, Chester, Delaware, and Montgomery), and Allegheny County, which identify specific MH/**ID** staff members to contact to arrange continuity of care services for an inmate returning to those jurisdictions. The LPM/MHC is encouraged to contact the **Central Office Psychology Office** with any questions regarding these arrangements.
  - (6) If the County MH/**ID** Administrator is non-responsive to the contact described above, the LPM shall contact the Regional Office of the OMHSAS or the OMHSAS Forensic Liaison and the Chief Psychologist in the Bureau of Health Care Services (BHCS).
  - (7) Staff should also consider contacting the inmate's family for assistance with aftercare planning, if the inmate has agreed and signed the **DC-108**.
- e. If the inmate is psychiatrically stable, the LPM/MHC shall arrange a community intake/evaluation appointment for the inmate. This includes the date and time of the appointment, location of the interview, and contact person. This information shall be provided to the inmate both verbally and in writing. The information shall also be documented in the medical record on the **DC-472** via a Subjective, Objective, Assessment, Plan (SOAP) note and in the correspondence section, and it will be shared with the county MH/**ID** contacts or the OMHSAS Liaison.
- f. If the Department treatment team believes that the inmate meets involuntary mental health civil commitment criteria outlined in the Mental Health Procedures Act, the MHC/psychologist shall advise the inmate's home county MH/**ID** Administrator/designee and/or OMHSAS Forensic Liaison/designee that the Department plans to file a 304 petition with the local court requesting involuntary inpatient mental health treatment. Prior to the commitment hearing, the MHC/psychologist shall provide documentation of the inmate's treatment history and current treatment needs to the County MH/**ID** Administrator of the county to which the inmate shall be released, and shall request that the county MH/**ID** Administrator designate a community hospital to which the inmate can be committed for the needed inpatient services.
- g. If the Department treatment team believes that the inmate meets involuntary mental health civil commitment criteria and the county MH/**ID** Administrator recommends direct admission to a state hospital, or is unavailable to make the designation of a community placement, the MHC/psychologist will provide documentation of the

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inmate's treatment history and current treatment needs to the OMHSAS Forensic Liaison/designee for review and determination of the most appropriate hospital to which the inmate can be committed for the needed inpatient services. Once reviewed and accepted for admission to a state psychiatric hospital, planned civil admissions can occur on any day of the week. There will be no admission of an inmate completing sentence to a state hospital Regional Forensic Center.

- h. If the inmate meets involuntary mental health commitment criteria and there is sufficient time prior to Sentence Complete, the LPM/MHC shall initiate an involuntary commitment to the FTC/MHU that can be "rolled over" into the civil commitment on the date of Sentence Complete. If this procedure is employed, staff shall request that the court order allows placement in both a Department MHU and a community hospital.
- i. If the inmate's condition is such that he/she is in need of immediate treatment, but is not committable under the Mental Health Act, the LPM/MHC shall contact the MH/**ID** agency to discuss treatment options including intervention by the county crisis services upon release.
- j. If the inmate refuses to accept processing for community aftercare or is non-responsive to recommendations for community aftercare processing, and the staff believes that the inmate's state of mental health is such that he/she poses a clear and present danger to himself/herself or others in the future following release from supervision (but the inmate does not meet inpatient commitment criteria), then the BHCS shall be contacted, and in consultation with the Chief Psychologist and the Office of Chief Counsel, the following options shall be considered:
  - (1) the mobile crisis or Intensive Case Management (ICM) units of the County MH/ID Program can be alerted and may be able to make community contact even though unsolicited by the inmate;
  - (2) notify local law enforcement authorities of the pending release and the inmate's condition (seriously mentally ill and non-cooperative);
  - (3) the psychologist is not able to contact the individual, the local law enforcement authority shall be notified; and
  - (4) the identity of those individuals who were contacted and the substance of the communication shall be documented in the medical record, with copies to the **ICAR, DC-15, Inmate Records Jacket**, and the Facility Manager.
- k. The Medical Department shall provide the inmate with a **60**-day supply of prescribed medication, in accordance with Department policy **13.2.1, "Access to Health Care"** to prevent disruption of treatment until the inmate can be seen by a psychiatrist/PCRNP. A supply of fewer days may be provided if an overdose potential exists and/or an appointment with a psychiatrist/PCRNP can be secured sooner.

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Information concerning medication shall be conveyed to the community treatment provider.

- i. In cases where an inmate is not able to travel on his/her own due to mental health status and has no other option, the facility shall provide transportation prior to the Sentence Complete. If an inmate, who will require transportation, is approaching Sentence Complete, but the facility cannot provide this service due to distance, then the unit management team may initiate a transfer petition. In this manner, the inmate may be moved to a facility closer to his/her home. In these cases the LPM/MHC in the referring facility shall be responsible for continuity of care planning, and these activities should be documented on the **DC-551**.
- m. In situations in which the inmate is seriously mentally ill and will need benefits immediately upon Sentence Complete, the staff may complete the Commonwealth of Pennsylvania Application for Social Services (COMPASS) on-line applications to help the inmate access Medicaid and other health care services that he/she shall need in the community. COMPASS interfaces with the Pennsylvania **DHS**, Insurance Department, medical providers, community-based organizations, advocates, and others.
  - (1) COMPASS requires internet access, and staff shall use the computer in the CHCA's office to complete on-line application.
  - (2) COMPASS can be reached directly at <http://www.compass.state.pa.us>.
  - (3) Staff shall submit monthly lists of the number of on-line COMPASS applications completed to the CHCA.
- n. Continuity planning activities need to be documented via the **DC-551**, entries in the **DC-472**, and the correspondence section of the medical record, with information copied to the Corrections Counselor for placement in the **ICAR**.

2. Procedures for a Hard to Place Inmate on the MH/ID Roster Being Paroled/Re-Paroled

Whenever possible, an inmate with a mental illness should be returned to the community via parole, rather than Sentence Complete, so that he/she can be mandated to receive the community treatment and management services.

- a. Procedures for a Hard to Place inmate will be in accordance with Department policy **7.3.1, "Inmate Reentry and Transition."** In addition:
  - (1) the facility LPM shall attend the parole staffing at the facility for all cases identified as "Hard to Place," and which are also placed on the MH/ID Roster; and
  - (2) the LPM shall coordinate the activities of the "Hard to Place" meetings and PRT meetings for an inmate receiving mental health treatment.

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- b. The LPM/MHC shall monitor the MH/ID roster to identify any inmate approaching one year to his/her parole date and schedule a PRT meeting to update the inmate's **IRP** on the **DC-551** to ensure that the **IRP** includes objectives that are related to community reentry. The PRT shall supplement the "Hard to Place" procedures outlined above.
- (1) The **IRP** shall be recorded on the **DC-551** and shall address mental health and medical treatment needs, co-occurring disorder treatment needs, housing needs and family integration, educational/vocational needs, and community management and support issues. The PRT shall develop relevant, specific plans to complete entitlement applications such as MA, Veterans Administration (VA) benefits, SSI, SSDI, and Income Maintenance.
  - (2) Participants at the PRT meeting shall include the LPM, consulting psychiatrist/PCRNP, CHCA, MHC, DATS, Corrections Counselor, Unit Manager, and facility parole representative. The county MH/ID liaison should be invited to the meeting.
    - (a) Department policy **7.2.1** mandates that the Facility Parole Representative shall attend the PRT meeting for any MH/ID inmate who is likely to receive facility support for parole so that the PBPP can participate in aftercare planning.
    - (b) School staff may attend the meeting if vocational/educational issues are being considered.
  - (3) The PRT shall review every inmate on the MH/ID roster to determine if he/she meets the referral criteria for placement in one of the Department's Community Corrections Centers (CCCs) for parolees who suffer from mental illness and/or co-occurring substance abuse disorders.
  - (4) The LPM, MHC, Corrections Counselor, and/or DATS shall meet with the inmate to determine where he/she plans/wishes to live, ascertain his/her view of his/her treatment and benefit needs, and review reentry plans. These discussions may occur during the PRT review meeting, facility release, or parole staffing.
  - (5) The psychiatrist/PCRNP shall conduct a psychiatric parole evaluation that **will be dictated and typed and shall** be ready at the time of the parole staffing, addressing medication and other aftercare mental health treatment needs.
    - (a) The psychiatric evaluation shall be scheduled as close as possible to the release date so that the report and medication prescribed will be current when the inmate enters the community.
    - (b) The report shall include an updated ICD diagnosis and **WHODAS** score.

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- (6) The psychologist shall conduct a psychological evaluation for parole, employing the PA Clinical Risk Assessment (P-CRA), to identify community risk management and treatment needs and make community treatment recommendations. The psychological report shall be submitted at least six months prior to the inmate's minimum date.
  - (7) The LPM and/or MHC shall be available to the PBPP to respond to any questions regarding the inmate's mental health assessment or response to treatment in the facility. The LPM shall visit the facility parole office regularly to discuss referrals.
3. Procedures for a Non-Hard to Place Inmate on the MH/ID Roster Being Paroled/Re-Paroled
- a. The Psychology Department, Unit Manager, and the Corrections Counselors and/or DATS shall monitor the MH/ID Roster to identify an inmate approaching his/ her parole date.
  - b. The LPM/MHC shall monitor the MH/ID roster to identify any inmate approaching one year to his/her parole date and schedule a PRT meeting to update the inmate's **IRP** on the **DC-551** to ensure that the **IRP** includes objectives that are related to community reentry.
    - (1) The **IRP** shall be recorded on the **DC-551** and shall address mental health and medical treatment needs, co-occurring disorder treatment needs, housing needs and family integration, educational/vocational needs, and community management and support issues. The PRT shall develop relevant, specific plans to complete entitlement applications such as MA, Veterans Administration (VA) benefits, SSI, SSDI, and Income Maintenance.
    - (2) Participants at the PRT meeting shall include the LPM, consulting psychiatrist/PCRNP, CHCA, MHC, DATS, Corrections Counselor, Unit Manager, and facility parole representative. The county MH/ID liaison should be invited to the meeting.
    - (3) School staff may attend the meeting if vocational/educational issues are being considered.
  - c. The PRT shall review every inmate on the **Active MH/ID** Roster to determine if he/she meets the referral criteria for placement in one of the Department's CCC's for parolees who **are diagnosed with** mental illness and/or substance abuse. Flow charts outlining the Mental Health CCC Referral Procedures are contained in the **Referral Procedure for Cromisa Project (Attachment 2-L)**.
  - d. The psychiatrist shall conduct a psychiatric parole evaluation addressing medication and other aftercare mental health treatment needs that shall be ready at the time of the parole staffing.

- (1) The psychiatric evaluation shall be scheduled as close as possible to the release date so that the report and medication prescribed shall be current when the inmate enters the community.
  - (2) The report shall include and update the ICD diagnosis and Global Assessment of Functioning (GAF) score.
- e. The psychologist shall conduct a psychological evaluation for parole employing the Pennsylvania Critical Risk Assessment (P-CRA) to identify community risk management and treatment needs and make community treatment recommendations. The psychological report shall be submitted at least six months prior to the inmate's minimum date.
- f. The Corrections Counselor or DATS and the MHC or LPM shall arrange for a meeting with the inmate to discuss and review aftercare treatment needs. Psychology staff shall be careful not to usurp the casework prerogatives of the counseling staff. These discussions may occur during the PRT review meeting or parole staffings. The counselor shall advise the facility parole agent of those aftercare needs at least six months prior to the inmate's parole eligibility date.
- g. The Corrections Counselor shall coordinate with the PBPP to provide whatever documentation or updated evaluations are necessary for aftercare placement.

#### **I. Confidentiality and Informed Consent**

1. The **DC-484** shall be completed with the inmate by the psychiatrist/PCRNP and/or psychologist, as well as the counselor conducting sex offender treatment, prior to:<sup>23</sup>
  - a. conducting therapeutic and forensic interviews; and/or
  - b. initiating a regimen of individual or group counseling.
2. Unless the staff can be reasonably certain that the inmate can read and understand **the informed consent document**, the document shall be read aloud to the inmate; the clinician shall provide him/her with the opportunity to ask questions, and the inmate shall be asked to sign the form. This form may be administered individually or in groups. The inmate will sign one **DC-484** for psychiatry services and one for psychology to indicate consent for every subsequent service within his/her present facility. If he/she is transferred to another facility, another set of documents shall be completed.
3. If the inmate signs the release, the original document shall be placed in the Psychiatric section of the medical records and a copy given to the inmate.

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4. If the inmate refuses to sign the release to participate in an assessment, the clinician shall write, "refused to sign" across the form and sign and date the entry. The clinician shall still attempt to conduct the evaluation. However, the inmate shall be advised that the required written report will have to be generated using information that is available from other sources (Department and court records); he/she shall be cautioned that assessments by recipients of the report (staffing committees and PBPP) might be affected by the lack of information resulting from the refusal. The inmate shall be advised that he/she may later agree to sign the release and the evaluation can be modified, only if the report has not been written.
5. If the inmate refuses to sign the release to participate in individual or group therapy, the clinician shall write "refused to sign" across the form and sign and date the entry; however, the inmate may still be allowed to be involved in the treatment.
6. It shall be stressed that this is an Informed Consent Document that describes conditions under which information may be disclosed. This is not consent to assessment and treatment form. Nothing in the document or these directions shall discourage staff members from providing health/mental health sustaining services to the inmates.
7. Since mental health assessment is routine for inmates placed in the DCC's, the **DC-484** will not be employed in the DCC.
8. The **DC-484** shall be updated annually.

**J. Guilty But Mentally Ill (GBMI) Inmates**

The purpose of these procedures is to aid staff in processing GBMI commitments. It is incumbent upon every reception and DCC staff, as well as all treatment staff in the permanent facility, to become familiar with the GBMI Act (Act 286-82).

1. Reception
  - a. The GBMI statute is **Act 286-82 (18 Pa.C.S.A. §§314 - 315 and 42 Pa.C.S.A. §9727)**. Since not every GBMI commitment may be clearly identified as such, the Records Specialist shall carefully review every court commitment order for any indication suggesting a GBMI commitment. If any mention of mental illness is noted in the commitment order, a check shall be made to determine if this commitment was intended to be a GBMI commitment.
  - b. GBMI commitments fall into two categories. Once a commitment has been identified as a GBMI commitment, the Records Specialist shall determine which of the following categories a particular commitment falls under.
    - (1) Category I consists of those GBMI commitments for whom:

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- (a) the court held a hearing at the time of sentencing and found the defendant to be seriously mentally disabled and in need of treatment pursuant to the provisions of the Mental Health Procedures Act at the time of sentencing;
  - (b) the defendant was represented by counsel at this hearing; and/or
  - (c) not more than 90 days has elapsed since the date of the court order finding the defendant to be seriously mentally disabled and in need of treatment.
- (2) Category II consists of those GBMI commitments for whom:
- (a) the court held a hearing at the time of sentencing and found that the defendant was NOT seriously mentally disabled and in need of treatment pursuant to the provisions of the Mental Health Procedures Act at the time of sentencing;
  - (b) more than 90 days have elapsed since the date of the court order finding the defendant to be seriously mentally disabled and in need of treatment; and/or
  - (c) the defendant was not represented by counsel at the court hearing to determine if he/she was presently seriously mentally disabled and in need of treatment.
- c. Upon determination of the above information, the Records Specialist shall immediately contact the Corrections Classification Program Manager (CCPM) and advise of the reception of a GBMI commitment and of the category under which the commitment is determined to fall.
- d. A GBMI commitment who is identified as a Category I commitment shall be housed in the infirmary or other appropriate mental health setting if space, facilities, and security considerations permit.
- e. While awaiting transfer to a mental health facility, the severely mentally disabled (Category I) inmate shall receive such care as available resources permit.
- f. A GBMI commitment who is identified as a Category II commitment will complete the normal reception procedures and will, after appropriate staff has been notified, be placed in regular DCC housing unless contraindications to such placement are noted during the reception process.
- g. A Category I GBMI inmate shall not be double celled in a DCC until reviewed by the treatment team and/or psychiatrist/PCRNP. ***This review shall be completed as soon as operations permit, but no later than 72 hours.*** If the team or psychiatrist/PCRNP find the inmate to be neither seriously mentally ill, a serious threat to others, nor disruptive, double celling may be considered if approved by the

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psychiatrist/PCRNP or team. A Category II GBMI inmate who exhibits no serious mental illness, is not a threat to others, and is not disruptive may be double celled if approved for double celling by the psychiatrist/PCRNP or reviewing team.

2. Staff Contacts and Procedures

- a. Upon notification from the Records Specialist that a GBMI inmate has been received, the DCC Director/designee or CCPM/designee shall:
  - (1) immediately review the case and its category designation; and/or
  - (2) immediately notify the appropriate counselor and the MHC of the reception of a GBMI commitment; and
  - (3) immediately ensure the inmate is scheduled for review by PRT within 72 hours or as soon as operations permit.
- b. The counselor assigned to the case shall see the GBMI inmate as soon after reception as possible, but no later than one week after reception.
- c. Counselor contacts shall be continued on at least a weekly basis, or more frequently if necessary, throughout the classification period.
- d. The classification profile shall be developed as soon as possible after reception, but no later than one week after reception.
- e. The MHC shall visit the GBMI inmate as soon after reception as possible, but no later than one working day after reception.
- f. The MHC shall contact other relevant staff to determine what mental health needs have been identified for the GBMI inmate and shall assist in coordinating these needs.
- g. Within one working day after reception, the DCC Psychologist or PSS shall see the GBMI inmate for an initial evaluation.

3. Psychiatric Evaluation

- a. A GBMI commitment who was found by the court to be severely mentally disabled and in need of treatment at the time of sentencing (a Category I commitment) does not require a psychiatric reevaluation prior to transfer to a mental health facility; however, he/she shall be seen and evaluated by the psychiatrist/PCRNP as soon after reception as possible, but by the next working day. Appropriate treatment shall be prescribed and implemented until the inmate is transferred to a mental health facility.

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- b. If the GBMI commitment is a Category II commitment, a psychiatric evaluation shall be arranged as soon after reception as possible and in no case longer than five days after admission for those facilities with psychiatric services routinely available. If psychiatric services are not available, a psychological evaluation may be substituted.
- c. If it is determined that a Category II commitment is in need of commitment to a mental health facility, Mental Health Procedures Act commitment procedures shall be followed and a current psychiatric evaluation shall be obtained.

4. Transfer to a Mental Health Facility

If a Category II commitment is subsequently found to be severely mentally disabled and in need of treatment, normal commitment procedures as required by the Mental Health Procedures Act shall be followed.

5. Return from a Mental Health Facility

- a. When the treating mental health facility determines that a GBMI inmate sent to them from the Department is ready to return to the correctional system, the mental health facility shall contact the receiving facility and work out a return date.
- b. The receiving facility shall arrange to pick up the returning GBMI inmate.

6. Mentally Disabled GBMI Commitments

If a GBMI commitment is found to be so mentally impaired as to suggest the likelihood of being intellectually disabled, a psychological and psychiatric evaluation of his/her intellectual and functioning level shall be made by the DCC staff.

7. Transfer to an Intellectual Disability Program

If a GBMI commitment is found to be so cognitively impaired as to be unable to function in a correctional setting, a petition for commitment to an Intellectual Disability facility shall be initiated. Submission of this petition shall be guided by the procedures found in the Mental Health Procedures Act.

8. Transfer to a Department Permanent Facility

- a. Upon completion of the classification process for a GBMI inmate, a transfer petition shall be submitted to Central Office in the same manner as every other DCC case, except the case shall be clearly identified as a GBMI case.
- b. Once the transfer petition has been approved, the Director of the DCC shall, via memo, inform the Facility Manager of the permanent facility that a GBMI inmate is being transferred to that facility.

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- c. The memo to the Facility Manager shall include appropriate identifying data, a statement of the essential DCC findings in the case, and any treatment recommendations for needed follow-up treatment. The memo shall include the anticipated date of transfer. The Facility Manager of the receiving facility shall distribute copies of the memo to appropriate staff.
- d. When any GBMI inmate is being transferred from a DCC to a permanent facility, it is the responsibility of the DCC LPM to contact the LPM in the receiving permanent facility and review with him/her the mental status of the GBMI inmate being transferred. The DCC LPM shall provide the permanent facility LPM with the name and number of the GBMI inmate, the essential psychiatric/psychological findings of the DCC staff, any treatment recommendations for needed follow-up treatment, and the anticipated date of transfer.

9. Programming GBMI Inmates at Permanent Facilities

a. Reception

- (1) Upon reception of a GBMI inmate, his/her case shall be reviewed by appropriate intake staff. This staff shall make the proper housing assignment and shall refer the inmate to the mental health review team or counselor, as the case warrants.
- (2) Based on a review of the case and the recommendations of the DCC staff, the intake staff of the permanent facility shall develop an appropriate program for the inmate. If follow-up psychiatric/psychological treatment is needed, arrangements shall be made, subject to available resources, to provide needed treatment.

b. Programming

- (1) For the first month after reception, the counselor assigned to the case shall see the inmate on a weekly basis. The facility Psychologist shall see the GBMI inmate at least once during the first month, more frequently if necessary.
- (2) After the first month, the counselor in conjunction with his/her supervisor and the facility Psychologist shall determine the continued frequency of counselor contacts. However, the counselor contacts shall be no less than once a month for the first year. If the inmate's behavior remains stable for that period of time (a year), the counselor and his/her supervisor will determine frequency of contact thereafter. The decision shall be documented on the **DC-14, Counselor File** and copied to the Medical Record.
- (3) A GBMI inmate shall receive a staff review every six months for the first year. Thereafter, the frequency of staff reviews shall be determined by the staff based on the inmate's stability, needs, and Department policy.

- (4) A GBMI inmate not receiving ongoing psychological or psychiatric treatment shall be evaluated by the facility Psychologist every six months for the first year. A report of the psychologist's findings shall be made available to the treatment staff prior to the staff's six month review. For a GBMI inmate receiving ongoing treatment, the psychologist or psychiatrist/PCRNP will submit the six month report.
- (5) After the first year, the facility Psychologist and Psychiatrist/PCRNP shall evaluate each GBMI inmate on an annual basis.
- (6) Any GBMI inmate, who decompensates to the point where inpatient care is required shall be considered for commitment to a mental health facility via the Mental Health Procedures Act, and usual commitment procedures shall be followed.

#### **K. Dealing with a Potentially Suicidal Inmate and an Inmate who Attempts Suicide**

Suicide and self-injurious acts are serious dangers in any correctional setting. Therefore, early identification, appropriate housing and monitoring, and proper treatment of a potentially self-destructive inmate is critically important, both for the individual in need of service and for the facility charged with his/her care.

##### **1. Assessment of Suicide Risk**

Suicide potential can be evaluated by using the criteria listed below. These criteria are intended to help staff formulate a plan of prevention and treatment.

##### **a. Suicidal Plan**

The potential for suicide is greater when there is a well-organized and detailed plan developed by the inmate. The potential also increases when the means of the suicide identified in the plan is readily available to the inmate and can be lethal.

##### **b. Prior Suicidal Behavior**

The potential for suicide is greater if the individual has experienced one or more prior attempts of a lethal nature or has a history of repeated threats and depression. In addition, individuals involved in many episodes of self-injurious behavior (SIB) are at increased risk to complete suicide.

##### **c. Stress**

The potential for suicide is greater if the individual is subject to stress from increased pressures such as, but not limited to:

- (1) difficulties in coping with legal problems;

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- (2) the loss of a loved one through death or divorce;
- (3) the loss of valued employment (high paying position in Correctional Industries [CI]);
- (4) anniversary of incarceration date or offense;
- (5) serious illnesses or diagnosis of terminal illness;
- (6) threats or perceived threats from peers;
- (7) sexual victimization, particularly after the first submission;
- (8) placement in RHU/Special Management Unit (SMU);
- (9) unexpected punishment (misconducts or additional sentence or parole denial);
- (10) cell restriction;
- (11) recent transfer from another state or county facility;
- (12) recently returned to prison due to a parole violation;
- (13) any movement to and from Level 5 Housing Unit (watch closely for several hours);
- (14) long sentence coupled with poor external supports (family or volunteers) and/or minimal involvement in facility supports (education, treatment, activities, and employment);
- (15) somatic complaints of a vague nature that do not respond to treatment;
- (16) history of violence toward others;
- (17) low IQ;
- (18) requesting protective custody;
- (19) deemed to be a “high profile” case;
- (20) long sentence, including life;
- (21) history of alcohol and/or drug abuse; and/or
- (22) ***transition periods within a correctional institution (i.e. release from a POC, placement into an RHU, removal from general population).***

d. Prior Suicidal Behavior of Significant Other

The potential for suicide is greater if a parent, spouse, or other close relative has attempted or committed suicide.

e. Symptoms

The potential for suicide is greater if the individual manifests such symptoms such as:

- (1) auditory and/or visual hallucinations, particularly command hallucinations ordering the person to harm himself/herself;
- (2) delusions;
- (3) any change from the individual's sleep pattern (this may be manifested by either a decrease or increase in sleep);
- (4) any change from the individual's ordinary eating pattern. (This may be manifested by either a decrease or an increase in the individual's appetite with an accompanied decrease or increase in weight);
- (5) social withdrawal;
- (6) apathy;
- (7) despondency;
- (8) severe feelings of hopelessness and helplessness;
- (9) general attitude of physical and emotional exhaustion;
- (10) agitation through such symptoms as tension, guilt, shame, poor impulse control or feelings of rage, anger, hostility, or revenge;
- (11) giving away personal property;
- (12) removal of every visitor from the visiting list;
- (13) changing next of kin notifications;
- (14) ***expressions of death or finality (i.e. "it will all be better tomorrow" or "the world is better off without me")***;
- (15) ***frequent engagements in self-injurious behaviors and/or serious suicide attempts***;



- (16) sudden elevated mood (“everything’s OK attitude”); and/or
- (17) psychic or somatic anxiety.

f. Personal Resources

The potential for suicide is greater if the person has no family or friends, or his/her family and friends are unwilling to help. Potential is greater if a significant other evidences a defensive, rejecting, punishing attitude, or denies that the individual needs help.

g. Acute vs. Chronic Aspects

The potential for suicide is greater when there is a sudden onset of specific symptoms. An individual who has recently learned that he/she has a serious disorder is at greater risk than a person who has been coping with the problem for years. The acute risk is higher if the person appears anxious.

h. Medical Status

The potential for suicide is greater when there is a chronic, debilitating illness, especially when it involves an alteration of body image or life style.

- i. A person considering suicide does not demonstrate all of these signals. Generally, the more characteristics the individual has, the greater the potential for self-destruction. Every suicide attempt, including gestures, shall be taken seriously.

2. Screening/Assessment

- a. Every contact employee will receive training in suicide prevention in accordance with Department policy **5.1.1, “Staff Development and Training.”** If a staff member observes suicidal behavior, the Unit Manager shall be notified, and a referral shall be made to the LPM/designee. In the absence of the Unit Manager, the staff person shall contact the Shift Commander. The Unit Manager or Shift Commander shall immediately contact the LPM/designee and brief him/her on the situation.
- b. The LPM/designee shall assess the inmate's suicidal potential in the most appropriate location depending on the inmate's level of agitation and security needs (inmate's cell, psychologist's office or observation area).
- c. A suicidal inmate shall never be left alone.<sup>24</sup>
- d. Based on the screening, a referral to the psychiatrist/PCRNP for further evaluation and treatment may be necessary. If the psychiatrist/PCRNP determines the inmate is a danger to self and/or others, he/she shall order a watch. The inmate shall be initially

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<sup>24</sup> 4-4257

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placed on constant visual watch. The watch may only be reduced or terminated by a physician or psychiatrist/PCRNP.<sup>25</sup>

- e. In the absence of the psychiatrist/PCRNP, and with the authorization of the senior ranking official in the facility, the LPM/designee, or the Nurse Supervisor can order that the inmate be moved to the POC to be placed on constant watch. Procedures for monitoring the watches in the POC are described in **Subsection K. 3. below**.
- f. Every inmate placed in Level 5 Housing Units shall be assessed on the **DC-510, Suicide Risk Indicators Checklist (refer to Attachment 1-F in Section 1 of this procedures manual)**. The checklist shall also be used for every returned parole violator. **Every inmate placed in a Level 5 housing unit shall also be provided with the “Living through it” brochure.**
  - (1) The ranking Corrections Officer present in the unit shall ensure that the checklist is completed immediately when an inmate is brought to the L5 Housing Unit/Intake Unit.
  - (2) The escorting officer shall note any special physical/behavioral characteristics (crying, poor hygiene, and cuts and/or bruises); he/she shall be asked:
    - (a) why the inmate is being brought to the Level 5 Housing Unit/Intake Unit;
    - (b) if the inmate is expressing suicidal thoughts/making threats to harm himself/herself;
    - (c) whether the inmate shows signs of depression (crying, withdrawn, passive);
    - (d) is the inmate acting/talking in a strange manner (hearing/seeing things that aren't there?);
    - (e) whether the inmate appears to be under the influence of drugs/alcohol;
    - (f) whether there is any information that the inmate may be self-destructive; and
    - (g) whether the inmate is requesting protective custody.
  - (3) The inmate shall be asked:
    - (a) whether he/she has experienced a recent family change (i.e. death of child/spouse/parent or “Dear John letter”);

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<sup>25</sup> 4-4257

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- (b) if there has been a recent legal status change (i.e. parole violation or new detainer);
  - (c) if this is his/her first placement in L5 Housing (if applicable);
  - (d) if he/she has any special problems or needs the staff shall be made aware;
  - (e) whether he/she has been assaulted (physically or sexually) by another inmate; and/or
  - (f) if he/she is on any psychotropic medication.
- (4) Staff shall note whether the inmate:
- (a) shows anger, hostility, and threats;
  - (b) appears anxious, afraid (pacing, wringing hands);
  - (c) displays signs of self-neglect or abuse (i.e. poor hygiene or cuts); and/or
  - (d) states that he/she is taking psychiatric medication.
- (5) If any of the items in **Subsection K.2.f. above** are present the Unit Officer shall immediately phone the following staff:
- (a) Between 8:00 AM and 4:30 PM, nursing and LPM or MHC. A psychologist will immediately visit the unit to review the checklist, assess the inmate, and discuss the case with unit staff **prior to the inmate being placed in cell**. The time and results of the assessment will be recorded in the “Clinical Staff Action” section **including a plan**.
  - (b) After hours, or on weekends, the **Shift Commander shall notify nursing staff and nursing staff shall immediately review the checklist, assess the inmate, and discuss the case with unit staff prior to inmate being placed in cell**. The time and results of the assessment will be recorded in the “Clinical Staff Action” section. **Psychology staff will review the checklist, assess the inmate, and discuss the case with unit staff upon the next available working day**.
- (6) Even if no items are present the nurse and/or psychologist will assess the inmate within 24 hours and note the date, time, and the results of the assessment in the “Clinical Staff Action” section. The completed form will remain in the **ICAR** until reviewed by PRC.
- (7) Any time an inmate appears in immediate danger of harming himself/herself or someone else, the unit staff shall contact the Shift Commander, nursing staff, and LPM or MHC to request an immediate assessment.

3. Levels of Observation and Housing in POCs, Infirmary Settings, and Other Non-RHU Areas
  - a. This subsection addresses observation and housing in all areas, except for MHUs. For MHUs, the administrative and clinical staff of the MHU have governing authority and provide watches and all other operational requirements over inmates committed to the MHU. All watches will occur in accordance with Department policy **DC-ADM 008, “Prison Rape Elimination Act (PREA).”**
  - b. Each facility shall provide an observation area to monitor suicidal inmates. Such an area requires well lit, adequately ventilated and heated cells that allow for quiet and necessary communication with appropriate treatment and custody staff. The area shall be as nearly suicide-proof as possible, without protrusions of any kind that would enable the inmate to hang himself/herself. Observations shall be conducted in infirmary areas or other areas outside of the RHU. At a facility without an infirmary, the POCs shall be located close to the medical area to allow for frequent observation and rapid response.
  - c. Staff safety is a critical consideration in deciding where to conduct the observation. Custody and supervisory staff shall not enter a cell until sufficient staff is available to handle the inmate.
  - d. An individual placed in these settings shall be provided with basic items needed for personal hygiene, as well as items such as eyeglasses, writing materials, **and reading materials** consistent with his/her custody level. If mental health staff judges there is imminent danger that an inmate will destroy an item or use it to induce self-injury, the inmate may be deprived of the item; however, every effort shall be made to provide a substitute for the item or allow the inmate to use the item under the supervision staff. Watches and precautions should not be punitive. For example, except in extreme circumstances **where contraindicated due to active suicidality or otherwise**, inmates should be permitted **reading materials** without staples, mattresses, etc.
  - e. The different levels of observation require different types of restrictions. In every case, the least restrictive measures shall be determined by the psychiatrist/PCRNP, LPM/designee, and the senior ranking official (in consultation with the facility nursing supervisor or charge nurse) based on the inmate's security needs. However, every inmate shall initially be **evaluated for** constant watch. If the inmate is behind a locked door, the observing staff shall be able to open the cell door immediately.<sup>26</sup>
  - f. The levels of observation are described below. Post orders for the observation shall specify the officer's duties in providing for custody and control and the treatment staff responsibility in providing clinical services.

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<sup>26</sup> 4-4191

(1) Constant Watch

**Constant watch** is the most restrictive watch and requires constant visual contact with recording of observations **on an irregular schedule that does not develop a pattern but occurs at least once every ten minutes for a total of at least seven entries per hour.**<sup>27</sup> **The DC-483, Psychiatric Observation Monitoring Form shall not be made out in advance with times entered in advance i.e. 0810, 0820, 0830, 840, and 0850.** All personal clothing shall be removed from the inmate and an anti-suicide smock and blanket shall be provided.<sup>28</sup> **The psychiatrist/PCRNP will determine what items are permitted in the cell based on security needs and the inmate's current behavior. Any items not permitted need an explanation on the DC-447, Psychiatric Observation Cell Orders.** If this level of observation is **required**, a mental health commitment shall be initiated as soon as possible. An officer shall be assigned to provide constant watch. If more than one inmate is on constant watch at the same time, they may be placed in adjacent POC cells so that one officer may watch more than one inmate. Constant watch may not be assigned to one officer who cannot observe both inmates simultaneously.

(2) Close Watch<sup>29</sup>

This is less restrictive than constant watch; however, there is still potential danger for self-injurious behavior (an inmate cannot give firm commitment not to harm himself or herself, **but is not actively suicidal**). Visual checks **shall be made in such a fashion that the inmate is not aware of a pattern developing, but at least once in every ten-minute period for a total of seven entries per hour.** This watch does not require the assignment of a dedicated officer. **Checks are made by the officer regularly assigned to the area.** The type of clothing and cell items permitted is based **on the clinical judgment of the psychiatric provider based on** the inmate's security needs and current behavior.<sup>30</sup> **Any items not permitted require an explanation on the DC-447.** A log is kept of the visual checks, and a record is maintained for the approved clothing and related items employing the **DC-483.**

(3) Regular Watch

This is the least restrictive level of observation and is usually the last step prior to release from observation. Visual checks shall be made in such a fashion that the inmate is not aware of a pattern developing, but at least within a 30-minute period. This level of observation does not require the assignment of a dedicated officer. Periodic checks are to be made by the officer regularly assigned to the

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<sup>27</sup> 4-4373

<sup>28</sup> 4-4416

<sup>29</sup> 4-4373

<sup>30</sup> 4-4416

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area. A log is kept of the visual checks, and a record is maintained for the approved clothing and related items employing the **DC-483**.

- (4) A **Recovery** Plan shall be designed by the PRT with goals to reduce the level of observation as soon as possible and eventually discharge the inmate from the observation area to a follow-up plan. Double celling should be considered, particularly for inmates under regular or close watch. PRT entries shall be made on the **DC-472** and in the psychiatric section of the Medical Record.

#### 4. Governing Authority over the Watches

- a. A psychiatrist/PCRNP shall order an admission to the POC and specify the type of suicide watch **and any items permitted in the cell (i.e. clothing, reading materials, etc.)**. However, in an emergency, the Facility Manager/designee and/or Shift Commander, LPM/designee, or Nurse Supervisor/Charge Nurse can order an admission. The psychiatrist/PCRNP or physician shall order discharges from the watch and Infirmary.
- b. Administration and clinical staff of the MHU govern operation of a watch in the MHU.
- c. Confinement outside of the infirmary area is governed by Department policies **DC-ADM 801, "Inmate Discipline"** and **DC-ADM 802, "Administrative Custody Procedures."** Each inmate shall be allowed privileges and personal property, encouraged to exercise, and provided personal property consistent with his/her level of custody and within the guidelines established by Department policy.
  - (1) Every inmate placed on suicide observation, both inside and outside the infirmary, shall be given written notice of the reasons for Administrative Custody using a **DC-141, Part 1, Other Report Form**. For an inmate placed in observation outside of the infirmary, a hearing is scheduled according to the provisions of **DC-ADM 802**.
  - (2) An inmate placed in observation status outside the infirmary shall be given a review whereby he/she is presented with the reasons for Administrative Custody and given the opportunity to discuss the situation with PRC.
  - (3) The PRC controls the level of observation outside of the infirmary area and based on the recommendations made by members of the PRT. Privileges are recommended by the mental health staff and authorized by the PRC.
- d. Each facility shall develop local procedures to ensure close collaboration between the health care, treatment, and custody departments, and compliance with the National Commission Correctional Health Care (NCCHC) and American Correctional Association (ACA) standards, DHS regulations for MHUs/FTCs, and Department policies and directives.

5. Use of Psychiatric Restraints

Psychiatric restraints shall be used to protect a mentally disabled inmate from harming himself/herself or others in accordance with Department policy **6.3.1, “Facility Security,” Section 32 and Section 33.**

6. Mental Health Commitment

If the inmate remains a high suicidal risk, the facility mental health staff shall initiate a mental health commitment to a licensed inpatient facility using established local procedures for processing the necessary commitment.

- a. Emergency Involuntary (302) Commitments may be initiated to one of the MHUs in the Department or to the FTC at SCI Waymart.
- b. Long Term Involuntary (304) Commitments may be initiated to the FTC at Waymart, or to a DHS Forensic State Hospital if the inmate is a female. Although the FTC and Forensic State Hospital are the preferred sites for long-term commitments, 304’s may also be conducted in the MHUs.
- c. Voluntary (201) Commitments may be placed in a Department MHU, or in the FTC at SCI Waymart.

7. Discharge of an Inmate from a POC

- a. The staff shall be aware of the increased risk of suicide for an inmate released from a POC and shall be conservative in discharging him/her.
- b. If the inmate who has been housed in an infirmary observation cell is returning to general population, the following precautions shall be ensured by the discharging authority:
  - (1) the inmate shall be closely monitored by staff;
  - (2) **psychology staff will interview the inmate in the POC on the day of discharge. Additionally, the inmate will be interviewed by psychology on the day of discharge on the unit they are discharged to, the following day, and as clinically indicated until PRT convenes (i.e. within seven days);**
  - (3) arrangements shall be made to discuss the case with staff assigned to the unit to which he/she shall be released;
  - (4) PRT develops an aftercare plan for the inmate; and
  - (5) **the inmate will be scheduled for PRT within seven days of discharge.**

- c. **Release of an inmate from POC to housing units that are not general population:**
- (1) **PRT will create an aftercare plan, to include an updated Change of Status IRP. Arrangements should be made to discuss the aftercare plan with staff on the housing unit receiving the inmate;**
  - (2) **placement of the inmate in a cell within close observation of Corrections Officers;**
  - (3) **15-minute close observation and/or continuous video monitoring is initiated and maintained;**
  - (4) **the psychology staff, in conjunction with the inmate's counselor, shall maintain daily contact with the inmate and review the corrections staff logs, incident reports, and any classification materials;**
  - (5) **the psychiatrist shall visit the inmate at least once per week; and**
  - (6) **the inmate shall be scheduled to be reviewed by PRT within seven days of discharge. PRT shall continue to review the inmate until the team determines that close observation is no longer needed. PRT will also review roster status upon discharge and assess for credible evidence of functional impairment.**

8. Treatment Planning and Responsibilities

a. PRT

The PRT members shall meet within three working days of the inmate's placement in observation to discuss present and future interventions. The PRT shall develop an aftercare plan based on the inmate's therapeutic needs. The PRT shall monitor the inmate's progress for at least 30 days after his/her release from observation. Monitoring may be extended, based on the inmate's risk level, if determined by team members.

b. Continuity of Care

An aftercare plan is developed by the PRT based on the inmate's therapeutic and custodial needs. Recommendations for **RTU** placement (if one is available in the facility), monitoring via the regular facility tracking system, and/or weekly counselor or psychologist contacts are possible components of a plan. The PRT monitors the inmate's progress for at least 30 days after his/her release from observation. Monitoring may be extended, based on the inmate's risk level, if determined by team members.



c. Unit Psychologist and Counselor/DATS

Based upon the recommendation of the PRT, both the Unit Psychologist and counselor/DATS, as part of the PRT, shall visit the inmate daily while, he/she is on a constant or close watch. Afterward, follow-up is determined by the PRT.

d. Psychiatrist/PCRNP

These visits are determined by the psychiatrist/PCRNP's availability during a one-week period. If the inmate is on constant or close watch, the treating psychiatrist/PCRNP shall visit the inmate every day he/she is in the facility.

e. Physician

The facility physician shall visit the inmate daily.

f. Licensed Psychologist Manager (LPM)

The LPM/designee shall arrange for timely mental status examinations and monitor the daily adjustment of every inmate in the observation area. The LPM shall chair the PRT meetings and ensure that recommendations are provided to the PRC when the inmate is released from the POC cell.

g. Unit Manager

The Unit Manager shall provide information regarding the inmate's current situation, and assist in the implementation of the aftercare plan after the inmate's release from observation.

h. Nursing Staff

The nursing staff shall open a psychiatric inpatient record upon admission. The registered nurse shall be the contact person for the psychiatrist/PCRNP. Nursing staff shall visit each inmate in a POC every two hours in accordance with Department policy **13.2.1**

i. Training Coordinator

The Training Coordinator shall ensure that all contact staff receive training in suicide prevention, in accordance with Department policy **5.1.1**. The training sessions shall be team-taught by a member of the treatment staff and a custody staff member.

## **L. Suicide Prevention Committee**

1. The Suicide Prevention Committee at each facility is a multi-disciplinary, multi-level committee with a designated chairperson who is expected to remain current on research and scholarship about correctional suicide prevention. The composition of this committee is the same as the clinical review team referenced in Department policy **13.1.1**,

**“Management and Administration of Health Care,” Section 9** although the Facility Manager/designee has the discretion in adding members as deemed clinically and professionally necessary. This committee meets monthly and reviews completed suicides, serious suicide attempts and recommends changes for the future. The purpose of the Suicide Prevention Committee is to review ACA standards pertaining to suicide prevention and evaluate local facility processes and procedures as they relate to suicide prevention with the intent of improving and developing best practices. ***Additionally, each month the Suicide Prevention Committee will review the most recent and available Central Office Special Needs Psychiatric Review Team (COSNPRT) packet for the specific purpose of completing all outstanding DC-516, Evaluation of Inmate Self-Injury and clinical reviews. A specific plan of action will be included in the Suicide Prevention Committee meeting minutes to resolve the outstanding DC-516s and clinical reviews identified by COSNPRT. Furthermore, operational recommendations regarding systemic and institutional suicide prevention should be considered and proposed from the data provided by COSNPRT. A copy of the most recent and available COSNPRT packet will be provided for all Suicide Prevention Committee members at the time of this meeting or earlier, if possible, for planning purposes.***

2. Examples of what this committee should review shall include, but not be limited to the following:
  - a. ACA standards in regard to all contact staff receiving annual refresher training in suicide prevention also in concert with Department policy **5.1.1**;
  - b. the process by which all inmates received at the facility receive a suicide prevention orientation within 30 days of their reception at the facility;
  - c. methods for distributing the “Living Through It” brochure;
  - d. POC procedures;
  - e. developing and updating a video to be aired on the inmate dedicated channel introducing mental health staff and services offered by psychology;
  - f. developing wallet or pocket cards for dealing with inmates suffering from mental illness or intellectual disability and potentially suicidal inmates;
  - g. ensuring proper submission and review of all **DC-516s**; and
  - h. **quarterly** suicide drills for response time from medical, custody, and other appropriate staff, which are to be submitted to the institutional Critical Incident Manager to ensure that the Critical Incident Stress Management (CISM) Team is activated afterward.

#### M. Mental Health Services Review Committee (MHSRC)

The Mental Health Services Review Committee (MHSRC) at each facility shall annually review this procedure manual and make recommendations for changes or improvements **believed to** be helpful. Recommendations for changes or additions to the procedures manual shall be submitted to the **Chief of Psychiatry**, Chief of Psychological Services, and **the respective Regional LPM** for review and coordination. In addition, the MHSRC shall review the facility's written procedures for screening, treating, tracking, and follow-up of inmates in need of mental health services and recommend changes and updating as necessary. **All staff participating in the MHSRC (i.e. to include all psychology staff members) shall sign a training roster reflecting that they have received training on this procedures manual. The MHSRC report is due the month preceding the SCI's annual audit month.**



**BULLETIN**  
Commonwealth of Pennsylvania • Department of Corrections

**Policy Subject: Psychiatric Medication Monitoring**

**Policy Number: 13.08.01, Section 3 – Delivery of Psychiatric Services, Bulletin 01**

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<b>Date of Issue:</b>  <b>June 6, 2016</b>	<b>Authority:</b>  <b>Signature on File</b>  <b>John E. Wetzel</b>	<b>Effective Date:</b>  <b>June 13, 2016</b>
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The purpose of this bulletin is to add policy and procedures for the management of Psychiatric Medication Monitoring pertaining to Antipsychotics, Mood Stabilizers, and Tricyclic Antidepressants (TCA).

A new subsection shall be added and designated **Subsection H.** on page 3-16 and shall read:

**H. Psychiatric Medication Monitoring**

The Department provides clinical management of psychiatric illness and medication management through chronic care clinics. Medications specifically reviewed and monitored include Antipsychotics, Mood Stabilizers, and TCA. Minimum guidelines shall be followed in order to monitor and evaluate for possible side effects of antipsychotic medications, mood stabilizers, and tricyclic antidepressants.

1. Antipsychotic Medication\*\*
  - a. Initial Work Up – Fasting Serum Glucose, Fasting Lipid Panel, Complete Blood Count (CBC), Basic Metabolic Panel (BMP), Prolactin level\*, Weight plus Body Mass Index (BMI), Blood Pressure, Electrocardiogram (EKG), Abnormal Involuntary Movement Scale (AIMS).
  - b. Every Six Months – Fasting Serum Glucose, Cholesterol Panel, BMP, CBC, Blood Pressure, Weight plus BMI, AIMS.
  - c. Every 12 Months – EKG

\*Prolactin level initially, at six month mark and 12 month mark, then only if clinically indicated.

\*\*Pregnancy test if applicable.

d. Documentation

(1) **DC-468C, Antipsychotic Medication Flow Sheet (Attachment A)**

- (a) A Psychiatric Provider/Registered Nurse (RN)/Licensed Practical Nurse (LPN)/designee can complete the **DC-468C**. The Psychiatrist/Psychiatric Certified Registered Nurse Practitioner (PCRNP) shall review and sign the form and document any clinically significant findings in a progress note (**DC-472C, Outpatient Psychiatry Progress Notes** or **DC-472, Progress Notes**).

(2) Practitioner orders

- (a) Psychiatrist/PCRNP shall order required labs, EKG, AIMS, etc. and document any clinically significant findings in the progress note.
- (b) Any labs/EKG done within 30 days of the due date are acceptable. The provider shall review the lab results/EKG. Provider shall order new labs/EKG if they are clinically indicated, and shall document the same in the progress note.

(3) **DC-470, Abnormal Involuntary Movement Scale (AIMS)**

- (a) The AIMS shall be completed in accordance with Department policy **13.2.1, "Access to Health Care," Section 3.**

2. Mood Stabilizer Medication\*

a. Lithium:

- (1) BMP with Liver Function Test (LFTs), CBC with Platelets, Thyroid Stimulating Hormone (TSH) done: Initially, at three months, at six months, then every six months thereafter.
- (2) Lithium level weekly x two at initiation or dose change, then at three months. Once stable, every six months.

b. Depakote:

- (1) BMP with LFTs, CBC with Platelets: Initially, at three months, at six months, then every six months thereafter.
- (2) Depakote level weekly x two at initiation or dose change, then at three months. Once stable, every six months.

c. Trileptal:

BMP with LFTs, CBC with Platelets: Initially, at three months, at six months, then every six months thereafter.

d. Tegretol:

- (1) BMP with LFTs, CBC with Platelets: Initially, at three months, at six months, then every six months thereafter.

- (2) Tegretol level weekly x two at initiation or dose change, then at three months. Once stable, every six months.

\*Pregnancy test if applicable.

e. Documentation

- (1) **DC-468B, Lithium, Depakote, Trileptal, Tegretol Flow Sheet (Attachment B)**

A Psychiatric Provider/RN/LPN/designee can complete the **DC-468B**. The Psychiatrist/PCRNP shall review and sign the form and document any clinically significant findings on a progress note.

- (2) Practitioner Orders

- (a) Psychiatrist/PCRNP shall order required labs and document any clinically significant findings on a progress note.
- (b) Any labs done within 30 days of the due date are acceptable. The provider shall review the lab results. The provider shall order new labs if they are clinically indicated, and shall document the same in the progress note.

3. Tricyclic Antidepressants (TCA)\*

- a. TCA: Laboratory tests (BMP, CBC, and LFTs), EKGs will be ordered as clinically indicated based on patient's Cardiac History (i.e. Cardio Vascular Disease, Coronary Artery Disease, history of A-fib, etc.) and/or knowledge of any adverse reactions.

\*Pregnancy test if applicable.

b. Documentation

- (1) Practitioner Orders

- (a) Psychiatrist/PCRNP shall order required labs/EKG and document any clinically significant findings on a progress note.
- (b) Any labs/EKG done within 30 days of the due date are acceptable. The provider shall review the lab results/EKG. The provider shall order new labs/EKG if they are clinically indicated, and shall document the same in the progress note.

4. Other Special Labs

Any special lab orders (Haldol levels/TCA levels/Clozaril levels etc.) shall require Mental Health (MH) Contract Statewide Psychiatric Director Approval.

## Section 3 – Delivery of Psychiatric Services

### A. Documentation of Psychiatry Services

***This section establishes procedures for the delivery of psychiatric services. All psychiatric reports, assessments (practitioner/nursing), exams, progress notes, etc. shall be filed under the psychiatric divider in the inmate medical record.***

#### 1. DC-472C, Outpatient Psychiatry Progress Notes (Attachment 3-A)

- a. A **DC-472C** shall be used by a Psychiatrist or a Certified Registered Nurse Practitioner – Psychiatric Services (PCRNP) to document face-to-face patient care in any routine outpatient appointment including such appointments through telemedicine. The Subjective Objective Assessment Plan (SOAP) format with free text entries shall be used as a basis, although additional information and comments can be added in spaces allotted. The SOAP format includes:
- (1) military time and date;
  - (2) S (Subjective) – The inmate’s described interval (since last visit) and current psychiatric and medical symptoms, pertinent interval history, pertinent pharmacology or medication concerns, etc;
  - (3) O (Objective/Observations) – The clinician’s mental status examination (MSE), Abnormal Involuntary Movement Scale (AIMS) score, other test or observation results (including cognitive screening examinations), and significant laboratory test results which the work up and/or treatment will be based upon. Additional components of an MSE can be described in the line spaces provided. Behaviors observed by other staff and reported to the clinician, can be described here;
  - (4) A (Assessment) – A (Assessment) – Diagnosis/rational – need for treatments, medications/medication adjustments/change in medications; and
  - (5) P (Plan) – The clinician’s treatment plan, including a diagnostic component and a therapeutic component, could include:
    - (a) psychotropic medications (new or modify pre-existing) with rationales;
    - (b) laboratory test including blood levels, EKG, X-Rays, etc;
    - (c) consultations (medical, surgical, dental, psychology testing). The **DC-97, Mental Health Referral Form** shall be completed for psychotherapy, counseling, or other activity referrals, and psycho education;
    - (d) **request/review of** medical records from outside sources;
    - (e) administrative/security concerns to be addressed;

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- (f) Program Review Team (PRT) and roster issues;
  - (g) next appointment (routine and/or brief follow-up); and
  - (h) statement of discussion with the inmate.
- b. All outpatient psychiatry progress notes shall be signed by the psychiatric provider, above a block stamp of the name and professional degree-certifications.

**2. DC-472, Progress Notes**

Documentation of emergency outpatient psychiatry care, Forensic Treatment Center (FTC) inpatient psychiatry care, and administrative psychiatry matters relating to the inmate's care can be recorded on a standard **DC-472**.

**3. Psychiatric Reports/Examinations**

a. ***The following are examples of psychiatric reports and examinations:***

- (1) ***initial psychiatric examination;***
- (2) ***commutation;***
- (3) ***pardon;***
- (4) ***parole;***
- (5) ***guilty but Mentally Ill (GBMI) annual;***
- (6) ***specialized housing units, e.g. Security Threat Group Management Unit (STGMU), Secure Residential Treatment Units (SRTU);***
- (7) ***annual psychiatric evaluation for an inmate who is confined continuously for one year in a Security Level 5 housing unit; and/or***
- (8) ***other reports as requested.***

b. ***Each report shall be dictated and signed. The exam evaluation shall cover:***

- (1) ***demographic information;***
- (2) ***current psychiatry history;***
- (3) ***past psychiatric history;***
- (4) ***substance abuse/dependence history;***



- (5) ***current psychotropic medications and compliance;***
- (6) ***mental status examination;***
- (7) ***diagnostic impression;***
- (8) ***recommendations including ongoing and routine treatment; and***
- (9) ***any other relevant information.***

#### **4. Informed Consent for Psychotropic Medication**

- a. ***The DC-452D, Informed Consent for Psychotropic Medication (Attachment 3-B) shall be completed by a Psychiatrist/PCRNP when a new medication is ordered. The purpose of the form is to ensure the inmate is aware of possible side effects, and verbalizes an understanding of the medications. A Spanish version of the DC-452D is available (Attachment 3-C).***
- b. ***The inmate shall be required to document whether he/she wants, or does not want, to take the medication.***
- c. ***Upon form completion, the inmate shall be required to date/time and sign the document.***
- d. ***When an inmate refuses to sign the form, the Psychiatrist/PCRNP shall document the inmate refusal on the DC-452D. If the inmate needs the medication, and wants to continue taking it, refusing to sign the form does not mean the medication shall be stopped; this shall be documented in the progress notes under the psychiatry divider.***
- e. ***The Psychiatrist/PCRNP shall be required to date/time and sign the form.***

#### **B. Provisions of Psychiatric Services by a PCRNP**

##### **1. Terms of Practice**

- a. A PCRNP is subject to the terms of agreement for credentialing and privileging established by the Bureau of Health Care Services (BHCS) (refer to Department policy **13.1.1, “Management and Administration of Health Care Services,” Section 1**) and the contract services provider providing psychiatric services. The individual PCRNP’s practice is also subject to the terms specified in the Collaborative Agreement for Prescriptive Authority (“Collaborative Agreement”) between a collaborating psychiatrist and the PCRNP, as stipulated by the Pennsylvania State Board of Nursing.
- b. The Collaborative Agreement is signed by the PCRNP, the Collaborating Psychiatrist and a Substitute Psychiatrist who can provide collaboration for up to 30 days if the

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collaborating Psychiatrist is unavailable. The Collaborating Psychiatrist may designate another Psychiatrist to be contacted in urgent situations where he/she and the Substitute psychiatrist are both not immediately available. The Collaborative Agreement also describes the PCRNP's ability to prescribe psychotropic medications and limitations in prescribing controlled substances. A copy of the signed Collaborative Agreement shall be kept on file at the contract service provider's regional office and by the Correctional Health Care Administrator (CHCA) at the PCRNP's facility of clinical practice. More than one Collaborative Agreement may be necessary, if the PCRNP practices at two or more facilities with different Psychiatrist(s). At a minimum, the PCRNP and his/her Collaborating Psychiatrist/Substitute Psychiatrist shall meet, or talk by telephone, weekly to discuss cases or other practice issues. Case discussions shall be documented by the PCRNP in the inmate's medical record or elsewhere.

2. Scope of Psychiatric Practice

- a. The scope of PCRNP practice is the same as that for a contract service provider Psychiatrist working in the Department, except for the following limitations in accordance with Commonwealth statutes:
  - (1) may not provide the required **first or** second psychiatric opinion in cases where the involuntary administration of psychotropic medication is being considered, in accordance with **Subsection E.2.g. below**;
  - (2) may not assume the role of examining physician for the purposes of any voluntary or involuntary mental health commitment, in accordance with Section 2 of this procedures manual;
  - (3) may not be assigned as, or assume the role of, a Clinical Director of a Mental Health Unit (MHU) or of a Psychiatric Director of a unit in the FTC of the State Correctional Institution (SCI) Waymart;
  - (4) may not order the initiation, renewal/continuation, reduction, or discontinuation of psychiatric restraints for an inmate in the FTC, MHUs, or a Psychiatric Observation Cell (POC); and
  - (5) shall prescribe controlled substances in accordance with Pennsylvania Code:
    - (a) schedule I: cannot prescribe;
    - (b) schedule II: 30 day maximum prescription order;
    - (c) schedule III and IV: 90 day maximum prescription order; and
    - (d) schedule V: cannot prescribe, as these are not part of the Collaborative Agreement.

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- b. Can function as the sole outpatient psychiatric provider at a facility.
- c. May provide psychiatric services at all Department facilities, including:
  - (1) any of the outpatient housing units;
  - (2) Diagnostic and Classification Centers (DCCs) at SCI Camp Hill and SCI Muncy;
  - (3) admission to, and discharge from, a POC;
  - (4) admission **assessments**, discharge, and routine care of patients in the MHUs and FTC;
  - (5) parole psychiatric evaluations; and
  - (6) after hours on-call for a facility, as contracted by the contract services provider.

**C. Psychiatric Therapeutic Restraints**

1. ***Psychiatric therapeutic restraints are designed to control acute, or episodic, aggressive behaviors of inmates, only when less restrictive measures and techniques have proven to be less effective.***
2. ***Therapeutic restraints shall only be used when an inmate is acting in a manner as to be a clear and present danger to himself, to other inmates, or employees due to psychiatric, or organic medical, causes or conditions.***
3. ***Psychiatric therapeutic restraints shall be used in accordance with Department policy 6.3.1, "Facility Security," Section 33.<sup>1</sup>***

**D. Guidelines for Psychiatric Observation Cells (POC)**

1. General Procedures
  - a. ***The Registered Nurse Supervisor/designee shall notify*** the Shift Commander of every POC admission and discharge.
  - b. Every inmate placed in a POC shall be within sight or sound observation of the medical and/or operations staff at all times. A facility with an infirmary shall locate the POC close to the medical area.
  - c. The Department discourages POC admissions beyond three days, unless the inmate is steadily improving and awaiting discharge to an appropriate housing unit, MHU, or FTC.

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<sup>1</sup> 4-4405

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- d. In accordance with Department policy **6.3.1, a DC-141, Part I, Other Report**, must be prepared by the facility staff witnessing the event; **completed reports shall be submitted to the Shift Commander. The Shift Commander/ designee shall distribute** copies of the **DC-141** to the Program Review Committee (PRC), Facility Manager, Psychiatrist, PCRNPs, Mental Health Coordinator (MHC), Control, CHCA, Unit Manager, counselor and/or Drug and Alcohol Treatment Specialist (DATS), and Inmate Records.
  - e. An inmate shall only be discharged from a POC upon being assessed face-to-face by the Psychiatrist/PCRNP **with a documented DC-474A, POC Discharge Summary Form (Attachment 3-D)**, and only upon a written order by the Psychiatrist/PCRNP. Verbal or telephone orders for discharge are not acceptable.
  - f. The **Registered Nurse Supervisor/designee** shall ensure that the PRC is notified of planned POC discharges so that PRC may arrange for appropriate housing.
2. Notification of Facility Psychiatrist/PCRNP or MHC for Psychiatric Emergencies by Facility Staff
- a. During regular working hours, the MHC/designee shall call the Facility Psychiatrist/PCRNP. The Psychiatrist/PCRNP shall evaluate the inmate for a POC admission and may **order/instruct** the nursing staff to admit the inmate to a POC if a psychiatric emergency exists. The Psychiatrist/PCRNP **shall complete a DC-447, Psychiatric Observation Cell Order (Attachment 3-E), by ordering/instructing** as to the level of watch required, either constant, close, or regular, **and the items permitted to be in his or her possession.**
  - b. During non-regular working hours, the Shift Commander may place an inmate into a POC. The **Registered Nurse Supervisor/designee** shall evaluate the inmate **using a DC-586NN, Nursing Evaluation Tool: General Psychiatric Concern and contact the on-call Psychiatrist/PCRNP to report** the inmate's condition and behavior. If a psychiatric emergency exists, the Psychiatrist/PCRNP shall order a POC admission, which shall include the level of observation required **and the items permitted to be in his or her possession; the nurse receiving the verbal/telephone orders shall initiate/complete a DC-447, and other documents as outlined in Section 3 below.** If no emergency exists, **nursing staff shall follow the recommendations made by the Psychiatrist/PCRNP; special medical orders may be issued, and require follow-up, during this correspondence. The inmate will be scheduled for a follow-up assessment with psychology or the Psychiatrist/PCRNP the next working day. All correspondence will be documented in the progress notes under the psychiatry divider.**

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3. Nurses shall be required to perform/ensure the following:
- a. ***The Registered Nurse shall perform an initial nursing assessment; and document the findings in a progress note. The note must include:***
    - (1) ***chief complaint;***
    - (2) ***vital signs;***
    - (3) ***reason for admission (to include admission date and time);***
    - (4) ***nursing assessment; and***
    - (5) ***plan of care.***<sup>2</sup>
  - b. ***The Registered Nurse shall contact the psychiatric practitioner to report the inmate's condition, and to obtain physician orders; if receiving verbal orders, initiate the DC-447.***
  - c. ***Initiate and maintain the Inpatient Area Admission/Discharge Log (Attachment 7-E of Department policy 13.2.1, "Access to Health Care," Section 7) which shall be used daily for updating the automated infirmary tracking log.***
  - d. ***Initiate, and maintain the inpatient medical record in accordance with Department policy 13.1.1, "Management and Administration of Health Care," Section 10.***
  - e. ***The Registered Nurse shall initiate a DC-478, Inpatient Unit Nursing Care Plan (Attachment 7-G of Department policy 13.2.1, Section 7). The DC-478 shall include active psychiatric or medical problems, interventions, and expected outcomes. The DC-478 shall be updated according to change of patient status.***<sup>3</sup>
  - f. ***Ensure the outpatient record is available in the inpatient unit nurse's station.***
  - g. ***Inform the Corrections Officer regarding the level of watch for the inmate, and the items permitted to be in his or her possession.***
  - h. ***Transcribe and initial all verbal and written practitioner orders. The practitioner must sign-off on all verbal orders within 2 hours on regular working days, and within 72 hours/next working day during off hour, weekends, and holidays.***
  - i. ***Verbal orders for medications shall be entered in the electronic Medication Administration Record (e-MAR).***

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<sup>2</sup> 4-4350

<sup>3</sup> 4-4350

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- j. **Advise the CHCA and the Deputy Superintendent for Centralized Services (DSCS) of the recommended duration of the POC placement and, if possible, the anticipated date of discharge.**
  - k. **Procedures for Psychiatric Therapeutic Restraints shall be followed in accordance with Department policy 6.3.1, Section 33.**
  - l. **The Registered Nurse shall observe and document (using the SOAP [IER] format) inmate behavior in the inpatient progress notes, at a minimum of every two hours, unless otherwise ordered by the psychiatric/medical practitioner.**
  - m. **The Registered Nurse shall report significant changes in the inmate's behavior or mental status to the psychiatric practitioner.**
  - n. **Give a verbal and written shift-to-shift report to the incoming infirmary nurse. The Inpatient Daily Shift to Shift Report must be completed by each infirmary nurse at the end of each shift.**
4. The facility Psychiatrist/PCRNP shall accomplish the following duties related to the POC:
- a. **complete the DC-447 and enter medication orders in the eMAR;**
  - b. **co-sign every verbal psychiatric order given to nursing staff upon admission within 2 hours on regular working days, and on off hour, weekends, and holidays, the next working day/72 hours;**
  - c. **document history of abnormal behavior which led to the POC admission, mental status exam, assessment, and an individual recovery plan in the progress notes within 2 hours on regular working days, and within 72 hours/next working day, during off hours, weekends, and holidays of POC admission.<sup>4</sup> The progress notes shall include mental status and diagnosis in accordance with the most current editions of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DCM). The Individual Recovery Plan (IRP) shall be completed with PRT;**
  - d. **evaluate the inmate, and document in the progress notes (via the SOAP format) recommended duration of the POC placement, if possible, the anticipated date of discharge, and follow-up visit recommendations/information;**
  - e. **complete the DC-474A or document the discharge summary via dictation within 48 hours of discharge;<sup>5</sup>**
  - f. **complete an on-site evaluation within two hours after the application of any psychiatric restraints in the POC (Psychiatrist only);<sup>6</sup> and**

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<sup>4</sup> 4-4350

<sup>5</sup> 4-4413

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- g. complete an on-site psychiatric examination in the POC at the request of the facility medical physician or Facility Manager/designee at any time.
5. The Facility Physician shall be required to ensure the following:
- a. Review the annual or bi-annual physical examination.
  - b. Perform an initial examination including:
    - (1) review of the medical problem list;
    - (2) review of the medical **record** including recent progress notes and orders;
    - (3) physical examination focused on current and newly developed medical problems, such as recent trauma and abnormal findings listed on the **DC-440, Physical Examination Form**;
    - (4) assessment with updated medical problem list; and
    - (5) medical treatment plan and orders to address current problems.<sup>7</sup>
  - c. Examine the inmate daily.
  - d. Document daily in the **progress notes** via the SOAP format.
  - e. Call the emergency on-call Psychiatrist/PCRNP to obtain treatment recommendations regarding difficult to manage clinical cases. This may include recommendations for commitment to an MHU.
6. The Psychologist shall be required to ensure the following:
- a. Provide counseling and support during regular working hours (Monday – Friday). The psychology staff shall evaluate the inmate **Monday – Friday with the psychiatric provider**.
  - b. **Update the IRP addressing behavior warranting POC admission on the day of admission, or as soon as normal institution operations permit.**<sup>8</sup>
  - c. Verbally communicate concerns about the inmate’s condition to the nursing staff and inmate’s counselor and/or DATS.
  - d. Document results of daily contacts in the **progress notes**.

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<sup>6</sup> 4-4405

<sup>7</sup> 4-4350

<sup>8</sup> 4-4350

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- e. Assign each inmate placed in a POC to the PRT list for discussion at the first PRT meeting after the POC admission date.
  - f. Facilitate, through the MHC, referrals and mental health commitments to MHUs or the FTC.<sup>9</sup>
  - g. **Complete the following monitoring when an inmate transfers from the POC to general population or an RTU:**
    - (1) ***the inmate shall be seen in the POC on the discharge day, or when normal institution operations permit;***
    - (2) ***the inmate shall be seen on the housing block, or when normal institution operations permit;***
    - (3) ***the inmate shall be seen the day after discharge from the POC; and***
    - (4) ***the inmate shall be seen as clinically indicated until the PRT convenes. PRT shall meet within seven days of the discharge.***
7. The Shift Commander shall be required to ensure the following:
- a. During non-working hours, order the POC placement and contact ***the Registered Nurse Supervisor/designee*** to evaluate the inmate.
  - b. ***Ensure*** Correctional Officers are documenting observation of behavior, as ordered.
8. The Correctional Officer assigned to the **POC** shall:
- a. Document observation of behavior on the **DC-483, Psychiatric Observation Monitoring Form (Attachment 3-F)** as ordered by the physician. ***For constant and close watches, a recording of observations is made on an irregular schedule that does not develop a pattern, but occurs at least once every ten minutes, for a total of at least seven entries per hour. The DC-483 shall not be completed with times entered in advance e.g. 0800, 0810, 0820, 0830, and 0840.*** Upon completion, the **DC-483** shall be forwarded to medical records **department** to be placed in the inpatient record on top of the lab reports.
  - b. Notify the nursing staff immediately of any unusual behavior.
  - c. ***Certified Peer Specialists can be used to provide support during watches conducted by Correctional Officers; the Correctional Officer must always be present during these watches.<sup>10</sup> Under no circumstances do Certified Peer Specialists replace staff; they increase supportive services. Certified Peer***

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<sup>9</sup> 4-4374, 4-4404

<sup>10</sup> 4-4393



**Specialist Supervisors should be aware, and explore any issues in regard to providing services in POCs during monthly supervision contacts. If issues arise requiring supervision sooner than the monthly interval, they shall occur.**

- d. **The supervisors of the Certified Peer Specialists, due to the sensitive nature of these assignments, will take considerable care in ensuring Certified Peer Specialists are mature, reliable, have credibility with both staff and inmates, are able to protect the suicidal inmate's privacy from other inmates, and can perform duties with minimal need for supervision.**
- e. **Each Certified Peer Specialist will receive a job orientation, and sign the Inmate Job Orientation Form (Department policy DC-ADM 816, "Inmate Compensation," Attachment 1-A) maintained by the Certified Peer Specialist Supervisor that such occurred. This orientation, and ongoing training, will cover:**
  - (1) **location of suicide watch area (POCs);**
  - (2) **summoning of staff;**
  - (3) **recognizing behavioral signs of stress or agitation;**
  - (4) **two hours of on-the-job training; and**
  - (5) **guidance on refraining from counseling or advising the inmate on watch.**

#### **E. Involuntary Administration of Psychotropic Medications<sup>11</sup>**

##### 1. Guidelines

Involuntary administration of psychotropic medication shall be given to an inmate only if:

- a. The inmate suffers from a mental disorder and/or an organic, mental, or emotional impairment that has a substantial adverse impairment on the inmate's cognitive/volitional function.
- b. The inmate is an imminent threat of danger to self or others.
- c. The inmate is either currently:
  - (1) under an involuntary commitment in an MHU or the FTC;
  - (2) under a voluntary commitment in an MHU or the FTC, but an involuntary commitment will now be initiated; **and**

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<sup>11</sup> 4-4401

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- (3) is housed in a POC or infirmary, and an involuntary commitment will now be initiated.

2. Procedures for Treating Acutely Mentally Ill and Unstable Inmates

- a. An inmate showing signs of significant, impairing mental disorganization, including significant inability to care for self, and/or who possess a danger of hurting himself/herself or others, shall be immediately placed in a POC by security staff.
- b. The inmate shall be assessed for danger of physical harm to himself/herself or others by POC security staff, and nursing staff will be contacted.
- c. If the inmate is deemed dangerous to himself/herself or others, or cannot care for self, the **Registered Nurse Supervisor/designee** shall call the on-site Psychiatrist/PCRNP during normal business hours. The on-site Psychiatrist/PCRNP shall examine the inmate immediately, and assess the need for psychotropic medication and/or other interventions. After conducting an assessment of the inmate, the on-site Psychiatrist/PCRNP shall document his/her findings in the **progress notes**.
- d. After normal business hours, or if there is no Psychiatrist/PCRNP currently available during normal business hours, the on-call Psychiatrist/PCRNP shall be contacted. The **Registered Nurse Supervisor/designee** shall discuss the inmate's condition with the on-call Psychiatrist/PCRNP, and document this discussion, and any psychiatric recommendations and verbal orders, **in the progress notes and the Physician's Order Sheet**.
- e. After determining that the inmate requires psychotropic medication, the inmate shall be offered the opportunity to voluntarily accept the prescribed psychotropic medication. The inmate's response(s) shall be recorded **in the progress notes** and filed in the psychiatric section of the inmate's medical record.
- f. If the inmate refuses to voluntarily accept the prescribed psychotropic medication, the on-site/on-call Psychiatrist/PCRNP shall be contacted for further instructions on how to treat the inmate.
- g. The on-site/on-call Psychiatrist may then consider ordering the involuntary administration of psychotropic medication; **however**, the Facility Psychiatrist must obtain a **second** opinion from another Psychiatrist on-site or elsewhere (a PCRNP cannot provide the **initial or** second opinion) **in order to proceed with this plan of care**.
- h. If this consulting Psychiatrist does not concur, then a third consulting Psychiatrist's concurring opinion must be obtained, prior to ordering this medication. In these cases, it is preferable that the Psychiatry Contract Service Provider's State Medical Director provides this opinion. If disagreement continues over the need for the involuntary

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administration of this psychotropic medication, then the **Bureau** Chief of Psychiatry shall be consulted.

- i. If a final decision is made by the Chief of Psychiatry to not involuntarily administer the psychotropic medication, the medication shall not be given. The reasons for final decision will be recorded by the attending Psychiatrist/PCRNP in the progress notes section of the inmate's medical record, and an alternative treatment plan shall be developed in order to stabilize, and ensure, the health and safety of the inmate.
- j. **In the case of extreme emergency:**

The on-site/on-call Psychiatrist determines that there is no less invasive means for preventing the inmate from causing harm to himself/herself or others prior to completion of mental health commitment procedures, the on-site/on-call Facility Psychiatrist may order the involuntary administration of psychotropic medication before seeking consultation with, and a concurring opinion, **from** another Psychiatrist. In such cases, consultation and concurring opinion must be sought at the earliest possible time after the medication is administered.

- (1) The Psychiatrist shall do a face-to-face evaluation within two hours, and document the rationale and need for the involuntary administration of psychotropic medication in the psychiatric section of the inmate's medical record. This documentation must include the immediate threat posed to the inmate or others, all the efforts to have the inmate accept the medications voluntarily, every previous unsuccessful treatment effort, and every emergency treatment that was needed to stabilize the dangerous behavior exhibited by the inmate. If psychotropic medication was administered involuntarily without first obtaining a concurring opinion, documentation must also indicate the reasons why this opinion could not be obtained.<sup>12</sup>

3. Process for the Administration of Involuntary Psychotropic Medication<sup>13</sup>

- a. Upon approval of order, the nurse shall administer the involuntary psychotropic medication with the assistance of the security staff. Every measure shall be taken to ensure the safety of the inmate and staff, including the use of restraints as **deemed necessary** by security staff, and with consultation, as needed, from the Psychiatrist; the ordering of psychiatric restraints can only be accomplished by a Psychiatrist, **not security staff**.
- b. After **the** administration **of medication**, vital signs shall be monitored by the **Registered** Nurse every 30 minutes at a minimum, **or** until otherwise directed by the Psychiatrist/PCRNP. Medication efficacy and side effects shall be monitored by the **Registered** Nurse, as stipulated by the Psychiatrist/PCRNP. In addition, hydration

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<sup>12</sup> 4-4401

<sup>13</sup> 4-4401

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status, food intake, changes in mental status, etc. shall also be routinely assessed and documented accordingly by **the Registered Nurse**.<sup>14</sup>

- c. The Psychiatrist, in telephonic or on-site consultation with the **Registered Nurse**, shall decide if the medication produced the desired results, or if there is a need for further medication.<sup>15</sup> The verbal nursing order(s) for the first dose of medication, and any subsequent doses, shall be cosigned by the Psychiatrist as soon as possible.
- d. The Psychiatrist shall come into the facility and perform an evaluation, as necessitated by reported concerns of inadequate response to one or more doses of the medication, deterioration of the inmate's overall condition, worsening risk of harm to self or others, or at the specific request of the nursing staff or medical physician.
- e. An individual **recovery** plan shall be documented in the medical record **by the Psychiatrist**.<sup>16</sup> Its goal shall be the termination of the involuntary administration of the medication when the inmate's mental, emotional, and behavioral status stabilizes.<sup>17</sup>
- f. The treatment team shall begin emergency commitment procedures if indicated. The transfer to the FTC or MHU shall be completed at the earliest possible date.<sup>18</sup> The inmate shall be placed on the PRT roster for review at the next meeting.
- g. This PRT review shall address the following:
  - (1) the reason for use of involuntary psychotropic medication;
  - (2) the inmate's current status;
  - (3) a review of proposed or completed commitments to an MHU or FTC; and
  - (4) notification of the actions taken; all recommendations/comments must be forwarded to the Facility Manager through the CHCA and DSCS. The CHCA shall notify the BHCS of this event in the next monthly CHCA report.

**F. Sleep Medications**

***Department practice specifically prohibits the use of sleep medications, as well as other soporific medication for sleep disorder alone (in the absence of psychopathology). If the inmate does not have a documented/diagnosed sleep disorder, the following shall occur:***

- 1. Psychiatrist/PCRNP shall refer the inmate to psychology for the Sleep Hygiene Enhancement Program by initiating/completing a DC-97;***

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<sup>14</sup> 4-4401

<sup>15</sup> 4-4401

<sup>16</sup> 4-4350

<sup>17</sup> 4-4401

<sup>18</sup> 4-4374, 4-4404

2. *sleep medications, and minor tranquilizers, are to be used only when other techniques, such as relaxation, and support groups, have been found to be ineffective;*
3. *minor tranquilizers, and sleep medications, shall only be prescribed when the need for such medication has been clearly documented by the Psychiatrist/PCRNP;*
4. *minor tranquilizers, and sleep medications, shall only be ordered for the shortest time period needed to achieve the therapeutic, or diagnostic goal, and not to exceed 30 days, unless re-evaluated by a Psychiatrist/PCRNP;*
5. *the Psychiatrist/PCRNP may renew the prescription only upon a face-to-face re-evaluation of the inmate. The Psychiatrist/PCRNP shall document the rationale for continuing/renewing the prescription in the inmate's medical record; and*
6. *the PRT must develop a treatment plan to address the sleep issues, and the discontinuation of the medication, as soon as therapeutically possible.*

#### **G. Benzodiazepines**

1. *Department practice specifically prohibits the use of benzodiazepines, as well as other soporific medications.*
2. *Use of benzodiazepine medication is discouraged because of the high potential for abuse through malingering and/or diversion, and because of the high potential for psychological and physiological dependence.*
3. *Benzodiazepines are not to be used when there is a history of abuse, dependence on drugs or alcohol, or if the inmate has been detected to have utilized illegal drugs on a prison urinalysis drug test.*
4. *When the use of benzodiazepines is deemed necessary, rationale for the same shall be documented in the progress notes; it is recommended that use be in accordance with guidelines limiting continued utilization for a maximum of two months.*
5. *The Psychiatrist/PCRNP may renew the prescription only upon a face-to-face re-evaluation of the inmate. The Psychiatrist/PCRNP shall document the rationale for continuing/renewing the prescription in the progress notes.*
6. *The PRT shall develop a treatment plan to address the issues, and the discontinuation of the medication, as soon as therapeutically possible.*
7. *In those instances in which benzodiazepines are being withheld, it is recommended that withdrawal is managed by a gradual reduction of the benzodiazepines, or by switching to a longer-acting cross tolerant drug with which to begin the taper. Schedules may vary from tapering by 25% every five to seven*

***days, which may produce some symptoms that are not severe, and still mitigates against seizures to a gradual reduction over six to eight weeks. If there is mixed alcohol and benzodiazepine dependence, use of a longer acting benzodiazepine with graded reduction is recommended. If there is polydrug abuse with benzodiazepine dependence, substitution of Phenobarbital for benzodiazepines with a slow tapering is sometimes recommended.***

- 8. In those cases where benzodiazepines are prescribed in association with other psychotropic medications and benzodiazepines are being discontinued, care shall be taken, as the psychotropic medications have the potential for lowering seizure threshold.***

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## Section 4 - Temporary Transfer of Mental Health Commitments

### A. General Considerations

1. If a state correctional facility has a Mental Health Unit (MHU) located on site, then the local MHU shall be used for voluntary (201) and involuntary (302), emergency commitments, extended involuntary emergency commitment (303), and interim placement for a patient with court ordered involuntary commitment (304c) awaiting transfer for extended care at the Forensic Treatment Center (FTC) at Waymart. If the facility does not have a MHU on site, then a Department Regional MHU shall be considered first for 201, 302 applications, and 303 commitments. An inmate requiring 304 commitments shall be referred to the FTC at Waymart through the Bureau of Health Care Services (BHCS).
2. Intra-facility transfers shall apply to Voluntary Commitments (201), and Involuntary Commitments for Evaluation and Treatment (302 and 304) as established by the Mental Health Procedures Act.
3. If there is no bed available at a Department Regional MHU or alternate MHU, the inmate shall be referred to the FTC at Waymart for the 302 application and 303 commitment.
4. If a MHU bed is available, but transportation considerations are prohibitive (due to distance and/or weather), a referral to the FTC may be approved by the BHCS.
5. When the Department Regional Mental Health Unit determines that the inmate is to be discharged due to improved condition or transferred to the FTC at Waymart for extended care or a Department of Public Welfare (DPW) Forensic MHU, the MHU shall advise the mental health staff at the sending facility. The treatment staff from the two facilities shall conduct a discharge planning conference phone call, and the sending facility shall pick up the inmate within 72 hours of the date of the discharge from the MHU or in conjunction with the new admission to the FTC at Waymart or a DPW forensic unit.
6. Each state correctional facility shall develop local procedures, assigning specific duties to appropriate staff, and develop special post orders for corrections officers conducting the transports.
7. Every facility is encouraged to use Psychiatric Observation Cells (POCs) to control problem behaviors such as self-inflicted injury or uncontrolled agitation toward others. These cells can be used for two to three days to further assess suicide ideation or threats until a treatment plan can be developed such as transfer to a MHU or return to general population when stable. The use of these cells for longer than three days is discouraged, unless the purpose is to wait for a 304c hearing, which can take five to seven days.

### B. Eligibility Criteria for Intra-Facility Transfer

1. The identification, evaluation, and petition for voluntary commitment via 201 application and involuntary commitment via 302 and 304 petition shall be conducted in accordance

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with the Mental Health Procedures Act<sup>1</sup> and **Section 2, Delivery of Mental Health Services** of this procedures manual.

2. Every facility referral to be considered for transfer to a Department Regional MHU shall meet the following criteria:
  - a. voluntary commitments shall have a **Voluntary Application For Mental Health Treatment Form** (refer to **Section 2, Attachment 2-F** of this procedures manual) completed by the sending unit and accepted by the receiving Department Regional MHU, as well as request for temporary transfer;
  - b. 302 and 304 commitments shall have appropriate forms completed, as well as a **Request for Temporary Transfer to a Mental Health Unit (Attachment 4-A)**;
  - c. the custody level of the inmate being transferred shall be suspended for the course of that inmate's time at the MHU or FTC;
  - d. males shall be housed in a men's MHU and females housed in a women's MHU;
  - e. the sending facility must guarantee a bed for the inmate when he/she is discharged from the Department Regional MHU or FTC;
  - f. the appropriate Department temporary transfer petition shall be completed; and
  - g. transportation to and from the Department Regional MHU or FTC shall be provided by the sending facility.

### C. Department MHU Commitment Process

1. At the Facility Manager's request, the facility mental health staff shall identify individuals who may be in need of inpatient psychiatric evaluation and treatment.
2. The facility Mental Health Coordinator (MHC) or designated psychology staff shall determine if the inmate meets the criteria for a mental health examination and commitment.
3. If a mental health examination and emergency involuntary commitment is deemed appropriate and the facility does not have a MHU on site, then the MHC or designated psychology staff shall pursue a placement at a Department Regional Mental Health Unit. If a male inmate meets the criteria for non-emergency involuntary commitment status, the staff shall refer the inmate to the FTC at Waymart if he is determined to be chronically mentally ill and unable to care for himself in the facility. A female inmate who meets this criteria shall be referred to the forensic units at either Mayview or Norristown State Hospitals.

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<sup>1</sup> 4-4404



4. The MHC or designated psychology staff shall contact the Department Regional MHU Director to discuss the case and obtain approval for MHU admission. The MHC or designated psychology staff shall also contact their facility CHCA or designee and provide the name and Department number of the inmate and the mental health facility to which the inmate will be transferred. The sending facility CHCA/designee shall review the medical file and contact the CHCA/designee of the designated receiving mental health facility and provide any additional medical information/status to ensure no lapse in medical treatment. The MHC shall fax a **Request for Temporary Transfer to a Mental Health Unit** to the MHU Director and the office of the Chief of Psychological Services that shall include the date of transfer. The sending facility shall telephone the Transportation Division at 717-731-7072 or email the transportation group at CR-DOC Inmate Transportation.
5. The sending facility shall telephone the Bureau of Treatment Services (BTS), Diagnostic and Classification Coordinator, who handles transport to advise of the impending transfer and provide the information from the **Request for Temporary Transfer to a Mental Health Unit**.
6. The facility mental health staff requesting commitment shall process the 201, 302, or 304 petition in accordance with the Mental Health Procedures Act. The preferred procedure for completing the 302 and 304c petition shall be for the physician examination sections to be completed by a psychiatrist or **physician** in the sending facility, not the receiving MHU or Waymart.
7. The MHC of the sending facility shall arrange vehicle transportation for the patient to the Department Regional MHU.
8. The MHC shall prepare the transfer package consisting of at least the following documents, which must accompany the inmate:
  - a. original 201 application, 302 or 304 petition;
  - b. complete **DC-15, Inmate Record** file;
  - c. complete medical/dental and psychiatric files;
  - d. a copy of the **DC-17, Conduct Record**; and
  - e. a copy of the **Inmate Cumulative Adjustment Record** for the past 90 days.
9. Staff shall ensure the inmate is sent with the minimum approved inmate property required for transfer in accordance with Department policy **6.3.1, "Facility Security"** (see **Approved Inmate Property for Transfer to a Mental Health Unit, Attachment 4-B**).
10. Upon arrival at the designated MHU, the transporting officer shall deliver the inmate and records to the Department Regional MHU staff through appropriate reception channels or procedures developed by the MHU staff. The complete medical/dental and psychiatric files shall be delivered to the facility's medical records department.

#### D. Department Regional MHU Responsibilities

1. The Department Regional MHU Director/designee shall immediately review any cases submitted for consideration for commitment. The Director may request any additional information he/she believes is necessary and may also request a telephone conference call with referring staff to discuss the case. The MHU Director/designee shall notify the facility CHCA/designee when such a conference is scheduled.
2. The MHU Director shall consult with the MHC to schedule the date and time for transfer and request any additional information.
3. If the patient is ready for discharge at or before the treatment limits, the Department Regional MHU or FTC shall notify the MHC of the sending facility of the impending discharge. Treatment staff from the MHU or FTC and sending facility shall conduct a discharge treatment planning conference call. The facility shall arrange to pick up the inmate within 72 hours following the discharge date. Both parties shall document the date of the conference call, the participants, and a summary of the plans that were agreed upon.
4. If an inmate needs care beyond the limits of the Regional MHU, the Regional MHU staff shall initiate a transfer to the FTC at Waymart or DPW Forensic MHU (females only). The referring facility shall be responsible for transportation of any transfer cases from the Department Regional MHU to the Forensic Psychiatric Unit at Waymart or a DPW Mental Health Unit.
5. If the Department Regional MHU is transferring the inmate to the FTC at Waymart or to a DPW Forensic MHU, the MHU staff shall follow procedures in **Section 2** of this procedures manual, including conference call, copy of 304 petition, Classification Summary, Mental Health Commitment - Medical Summary, and advising security and records office.
6. The MHU staff shall advise the Corrections Classification Program Manager (CCPM) of the receiving facility of the inmate's presence in the MHU.

## Section 5 – Residential Treatment Units (RTUs)

### A. Program Mission

1. The Residential Treatment Unit (RTU) is designed to provide structure, consistency, and support to inmates who have been diagnosed with a serious psychiatric disorder and/or a serious impairment with psychological functioning. The RTU will implement treatment strategies that rely on the Recovery Model, which is based on recovery principles that facilitate individual growth, hope, self-determination, overcoming obstacles, coping skills, and re-connection to support systems. The Recovery Model is an evidence-based practice. The RTU is intended to provide opportunities for inmates and staff to establish a therapeutic alliance which is of the utmost importance for the recovery of the RTU inmate. The ultimate goal of the RTU is to maximize functioning within the Department and to facilitate a successful community re-entry for relevant inmates.
2. All “D” roster facilities shall operate a RTU in accordance with this section. Each facility with a RTU is responsible for developing post orders, a unit operations manual, and local procedures consistent with this procedures manual. The manual, local procedures, and any revisions shall be reviewed and approved by the respective Regional Deputy Secretary. An annual review of every procedure and post order governing the RTU operation is to be conducted by unit staff and reviewed by the Facility Manager. Every revision, approval, and yearly review is to be maintained in the operations manual.

### B. Admission Criteria and Process for Transfer

1. The RTU is a unit designated for inmates with current, significant psychiatric and impaired psychological functioning. These inmates may be experiencing or may be predicted to have difficulty adapting to general population housing in the Department. Inmates currently in the RTU will not meet commitment criteria according to the Pennsylvania Mental Health Procedures Act.
  - a. Only inmates on the active Mental Health Tracking Roster (Mental Health Rosters “C” and “D”) are eligible for placement on the RTU. Intellectual limitations may be taken into account, but only in the case of inmates with current, significant mental health issues. ***Inmates who carry a stability rating of C or D and who are receiving psychiatric services may be considered for placement in the RTU even if he/she could be safely housed in general population.*** An inmate should not be considered for RTU placement without a current significant mental health issue(s)/diagnosis. Inmates of every age group, custody level (except custody level 5), program code, and sentence structure are eligible for RTU placement, if they are identified as “active” on the Mental Health Roster.

NOTE: The ultimate goal for RTU inmates is to be housed at the most independent/least restrictive level of care. This is especially important after Individual Recovery Plan (IRP) goals have been met.

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- b. An inmate who may have physical limitations, sensory impairments, is elderly, or who appears vulnerable, or who has other “special” needs that may inhibit positive adjustment to general population, but who does not have any current, significant mental health issues should be housed in another appropriate area of the facility.
2. Referrals from within the facility may be made by the Unit Management Team, Medical Department, Psychology staff, Program Review Committee (PRC), or any other staff member who perceives an inmate as having adjustment difficulties due to a limitation.<sup>1</sup> The referral shall be made to the Psychiatric Review Team (PRT), who shall screen and evaluate the referred inmate.<sup>2</sup> The inmate will attend this meeting and will have input into his/her potential placement in the RTU. If he/she declines to attend that meeting, this will be documented in the IRP and an **Inmate Cumulative Adjustment Record (ICAR)** entry shall be entered. Following the evaluation, the Unit Team shall prepare a **DC-46, Vote Sheet** concerning RTU admission. The recommendation shall be forwarded for administrative staff review and action through the Corrections Classification and Program Manager (CCPM), the Deputy Superintendent for Centralized Services (DSCS), and the Deputy Superintendent for Facilities Management (DSFM). The Facility Manager must review any split votes regarding RTU program admission or rejection.
3. Facility staff who identifies an urgent need for RTU placement may request admission approval directly from the Facility Manager/designee.
4. A referral from a facility where there is no RTU (such as a Security Level 2 facility), from a facility that has an inmate whose mental health needs it cannot accommodate, or where a separation is required, may be considered. Transfer requests shall be made via the transfer petition process as outlined in Department policy **11.1.1, “Population Management.”**
5. Every attempt shall be made to place any inmate who needs RTU housing into a suitable unit within 30 days of the initial evaluation.
6. In cases where an inmate has been approved for RTU placement and space is not available, the PRT shall prioritize placement in the program. The following criteria shall be used:
  - a. ability to function within general population;
  - b. alternative placement availability;
  - c. length of time inmate is likely to be in RTU;
  - d. programming offered in the RTU; and
  - e. objectives of the inmate’s IRP.

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<sup>1</sup> 4-4305

<sup>2</sup> 4-4399

7. In order to generate additional RTU bed space, the PRT shall consider the following:
  - a. double-celling an inmate; or
  - b. discharge of a higher functioning inmate to alternative housing (if available, step down unit or appropriate general population housing).
8. In those cases where an inmate is seriously disruptive within the unit, the RTU Management Team shall consider alternative but appropriate housing.<sup>3</sup>

### C. RTU Cell Assignment

1. ***Ideally, RTU inmates are compatibly double-celled.***
2. ***The Unit Management Team will make every effort to facilitate a double-celling agreement between compatible RTU inmates.***
3. ***Inmates may be double-celled as long as there are no compatibility contraindications present including, but not limited to, age differences, disparate physical size, Security Threat Group (STG) affiliation, security needs, PRAT scores, medical issues, geographic/regional differences, and/or a documented history of ethnic/religious violence.***
4. ***Involuntary double-celling of a RTU inmate should only occur under the direct oversight and supervision of the Unit Manager.***
5. ***The Involuntary Double-Celling Checklist (Attachment 5-A) shall be used prior to double-celling a RTU inmate. Any “yes” response in the Staff Review Section stops the process, pending review by the Unit Manager.***
6. ***Involuntary RTU double-celling after normal working hours is prohibited except in the event of extenuating circumstances, and should only occur with the authorization of the Shift Commander.***
7. ***RTU inmates will only be placed in a single cell if they meet the criteria for sing-cell/Z-code status as outlined in policy 11.2.1.***

### D. Individual Recovery Plans (IRPs) and Psychiatric Review Team (PRT)

1. An inmate on the Mental Health Tracking Roster requires an **Initial IRP, Parts 1-3 (Attachment 5-B)**. Within 14 days of admission, the RTU staff, in conjunction with PRT, Psychology staff, and the inmate shall complete an **Initial IRP** (if the inmate does not already have one) or a **Change of Status IRP (Attachment 5-C)**.

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<sup>3</sup> 4-4399

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2. All inmates on RTUs shall have their recovery plan updated every 120 days. This shall be accomplished using the **Review-IRP (Attachment 5-D)**.
  - a. IRPs should be specific to the inmate's needs and should include obtainable goals that the inmate has helped create. The IRP should be recovery-based keeping recovery principles as the focus. The inmate's input concerning his/her IRP should be taken into account by the PRT.
  - b. The **IRP Guidelines (Attachment 5-E)** provide additional guidelines for writing IRP's as well as which type of IRP is appropriate for the inmate such as an Initial, Review, and/or Change of Status IRP.
  - c. At SCI-Muncy, the Daily Adult Interactive Learning Experience (DAILE) staff will work in conjunction with the RTU staff and the inmate to complete their IRP's. The inmate's IRP will encompass both on-unit and DAILE goals. This will ensure that treatment is cohesive between both programs and not confuse the inmate with two separate treatment plans.
3. PRT will be held on the RTU or another appropriate location. RTU inmates will be permitted and encouraged to attend PRT meetings related to their treatment. If an inmate declines to attend the PRT meeting, this shall be noted in the IRP and an entry in the **ICAR** should be noted. RTU staff and/or PRT shall review the IRP every 120 days as stated above and make appropriate revisions.

**E. Treatment Team Meetings**

1. Treatment Team Meetings shall be conducted weekly if possible, bi-weekly at a minimum. Meetings shall include all disciplines of the RTU (Corrections Officer, Counselor, Psychology, Unit Manager, Psychiatry, AOD, Education, Medical, and Activities, as appropriate). Meetings shall be utilized to review IRP progress, review goals for inmates, review incentive programs, discuss inmate behavior, and evaluate inmates and recovery-oriented programming. **Attendance of the Treatment Team meeting should be recorded and kept on file.**
2. At SCI-Muncy, DAILE staff will be included in the RTU PRT meetings. This allows opportunity for pertinent information to be shared between the two programs.

**F. Treatment Programming**

1. The RTU staff offer at least 35 hours of programming per week; including two hours each day of unstructured recreational activity. Participation in religious services, employment or educational programs can be included in the required 35 hours. However, these areas cannot account for more than 10 hours and the **DC-43, Integrated Correctional Plan (ICP)** programs cannot account for more than eight hours. Remaining programs must be equally distributed through the provision of recreation, treatment specific, community, and therapeutic support.

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NOTE: At SCI-Muncy, the DAILE program's hours can be included in the required 35 hours per week.

2. Programming shall be voluntary, but highly encouraged, with assigned inmate participation in activities that should help the inmate meet his/her goals from their IRP.
3. Programming shall be designed to stabilize and stimulate the recovery needs of the inmate with the ultimate goal, where appropriate, of re-integration into a general population housing unit.
4. An inmate in RTU housing will be permitted to participate in group activities and other programs with general population inmates.
5. The required 35 hours of RTU programming should include programs on and off the unit to meet the needs of both higher and lower functioning inmates. Programming should focus on meeting IRP objectives to include influencing inmates to have frequent opportunities for social interaction and to be actively involved with recovery oriented activities.

NOTE: Trained Peer Assistants and/or Certified Peer Support Specialists can be utilized to assist staff in providing support programs and activities in compliance with Department policy **7.3.1, "Inmate Re-Entry and Transition."** At no time will a peer assistant or a peer support specialist be responsible for supervision of the RTU inmates. ***Peer Assistants and/or Certified Peer Support Specialists may be housed on the RTU even if they are not on the "C" or "D" Roster, as long as doing so does not take a bed away from an inmate who requires that level of care.***

6. A suggested menu of required and optional therapeutic groups is as follows:
  - a. Group Therapy
    - (1) \*goals group;
    - (2) \*coping skills;
    - (3) anger management;
    - (4) self-esteem;
    - (5) \*medication adherence;
    - (6) hygiene group;
    - (7) alcohol and other drugs;
    - (8) life management skills;

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- (9) \*support based groups;
- (10) daily living skills;
- (11) inter-personal relations;
- (12) communication skills;
- (13) stress management;
- (14) healthy relationships;
- (15) healthy living;
- (16) human sexuality;
- (17) relapse prevention;
- (18) mental health THU workshop;
- (19) wrap wellness; and
- (20) social skills.

b. Recreation

- (1) aerobics;
- (2) special exercise class;
- (3) recreational therapy;
- (4) art therapy;
- (5) music therapy;
- (6) specially designed tournaments;
- (7) bingo;
- (8) structured card and board games;
- (9) yard-out activities;
- (10) sports activities; and
- (11) game systems (Xbox, Wii).



- c. Insight Oriented Therapeutic Groups
  - (1) dialectical behavior therapy informed groups;
  - (2) depression-anxiety groups;
  - (3) adjustment groups; and
  - (4) prison adjustment.

- d. Standardized Psycho-Educational Groups
  - (1) Start Now;
  - (2) Seeking Safety;
  - (3) Taking a Chance at Change; and
  - (4) Medlin Sex Offender Treatment.

\*Required in every RTU due to the special recovery needs of the mentally ill individual. The Medication Adherence groups will be facilitated by a PSS/PSA, and may be co-facilitated by nursing, Psychiatry, or other appropriate staff members.

- e. The **Group Therapy Resources for RTU Inmates (Attachment 5-F)** references resources that have shown to be helpful with inmates who have participated in the DAILE program at SCI-Muncy and the Special Needs Unit (SNU) at SCI-Camp Hill. These resources should be considered for use during the required and optional group therapy sessions.
- f. The **Wellness Recovery Action Plan (Attachment 5-G)** is a template for facilitating a Wrap Wellness (Wellness Recovery Plan) group or for use on an individual basis. WRAPs can help reduce troubling feelings and behaviors, help individuals feel more control over their mental illness and have the potential to improve quality of life.
  - (1) Religion
    - (a) religious studies;
    - (b) regular services;
    - (c) musical group or choir; and/or
    - (d) literacy.

- (2) Education
    - (a) Adult Basic Education (ABE);
    - (b) General Education Diploma (GED); and/or
    - (c) life skills.
  - (3) Employment
    - (a) regular facility inmate details;
    - (b) specially designed details for mentally ill inmates;
    - (c) block workers; and/or
    - (d) janitors.
7. Programming should enlist a variety of facility staff or community volunteers who are essential in the development of appropriate programs.
8. A schedule for RTU programming must be posted in conspicuous areas in the RTU. A copy of the **RTU Program Schedule (Attachment 5-H)** shall be given to each RTU inmate by his/her counselor upon admission to the unit and reviewed with the inmate prior to the initial RTU IRP (within 14 days). RTU program schedule shall be posted by the Unit Manager/designee when updates/changes are made.

### **G. Milieu/Unit Atmosphere**

1. The RTU shall display posters that include motivational quotes and/or goal oriented language. Daily and/or weekly quotes are encouraged to be displayed throughout the unit. Decorative bulletin boards should be used to display inmate artwork, RTU program schedules, and the name of the selected “resident” of the week. Selecting a resident of the week has the potential to enhance motivation among the RTU inmates and can help facilitate a sense of pride. A resident of the week should be chosen using the following consideration:
- a. an inmate who participates in unit activities;
  - b. an inmate who has demonstrated improved behavior;
  - c. an inmate who has achieved identified IRP goal(s); and/or
  - d. an inmate who is helpful to others.

2. Rewards

a. The following are “rewards” that should be considered for the resident of the week:

- (1) chips;
- (2) **candy**;
- (3) **pretzels**;
- (4) **crackers**;
- (5) **popcorn; and/or**
- (6) **other small snack items.**

b. **The Unit Manager, in cooperation with the Business Office, will purchase a supply of the above listed items. The resident of the week will be allowed to choose any two items from that supply.**

c. **Other rewards that could be considered instead of or in addition to the above items are:**

- (1) **TV privileges**;
- (2) **first release to meals**;
- (3) **photo on the bulletin board; and/or**
- (4) **other privileges as allowed by policy.**

3. Community Meetings are encouraged on the RTU and should be facilitated by the Counselor, Unit Manager and/or Corrections Officer (CO) at least twice per month. Psychology staff are highly encouraged to attend. These meetings shall allow for inmate input regarding the happenings on the unit as well as to help facilitate a sense of ownership and connectedness with other inmates and staff.

4. The RTU is encouraged to have at least one “game” night a week which will provide structured opportunities for the inmate to socialize. Prizes should be considered as an option for participation/“winning” the game.

## **H. Treatment Team Responsibilities**

Staffing needs for each RTU shall vary based upon the unit size, physical structure, type of inmate services, etc. All staff directly assigned to the RTU will receive an annual review of their continued assignment to the unit in conjunction with their routine EPR. Re-assignment will be made based on approval through the Unit Manager, the staff member’s supervisor,

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and appropriate chain of command. The Unit Manager, Psychologist, Counselor, and COs shall have designated and trained staff to cover the unit in their absence to the greatest extent possible.

1. Unit Manager

The Unit Manager is responsible for supervision of all Unit Management members of the Treatment Team, as well as the delivery of security and program services for the RTU. The Unit Manager shall work in conjunction with other supervisors/Department Heads in providing staff and services for the unit. If space does not permit a permanent office on the unit, the Unit Manager shall attend PRT unit meetings and visit the unit on a daily basis (Monday through Friday). Unit visits will consist of meaningful interaction with staff and residents during activity/programs and through the use of cell tours, office hours, etc., with a minimum of three hours spent on the unit daily.

2. Counselor

The Counselor will perform case management duties to the RTU inmates, as assigned by the RTU Unit Manager. Such duties may include (but are not limited to) attending Commissary meetings, co-facilitating therapeutic groups, individual inmate contacts, and supervising inmate out-of-cell time. The Counselor shall manage the casework duties for every inmate assigned to the unit. He/she shall complete every necessary report, staffing, assist in the development of IRP's, and provide individual and group counseling. If space does not permit a permanent office on the unit, Counselors shall attend every unit meeting and visit the unit on a daily basis (Monday through Friday).

3. Corrections Officers (CO)

A CO must be selected to work in the RTU by a committee consisting of at least the Unit Manager, Major, Shift Commander, and/or Zone Lieutenant. LPM involvement in this decision is highly encouraged. The committee shall select officers who have demonstrated ongoing interest in and effective management skills working with mentally ill inmates. COs shall be assigned to the unit on a regular basis to foster investment in the program, as well as to maintain continuity of care. When possible, regular alternate COs should be selected to replace primary COs during off days, vacation, or illness. The alternate can also be used to replace the primary CO when he/she is rotated or otherwise leaves the unit. Due to required training and specialized selection process, assignment to this unit will not utilize a bid post process.

- a. The CO staffing complement for the RTU should be in accordance with the facility's staffing survey.
- b. COs shall make three security patrols per hour on the RTU.

4. Psychology Services Specialist/Associate

A member of the Psychology staff shall be responsible for providing ongoing monitoring, individual and group therapy, developing IRPs with the inmates, as well as required assessments and reports. If space does not permit a permanent office on the unit, the PSS shall attend PRT, unit meetings, and visit the unit on a daily basis (Monday through Friday). Unit visits will consist of meaningful interaction with staff and residents during activity/programs and through the use of cell tours, office hours, etc. with a minimum of one hour spent on the unit daily participating in these services; this hour does not include programs/workshops facilitated on the unit. Psychology staff is required to provide a total of 20 hours of Mental Health services on the RTU a week per 75 RTU inmates.

5. Licensed Psychologist Manager (LPM)

The LPM will not be dedicated solely to the RTU but he/she will also supervise and administer psychological services in other areas of the facility. The LPM will provide administrative and clinical supervision of all Psychology staff, including Psychology staff in the RTU. The LPM will also provide clinical oversight and guidance to the entire RTU team and should consult with the RTU Unit Manager on a regular basis.

6. Psychiatry Staff

The Psychiatrist/PCRNP will meet with RTU inmates as often as deemed clinically necessary but no less than once every 90 days. The psychiatrist/PCRNP will also attend the PRT meetings held on the unit. The psychiatrist/PCRNP will consult with the RTU staff on an as-needed and emergency basis and will attend RTU Treatment Team meetings as possible.

7. Medical Staff

Nursing or other medical staff assigned to the unit shall monitor the medical needs of the inmates on the unit, medication compliance, assist with psychiatric referrals, and provide health and hygiene education where staffing levels permit. Medications may be delivered by Nursing/Medical staff to the RTU and will be administered on that unit according to policy. ***RTU inmates may also participate in going to the infirmary for medication. Each facility will decide which method of delivery works better.***

8. Centralized Services Staff

Staff from other departments may be assigned to the unit to provide specific services. When possible, services shall be provided by the same persons to foster investment in the program and maintain continuity of care. When possible, services should be provided on the unit. The remaining list (**Subsections H.9.-13. Below**) of service providers is not mandatory nor is it all-inclusive.

9. Activities Staff

Corrections activities staff shall provide structured recreational programming, plan and facilitate special events, and coordinate the scheduling of space, supplies, and equipment. Requests for funding for supplies and equipment may be submitted to the Inmate General Welfare Fund (IGWF) through the Activities Department. Activities should be available to RTU inmates on the RTU. If RTU inmates are participating in a recreational activity in another area of the facility, they should be able to do so at a time that other inmates are not permitted in that area (e.g., RTU only gym time).

10. Education Staff

Education programs shall be developed in accordance with the needs of each inmate being serviced in the unit.

11. Alcohol and Other Drugs (AOD) Specialists

AOD staff, in conjunction with Psychology staff, shall develop and implement programs for dually diagnosed individuals and others with alcohol and other drug problems.

12. Contracted Services

A facility which has specific services provided by contracted vendors shall review the agreements and in conjunction with the director of the service, provide services for each inmate in need. Services such as art, music, recreational or occupational therapy may be obtained using the inmate IGWF as the funding source in accordance with Department policy **3.1.1, "Fiscal Administration."**

NOTE: At SCI-Muncy, MHM Correctional Services currently operates the DAILE program. This program will be available for the majority of the RTU inmates. However for those that do not attend, they will be encouraged to participate in the on-unit programming as outlined in the RTU policy. The RTU Team and DAILE Team will work together to determine which inmates will benefit from the DAILE program or the on-unit RTU programming.

13. Volunteer/Student Interns

When possible and appropriate, community volunteers or groups shall be used to provide support services. Facilities with student intern programs may assign students from appropriate fields of work in the unit.

**I. Medications**

For inmates housed in the RTU, medications shall be either delivered to the unit or an independent medication line movement shall be established. Medication compliance shall be

monitored in accordance with Department policy 13.2.1, “Access to Health Care,” Section 12.

#### **J. Razors**

RTU inmates are permitted to retain issued razors, razor blades, and mirrors in his/her cell. Unit Officers shall thoroughly inspect each razor upon an inmate’s admission to the unit to ensure the item has not been altered. The RTU staff member conducting the inventory of the inmate’s property will ensure the inmate only has one razor in his/her possession. RTU staff require PRT approval to restrict razor possession or shaving privileges of any RTU inmate. Restriction of shaving privileges or razor possession shall only occur when legitimate security, psychiatric, or other concerns exist. Examples of concerns include, but are not limited to, assaulting/threatening other with razor, inflicting/threatening self-injurious behavior with razor, or any physical modification to a razor. In the event an inmate is placed on razor restriction, this will constitute a status change. Accordingly, the inmate’s IRP will be updated to address this status change and to outline the specific goals, objectives, and time-frame necessary for razor restriction removal. RTU staff require PRT approval to remove any RTU PRT’s decision to approve the removal of any RTU inmate from razor restriction is contingent on the inmate’s performance with his/her updated IRP.

#### **K. Staff Training and Development**

Each contact staff member shall receive Crisis Intervention Training (CIT), Mental Health First Aid (MHFA), and Suicide Prevention in accordance with Department policy 5.1.1, “Staff Development and Training.” In addition, all RTU staff shall receive training on recovery model concepts, behavior modification, conflict intervention, and managing the intellectually impaired, etc. Newly assigned staff shall receive RTU Training within six months of their assignment to that unit. When this is not feasible, staff will be scheduled as soon as possible to meet with the Unit Manager and LPM. This meeting will provide a RTU briefing based on the approved RTU training material. RTU staff will also be scheduled to attend CIT prior to or soon after their assignment to that unit.

#### **L. Behavioral Adjustment Cell (BAC)**

The Behavioral Adjustment Cell (BAC) is an option when an inmate is experiencing behavioral decomposition that could potentially lead to the issuing of a misconduct. In this case the BAC is used as a behavioral management tool. The BAC is an option when the inmate is becoming disruptive due to inappropriate language and/or non-compliance, etc. The BAC is not appropriate for inmates who are threatening to harm themselves or others. The BAC is viewed as a therapeutic intervention. The goal of the BAC is to facilitate the positive adjustment of the inmate. Placement in a BAC must be made by the Unit Team and/or Shift Commander on off hours. The decision to use a BAC will be a Unit Team decision. The BAC shall be located in close proximity to the officer’s station. ***Ideally, two cells near the officer’s station should be reserved for use as BAC cells.***

1. The BAC should be considered by the Unit Team after all recovery oriented and established behavioral modification interventions have been exhausted.

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2. The Unit Team will use the **BAC Tracking Sheet (Attachment 5-I)** to outline the behaviors for BAC placement. The **BAC Tracking Sheet** will document initial time of placement and anticipated release, permitted in-cell contents, if regular inmate movement is permitted, goals for BAC discharge, and involved Unit Team members. Note that the time of anticipated release can change at the Unit Teams discretion but cannot exceed 48 hours.
3. COs should make three security patrols per hour of the BAC. Documentation of this observation should be made in the Housing Unit Log Book.
4. Inmates who are placed in the BAC shall be re-evaluated by the Unit Team/Shift Commander every 24 hours and as indicated below.
5. There should be clearly defined goals for behavioral improvement prior to discharging an inmate from a BAC. These goals should be immediately documented on the **Change of Status IRP** upon placement and included on the **BAC Tracking Sheet**. The Unit Team shall make an effort to work collaboratively with the inmate in the establishment of these goals and to encourage the inmate to achieve their recovery goals.
6. The PSS assigned to the RTU shall be contacted immediately upon inmate placement in the BAC during normal business hours. If an inmate is placed in the BAC outside of normal business hours, nursing staff shall be contacted immediately for an initial assessment. If the nursing staff (during off hours) makes initial contact, he/she will assess the inmate and determine if the BAC is appropriate and/or if the Psychiatric Observation Cell (POC) is warranted. The PSS should also be available for PRN contact with the inmate during his/her placement in the BAC.
7. If the PSS/designee makes initial contact with the inmate housed in the BAC, he/she will help the inmate to identify the origins of the problematic behavior and to encourage the inmate to achieve their recovery goals. The PSS shall also determine if the BAC is appropriate and/or if the POC is warranted. The PSS should also be available for PRN contact with the inmate during their placement in the BAC.
8. If no behavioral improvement is noted while the inmate is housed in the BAC, the Unit Team and/or Shift Commander will reassess placement. Confinement in the BAC should not exceed 48 hours.
9. If the inmate significantly decompensates in the BAC at any time, the Unit Team/Shift Commander will reassess the inmate's behavioral state and make alternate recommendations, which may include POC placement or MHU referral.

**M. Discharge and Transfer Procedures**

1. An inmate shall be considered for discharge by the RTU management team when he/she no longer needs the security, structure, and/or programming provided by the unit. This process is also to be used when alternate housing may be appropriate for a seriously disruptive inmate or for an inmate who refuses to participate in stipulated IRP activity,



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programs, and taking prescribed medication. Removal will be made only when it does not endanger his/her welfare and stability.

2. Prior to discharging an inmate from the RTU, the PRT will meet to consider such discharge. The PRT will be held on the RTU and the inmate will be offered the opportunity to attend that meeting and give his/her input and feedback related to potential discharge from the unit. If he/she declines to attend that meeting or provide input that will be documented in the IRP and an **ICAR** entry shall be made.

NOTE: At SCI-Muncy, the DAILE program staff will participate in the development of the discharge summary and process to include recommendations for continued care. Inmates may continue to participate in the DAILE program even though they are discharged from the RTU.

3. The recommendation for discharge of the inmate to general population or to other housing shall be done via **DC-46** by the RTU Management Team. Included in the body of the **DC-46** shall be a discharge summary that documents the inmate's progress, reasons for discharge and recommendations for follow-up monitoring, future programming and continuing care. The **DC-46** shall be sent, at a minimum, through the CCPM and DSFM for final action. The Facility Manager/designee must review every split vote.

NOTE: In those cases where the inmate is to be returned to another facility, a transfer petition shall be submitted in accordance with Department policy **11.1.1**. Inmates on the active MH/ID roster ("C" or "D" roster) must have an IRP attached to the petition.

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## Section 6 – Post Traumatic Stress Disorder Treatment Program

The Post Traumatic Stress Disorder (PTSD) Treatment program is for inmates who are combat veterans.

This section describes an abbreviated version of the earlier treatment program and is being retained in the policy to provide counseling and psychology staff members with general guidelines to conduct treatment with the inmate if sufficient resources are available in his/her facility. If not available, it may be necessary to initiate a transfer petition to another facility.

Although the PTSD program was developed for a combat veteran of the Viet Nam War, it is likely that components of the model may be relevant for an inmate combat veteran of other military conflicts.

### A. Awareness and Education Phase

The PTSD victim tends to be guarded, suspicious, and non-trusting of authority figures. Therefore, preplanning, structure, and communication are essential elements to the presentation and implementation of the program.

1. An inmate veteran who is interested in participating in the program shall be advised of the documents he/she needs to obtain in order to validate his/her combat service and to be evaluated for admission to the program.
2. An interested inmate veteran shall also complete the **DC-553, Military Veterans Scale (Attachment 6-A)** and the **DC-552, Military Experience Scale (Attachment 6-B)** at this meeting. The original of these forms shall be filed in the inmate's medical record and a copy shall be filed in the **DC-14, Inmate Cumulative Adjustment Record**.
3. Staff may choose to hold three or four "decision group" sessions with an interested inmate veteran to give him/her an opportunity to learn what the program is like and for treatment staff to get to know and evaluate him/her before proceeding with diagnostic evaluations.

### B. Evaluation

The evaluation phase shall be conducted to select candidates for the PTSD program.

1. Before being accepted for evaluation, the inmate veteran shall obtain and present documentation that he/she served in combat or a similar stressful position. The primary verification document shall be the Department of Defense form **DD-214, Report of Separation from Active Duty**. Staff shall provide the inmate with addresses of Veterans Administration (VA) Offices to request appropriate application forms. If the inmate has already been evaluated by the VA, other agencies, or individuals for PTSD or other similarly related disability claims, copies of the release of information for said reports shall be secured.

2. The PTSD treatment staff member shall conduct the intake interview. The in-depth interview shall develop a personal history including the veteran inmate's social, educational, criminal justice, vocational, and military experiences. A thorough background history prior to his/her military experience and prior to offense is essential to establish behavioral and personality characteristics and changes in line with criteria described in the DSM-IV.
3. The psychologist shall administer and interpret the Minnesota Multiphasic Personality Inventory (MMPI-2) or the Personality Assessment Inventory (PAI). If the inmate's reading level prohibits the use of the MMPI-2 or the PAI, an alternative battery of at least two projective techniques may be employed. A report shall be prepared that presents the standard scores and a narrative summary.
4. The licensed psychologist or psychiatrist/**Certified Registered Nurse Practitioner – Psychiatric Services(PCRNP)** shall make a diagnosis of PTSD based upon the criteria in the DSM-IV.
5. The PTSD treatment staff shall develop an Individual Treatment Plan (ITP), which shall be reviewed every 120 days. The ITP shall be filed in the **DC-14** if the inmate is not placed on the Mental Health/Mental Retardation (MH/MR) Roster. If the inmate is placed on the MH/MR Roster, the plan shall be filed in the psychiatric section of the medical record with a copy placed in the **DC-14**.

### C. Treatment Program

#### 1. Group Counseling

Group counseling shall be the primary treatment approach. The group may be led by an individual staff member or by co-leaders, if sufficient personnel are available. Emphasis shall be placed upon understanding the military experience, as well as related personal adjustment problems. Guidance shall be given to bring out feelings and develop emotional awareness. Attempts of the inmate to skirt the main issues and/or discuss prison concerns/complaints shall be kept to a minimum.

#### 2. Group Size and Frequency

Groups shall be run on a variable schedule as needed and as staff resources permit, but generally shall run for one to one and one-half hours, three times a week. Group size shall generally be limited to five to 10 participants.

#### 3. Individual Counseling

In rare cases, an inmate veteran may be assigned to individual counseling in conjunction with or instead of group counseling when needed. The program staff, at the time of initial evaluation, shall determine the inmate veteran who is in need of individual counseling. The staff member providing individual counseling shall determine the number of the counseling sessions based on the client's needs and resources available.

4. Personal Journal

Each inmate shall be required to maintain a personal, daily journal and/or complete readings of materials recommended by the program staff, counselor, and VA consultants. The personal journal shall be a confidential document to be used in the treatment process with the treatment staff, in group and individual counseling, and in peer interactions when deemed appropriate. The journal shall include, but not be limited to, the inmate's daily interactions, feelings, attitudes, and reflections. The journal shall not become a part of the inmate file.

5. Veterans Administration Services

Whenever possible, the treatment staff shall encourage VA representatives to provide services to each inmate veteran. VA representatives may be willing to visit the facilities to conduct groups and provide other supportive services.

6. Ancillary Services

In the evaluation phase and treatment plan development, the staff shall address ancillary services needs. Such areas as Alcoholics Anonymous/Narcotics Anonymous groups, drug/alcohol counseling, educational/vocational, and leisure time needs shall be considered. Consultation with, and participation of, staff from the Veterans Outreach Centers shall be encouraged.

7. Confidentiality

It is likely that program staff shall enter into a relationship with the inmate in which the client shares personal, sometimes sensitive, information. The position of the Department is consistent with the "Code of Ethics" for the treatment profession.

- (1) The confidential nature of the relationship between the inmate and the staff member is respected in most situations. However, when information is revealed to the staff person, which indicates clear and imminent danger to the inmate, other individuals, the security of the facility, or to society, the staff person is legally and ethically obligated to disclose such information to appropriate officials or supervisors.
- (2) The staff person shall enter the relationship with the client by indicating the limits of confidentiality. It is suggested that the conditions be stated during the treatment plan development phase and in initial group settings.
- (3) Each inmate shall be required to sign the **DC-484, Mental Health Informed Consent Form**.
- (4) Individual progress notes shall be documented on the **DC-14**.

**D. Training**

It shall be the responsibility of the Department to provide, when resources permit, training to selected PTSD program staff. The training shall include the recognition of PTSD signs and symptoms, diagnosis, and treatment.

**E. Program Discharge**

Upon completion of PTSD treatment, a narrative discharge summary indicating the inmate's initial treatment goals, progress, follow-up goals and recommendations shall be prepared. The report shall be filed in the **DC-14**. If the inmate is placed on the MH-MR roster, the report shall be copied to the psychiatric section of the medical record.

## **Section 7 – Special Assessment Unit (SAU)**

### **A. Mission/Purpose**

The intended purpose and overriding mission of the SAU is to conduct an in-depth and time-limited clinical assessment under the ultimate supervision of a licensed psychologist. Out-of-cell activities are encouraged and expected but solely for evaluation purposes as opposed to in-depth treatment efforts. The SAU enlists clinical assessments for the following reasons:

1. to determine the presence or absence of a serious mental illness;
2. to provide diagnostic clarification;
3. to determine the need for referral to a specialized program and housing status;
4. other treatment and housing recommendations; and
5. to determine reason(s) for Secure Residential Treatment Unit (SRTU) removal and proper subsequent placement.

### **B. Time Frame**

Assessments are short term and focused with the expectation that they be completed within 45 calendar days; the vast majority being able to be completed in 30 calendar days. If an assessment remains incomplete after 45 days, the Licensed Psychology Manager (LPM) at SCI Camp Hill or the Licensed Psychologist Director (LPD) at SCI Waymart will notify the LPD at Central Office.

### **C. Location**

The SAU is located within the State Correctional Facilities at Waymart and Camp Hill. SCI Waymart has five beds and SCI Camp Hill has seven beds. The units at both facilities have closed-circuit television monitoring for each SAU cell. Every inmate shall be single celled.

### **D. Admission Criteria**

Admission criteria includes, but is not limited to, the following:

1. uncertainty and lack of diagnostic clarification, or the case requires differential diagnosis for program placement. The information the referring facility requires for their decision making process should be clearly articulated in the referral question to guide the assessment;
2. may have lengthy or multiple admissions to the Restricted Housing Unit (RHU), Administrative Custody/Disciplinary Custody (AC/DC) (refer to Department policy **6.5.1, “Administration of Security Level 5 Housing Units”**);

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3. severe mental illness or a history of mental illness and not currently a danger to self or others and does not fulfill commitment criteria for an in-patient Mental Health Unit (MHU);
4. Special Management Unit (SMU) or long term RHU inmate four to six months prior to sentence completion may be referred;
5. medically cleared of acute medical problems by the referring facility's medical department;
6. a mental health inmate in the Diagnostic and Classification Center (DCC) who has accumulated a significant amount of DC time or a mental health inmate in the DCC who has unsuccessfully adjusted to the DCC Special Needs Unit with multiple admissions to the Psychiatric Observation Cell (POC), the Special Observation Unit (SOU) and/or the RHU; and/or
7. an inmate currently housed in a SMU or SRTU and who has been approved for program failure and an evaluation is requested to determine alternative program recommendations.

**E. Process for Transfer to SAU**

1. The Mental Health Coordinator (MHC) at any State Correctional Facility referring an inmate to a SAU program shall submit the following information to the Office of Population Management (OPM). The referral packet shall include the following:
  - a. a completed **Special Program Referral Approval/Rejection Form**, in accordance with Department policy 11.1.1, “**Population Management,**” **Section 2 – Transfer Petition System, Attachment 2-C**, requesting SAU and Program/Unit Admission;
  - b. **DC-14, Cumulative Adjustment Record** (past three months, unless significant details predate the cutoff);
  - c. **DC-46, Vote Sheet**;
  - d. **DC-186, Separation File**;
  - e. Pre-Sentence Investigation (PSI) (if available);
  - f. a current Individual Treatment Plan (ITP);
  - g. **DC-487, Transfer Health Information Form** (including Medication Compliance Records);
  - h. request for **Temporary Transfer to a Mental Health Unit Form**; and
  - i. a copy of the Mental Health Section of the medical record.

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2. Once the SAU referral packet is completed at the facility, it will be forwarded simultaneously to the OPM mailbox dedicated to the Special Programs Referral and the respective Regional LPM. This mailbox is located at: CR, CEN OPM Special Program REFERRALS. This packet must only be forwarded electronically. OPM will log and track the referral packet as it moves through the approval/rejection process.
3. The Regional LPM will review the SAU referral packet and schedule a face-to-face (on-site or via video conference) interview with the referred inmate. The purpose of this interview is to facilitate an appropriate referral to the SAU. This interview provides a focused independent assessment, upon which the Regional LPM can make further recommendations, then if needed, to the facility regarding the referral process. Additionally, this focused interview process will provide guidance to the Bureau of Health Care Services (BHCS) Chief Psychologist and Chief of Psychiatry in their approval process of this packet. The Regional LPM will notify OPM when the referral packet is ready to be forwarded to the Chief Psychologist and Chief of Psychiatry. The findings and recommendations of the Regional LPM will be communicated to the Chief Psychologist and OPM electronically, with a copy to the referring facility's LPM.
4. The Chief Psychologist, Chief of Psychiatry, and Regional Deputy Secretaries for the sending and receiving region will vote on the SAU referral. If the recommendations are not unanimous, the Executive Deputy Secretary will make the final recommendation.
5. Referrals for other specialized programs like the SMU or SRTU may be changed to SAU referrals by the Chief Psychologist, Chief Psychiatrist, Regional Deputy Secretaries or Executive Deputy Secretary if specialized assessment for diagnosis and program appropriateness is deemed relevant for clarity.
6. When an inmate is approved or disapproved for admission to the SAU, OPM notifies the referring facility via email with copies to the Chief of Psychology, BHCS, and Diagnostic and Classification Coordinator, Bureau of Treatment Services (BTS). This email includes the reasons for rejections and recommendations.
7. Once OPM has notified the referring facility that an inmate has been approved for SAU admission and the inmate is placed on the SAU waiting list, the referring facility will immediately implement the following protocol for Enhanced Mental Health Services which has been established for inmates on the SAU waiting list:
  - a. weekly out-of-cell psychology contact, at minimum, will be conducted, with the **Inmate Cumulative Adjustment Record (ICAR)** and the **DC-560, Mental Health Contact Note** documentation copies to the medical report;
  - b. additional psychological contacts, if requested by the inmate or a staff member, will be provided by the assigned psychologist during his/her scheduled daily psychology rounds;
  - c. monthly out-of-cell psychiatrist/Certified Registered Nurse Practitioner – Psychiatric Services contacts;



- d. weekly review by the Psychiatric Review Team (PRT);
  - e. monthly Program Review Committee (PRC) review; and
  - f. continued weekly Correctional Counselor visits.
8. If the referring facility cannot fully provide the above protocol for enhanced mental health services, the facility should contact OPM as soon as possible so that OPM can expedite transfer to the nearest facility which is able to provide this protocol.
  9. Once an inmate is approved for the SAU and is receiving enhanced mental health services, an interim mental health commitment should not preclude subsequent SAU placement, unless decided otherwise by Central Office.

## **F. Transportation**

Every inmate received into the SAU at SCI-Camp Hill or SCI-Waymart shall be a temporary transfer. Transfer procedures for the SAU shall be in accordance with Department policy **6.3.1, “Facility Security.”** Additional restrictions and/or requirements are listed below.

1. Every admission to the SAU shall be received no later than 2:00 p.m. Monday, Tuesday, and Wednesday of each week so that the inmate can be observed. Staff shall be available to conduct initial assessments and provide for a period of stabilization. The inmate can only bring personal property items permitted in accordance with **Section 4 – Temporary Transfer of Mental Health Commitments, Attachment 4-B** of this procedures manual.
2. An initial phone conference will be initiated by SAU staff and be held with the PRT at the referring facility to clarify the inmate’s behavior, psychiatric history, staff observations, what treatment interventions have worked and which have not, and general clarification of the referral questions and what the assessments should accomplish.
3. Transportation is the responsibility of the referring facility. The inmate will be transported alone without other inmates. The transport date will be coordinated between the SAU team, the referring facility, and the OPM.
4. Transfers out of this unit shall take place no later than five days after a final discharge decision has been made. Discharge transport can be via regular bus transport based on support of discharge summary and/or risk assessment. The SAU team shall determine the method and time of discharge in coordination with the referring facility.
5. When an inmate is discharged from the SAU, the inmate is permitted to return to the parent facility with only personal property items permitted in accordance with Department policy **6.5.1, “Administration of Security Level 5 Housing Units”** and **Section 4, Attachment 4-B** of this procedures manual.

## **G. Orientation**

The inmate shall be received in the Property Room and processed for the SAU. Once in the SAU, staff shall orient the inmate to the rules and regulations of the housing unit.

## **H. Admission Process**

Upon admission, the inmate shall meet with the SAU Team who shall:

1. review referral packet;
2. screen for suicide and/or assaultive potential; and
3. create a planned assessment battery under the direction of the LPM to answer the referral question.

## **I. Assessment Process**

1. Members of the Multidisciplinary Team shall conduct an intensive clinical assessment to determine the presence or absence of a serious mental illness, for diagnostic clarification or the need for referral to a specialized program and/or other treatment or housing recommendations.
2. The LPM shall supervise and provide oversight of all clinical assessments to determine the presence or absence of a serious mental illness, for diagnostic clarification or the need for clarification or the need for referral to a specialized program and/or treatment or housing recommendations. Additional out-of-cell testing and interviewing is expected to address the referral question. For example, the Million Clinical Multiaxial Inventory-3 (MCMII) may be given to clarify psychopathology and augment Personality Assessment Inventory results. Tests to address organicity, intellectual deficiency, and clarify diagnosis shall be utilized to address the referral question. Due to the specialized clinical nature of these assessments, licensed psychology staff should conduct them or supervise staff conducting SAU assessments.
3. Daily rounds will be conducted in concert by psychiatry and licensed psychology staff. Other members of the SAU team may include staff from nursing, counseling, and will provide important information/observations regarding the inmate's behaviors, actions, and verbalizations.
4. When the assessment is completed, the SAU shall hold a teleconference with members of the PRT from the inmate's parent facility. During the teleconference, the SAU Team shall provide a report to the PRT that shall include the assessment findings, an evaluation of the inmate's level of functioning while in the SAU, and recommendations for further programming.
5. If appropriate, the SAU Team shall initiate commitment proceedings to the Forensic Treatment Center (FTC) at SCI-Waymart. While in the FTC, the inmate is monitored

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periodically by a member of the SAU Team. Discharge planning shall include members of the Multidisciplinary Team with the PRT from the inmate's designated facility.

6. In those cases where continued DC time could result in further de-compensation of the inmate's mental status, the SAU Team shall make recommendations to the referring facility's Program Review Committee (PRC) to modify or systematically reduce that DC time per Department policy **DC-ADM 801, "Inmate Discipline."**

**J. Discharge Process**

1. The SAU Team will create a Discharge Summary which will address the following:
  - a. any previous mental health diagnosis(es);
  - b. the presence or absence of significant mental illness;
  - c. the need for referral to a specialized program;
  - d. any specialized housing considerations;
  - e. any treatment recommendations; and/or
  - f. transportation requirements, i.e., sedan or via regular bus transport.
2. The SAU will fax the Final Discharge Summary to the referring facility, with a copy being placed in the Medical Record. If questions arise after the inmate has returned to the referring facility, the SAU Team will make itself available for consultation with the referring facility's PRT.
3. ***In the event that the SAU staff recommends a specialized housing unit placement (e.g., SRTU, Behavior Management Unit [BMU], Intermediate Care Unit [ICU], SMU, etc.) they will contact the OPM who in turn will contact the Licensed Psychologist Director at Central Office for direction on placement. Arrangements shall be made for direct placement from the SAU to the recommended program. The inmate will not need to be returned to the referring facility prior to placement in the specialized housing unit.***

## **Section 8 - Intermediate Care Unit (ICU)**

### **A. Admission Criteria and Custody Level Overrides**

1. When an inmate is transferred to the Intermediate Care Unit (ICU), his/her custody level is suspended for the course of his/her time in the ICU. While security is always a concern, the primary purpose of the transfer is for the intensive mental health treatment of the inmate. The ICU has secure space for this population. Once the inmate is released from the ICU, the inmate's custody level shall be reinstated.
2. An inmate shall have the ability to learn, adapt, and participate in his/her Individual Treatment Plan (ITP), as developed by the ICU Treatment Team. Admission to the ICU shall be based on the following general criteria:
  - a. multiple admissions to the Forensic Treatment Center (FTC) and/or other specialized units due to mental illness;
  - b. patterns of inability to cope with general population or Special Needs Unit (SNU) stressors which are a result of mental illness; and
  - c. noted intermittent non-compliance with medication that results in decompensation of the inmate's overall mental health.

### **B. Process for Transfer**

1. The Mental Health Coordinator (MHC) at any facility referring an inmate to an ICU Program shall submit the following information for review to the Bureau of **Treatment** Services (BTS):
  - a. **DC-1, Classification Summary;**
  - b. **DC-13, Reclassification Summary** (if applicable);
  - c. **DC-14, Cumulative Adjustment Record** (past three months unless significant details predate the cutoff);
  - d. **DC-46, Staff Vote Sheet;**
  - e. **DC-2, A&B** (photo copies);
  - f. **DC-186, Separation File;**
  - g. initial or reclassification Pennsylvania Additive Classification Tool (PACT) form;
  - h. Pre-Sentence Investigation (if available);
  - i. a current ITP;

- j. **DC-487, Transfer Health Information form** (Including Medication Compliance Record);
  - k. request for **Temporary Transfer to a Mental Health Unit** form; and
  - l. **DC-3C, Transfer Petition for the purpose of "ICU Admission"** indicating "**Permanent** Transfer to the ICU," typed in the remarks section.
2. The packet containing all of the above information shall be sent by the BTS to the ICU Referral Coordinator for review by the ICU Admission Review Committee. This committee shall review the entire packet and respond to the BTS within 10 working days.

### C. **Transfers and Transportation**

Every inmate received into the SCI-Waymart ICU shall be a **permanent** transfer **for the duration of the program**. Transfer procedures for the ICU shall be in accordance with Department policy **6.3.1, "Facility Security."** Additional restrictions and/or requirements are as follows:

1. every admission to the ICU shall be received no later than 2:00 p.m. Monday, Tuesday, and Wednesday of each week so that the inmate can be observed. Staff shall be available to conduct initial assessments and provide for a period of stabilization;
2. transfers shall be via sedan and are the responsibility of the **referring** facility;
3. transfers out of this unit shall take place after a final discharge decision has been made. The ICU team shall determine the method and time of discharge in coordination with the **original** referring facility, **or facility designated for transfer by the Office of Population Management (OPM)**; and
4. **Upon discharge from the ICU Program, the following options will be available for transfer:**
  - a. **a Permanent Transfer Petition for the purpose of "ICU Discharge" will be entered by ICU and will specify the return of the inmate to his previously assigned/referring Permanent Facility;**
  - b. **a Permanent Transfer Petition for the purpose of "ICU Discharge" will be entered by ICU with the selected facility remaining open for OPM to evaluate and determine the most appropriate Permanent Facility based on ICU recommendations. ICU recommendations will be contained in the comment section of petition; or**
  - c. **inmates may be approved for Department bus transportation by the ICU Treatment Team upon discharge. If sedan transportation is required and the inmate is returning directly to the referring facility, that facility will provide pick**

***up and return transportation. All other sedan transportation requirements will be provided by ICU.***

#### **D. Bureau of Health Care Services (BHCS) Responsibilities**

1. The ICU Admission Review Committee shall make the final decision for admission.
2. Every transfer to the ICU shall follow established Department procedures through the Diagnostic and Classification Coordinator at Central Office.
3. When the transfer is approved, the ICU Referral Coordinator shall coordinate the transfer procedures, bed availability, waiting lists, etc. If bed space is not currently available, the ICU Admission Review Committee shall prioritize each inmate scheduled for placement.
4. The FTC Treatment Team shall process referrals from the FTC to the ICU ***between the FTC and ICU Treatment Teams***. This shall be formalized through local procedures.

#### **E. Orientation for an ICU Inmate**

The orientation procedures listed below shall be used upon admission to the ICU.

1. The Unit Registered Nurse shall meet with the inmate on the day of his/her admission to perform an assessment of his/her physical/mental needs.
2. Members of the ICU Treatment Team shall conduct an initial assessment within three working days of admission. At that time, a preliminary plan shall be developed based on a review of the inmate's current ITP, information available at the time of transfer, and observation of the inmate since his/her admission.
3. The Unit Treatment Team shall meet with the inmate following a variety of assessments to develop an ITP within 14 days of admission. These Treatment Plans shall be reviewed every 60 days or sooner, if needed.
4. Every inmate admitted to an ICU shall carry an "O" code.
5. An inmate processed for admission to an ICU is permitted to bring ***all*** personal property ***as a permanent transfer***.

#### **F. Treatment Programs/Levels of Treatment**

1. Treatment program components in the ICU include Group Therapy, Mental Health Rehabilitation, Therapeutic Activities, and Self-Help.
2. Participation in treatment programs shall be based on a level system. The treatment level system uses progressive steps to increase inmate privileges. Movement to a higher treatment level is based on appropriate inmate behavior and compliance with the treatment plan. The initial treatment level shall be determined by the inmate's present

level of functioning, recent historical information, and mental status. Within the ICU, the treatment team shall assign the treatment level. The unit team shall monitor the behavior of every ICU inmate and may grant specific privileges according to the level system. The Unit Team reserves the right to govern and/or terminate all levels and privileges at any time. Levels may be dropped and programs may be restricted due to inmate behavior (non-compliance with treatment plan, incurred misconducts, etc.). Treatment levels are listed below.

a. Level A

Intensive treatment shall continue in this level. Reintegration with general population programs and activities may be used. The inmate is prepared for discharge to a general population or SNU.

b. Level B

This is a more intense treatment level. Off-unit programs and more intense group therapy programs may be used.

c. Level C

This is the introductory level for on-unit group therapy. An inmate at this level shall begin to develop a basic understanding of his/her mental health problems.

d. Level D

This is the basic treatment level for most inmates admitted to the ICU. Every program shall be conducted on-unit.

## **G. Discharge Procedures**

1. While there are no definite periods which would determine the length of program involvement, discharge of an inmate from an ICU shall be considered when:
  - a. the treatment plan goals have been satisfied;
  - b. the unit staff feels the inmate has achieved maximum benefit from treatment;
  - c. the ICU Treatment Team concludes that the inmate remains resistant to participation in the ITP that was developed for him/her;
  - d. the inmate is found guilty of a serious misconduct unrelated to his/her mental illness. In this case, the inmate **may** be returned to his/her **referring** facility **or the designated new facility determined by OPM** to serve Disciplinary Custody (DC) time; and/or

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**Section 8 - Intermediate Care Unit**

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- e. commitment to the FTC may be appropriate for behavior directly related to the inmate's mental health diagnosis.
2. When an inmate is to be discharged from the ICU, the ICU treatment team shall conduct a conference phone call with the unit team of the **referring** facility or facility designated for transfer, to discuss the inmate's response to treatment. Both teams shall document the date, participants, and issues discussed in the conference call. At a minimum, the following issues shall be addressed:
- a. the inmate's progress toward meeting the goals of his/her ITP;
  - b. the extent to which he/she has achieved maximum benefits from treatment available at the ICU;
  - c. any on-going resistance to program participation;
  - d. any serious misconducts and whether these were related to his/her mental illness;  
and
  - e. any treatment needs that shall be addressed when the inmate returns to his/her home or designated facility.



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## Section 9 – Staffing and Security of Mental Health Units

### A. Responsibilities

1. Regional Deputy Secretary

Act as a point of contact along with the Chief of Clinical Services and/or the Chief of Psychological Services at the Bureau of **Treatment Services (BTS)** regarding the transportation, admission, programming, and discharge of capital case inmates requiring Mental Health Unit (MHU) treatment.

2. Bureau of Health Care Services (BHCS)<sup>1</sup>

The BHCS shall act as a central resource for the facilities MHU Directors and shall assist in the coordination of mental health treatment and services provided to an inmate and the annual training of staff members assigned to provide mental health services and treatment to an inmate housed within the Department.

3. Bureau of **Treatment Services**

Assist in coordinating the transportation and/or placement of every inmate being admitted or discharged from the MHUs in accordance with Department policies **11.5.1, “Records Office Operations,”** and **11.2.1, “Reception and Classification.”**

4. Central Office Security Division

- a. Assist in coordinating and transportation of every capital case admitted or discharged from the MHUs in accordance with Department policies **6.3.1, “Facility Security,”** and **6.5.8, “Capital Case Administration.”**
- b. Act as a point of contact regarding the transportation of a non-capital case inmate being admitted or discharged from a MHU.

5. Facility Manager

The Facility Manager shall ensure that the procedures set forth in this policy/procedures manual are implemented. The Facility Manager shall also ensure that any local procedures drafted and enacted to address issues not covered by this procedures manual, or that are unique to the facility, are reviewed and/or updated on an annual basis to ensure compliance with Department policy/procedures and to verify the continued need for the local procedures manual.

6. Deputy Superintendent for Facilities Management (DSFM)

The DSFM shall ensure:

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<sup>1</sup> 2-CO-1A-15, 2-CO-4E-01

- a. that an adequate number of corrections officers are assigned to the MHUs in accordance with Department policy **6.3.1, Section 15, Corrections Officer Staffing** and that the officers have been appropriately screened and approved according to the post orders for the MHUs and the staffing procedures and criteria contained in this procedure manual;
  - b. that every officer assigned to the MHU has received training regarding the procedures contained in **Section 2, Delivery of Mental Health Services** of this procedures manual; and
  - c. that every post order regarding the operation of the MHU is created according to Department policy **6.3.1, Section 5, Post Orders**, reviewed on an annual basis and rewritten, if necessary, to reflect any changes in the method and manner in which mental health services are provided to an inmate.
7. Deputy Superintendent for Centralized Services (DSCS)

The DSCS/designee shall be responsible for coordinating efforts between the facility and the medical department regarding access to medical/mental health treatments and other related medical programs. As the Facility Manager's representative, he/she shall have joint responsibility along with the Corrections Health Care Administrator (CHCA) and the BHCS to address those issues outlined in this procedures manual.

8. Director of the MHU

The Director of the MHU shall ensure:

- a. each MHU/Forensic Treatment Center (FTC)/Intermediate Care Unit (ICU) develops local seclusion and restraint procedures, consistent with Office of Mental Health and Substance Abuse Services (OMHSAS) regulations and Department policies and administrative directives, **Section 3** of this procedures manual and Department policy **6.3.1, Section 32**. Video recording of cell extractions in the MHU shall not be necessary if the recording might cause delay in providing necessary treatment and security. If the incident is video recorded, the recording of the incident shall be stopped once the inmate has been secured and the officer in charge has finished his/her debriefing of the extraction team and the incident;
- b. administer the program in compliance with the regulations promulgated by OMHSAS and every policy and procedure mandated by the Department;
- c. maintain liaison and optimal working relations between the contract health care provider, host facility, and the Department, including the BHCS and the Director of the FTC at Waymart;
- d. report to the DSCS either directly or through the CHCA or Chief Psychologist, as appropriate;

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- e. meet with the CHCA, Licensed Psychologist Manager (LPM), and Major of the Guard (CO5) at least quarterly and otherwise as needed, to coordinate activities. The Director, at his/her discretion, may appoint an MHU Advisory Board composed of key facility staff members to review policies, procedures, and address local problems;
  - f. provide monthly reports to the BHCS regarding census and other issues;
  - g. advise the BHCS, via fax, of every temporary mental health transfer between the MHUs and facilities;
  - h. coordinate with the Training Coordinator and Training Lieutenant to ensure that Corrections Officers (COs) working in the MHU are familiar with and aware of MHU duties and responsibilities (post orders);
  - i. coordinate with the facility LPM, CHCA, and Training Coordinator to ensure that training for MHU staff is conducted in accordance with Department policy **5.1.1, “Staff Development and Training.”** Training shall include, but not be limited to:
    - (1) suicide prevention;
    - (2) crisis intervention;
    - (3) access to health care;
    - (4) access to emergency care;
    - (5) security issues; and/or
    - (6) care, custody, and control of an inmate, which shall be provided to every CO in the facility, since every custody staff member is likely to rotate through the MHU.
  - j. have the responsibility for being the liaison between the MHU and outside agencies including OMHSAS, the courts, and county mental health/social service agencies;
  - k. compliance with the Mental Health Procedures Act for every necessary hearing for the involuntary commitment of an inmate patient to the MHU; and
  - l. arrange with the OMHSAS to schedule annual mental health audits.

**B. Corrections Officer Staffing Levels and Inmate Custody Levels in the MHUs**

- 1. Corrections Officer Assignments to MHUs
  - a. The MHU officer shall be required to perform a variety of complex tasks in the MHUs.
  - b. Although an inmate’s custody level is suspended while in the MHU, an inmate may still pose a significant danger to himself/herself and/or others. Enriched custody staffing levels are needed in the units to provide protection to staff and inmates and

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ensure that mental health programming can be provided. The DSFM shall ensure that CO coverage is maintained to allow the unit to conduct out-of-cell mental health programming, protect persons and property on the unit, and escort an inmate in and out of cells. The DSFM shall meet regularly with the MHU Director to discuss custody-staffing needs.

- c. The CO assigned to the unit shall provide input into MHU treatment decisions through regular contact with the treatment staff. It is expected that the CO shall report on his/her observations of every inmate activity, as well as any interaction that he/she may have had with a client.
- d. CO staff shall be provided with training on an annual basis regarding the confidentiality of Department and medical records.

2. Determination and Maintaining of Staffing Levels for the MHUs

- a. The DSFM and the Major(s)/designee shall be responsible for selecting and assigning Corrections Officer Staff to Mental Health Units. The MHU Director shall have input into this selection; however, the final determination shall be made by the DSFM.
- b. MHU assignments shall be made from COs who have submitted a written request to the Major(s)/designee to be considered for placement in a MHU position.
- c. Volunteers for these assignments must exhibit the following characteristics prior to placement in MHU positions:
  - (1) willingness to work in a non-traditional corrections environment;
  - (2) the ability and willingness to become an integral part of the MHU Treatment Team;
  - (3) the ability and willingness to perform non-professional counseling and crisis intervention with MHU inmates;
  - (4) good communications skills;
  - (5) the ability to react appropriately to crisis situations;
  - (6) good emotional stability;
  - (7) interest in mental health issues; and/or
  - (8) any other attributes considered important, but not listed above.
- d. A CO assigned to MHUs shall be reviewed for rotation out of the MHU at least annually by the DSFM and Major(s)/designee.

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- e. Removal from the MHU position may occur at any time if it is determined that the CO is inappropriate for his/her assignment or detrimental to the operation of the MHU. This determination shall be made by the DSFM with input from the Major, Shift Commander, and/or MHU Director and shall be based on written documented incidents.
  - f. An Officer assigned to a MHU beyond one year shall be interviewed by a facility psychologist to determine his/her fitness for the MHU assignment. Reports shall be confidential and shared only with appropriate personnel.
3. Custody Status of Inmates Transferred to the Mental Health Units
- a. A capital case shall be managed under Department policy **6.5.8, “Capital Case Administration,”** and shall be segregated from other inmates. Any exceptions to this procedure must be approved through the Regional Deputy Secretary in consultation with the Chief of Clinical Services and/or Chief of Psychological Services in the BHCS.
  - b. Custody levels of non-capital cases shall be suspended while the inmate is placed in the MHU so that they can participate in treatment to the maximum extent possible.
  - c. Every MHU reception shall be initially placed in “hard cell” observation cells until the inter-disciplinary treatment team can review his/her case to determine if special security and/or clinical precautions are required to protect staff and/or other inmates. Issues to be considered include, but are not limited to:
    - (1) separation from other inmates or staff members, or transfer of the patient to another MHU for treatment;
    - (2) reason for any disciplinary time (assaults, verbal abuse, possession of contraband); and/or
    - (3) clinical conditions that require special treatment such as extreme agitation, lability, acute suicide threats, or other detrimental behavior.
  - d. The MHU clinical staff shall determine when the patient can leave the hard cell to enter the therapeutic environment, using consultation from the custody staff.
  - e. In some situations, the psychiatrist/**Certified Registered Nurse Practitioner – Psychiatric Services (PCRNP)**, psychologist, or Director may have already evaluated the inmate, before the patient arrived on the unit, and recommendations made at that time concerning cell placement may be followed. This placement shall be reviewed at the next meeting of the treatment team, or earlier if required.

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### C. Tracking System Access

Vendor and Department staff members working in specialized units shall have reading and inquiry access to the MH/MR tracking system, and reading access to Inmate Classification, Inmate Records, Separations, Medical Tracking, and Misconduct information that is maintained on the Department mainframe.

1. Staff members shall be able to review the clinical information contained in the PRT and Mental Health/Mental Retardation (MH/MR) rosters (entering new International Classification of Diseases (ICD codes) and Global Assessment Functioning (GAF) scores.
2. The treatment unit staff shall monitor the mainframe system to note any changes in the inmate's status (impending max date).
3. The BHCS Chief Psychologist shall ensure that training is provided to vendor staff in the use of the mainframe data system.

### D. Discharge Procedures

1. Pre-discharge Procedures
  - a. Every patient scheduled for discharge from the MHU must be approved, both medically and in terms of security, for transport back to his/her parent facility according to Department policy **6.3.1**.
  - b. Before the patient is discharged from the MHU, the MHU treatment team shall conduct a teleconference with the treatment team in the patient's home facility.
  - c. The MHU treatment staff shall provide a summary of the patient's response to treatment and recommendations for aftercare in the facility. This summation shall be based upon the inmate's treatment and his/her Individual Treatment Plan (ITP).
  - d. The MHU team shall also make recommendations to the treatment team and the Program Review Committee (PRC) regarding adjustments or forgiveness of the inmate's Disciplinary Custody (DC) time, consistent with policy **6.5.1**, "**Administration of Security Level 5 Housing Units**," and **DC-ADM 801**, "**Inmate Discipline**."
  - e. If the treatment team and PRC in the sending facility have reservations regarding the MHU recommendations for treatment and adjustment of DC time, a teleconference via phone or telemedicine consultation shall be the forum for the discussion of these concerns.
  - f. If the PRC elects to disregard the MHU's recommendations regarding disciplinary time, the Facility Manager of the facility shall submit a memorandum to the Regional Deputy Secretary, copied to the BHCS, outlining the rationale for PRCs disagreement.

2. Continuity of Care Planning for Parole and Final Discharge Maximum Expiration (FDME) Inmates
  - a. Mental health staff members from the sending facility and a MHU/FTC/ICU staff member shall share joint responsibility for an inmate nearing parole or FDME.
  - b. For an inmate who is within one year of parole or FDME when he/she is referred to the MHU/ICU/FTC, the staff in the sending facility shall advise the treatment unit staff of every continuity care activity that has been initiated.
  - c. For an inmate who is within one year of parole or FDME while he/she is placed in the MHU/FTC/ICU, staff members in the sending facility and the treatment unit shall conduct teleconferences to coordinate continuity of care activities.
3. Transferring Inmates to a Second Facility Following Completion of Treatment at the MHU/FTC/ICU
  - a. In some cases (due to classification to another facility, separations, or special treatment needs), it may not be appropriate to return an inmate to the sending facility.
  - b. In these cases, the sending facility staff shall initiate transfer petitions through the classification section of the **BTS**. The BHCS mental health staff shall approve the transfer petitions when completed by **BTS** before the inmate is transferred.
  - c. The MHU/FTC/ICU staff shall be responsible for initiating a teleconference with the treatment team staff in the third (receiving) facility to:
    - (1) ensure that appropriate bed space is available for the inmate (in the Special Needs Unit); and
    - (2) advise the team of the inmate's needs.
  - d. The sending facility shall be responsible for picking up the inmate and his/her property and transporting the inmate from the MHU/ICU/FTC to the new facility.

## Section 10 – Secure Residential Treatment Unit (SRTU)

### A. Program Mission<sup>1</sup>

1. The Secure Residential Treatment Unit (SRTU) is designed to provide management, programming, and treatment for an inmate who exhibits Serious Mental Illness (SMI), chronic disciplinary issues, and demonstrates an inability to adapt to a general population setting. This is a secure diversionary unit for mentally ill inmates who do not currently meet commitment criteria according to the Pennsylvania Mental Health Procedures Act and require a secure setting due to their demonstrated problematic behavior in less secure environments. The unit is intended to provide focused staff interaction, programming, and treatment for this select inmate population. The focus of the SRTU is to convey sufficient skills in behavioral control, coping, and compliance with recommended treatment.
2. Each inmate in the SRTU will be scheduled and offered a minimum of 20 hours out-of-cell activity per week; 10 hours of structured activity and 10 hours unstructured activity. This intensive specialized treatment program will assist an inmate in progressing to the least restrictive environment for managing his/her demonstrated behavior. The least restrictive environment will vary among inmates and may include eventual return to a general population, continued placement within the SRTU, and even fulfillment of the inmate's reentry plan upon Sentence Complete. An inmate's custody level will be suspended while in the SRTU but their Disciplinary Custody (DC) sanctions, if they have any, will run concurrent to their time in the SRTU until the sanction expires or until placed in Phase 1 of the program. This occurs so the inmate may still participate in and benefit from treatment to the maximum extent possible and be returned to the least restrictive setting as soon as possible. An inmate who is unable to transition from the SRTU, complete the SRTU program, or requires a therapeutically recommended transfer to another SRTU, will be processed for alternative placement by review of the Central Office Special Needs/Psychiatric Review Team (COSN/PRT).

### B. Location

SRTUs will be located at various facilities within the Department as outlined on the **Institutions with SRTUs Listing (Attachment 10-A)**.

### C. Staffing<sup>2</sup>

1. SRTU Treatment Team
  - a. Comprised of the Licensed Psychologist Manager (LPM), Unit Manager, Unit Counselor, Psychiatrist/Certified Registered Nurse Practitioner (CRNP), full-time Psychology staff (Psychological Services Specialist [PSS] and/or Psychological Services Associate [PSA]), Activities, and SRTU Correctional Officers (COs). The

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<sup>1</sup> 4-4368

<sup>2</sup> 4-4368



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SRTU Treatment Team will meet with and review all SRTU inmates at least every 30 days. Inmates placed on Accountability Status in accordance with **Subsection M. below** will be reviewed **daily**. This team follows the inmate in all phases, including at least three months of probationary status in a general population **Residential Treatment Unit (RTU)** or other population housing unit deemed appropriate by the Treatment Team; this probation can be extended for an additional three months if indicated. However, the duration of Phase 1 must not exceed six months' time, irrespective of any off unit placements. Other staff and teams involved in the daily operation of the SRTU include, but are not limited to: the Program Review Committee (PRC), staff members from Alcohol and Other Drug (AOD) treatment, Education, Social Worker, **Therapeutic Activities Services (TAS)** Worker, Medical - Nursing, Chaplaincy, and Certified Peer Specialists (CPS). Staff contacts with inmates participating in the SRTU will be noted on the **SRTU Accepted/Refused Structured Out-of-Cell Program Log (Attachment 10-B)** and the **SRTU Accepted/Refused Unstructured Out-of-Cell Program Log (Attachment 10-C)**. In addition, the SRTU Treatment Team will meet at least twice each week to discuss the general operation of the unit and review the **recovery** plans of each inmate. These meetings will be facilitated by the Unit Manager and the LPM and should generally be held at the change of shift in order to maximize Officer involvement.

b. Responsibilities and Ratios<sup>3</sup>

(1) SRTU Unit Manager (1:60 inmates)

The Unit Manager will provide manager-level direction with the assistance of the Lieutenants. The Unit Manager will provide the team with daily leadership and will review and direct the treatment and activity of the inmates in his/her care. If not permanently assigned to the SRTU, the Unit Manager will visit the unit daily and sign the log book.

(2) LPM

The LPM is not solely assigned to the SRTU, but also oversees all psychological services in the institution. The LPM functions as the administrative and clinical supervisor of all psychological staff on the SRTU. The LPM also provides clinical oversight, via the Treatment Team and the **Individual Recovery Plan (IRP)**, to the entire SRTU Treatment Team. The LPM is responsible for chairing any treatment team meetings held on the SRTU. However, in all aspects of the program, the LPM will closely collaborate with Psychiatry and the Unit Manager.

(3) Psychiatrist/Psychiatric Certified Registered Nurse Practitioner (**PCRNP**)

The **Psychiatrist/PCRNP** will be responsible for reviewing and interviewing all SRTU cases weekly. In addition, they will coordinate medication monitoring. Psychiatric coverage will include 30 minutes per inmate per week. All Psychiatric

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<sup>3</sup> 4-4368

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contacts are to be out-of-cell unless the inmate refuses or security issues prohibit out-of-cell contact at that time. This includes those SRTU inmates who may be on Accountability Status. The **Psychiatrist/PCRNP** will also be required to participate in all scheduled Treatment Team meetings.

(4) PSS/PSA 1:20 inmates

For SRTUs that have more than one full-time equivalent PSS/PSA assigned, a portion of those additional hours will be assigned to a 12-8 work shift. The PSS/PSAs assigned to the SRTU will be responsible for developing **IRPs** with their assigned inmate caseload. These **IRPs** will specifically identify goals and objectives designed to restore the inmate to a stable and healthy level of functioning. **The goals on the IRP, established collaboratively with the SRTU Treatment Team and the inmate shall drive the clinically structured out-of-cell offerings on the unit.** The PSS/PSA will work closely with custody staff and all disciplines assigned to the SRTU. The PSS/PSA will be responsible for delivering individual and group therapy directed at addressing the issues outlined in the **IRP**. All contacts will be noted on the **SRTU Accepted/Refused Structured Out-of-Cell Program Log**, at a minimum weekly **Inmate Cumulative Adjustment Record (ICAR)**, and **DC-560, Mental Health Contact Note** entries are required. The PSS/PSA will also **offer** all inmates on Accountability Status **daily AM and PM 30 minute out-of-cell contacts for the duration of accountability status.** At the discretion of the LPM, the PSS/PSAs assigned to the SRTU may have other assigned facility duties.

(5) Corrections Counselor (CC) (1:30 inmates)

The CCs will provide professional counseling and case management activities to an inmate caseload assigned by the Unit Manager. This will include treatment groups, individual contacts, and supervising inmate unstructured out-of-cell time. All contacts will be noted on the **SRTU Accepted/Refused Structured Out-of-Cell Program Log** and **SRTU Accepted/Refused Unstructured Out-of-Cell Program Log**, and at a minimum weekly **ICAR** entries will also be made to document the inmate's status. The CCs will work with the SRTU Staff to assure that proper documentation is kept by maintaining the tracking forms for all out-of-cell structured and unstructured activity. In addition, the CCs will ensure that all incentive tracking charts are up-to-date on a weekly basis with results reported as an **ICAR** entry. Thus, charting the progress each inmate is making in preparation for their possible graduation from the program and possible reentry into the general population.

(6) TAS Worker (1:60 inmates)

The **TAS** Worker will develop and deliver activities during the days, evenings, and on the weekends. The **TAS** Worker will implement, monitor, and evaluate the therapeutic recreational segments of **IRPs** including instructing, directing, and providing support in a variety of activities relating to therapeutic recreation,

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occupational therapy, and vocational adjustment services. The activities would be directed at engaging self-isolated or reclusive inmates and providing structured and unstructured recreational time for SRTU inmates. The increased activity and out-of-cell time will be assisting with improving the inmate's emotional control. All contacts will be noted on the **SRTU Accepted/Refused Structured Out-of-Cell Program Log** and the **SRTU Accepted/Refused Unstructured Out-of-Cell Program Log**. This employee may also be assigned to work with inmates on the General Population RTU as supervised by the Activities Manager and in collaboration with the Unit Manager.

- (7) Custody Staff
- (a) The Facility Manager/designee shall establish local procedures outlining the appropriate security staffing levels and security measures to be followed for inmate movement, showers, meals, activities, etc. Unit staffing and security measures may be reduced by the Unit Team and the PRC for an SRTU inmate in Phases 3, 2, and 1 but, should always remain at a level to provide escort coverage for daily out-of-cell contacts.
  - (b) COs assigned to the unit will provide daily input for the SRTU Treatment Team decisions through regular contact with treatment staff and via documentation utilizing the **SRTU Shift Pass Down Form (Attachment 10-D)**. This form is utilized in order to ensure accurate communication between shifts and the Treatment Team. In addition, it is important for custody staff's observations to be included in the Treatment Team's review of the inmate's progress with their treatment objectives. COs are expected to communicate their observations of an inmate's activity and any interactions they may have had with the inmate. In addition, custody staff will participate in all Treatment Team meetings, comment on, and sign the **IRP**.
  - (c) Because the potential exists that an inmate may become a significant danger to him/her and/or others, enriched custody staffing levels are required in the units to provide protection to staff and inmates. This modification ensures that out-of-cell mental health programming can be provided as well. The Deputy Superintendent for Facilities Management (DSFM) shall ensure that CO coverage is maintained and sufficient to permit the unit to conduct out-of-cell structured and unstructured activities, protect persons and property on the unit, and escort inmates in and out of cells throughout the day, even during count time. The DSFM shall meet regularly with the Major of the Guard and Unit Manager to discuss custody staffing needs.

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2. Other Staff Involved on the SRTU

a. PRC

This committee is generally comprised of the DSFM, the Deputy Superintendent for Centralized Services (DSCS), and the Corrections Classification Program Manager (CCPM). The PRC will review all SRTU inmates monthly or as necessary as indicated by submissions of **SRTU Program Review Sheet (Attachment 10-E)** by the SRTU **IRP**. Inmates in the SRTU on Accountability Status will be reviewed by the PRC at least weekly.

b. AOD

Drug and Alcohol Treatment Specialists (DATS) will provide group and/or individual structured out-of-cell contacts for SRTU inmates with identified AOD treatment needs. The goals/objectives of such treatment will be reflected on the inmate's **IRP**. All contacts will be noted on the **SRTU Accepted/Refused Structured Out-of-Cell Program Log**.

c. Education/Adult Basic Education (ABE) Teacher (1:60 inmates)

This staff member will address the educational needs of the inmates participating in the SRTU. He/she would provide educational opportunities for those who are mandated to participate in education to meet guidelines and also those who wish to volunteer. The goal would be to have inmates prepare for reentry to general population classes or reentry into society. All out-of-cell contacts will be noted on the **SRTU Accepted/Refused Structured Out-of-Cell Program Log**. This team member will be supervised by the School Principal in collaboration with the Unit Manager.

d. Social Worker (Master of Social Work [MSW] 1:60 inmates)

This employee will develop, implement, and provide social work, counseling, and case management services to SRTU inmates to enhance their social functioning and to help them attain a more satisfactory social, economic, emotional, or physical adjustment within a Department facility. All out-of-cell contacts will be noted on the **SRTU Accepted/Refused Structured Out-of-Cell Program Log**. This employee will be interacting with inmates, inmate family members, inmate guardians, and community agency staff to plan, provide, or coordinate needed social work services upon release to the community. This employee will work primarily within the SRTU, however, at the direction of the LPM; the Social Worker will also assist the general population Mental Health Coordinator (MHC) with reentry services to general population inmates.

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e. Medical-Nursing

Any medication concerns identified will be forwarded to the **Psychiatrist/CRNP**, the assigned PSS/PSA, and recorded in the inmate's medical file. All out-of-cell contacts will be noted on the **SRTU Accepted/Refused Structured Out-of-Cell Program Log**.

f. Chaplaincy

The Facility Chaplaincy Program Director (FCPD) will provide structured individual and group religious services to inmates in the SRTU. Structured group contact will be available at least weekly. All out-of-cell contacts will be noted on the **SRTU Accepted/Refused Structured Out-of-Cell Program Log**.

g. CPS

CPSs will be available on the unit to provide support for participants in the program. Duties may include individual out-of-cell contacts with inmates, educational group programming, recreational activities, and assistance with daily living skills. CPSs will function under the direct supervision of the Unit Manager. Contacts will be noted by supervising staff on the **SRTU Accepted/Refused Unstructured Out-of-Cell Program Log**.

**D. Determination and Maintenance of Staffing Levels for the SRTUs**

1. The DSFM and the Major(s)/designee shall be responsible for selecting and assigning CO Staff to SRTUs. The Unit Manager and LPM shall have input into this selection; however, the final determination shall be made by the DSFM.
2. SRTU assignments shall be made from COs who have submitted a written request to the Major(s)/designee to be considered for placement in a SRTU position.
3. Volunteers for these assignments must exhibit the following characteristics prior to placement in SRTU positions:
  - a. willingness to work in a non-traditional corrections environment;
  - b. the ability and willingness to become an integral part of the SRTU Treatment Team;
  - c. the ability and willingness to perform non-professional counseling and crisis intervention with SRTU inmates;
  - d. good communications skills;
  - e. good emotional stability;
  - f. interest in mental health issues;

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- g. Crisis Intervention Team (CIT) and Mental Health First Aid (MHFA) trained or willing to obtain the training; and/or
  - h. any other attributes considered important, but not listed above.
4. A CO assigned to the SRTU shall be reviewed for rotation out of the SRTU at least annually by the DSFM and Major(s)/designee.
  5. A CO assigned to an SRTU beyond one year shall be interviewed by the facility LPM/designee to determine his/her fitness for the SRTU assignment. Reports shall be confidential and shared only with appropriate personnel.
  6. Removal from the SRTU position may occur at any time if it is determined that the CO is inappropriate for his/her assignment or detrimental to the operation of the SRTU. This determination shall be made by the DSFM with input from the Major, Shift Commander, and/or SRTU Unit Manager. In addition to custody staff, any staff member, recommended by the Unit Manager and the LPM, may be removed from being assigned to the SRTU if that staff is deemed inappropriate for assignment to the SRTU.

**E. Chain of Command**

1. The Unit Manager shall provide daily guidance/direction for all officers assigned to the SRTU. The Unit Manager and Shift Commander are responsible for monitoring and evaluation of staff performance.
2. The Shift Commander is in charge of use of force situations and assumes responsibility for operation of the unit in the absence of the Unit Manager.
3. The Unit Manager shall have the discretion to make essential administrative, program, and operational decisions regarding unit security and inmate management. Clinical decision will be made via the SRTU Treatment Team as directed by the LPM.

**F. Staff Training**

All staff selected or assigned to the SRTU to provide programming and supervision will be required to complete certain Department training. Within six months of placement into the unit, staff will be required to have completed the Department's Crisis Intervention Team Training (CITT) and the Department's MHFA Training. If it is necessary to assign a staff member to the SRTU who has not completed this training, the facility shall, within two weeks, **advise the CITT Program Coordinator of the need. The facility's Training Coordinator shall also communicate such training needs to the CITT Program Coordinator to ensure that sufficient training is conducted to meet the needs of the facility.** CO Trainees (COTs) will not be assigned to the SRTU.

## G. Admission Criteria<sup>4</sup>

Admission criteria shall include the following:

1. a diagnosis of SMI as defined in the **Definition of a SMI Outline (Attachment 10-F)** of this policy.
2. history of multiple admissions to a Restricted Housing Unit (RHU) either AC or DC status, a Mental Health Unit (MHU), and/or the Forensic Treatment Center (FTC);
3. presenting problems may include significant difficulties such as self-injury, overtly aggressive behavior, and/or impulse control disorder;
4. a Special Assessment Unit (SAU) evaluation may be required;
5. ***C stability code inmates may be considered for placement in an SRTU;*** and
6. he/she is cleared of acute medical problems by the referring facility's medical department.

## H. Process for Transfers

1. When an inmate is being recommended by the PRT, Unit Management Team, or Psychology staff, for placement in a SRTU, the PRC shall review the recommendation with the inmate and inform him/her of the reason(s) for the transfer recommendation. The recommendation shall be documented on the **DC-141, Part 4, Facility Manager's Review**, with a copy to the inmate. The inmate will be given the opportunity to respond to the rationale given and object to his/her placement in a SRTU, if he/she so desires. The inmate may appeal the recommendation for transfer to the Facility Manager/designee and Central Office, as outlined in Department policy **DC-ADM 802, "Administrative Custody"** and **DC-ADM 801, "Inmate Discipline."**
2. The MHC/designee at the referring facility shall simultaneously submit a completed referral packet to the Office of Population Management (OPM) mailbox (**CR, CEN OPM Special Program REFERRALS**) dedicated to the Special Programs Referral and to the respective Regional LPM. OPM is responsible for tracking the SRTU Referral Packet through the approval/rejection process. This packet must only be forwarded electronically.
  - a. The Regional LPM will review the SRTU referral packet and schedule a face to face (on site or via videoconference) interview with the referred inmate. The purpose of this interview is to facilitate an appropriate referral to the SRTU. This interview provides a focused independent assessment, upon which the Regional LPM can make further recommendations to the facility regarding the referral process if needed. Additionally, this focused interview process will provide guidance to the Bureau of Health Care

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Services (BHCS) Chief Psychologist and Chief of Psychiatry in their approval process of this packet. The Regional LPM will notify OPM when the referral packet is ready to be forwarded to the Chief Psychologist and Chief of Psychiatry. The findings and recommendations of the Regional LPM will be communicated to the Chief Psychologist and OPM electronically, with a copy to the referring facility's LPM/designee.

- b. The SRTU referral may be changed to an SAU referral by the Regional LPM if a specialized assessment for diagnosis and program appropriateness is deemed necessary.
- c. The referral packet will include the following information:
  - (1) a completed **Special Program Referral Approval/Rejection Form** (refer to Department policy 11.1.1, "**Population Management,**" **Attachment 2-C**) which will serve as the face sheet when forwarding an SRTU referral packet. In the Requested Action Section, the Program/Unit Admission box should be checked;
  - (2) **DC-46, Vote Sheet**;
  - (3) a current **IRP** (refer to **Section 5** of this procedures manual);
  - (4) **Integrated Case Summary** or **Pre-Sentence Investigation (PSI)** (if available);
  - (5) the most recent Psychological Report;
  - (6) a copy of the **SAU Discharge Summary** if one is available;
  - (7) **DC-14, Cumulative Adjustment Record** (past three months, unless significant details predate the cutoff);
  - (8) **DC-487, Transfer Health Information Form**, including Medication Compliance Record;
  - (9) **DC-17X, RHU Conduct Record** for prior month, and PRC notes from the past three reviews;
  - (10) a copy of the last six months of the Mental Health Section of the inmate's medical record;
  - (11) a copy of the last six months of the misconduct history from DOC Info.
  - (12) A mental health report prepared within the last three months by the psychology staff or Psychiatrist/CRNP which identifies a current diagnosis and assesses the inmate's suitability for placement in the SRTU. This report should delineate the specific diagnostic criteria utilized to support the given diagnosis. If a current



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diagnosis is not available or clearly established, the referring facility should consider a referral to the SAU prior to submission of a SRTU Referral Packet.

- (13) a copy of the inmate's cell history, obtained from DOC Info; and
  - (14) a list of separations.
3. The OPM will then electronically forward the SRTU Referral Packet to the Chief Psychologist, Chief of Psychiatry, and the Regional Deputy Secretaries for the sending and receiving region who will vote on the SRTU referral. If the recommendations are not unanimous, the Executive Deputy Secretary will make the final recommendation.
  4. The approved and/or rejected SRTU Referral Packet will then be sent to the OPM. The OPM will record the disposition of the Referral Packet in the Transfer Petition System. OPM notifies, via email, the referring facility with copies to the Chief of Psychological Services, BHCS, and Diagnostic and Classification Coordinator, Bureau of Treatment Services (BTS). This email will include the rationale for the rejection and recommendations.
  5. The OPM will return any disapproved Referral Packets to the referring facility's LPM/designee.
  6. Following final approval, BHCS will coordinate, with the sending and receiving facilities and the OPM, the inmate's transfer to the designated SRTU. If space is not available, the OPM and BHCS shall retain the inmate's name on a waiting list. If an inmate is placed on the approved SRTU waiting list and his/her circumstances change and there is no longer a need for program placement, the referring facility must obtain written approval from the Regional Deputy Secretary to remove the inmate from the SRTU waiting list. This approval shall be obtained by sending a written memo with justification to the Regional Deputy Secretary. If the Regional Deputy Secretary grants this change, the written memo with the Deputy Secretary's approval will be forwarded to the requesting facility and copied to BHCS.
  7. Prior to an inmate's transfer, the transferring facility's PRT shall conduct a videoconference or teleconference call, with the SRTU Treatment Team at the receiving facility. The sending facility shall document the date, names of participants, and issues discussed in the conference call in the **ICAR/DC-14** and on the **DC-472, Progress Note**.
  8. Once BHCS has notified the referring facility that an inmate has been approved for SRTU placement, and the inmate is placed on the SRTU waiting list, the referring facility will immediately implement the following Protocol for Enhanced Mental Health Services which has been established for inmates on the SRTU waiting list. The protocol is as follows:
    - a. a weekly out-of-cell psychology contact, at minimum, will be conducted, with **ICAR** and **DC-560** documentation copied to the medical record;

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- b. additional psychological contacts, if requested by the inmate or a staff member, will be provided by the assigned psychologist during his/her scheduled daily psychology RHU rounds;
  - c. monthly out-of-cell Psychiatrist/CRNP contacts;
  - d. weekly review by the PRC;
  - e. monthly PRT review; and
  - f. continued weekly Correctional Counselor visits.
9. If the referring facility cannot fully provide the above protocol for enhanced mental health services, the facility should contact OPM as soon as possible so that OPM can expedite transfer to the nearest facility which is able to provide this protocol.
10. An inmate who is on the waiting list for the SRTU can be transferred to a MHU/FTC if necessary. This does not affect their SRTU waiting list status, unless decided otherwise by Central Office.

**I. Transportation**

An inmate received into the SRTU will be sent as a permanent transfer. Transport procedures for the SRTU shall be in accordance with Department policy **6.3.1, “Facility Security.”** Additional restrictions and/or requirements are as follows:

1. all of the inmate’s property will be transported with him/her to the SRTU;
2. an inmate transferred to the SRTU shall be received no later than 2:00 PM Monday, Tuesday, or Wednesday. This schedule allows staff to be available to conduct an initial assessment and provides for a period of stabilization; and
3. the inmate shall be transported via sedan; this is the responsibility of the referring facility.

**J. Admission and Orientation**

1. All inmates will receive a standardized “SRTU Inmate Handbook.” This handbook will be distributed to all inmates upon arrival and admission to the SRTU. The inmate handbook will address and include at a minimum the following:
  - a. general program description and purpose of the unit;
  - b. SRTU rules and regulations;
  - c. the process of treatment planning and the inmate’s involvement in that process;

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- d. overview of the Levels of Treatment/Phase System and the role of the **Treatment Team**;
  - e. what an inmate needs to do to advance through the Phases/Levels of Treatment;
  - f. earning and utilizing incentive points;
  - g. property and privileges;
  - h. description of groups and treatment milieu;
  - i. discipline and “Accountability Status;” and
  - j. discharge and transition from the SRTU.
2. Once admitted to the SRTU, the inmate shall receive the SRTU Inmate Handbook and staff will orient the inmate to the rules and regulations of the unit, within 48 hours of arrival. The inmate will be asked to sign the **SRTU Inmate Handbook Receipt Form (Attachment 10-G)**.
  3. Staff shall complete the **DC-510, Suicide Risk Indicators Checklist** *in accordance with Section 1 of this procedures manual*.
  4. Inmates housed in a SRTU, will be issued royal blue hobby jeans and a royal blue shirt with DOC printed in large white block letters on the back.
  5. SRTU Cell Assignments
    - a. An inmate shall be housed in a single cell for Phases 5, 4, and 3 of the SRTU program. Suitability for double celling will be considered in Phases 2 and 1 and will be contingent upon the inmate’s program code in accordance with Department policy **11.2.1, “Reception and Classification.”**
    - b. When considering double celling Phase 2 inmates on the unit, the SRTU Treatment Team should make every effort to facilitate voluntary double celling agreements between SRTU inmates.
    - c. If no compatibility contraindications are present (these include, but are not limited to: age differences, disparate physical size, gang affiliations, security needs, custody level, medical issues, geographic/regional differences, and a documented history of ethnic/religious violence, or propensity for such) the SRTU Treatment Team may consider voluntary double celling.
    - d. SRTU double celling after normal working hours is prohibited, except in extenuating circumstances, and only with authorization from the Shift Commander. The double celling assignment will be reviewed by the SRTU Treatment Team the next working day.

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6. Medical staff shall conduct the medical screening in accordance with Department policy **13.2.1, “Access to Health Care.”**
7. Upon admission, psychology staff will interview/assess the inmate and:
  - a. review the Referral Packet; and
  - b. screen for any acute mental health symptoms including potential suicide risk.
8. Within 48 hours, the unit Psychology staff will review the **SRTU Initial Annual Recovery Treatment Plan (Attachment 10-H)** with the inmate and outline specific targeted goals and objectives. Documentation that the **IRP** was completed with the inmate will be made in the **ICAR**.
9. The SRTU Treatment Team shall conduct an initial review of the inmate’s **IRP** within three working days.
10. ***Within seven working days, a Psychiatric admission summary note with treatment recommendations will be completed. Summary of the SRTU admission shall include at a minimum, but not limited to the following information:***
  - a. ***history of present illness/reasons for SRTU admission;***
  - b. ***past psychiatric treatment history in the community/Department;***
  - c. ***mental status examination;***
  - d. ***diagnosis;***
  - e. ***risk assessment; and***
  - f. ***treatment recommendations and any needed referrals.***
11. While the inmate progresses through Phases 5, 4, 3, and 2, the Psychiatrist/PCRNP will see the inmate weekly. At least one session per week will be held out-of-cell.

**K. Transfers of Inmates in the SRTU System**

1. An inmate who is participating in the SRTU program may be permanently transferred between SRTUs, only when the SRTU Treatment Team believes it would be of therapeutic benefit and then only with the approval of both the receiving and sending facility’s Regional Deputy Secretary with input from the Chief of Psychological Services. These transfers will be coordinated through the BHCS and OPM. Any permanent transfer of an SRTU inmate to a non-SRTU location will require written approval by the Executive Deputy Secretary.

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**NOTE:** Transfers between SRTUs will be coordinated with an exchange of transfer packets, a **DC-46**, including a transfer rationale and a copy of the most recent Psychiatric Assessment.

2. At times it may be necessary to temporarily transfer an inmate from a SRTU to a non-SRTU facility. In these cases, the SRTU inmate will be housed in a Psychiatric Observation Cell (POC), unless written approval has been granted by the Executive Deputy Secretary **for placement in another setting such as a Diversionary Treatment Unit (DTU) or RHU**. The Chief of Psychological Services, BHCS, must be notified within 24 hours of any temporary transfer of a SRTU inmate.
3. Prior to a SRTU inmate's temporary or permanent transfer, a member of the transferring facility's SRTU Treatment Team shall communicate, with a member of the SRTU Treatment Team or PRT at the receiving facility. The sending facility shall document the date, names of participants, and issues discussed in the conference call in the **ICAR** and on the **DC-472**.
4. If an inmate is committed to a Department MHU or the FTC, that inmate's SRTU bed will be held open for a reasonable period of time, pending the inmate's return from the MHU or FTC.

**L. Treatment Programs/Levels of Treatment<sup>5</sup>**

1. The program components in the SRTU include a multi-disciplinary treatment environment.
2. All inmates in the SRTU will have an **IRP**. These **IRPs** will be created using the "Recovery Model" of treatment. The recovery model has the goal of enhancing the individual's quality of life. It supposes that the treatment delivered will be tailored to the individual's strengths, needs, and directions; and treatment decisions are made in partnership with the individual. In adopting the recovery model, we understand that the focus is on a path of recovery, not just goals. We also understand that recovery is an ongoing process and does not mean there is an absence of symptoms. Overall, this person-centered approach can reduce therapeutic disruption, noncompliance, decompensation, violence, and self-harm.
  - a. The first step in developing a "Recovery Model" **IRP** is to identify the "person-centered" goal. Listening to the individual with empathy, acceptance, and validation will allow the goal to be expressed. Second, identify the individual's strengths. This will tell us what is already working that can be amplified, supported, and used as a resource to facilitate change. Third, identify obstacles that prevent the individual from reaching their goal. Fourth, identify treatment objectives. These treatment objectives need to be measurable, concrete, and clear. It is important that the treatment objectives are relevant to the individual's stated recovery goal and to the obstacles that are hindering the inmate from reaching their goal. Fifth is to identify treatment

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<sup>5</sup> 4-4368

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- interventions. Treatment interventions will be chosen that are likely to increase the individual's strengths.
- b. Treatment planning may also include variations to the standard phases, treatment goals, and length of time in a phase, privileges, and management of problematic behavior. Modifications to the inmate's level of security related to restraints and escort will also be noted on the **IRP**. These security modifications will also be clearly noted in the Unit control booth. An overview of property and privileges associated with each Phase of treatment is found in the **SRTU Property, Privileges, and Services Chart (Attachment 10-I)**.
  - c. In conjunction with the SRTU Treatment Team, the Psychology staff will update the Initial/**Annual IRP**, using the **SRTU Recovery Treatment Plan Review (Attachment 10-J)**, every 30 days while the inmate is in Phases 5 through 1. The **IRP** shall be reviewed out-of-cell with the SRTU inmate at a minimum of every 30 days. The inmate must have input into the goals rather than all of them being generated by the SRTU Treatment Team in a standardized fashion. All inmates will be invited to personally attend and participate in all SRTU Treatment Team meetings. Treatment plan reviews will be documented in the **ICAR**.
  - d. ***The goals on the IRP, established collaboratively with the SRTU Treatment Team and the inmate drive the clinically structured out-of-cell offerings on the SRTU.***
3. Participation in treatment programs is based on a phase system. Movement to a lower treatment phase is based on appropriate inmate behavior and compliance with the **IRP**. The initial treatment phase shall be determined by the inmate's present level of functioning, recent historical information, and mental status. The SRTU Treatment Team shall recommend all treatment phase changes. Ultimately the PRC, with input from the SRTU Treatment Team, has the final decision on awarding or terminating privileges and granting phase changes.
  4. The SRTU treatment program includes a progressive phase system that may include, but is not limited to, Phases 5 through 1, plus Accountability Status, and Post-SRTU aftercare. The length of time spent in each phase is dependent on the inmate's demonstrated level of adjustment. The specific time parameters for each phase movement will be defined in the inmate's **IRP**.
  5. Changes in status from phase to phase shall be accomplished through staff action by the SRTU Treatment Team and documented by circulating a **SRTU Program Review Sheet**, with final approval by the Facility Manager. All status changes will be documented in the **ICAR** by the Unit Counselor. A **DC-46** is not required for phase change following placement on Accountability Status. A **DC-46** will be required to be circulated for all Phase 1 approvals.

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6. The SRTU is designed to support inmates with mental health problems in achieving the highest level of functioning within a safe environment. The phase system is designed to provide incentives for inmates who are able to remain free of self-injury, aggression, and other problematic behaviors as well as for attendance and participation in programming. Incentives will be earned when inmates engage in appropriate behavior. Incentives may be purchased weekly via the points system and points are deducted at the time they are redeemed.
7. ***The SRTU Treatment Team is aware that from time to time participation in programming may be difficult for some individuals. They may exhibit a lack of meaningful participation in the milieu offered. It is the goal of the SRTU that all participants receive the maximum benefit from treatment. Therefore, the SRTU Treatment Team will closely monitor program participation. Each month, every participant's IRP and out-of-cell participation will be reviewed by the Treatment Team. Should an individual's participation in out-of-cell offerings fall below 60% of the minimum 20 hours programming, the institution's LPM will lead the Treatment Team in collaborating with the individual to discuss goals/objectives/barriers to out-of-cell participation. Part of that review will include a discussion of the programming offered in order to ensure that it addresses the individual's expressed needs. In addition, as a part of the Treatment Team, the Psychiatric Provider will review the individual's medication and ensure there are no medication side effects which may be hindering program participation. The Psychiatric Provider will also assess the individual for possible in-patient treatment if clinically indicated. The institution's LPM will forward the updated IRP for review to the institution's Regional LPM and the Chief of Psychology at Central Office. The institution's LPM will coordinate a videoconference with their Treatment Team, their respective Regional LPM, and the Mental Health Advocate at Central Office, to discuss and review the Recovery Plan changes recommended by the institution's LPM and their Treatment Team.***
8. Consequences for engaging in self-injurious, aggressive, or other problematic behavior will be immediate with the inmate being placed on Accountability Status where the capacity to earn incentives is limited.
9. Phase advancement will be recommended by the SRTU Treatment Team, which includes mental health staff, security staff, and unit team staff. Phase advancement shall be based on behavior and attendance as well as participation in programming. The SRTU is an incentive-based program, meaning that as behavioral stability is demonstrated, more privileges are earned. Inmates who engage in problematic behavior will not be afforded these privileges until they demonstrate they are able to function more independently. Overriding goals include no disciplinary reports, treatment compliance, and active program participation.
10. Criteria for consideration of cutting set-aside-disciplinary sanctions and for advancement from phase to phase include:

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- a. remain free of misconducts and problematic behavior reports;
- b. remain free of self-injury;
- c. attend at least **60%** of **the minimum 20 hours out-of-cell structured and unstructured programming**;
- d. attend at least 90% of individual sessions; and
- e. other individualized recommendations on the **IRP** made by the SRTU Treatment Team.

11. Phase System

a. Phase 5 (**seven** days)

- (1) This is the starting point for new admission to the program. The inmate is eligible to advance to Phase 4 programming after **seven** days with no problematic behavior demonstrated and active participation in out-of-cell programming. This phase includes:
  - (a) the initial assessment of the inmate;
  - (b) works with staff to develop an **IRP** to identify behavioral and clinical needs and goals;
  - (c) attend initial SRTU Treatment Team session and orientation to the unit;
  - (d) introduction to incentive plan;
  - (e) rules of the unit;
  - (f) behavioral expectations;
  - (g) overview of the phase system;
  - (h) group descriptions; and
  - (i) unit schedule of activities and programs.
- (2) Phase 5 privileges and restrictions include the following:
  - (a) as outlined in the **SRTU Property, Privileges and Services Chart**;
  - (b) may earn up to 50 incentive points per week. Incentive points may be used on Phase 5 for items approved on the **SRTU Incentive Order Form (Attachment 10-K)**; and



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- (c) escorted in restraints to all out-of-cell activities. Restrained inmates will not be in mixed out-of-cell groups/activities with unrestrained inmates.
- b. Phase 4 (60 days or longer based on clinical recommendation)
- (1) After **seven** consecutive days on the Phase 5/Stabilization Phase without problematic behavior, the inmate is eligible for transition to Phase 4. Advancing through phases depends on active participation in programming. After 60 days on Phase 4, the inmate is eligible to move to Phase 3.
  - (2) Phase 4 privileges and restrictions include the following:
    - (a) as outlined in the **SRTU Property, Privileges, and Services Chart**;
    - (b) may earn up to 50 incentive points per week;
    - (c) **15** incentive points may be used for food items;
    - (d) 30 additional earned points may be used for Phase 4 incentive point menu items; and
    - (e) escorted in restraints to and from all activities. Restrained inmates will not be in mixed out-of-cell groups/activities with unrestrained inmates.
- c. Phase 3 (60 days or longer based on clinical recommendation)
- (1) An inmate may be considered appropriate for transition from Phase 3 to Phase 2 when the following is evident:
    - (a) demonstrates the ability to maintain safe behavior for at least 60 days;
    - (b) compliant with institutional regulations for at least 60 days;
    - (c) demonstrates an overall level of functioning that is consistent with general population; and
    - (d) compliant with treatment objectives as outlined in the inmate's **IRP**.
  - (2) Phase 3 privileges and restrictions include the following:
    - (a) as outlined in the **SRTU Property, Privileges, and Services Chart**;
    - (b) may earn up to 50 incentive points per week;
    - (c) **30** incentive points may be used for food items;

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- (d) any incentive point value may be used for incentive point menu items other than food items up to a total of 70 points per week;
- (e) in Phase 3 the inmate can be considered for on-unit employment based on team approval and job-availability. The Phase 3 inmate may be permitted to eat meals out-of-cell. Phase 3 inmates will be paid General Labor Pool (GLP) for five days per week; and
- (f) restraints - Upon placement on Phase 3 the Treatment Team may approve reduced restraints during escort to and from therapeutic modules for groups, recreation, and showers. However, Phase 3 inmates are generally unrestrained for regular movement within the unit unless out with another inmate who requires restraints.

d. Phase 2 (30 days or longer based on clinical recommendation)

Phase 2 privileges and restrictions include the following:

- (1) as outlined in the **SRTU Property, Privileges, and Services Chart**;
- (2) may earn up to 50 incentive points per week;
- (3) any incentive point value may be used for any incentive point menu item including food up to a total of 70 points per week;
- (4) may generally move unrestrained out-of-cell unless out with another inmate who requires restraints;
- (5) in Phase 2 the inmate can be considered for on-unit employment based on team approval and job-availability and may be permitted to consume meals out-of-cell. Phase 2 inmates will be paid GLP for five days per week; and
- (6) may exercise in a group with up to six other unrestrained inmates.

e. Phase 1 (90 days or longer)

- (1) An inmate attaining this phase is considered ready to begin reintegrating into a general population RTU or other housing unit deemed appropriate by the Treatment Team at the current treating facility or another SRTU facility. This probationary phase will be 90 days in length; with an option to extend probation for another 90 days through the Vote Sheet process. However, the maximum amount of time this phase will last is 180 days. Should the inmate be away from the facility for any reason, such as Authorized Temporary Absence (ATA) or a Mental Health Commitment, Phase 1 time will be suspended until such time as the inmate returns to the facility.

- (2) **While on Phase 1, the SRTU Treatment Team will continue to review the individual's IRP every 30 days.** Incentive points will not be earned nor can they be used while an inmate is on Phase 1. The focus of this Phase will be to continue to address treatment goals while adjusting to the general population setting. Thus, acclimating and blending into the general population routine is vital. Incentive points should be used prior to earning Phase 1. Once promoted to Phase 1, any unused points will be lost.
- (3) When an inmate successfully completes the probationary status after 90 **to** 180 days without any significant incidents of behavioral or mental health regression, the SRTU Treatment Team will staff him/her for discharge/**graduation** from the program. **Graduation from the SRTU will be completed by vote sheet with final approval from the Facility Manager.** Since the inmate has completed/**graduated** the program, the Treatment Team may consider transferring him/her to another facility, or permit him/her to remain at the current facility. **After completing the probationary** period, the **release** of any Phase 1 inmate to general population requires facility approval via the Regional Deputy Secretary.

## M. Accountability Status

Accountability Status is a temporary placement within the unit or off of the unit for SRTU inmates whose behavior is acutely dangerous to self or others or whose behavior is threatening and disruptive to programming and the operational functioning of the unit. The inmate on Accountability Status will be evaluated daily with a plan for their timely return to the program.

### 1. Purpose of Accountability Status

- a. It is the goal of the SRTU to provide quality out-of-cell programming to inmates who can benefit from treatment, but who, because of their behavior, have been restricted to units where intensive therapy is difficult to provide. An essential part of all Behavior Management programs is the provision for an immediate consequence for serious negative behavior. Therefore, Accountability Status **may** be instituted to temporarily **address** an acutely aggressive, threatening, disruptive inmate **participating in** SRTU programming. This ensures the education of the inmate; safety of staff and other inmates; and the smooth continuation of the program for treatment compliant inmates.
- b. The SRTU inmate may be held on Accountability Status no longer than **24 hours**. **Additional placement on Accountability Status may be approved by the Facility Manager in 24-hour increments up to an additional 72 hours if the individual's status has not stabilized after the first 72 hours, the Psychiatrist will be consulted to determine the need for POC or inpatient placement. In addition, upon reaching the initial 72-hour time frame, the institution's LPM will forward the SRTU Change of Status IRP to the institution's Regional LPM and the Chief of Psychology for review. Also, the SRTU Treatment Team will schedule and conduct a videoconference with the Department's Mental Health Advocate.**

**Recommendations for case management will be made in conjunction with Central Office.**

2. Indicators for Accountability Status Process

- a. SRTU inmates who are exhibiting acutely aggressive and/or threatening behavior toward themselves or others or are exhibiting extremely disruptive behavior that interferes with the safe and orderly functioning of the program will immediately be placed on Accountability Status. These behaviors may be reported and documented by utilizing the:
  - (1) **DC-141, Misconduct or Other report;** or
  - (2) **DC-121, Part 3, Employee Report of Incident.**
- b. Once a staff member observes a harmful, potentially harmful, or disruptive behavior, they will inform the area Lieutenant, Unit Manager, and the LPM/designee. They will also complete one of the above noted documents. The area Lieutenant will notify the Shift Commander of the noted behavior and the recommendation to place the inmate on Accountability Status. The Lieutenant, Unit Manager, or LPM will complete the **SRTU Accountability Status Restriction Form (Attachment 10-L)**. Recommended property and privilege restrictions must relate to the behavior which prompted the inmate's placement on Accountability Status. All documentation will be completed immediately and forwarded to the Shift Commander for initial disposition.
- c. In general, cells utilized for Accountability Status should be away from the routine activity of the SRTU program. However, cells should be outfitted to ensure the maximum ability to observe and ensure the safety of the inmate.
- d. Prior to placing the inmate into Accountability Status, he/she will be strip searched and given property and privileges as indicated on the **SRTU Accountability Status Restriction Form**. Once placed on Accountability Status, the inmate will be seen by his/her assigned psychology staff member. Together they will complete the **SRTU Accountability Status – Individual Recovery Plan (Attachment 10-M)**. This **recovery** plan will specifically address the inmate's goals related to why he/she is on Accountability Status and his/her return to regular programming. Placement in Accountability Status and subsequent treatment planning will be documented in the ICAR. **After being reviewed by the institution's LPM, the SRTU Accountability Status – Individual Recovery Plan will then be scanned to the institution's Regional LPM for review.** They will then be scheduled for the next Treatment Team meeting. All staff contacts will occur as described in the Accountability Status Monitoring Protocol as follows:
  - (1) **The assigned psychology staff member will offer daily 30 minute AM and PM out-of-cell contacts for the duration of the Accountability Status placement. Contacts will be documented in the ICAR and DC-560 documentation copied to the medical record;**

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- (2) additional psychological contacts, if requested by the inmate or a staff member, will be provided by the assigned psychologist during his/her scheduled daily psychology unit rounds;
  - (3) one **30 minute daily** out-of-cell Psychiatrist/CRNP contact;
  - (4) **one 30 minute daily out-of-cell Therapeutic Recreation Specialist contact,**
  - (5) **one 30 minute daily out-of-cell Social Worker contact,**
  - (6) **one 30 minute daily out-of-cell CPS contact,**
  - (7) **one hour of yard daily,**
  - (8) PRC **review during the Accountability Status placement,**
  - (9) SRTU Treatment Team review **at the initiation of the Accountability Status placement,** including review of treatment compliance, and property and privileges permitted with recommendations forwarded to PRC on a new **SRTU Accountability Status Restriction Form;** and
  - (10) continued **30 minute daily out-of-cell** Correctional Counselor visits.
- e. While on Accountability Status, the Treatment Team will make the final decision as to when and whether the inmate may have more property privileges or programming, or qualify for ending Accountability Status. While on Accountability Status inmates may earn one incentive point for each day without exhibiting acute aggressive and/or threatening behavior toward themselves or others or are exhibiting extremely disruptive behavior to the safe and orderly functioning of the program.
- f. To be removed from Accountability Status an inmate must be treatment compliant, **(including out-of-cell participation of at least 50%),** in behavioral control, and misconduct free to finish Accountability Status. The Treatment Team will decide when an inmate has successfully completed Accountability Status. The inmate will then be returned to the program Phase deemed appropriate by the SRTU Treatment Team.

## **N. Structured Versus Unstructured Programming**

1. All structured and unstructured programming will take place in therapeutic modules and Restart Chairs upon determination by the Treatment Team. **Each facilitator of structured and unstructured programming will document their group contact with each individual on the SRTU Group Participation Form (Attachment 10-N). Each facilitator will keep the SRTU Group Participation Form in their possession. At the end of each 30 days, the SRTU Group Participation Form will be forwarded to the medical record for filing. At the same time, the facilitator will place a brief monthly summary in the ICAR.**

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2. Structured activities are those that are lead/facilitated by a Department or contracted staff member, or a Volunteer. These may include: Morning Meetings, Mental Health groups, the HELPING: Multimodal Self-Change Approach, **Carey Guides**, Relapse Prevention Plan, AOD, chaplaincy, Thinking for a Change groups, **Violence Prevention**, Taking a Chance on Change groups, Start Now program, groups run by activities staff, education, Reentry groups and modules on accepting mental illness, activities for challenged inmates, body basics, staying healthy on your medications, exploring the United States, handle anger better, personal hygiene, planning for a better life, self-esteem, social skills for challenged inmates, and substance abuse treatment introduction and other treatment interventions. Staff may also choose to use the “Traffic Light” Tool in order to illustrate targeted goals and objectives for each inmate. This visual representation of their immediate objectives can be placed where the inmate may view and have immediate feedback concerning appropriate and inappropriate behavior. This intervention will be utilized in a way that protects the confidentiality of the inmate. These resources and activities may be acquired from the LPM assigned to your region.
3. Unstructured activities are defined as activities occurring outside the cell but not conducted by Department staff members. For example: law library, recreation, visits, viewing movies, eating in small groups, and reading out-of-cell. They do not include activities of daily living like showers; however, eating meals in a small group would be considered unstructured.
4. At a minimum, ten structured and ten unstructured out-of-cell hours of programming will be offered to all inmates housed in the SRTU. The number of structured out-of-cell hours or portions of an hour of programming the inmate participates in will be logged by the staff member who provides the structured out-of-cell contact. The staff member will log the completed time on the **SRTU Accepted/Refused Structured Out-of-Cell Program Log**. The number of unstructured out-of-cell hours or portions of an hour of programming the inmate participates in will be logged by a CO assigned to the unit. The CO will log the completed time on the **SRTU Accepted/Refused Unstructured Out-of-Cell Program Log**.
5. Weekly, the SRTU Counselor will compile the total hours of programming for each inmate, document the total in the **ICAR** and report the data on the **Weekly Structured/Unstructured Out-of-Cell Program Report (Attachment 10-O)**. Completed logs will be forwarded to the SRTU Unit Manager for filing. The **Weekly Structured/Unstructured Out-of-Cell Program Report** will be forwarded to the Chief of Psychological Services.

## **O. Phase Modification**

The SRTU treatment program will tailor individualized phase modifications/alternatives when necessary. The modifications will be documented on the **IRP** with the rationale and goals for the modification and the steps to be taken to reach those goals. These alternatives include, but are not limited to:

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1. Accountability Status for a SRTU inmate who is celled in an area apart from the SRTU (if available) due to his/her behavior, psychiatric symptoms, and/or facility need. The inmate may be committed to a MHU, or other appropriate housing unit;
2. temporary phase change *and/or phase demotion*;
3. phase freeze (a hold in one phase for various reasons, where privileges may be modified); and
4. modified phase (e.g., an inmate with previous assaults on female staff will lock up when female staff are on the unit, or a Phase 4 inmate may be permitted uncuffed out-of-cell time when other inmates are all in their cells).

**P. Incentive Program**

1. The Incentive Program is designed to allow inmates in the SRTU the opportunity to earn incentive points that may be redeemed for items on a regularly scheduled basis. Incentive points are earned based on individual performance and for positive and pro-social behaviors.
2. Incentives are a proven method for increasing pro-social behavior and reducing problematic (target) behaviors. Once the target behaviors and goals are identified with the inmate, incentives are used as a reward for achieving identified goals. Within the Incentive Program design is also life skill opportunities such as basic math and reading, learning to save and plan, and facilitating positive social communication.
3. Program Design
  - a. Inmates who follow facility rules and regulations evidenced by not receiving a misconduct report or demonstrating any problematic behavior will earn a point for the day. A notation in the **ICAR** will be written as supporting documentation for an inmate who does not earn his/her point for the day. This will be noted by the Unit Counselor.
  - b. Treatment points are earned based on treatment attendance and participation without problematic disruptive behavior. Inmates earn two points for each hour of structured activity and one point for each hour of unstructured activity they attend. Structured and unstructured programming will occur daily. Inmates are assigned to specific groups based on individual needs. Inmates who do not have an excused absence, who ask to leave group before it is finished, or who are escorted out due to disruptive behavior do not earn points for that group.
  - c. Inmates' points are aggregated each week. Inmates are informed, weekly, both verbally and in writing of all points earned. Inmates then may order items or purchase privileges using their points. Items are given point values from 5 to **50** points. Unused points may be carried over from week to week and month to month, but an inmate may not use more than the total stated for each phase in a given week. Once a point

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or privilege is earned, it cannot be taken away. Points and privileges will be held in abeyance should the inmate be placed in Accountability Status.

- d. The following is an overview of the incentive points that may be earned in each week:
- (1) seven daily points for no disciplinary reports or information reports (Maximum to be earned is seven);
  - (2) seven daily points for Good/Fair ratings for Cell Cleanliness and Hygiene (Maximum to be earned is seven);
  - (3) two points for each hour of attendance and participation in structured programming (Maximum to be earned is 20);
  - (4) one point for each hour of attendance and participation in unstructured programming (Maximum to be earned is ten);
  - (5) six bonus points for attending and participating in all groups and meeting **recovery** plan requirements for one week; and
  - (6) seven daily points for no disciplinary reports or information reports while under Accountability Status (Maximum to be earned is seven).
- e. At the end of each week, the SRTU Counselor will tabulate each inmate's incentive point total for the previous week using the **SRTU Weekly Point Summary (Attachment 10-P)**. The total points will be transposed to the **SRTU Monthly Point Summary (Attachment 10-Q)** in order to track the total incentive points earned and redeemed over time. After tabulating the weekly point totals, the SRTU Counselor will then distribute the **SRTU Incentive Order Form** to each inmate. They will then complete and return the forms by the end of the day. Incentives earned will then begin to be distributed no later than the week following when they were redeemed.

**Q. Misconducts**

1. The alleged commission of class 1 misconduct charges 1 to 14 will result in formal disciplinary action if found guilty and accountability status for no **more** than **three** days.
2. The alleged commission of a class 1 misconduct charge 15 to 25 **may** result in formal disciplinary action if found guilty and placement in accountability status for **no more than three** days.
3. An inmate will not be issued misconducts for self-mutilation, however, a **DC-121, Part 3** will be generated. This may result in the inmate's placement in the POC or on Accountability Status.



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4. **The assigned psychology staff** will provide input to the Hearing Examiner for all formal hearings in regard to whether the infraction was due to the inmate's mental illness or volitional. The Hearing Examiner will use this input for sanctions or modifying sanctions.
5. An inmate on probationary status in Phase 1 in a general population RTU does not automatically need to be returned to the SRTU. This decision will be made by the PRC with input from the SRTU Treatment Team.

## **R. Changes in Status**

1. Inmates may be transferred to the SRTU in either Administrative Custody (AC) or DC status. DC sanctions should not be cut by the sending facility. The major goal of the SRTU program is to stabilize the inmate's behavior so he/she can progress to placement in the least restrictive environment, based on their demonstrated behavior. Any remaining DC time will be addressed by the PRC at the SRTU facility.
2. While in the SRTU, DC status is set aside. As stated above, the DC sanction time continues to expire while the inmate is in the SRTU. An inmate can earn further reductions in their DC sanctions for appropriate behavior.
3. An inmate who exhibits misconduct-related behavior while in the SRTU will generally serve a period of suspension on Accountability Status with a phase change (reduction in privilege level) based on the recommendation of the SRTU Treatment Team and approval of PRC.
4. All changes in status in regard to Phase progression will be completed via the **SRTU Program Review Sheet**. Once the unit team makes a recommendation to PRC to advance a phase, and PRC approves, an **ICAR** entry will be made by the counselor indicating such.

## **S. Release of SRTU Inmates**

1. Phase 1 constitutes the release of the inmate to a general population housing unit generally within the treating facility. The release of any Phase 1 inmate from the SRTU to a general population RTU or appropriate housing unit requires approval of the Regional Deputy Secretary.
2. An inmate who is being considered for release to general population as a result of placement on Phase 1 must have completed all requirements of his/her **IRP** for Phase 2.
3. Approval to move to Phase 1 and release to a general population RTU shall be requested via memo to the office of the Regional Deputy Secretary. Documentation should include the SRTU Treatment Team's approval, PRC action, Facility Manager's approval, and submission of appropriate rationale concerning the inmate's progress in the SRTU program. The release is usually to the general population RTU of the treatment facility.

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4. If approval is granted for transition to Phase 1 and ultimate discharge to the designated facility, the Unit Manager/designee shall verify the status and move date.
5. The Unit Manager shall ensure that the following are completed:
  - a. the inmate is readied for transition on the approved date;
  - b. the inmate packs his/her property and cleans the cell;
  - c. the inmate's property is inventoried by unit staff;
  - d. all SRTU property, clothing, etc., is returned to the SRTU inventory;
  - e. the inmate's property is released to the inmate and/or the Department transportation crew;
  - f. if the inmate is being released to the SRTU facility's general population, request appropriate staff to escort the inmate to the newly assigned housing unit;
  - g. review all documentation to ensure proper log entries, forms, location boards, and SRTU paperwork is completed accurately and in a timely manner;
  - h. notify the facility's Control Center to ensure inmate movement forms for count procedures are completed; and
  - i. in a case where the inmate is being discharged to a RTU placement at another facility with a SRTU, the SRTU Treatment Team shall conduct a videoconference or teleconference call, with the Unit Management Team of the receiving facility to discuss the inmate's response to treatment. The referring facility shall document in the **ICAR** and on the **DC-560** the date, names of participants, and issues discussed in the conference call. At a minimum, the following issues shall be addressed:
    - (1) the inmate's progress toward meeting the goals of his/her **IRP**;
    - (2) the extent to which he/she has achieved maximum benefit from treatment available at the SRTU;
    - (3) any ongoing resistance to program participation; and/or
    - (4) any treatment needs to be addressed when the inmate arrives at his/her designated facility.
6. An inmate being transferred to another facility as a Phase 1 SRTU inmate on probationary status will be afforded the same privileges and services as defined in the SRTU Privileges and Services Chart (Phase 1) and placed in general population.

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7. In the event that an inmate's behavior deteriorates, during his/her Phase 1 probationary period, the inmate may be returned to the SRTU. If the inmate's behavior deteriorates, after he/she has completed Phase 1, return to the SRTU is an option, but is not mandated. If a decision has been made to place the inmate back into SRTU programming, a new referral packet will be generated and the packet submitted for review as stated in this policy. Depending on the nature of the deterioration, the inmate may require a short time stay in the RHU and/or a mental health inpatient setting. If there are questions regarding the preferred option, cases in this status can be reviewed with the COSN/PRT and the Regional LPM.

## **T. Discharge Procedures**

1. Discharge/**Graduation** of an inmate from SRTU programming after successful completion of the Phase 1 **probationary period** shall be considered when:
  - a. the **IRP** goals have been satisfied with successful reintegration into a general population RTU or step-down unit for three to six months in a permanent facility;
  - b. when it is necessary to place an SRTU graduate in the RHU they will be managed according to their Stability Rating and Department policy **DC-ADM 801**; or
  - c. ***an inmate successfully completing Phase 1 probationary period and graduating from SRTU programming may be eligible for transfer to a facility in his/her home region by submission of a permanent transfer petition utilizing the purpose, Other and Comments: SRTU Graduate.***
2. Discharge of an inmate from the SRTU for other than successful program completion shall be considered when:
  - a. the SRTU Treatment Team concludes that the inmate remains resistant to participation in the **IRP** that was developed for him/her; and/or the inmate engages in repeated negative behavior which is contrary to the mission of the SRTU, and undermines the treatment of other SRTU participants;
  - b. all inmates being considered for discharge from the SRTU for reasons other than successful completion shall be automatically referred to the SAU for review and recommendation for subsequent placement. The SAU recommendations will then be included in the Referral Packet; and
  - c. the following criteria should be met when an inmate is being considered for removal from overall SRTU programming:
    - (1) clinician and custody consensus that the inmate's presentation is intentional and volitional and is not driven by SMI; and
    - (2) evidence of both disruptive actions and deleterious impact on valid SRTU inmates' progress.

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3. The facility recommending an inmate for removal from SRTU programming should send a Referral Packet to the OPM for review at COSN/PRT. The Referral Packet should include the following information:
  - a. a completed **Special Program Referral Approval/Rejection Form**, which will serve as the face sheet. In the Requested Action Section, the Program/Unit Removal box should be checked;
  - b. **DC-46** circulated through the SRTU Treatment Team and the referring facility's administrative staff;
  - c. rationale for the inmate's removal from SRTU programming to include listing of disruptive behaviors, misconducts, and actions of self-injury;
  - d. the review and recommendations as prepared by the SAU; and
  - e. documented evidence of behaviors to include, but not limited to Misconduct Report(s), **DC-121's**, **ICAR** entries from SRTU Treatment Team, and PRT notes.
4. If the COSN/PRT determines that removal from the SRTU programming is not appropriate, all options will be reviewed and a decision as to the disposition of the inmate's case will be generated.
5. If the final recommended disposition by COSN/PRT does not include placement in another SRTU, the Executive Deputy Secretary will conduct the final review.
6. If removal from SRTU Programming is approved by the COSN/PRT and the Executive Deputy Secretary, then a Transfer Petition will be completed by the OPM. COSN/PRT will determine where the inmate should be placed and the OPM will assign a facility accordingly.
7. The receiving facility can submit the inmate for consideration by COSN/PRT for reentry into the SRTU programming, if the inmate displays behaviors consistent with SRTU admission criteria.
8. ***Prior to discharge or transfer to another SRTU or other placement, documentation from the Psychiatric provider shall include at a minimum, but not limited to the following information:***
  - a. ***overall progress, any symptoms which have not responded to treatment;***
  - b. ***summary of response to medication trials, reasons/need to continue any polypharmacy, and any significant events while in the SRTU;***
  - c. ***SRTU discharge treatment recommendations; and***

- d. *any inmate who's Psychiatric Evaluation is over two years old, shall have an updated Summary Psychiatric Assessment at the time of his/her discharge from the SRTU which shall include the above information.*

#### U. Release via Sentence Complete (Formerly Final Discharge Maximum Expiration)

1. If an inmate is scheduled for release via Sentence Complete before completion of the SRTU program, the inmate shall be referred to the facility Psychology Department 12 months prior to release for continuity of care/release planning, in accordance with **Section 2** of this procedures manual.
2. Any release of a highly assaultive inmate due to sentence completion shall follow procedures set forth in Department policy **6.5.1, "Administration of Security Level 5 Housing Units" Section 1.**

#### V. Unit Operation Evaluation

1. Monday of each week, the SRTU Unit Manager/designee will provide, via email, the Licensed Psychologist Director at Central Office with an updated roster to include SRTU inmates on Mental Health (MH) commitment, WRIT, etc. This roster shall include phases, effective date of current phase, and date admitted to the SRTU.
2. Also, on Monday of each week, the SRTU Unit Manager/designee will submit via email, to the Licensed Psychologist Director at Central Office, the log sheet of out-of-cell hours on the **SRTU Accepted/Refused Structured Out-of-Cell Program Log** and the **SRTU Accepted/Refused Unstructured Out-of-Cell Program Log**.
3. *In conjunction with this review, the SRTU Unit Manager/designee will submit a list of SRTU individuals who participated in out-of-cell programming at less than a 60% average for the previous month. This list will be reviewed by the institution's LPM who will ensure that all listed individual's IRPs have recovery plan goals/objectives related to program participation and overcoming obstacles to treatment. This list will be forwarded to the institution's Regional LPM and the Chief of Psychology. The type and content of programming offered will be evaluated as to its efficacy in engaging the individuals in the therapeutic process. Upon Central Office review, consultations with the institution may occur with recommendations to modify the programming delivered to the SRTU.*
4. The SRTU Unit Manager/designee shall provide, via email, a summary of the monthly **Treatment Team meeting** to the Licensed Psychologist Director (LPD) on the first of each month.
5. In order to evaluate the operation of the SRTU, each Facility Manager/designee shall ensure that an **SRTU Semi-Annual Report (Attachment 10-R)** is completed and submitted to the Executive Deputy Secretary, the LPD, and the Regional LPM by July 31 (reporting period 1/1 to 6/30) and January 31 (reporting period 7/1 to 12/31) of each calendar year. This report shall include, but not be limited to, the following:

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- a. the number of inmate receptions by month;
- b. a list of facilities transferring inmates to the unit;
- c. the name and Department number of every inmate transferred to the unit;
- d. the name and Department number of every inmate promoted to Phase 1;
- e. the average length of an inmate's stay in all Phases (5, 4, 3, 2, and 1);
- f. the name and Department number of every inmate released from the unit and the location where he/she was transferred;
- g. the name and Department number of every inmate with Sentence Complete expiring while in the unit;
- h. the name and Department number of every inmate moved to Accountability Status and Post SRTU;
- i. the number of grievances filed by inmates in the unit;
- j. the number of misconducts issued to inmates in the unit;
- k. the number of SRTU inmates at the beginning and end of the reporting period;
- l. any recommendations to facilitate the operation of the unit; and
- m. any concerns regarding the operation of the unit.

## Section 11 - Sex Offender Treatment (SOT)

### A. Standards, Guidelines, and Theoretical Orientation for the Assessment and Treatment of Adult Sex Offenders

#### 1. Standards and Guidelines

The Department's **Standards and Guidelines for the Assessment, Evaluation and Treatment of Adult Sex Offenders** are found in **Attachment 11-A**. Every provider of sex offender-specific treatment shall thoroughly familiarize himself/herself with these prior to facilitating treatment.

#### 2. Theoretical Orientation

The theoretical orientation of the Department is derived from the current thinking in the field of Sex Offender Treatment, the standards and practices of the Association for the Treatment of Sexual Abusers (ATSA), the Pennsylvania Sex Offenders Assessment Board (SOAB), and the Sex Offender Treatment Programs (SOTP) operating in other state correctional jurisdictions and agencies. All program components and therapeutic strategies are based on an evidenced-based, cognitive behavioral model.

Social learning theory supports the principle that cognitive processes mediate environmental and experiential events; that social learning experiences influence how an offender thinks about himself/herself and his/her world and that his/her thinking, in turn, influences how he/she perceives and reacts to his/her environment. This perspective is a basic tenet of the Department's SOTP. Further discussion of the **Theoretical Orientation** upon which the SOTP is based is presented in **Attachment 11-B**.

### B. Risk/Need Assessment

#### 1. Assessment Strategy

- a. An **Adjusted Actuarial Approach** shall be employed in evaluating sexual offenders. This strategy, involving first the use of a validated sex offender risk instrument that measures static or unchangeable risk factors shall be adjusted based on an analysis of the inmate's dynamic changeable risk factors.
- b. The risk assessment should be updated as an inmate's dynamic risk factors change, minimally post-treatment and (if different) at time of parole review.
- c. When the inmate's reentry into the community is being considered, reports to the Pennsylvania Board of Probation and Parole (PBPP) should specify the offender's dynamic risk factors that are more acute in nature (those that have a stronger temporal association with re-offending and/or those that may change rapidly), such as negative mood or intoxication, as these may be more amenable to observation by supervising officers and service providers, and may indicate that risk has increased such that offending is more imminent than it was previously.

2. Facility Responsibilities

- a. Permanent facilities are responsible for identifying, tracking and assessing all sexual offenders received. All facilities shall use the automated Unit Management System for recommending Sex Offender Programs and maintaining waiting lists. A trained SOT provider shall conduct specialized assessments of a sexual offender within two months of his/her arrival at the facility, and, subsequent to the assessment, ensure the appropriate program is placed on the offender's Individual Treatment Plan (ITP).
- b. Participation in sex offender-specific treatment shall be "minimum sentence-driven," with an offender closest to his/her minimum date taking priority over those further from his/her minimum sentence date. However, this is not to say that lifers and/or offenders with very long sentences shall not be afforded treatment. Whenever possible (when it would not take a slot needed for an offender two years within his/her minimum date), these offenders shall be considered for placement in treatment.

3. Informed Consent

Prior to initiating an interview for the purpose of initial risk assessment, the evaluator shall explain the nature, scope and purpose of the interview to the inmate, emphasizing its importance in determining treatment needs. The **DC-484, Mental Health Informed Consent** form (**Attachment 2-K**) shall be completed in accordance with **Section 2, Delivery of Mental Health Services, Subsection F.** of this procedures manual.

4. Assessment protocol for an inmate offender with a current sex offense

- a. Every offender (received subsequent to the effective date of this procedure) currently incarcerated for a sex offense shall be assessed for level of risk within two months of arrival at the permanent facility. (Staff are not expected to retroactively complete risk assessments on an inmate incarcerated prior to the effective date of this procedure.) The inmate will eventually have to be assessed for risk level, but this can be done at the time the staff member is ready to initiate a new group.
- b. For every male sexual offender, assessment shall include, but not be limited to, a case file review, and completion of the *Static-99* (**Attachment 11-C, Static-99 Coding Rules Revised and can also be found online at [www.sgc.gc.ca](http://www.sgc.gc.ca)**). Unless the convicted sexual offender refuses, an individual interview shall also be part of the assessment process, and during the interview the **DC-577, Adult Sex Offender Data Collection Instrument (Attachment 11-D)** shall be completed. Note: Much of the information required for completion of the **DC-577** can be gleaned through the case file review, but can be verified and/or clarified in the individual interview. The same assessment process shall occur with every convicted female sexual offender, excluding the completion of the *Static 99* as this risk assessment tool has not been cross-validated with this population.
- c. Every inmate refusal to be interviewed for purposes of risk assessment shall be



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documented using the **Inmate Cumulative Adjustment Record (ICAR)**, and this documentation shall be sent to the inmate's Corrections Counselor for maintenance in the **ICAR**, with a copy maintained in the offender's sex offender-specific record. Upon refusal, the inmate shall be counseled as to the possible consequences of failure to participate in treatment, including the possibility of being denied parole and of increasing his/her chances of re-offending upon return to the community. In cases where the inmate is appealing his/her case based upon claim of innocence and/or is in total denial of the crime(s) and refusing treatment, this shall also be documented using the **ICAR**.

- d. Once the *Static 99* and the **DC-577** have been completed, the treatment provider (in the case of the male sex offender) shall determine if the risk level gleaned from the *Static-99* is to be adjusted based upon the following static and dynamic risk factors that have been empirically linked to increased risk of sexual recidivism.
  - (1) indication that the offender is at high risk for general recidivism based on Level of Services Inventory - Revised (LSI-R) scores (if available);
  - (2) indication that the offender maintains attitudes that support sexual offending (articulates belief that children are not harmed by sexual activity with adults);
  - (3) indication that the offender has a primary sexual attraction to children and/or becomes sexually aroused by violence;
  - (4) indication that the inmate has engaged in a high degree of deviant sexual behavior rather than appropriate sexual behavior;
  - (5) indication based on historical data or behavioral observations that the inmate has serious emotion management/impulsivity problems;
  - (6) indication that the inmate has significant history of conflict-ridden intimate relationships; and/or
  - (7) documented evidence of early onset sexual offending behavior.
- e. In the case of the female sexual offender, the treatment provider shall determine the level of risk based upon the case file review, the individual interview using the **DC-577** and the presence (or absence) of the above-cited dynamic risk variables.
- f. In making decisions to adjust the risk level obtained from the *Static 99* based upon identification of the above-cited static and dynamic risk factors, the following guidelines apply:
  - (1) *Static 99* scores translated into Low and Low-Moderate risk categories shall be adjusted upward (Moderate/High Risk) in cases where the presence of the stable dynamic risk factor (3) (deviant arousal) is confidently identified. (There should be documented evidence of a pattern of deviant behavior as evidenced by

multiple offenses and/or victims over an extended period of time.)

- (2) *Static 99* scores translated into Low and Low-Moderate risk categories shall be adjusted upward (Moderate/High Risk) in cases where four or more of the risk factors (1) through (7) are confidently identified.
  - g. In the event that the inmate does not self-refer (via written or verbal request) to treatment within a period of one year, the Corrections Counselor shall ensure that he/she is again counseled regarding the possible consequences of failure to participate in treatment at the time of his/her annual review. In the event that an inmate does self-refer for treatment, a risk assessment shall then be completed.
  - h. The results of the sex offender assessment shall be summarized using the **DC-578, Sex Offender Program Evaluation** form, which provides two levels of risk (Low, Moderate/High). A male offender assessed to be low risk shall be prescribed Low Intensity SOTP, while an offender assessed to be moderate or high risk shall be prescribed Moderate/High Intensity SOTP. Assessment results (including copies of the completed *Static 99*, **DC-577** and the **DC-578**, along with copies of the inmate's Pre-Sentence Investigation (PSI), and any existing police reports and/or victim statements shall be the beginning of the sex offender-specific record. Copies of the completed **DC-578** shall be distributed to the inmate's Corrections Counselor and the Facility Parole Agent.
5. Assessment Protocol for a Technical Parole Violator

When a male inmate convicted of a sexual offense (previously a successful completer of sex offender-specific treatment) fails on conditional release and is returned to prison as a parole violator, decisions about what level to return him to treatment shall be based in the following assessment protocol:

- a. Following completion of a case file review and the *Static 99* (if not accessible from prior records), the **Table for Adjustments in Risk Based on Time Free (Attachment 11-F)** shall be used to determine risk of sexual re-offense. Guidelines for recommendations based upon the results of this procedure are as follows:
  - (1) In cases where the risk (of sexual recidivism) is less than 12% over a 10-year post-release follow-up period, placement in a Maintenance group shall be recommended, unless the behavior leading to revocation of parole signified imminent re-offense (the parolee was caught taking a nine-year old boy he had befriended at a mall over the state line), in which case the Moderate/High Intensity Program shall be recommended.
  - (2) In cases where the risk is found to be between 12% and 20% over a 10-year post-release follow-up period, the Low Intensity Program shall be recommended, again, unless the behavior leading to revocation of parole signified imminent re-offense, in which case the Moderate/High Intensity Program shall be recommended.

- (3) In cases where the risk is found to be greater than 20% over a 10-year post-release follow-up, the Moderate-High Intensity Program shall be recommended.
  - b. Assessment results for technical parole violators shall be documented using the **Assessment Results for Inmates Referred for Evaluation for Sex Offender Treatment due to a Technical Parole Violation or a Prior Sex Offense (Attachment 11-G)**. Copies of this shall be distributed to the Facility Parole Agent and the Corrections Counselor.
6. Assessment of a Convicted Parole Violator
  - a. A convicted Parole Violator, re-incarcerated due to sexual recidivism shall be evaluated as described in **Subsection B. 4.** above, using the most recent sex offense as the index offense. Results of the evaluation, along with the programming recommendation shall be summarized using the **DC-578** with copies distributed to the Corrections Counselor and the Facility Parole Agent.
  - b. A convicted Parole Violator, re-incarcerated due to non-sexual recidivism shall be evaluated as described in **Subsection B. 4.** above (using the prior sex offense as the index offense, scoring the *Static 99* retrospectively if not available in prior records, and adjusting, if indicated, as described in **Subsection B. 4.**). This includes the parole violator who was on parole for a non-sexual offense, but has been referred for an evaluation because of a prior sex offense, providing the prior sex offense occurred within 10 years of the current offense. Results of the evaluation and the programming recommendation shall be summarized using the **DC-578** with copies distributed to the Corrections Counselor and the Facility Parole Agent.
7. Assessment of a male inmate referred for evaluation by the Corrections Counselor and/or the PBPP due to a prior sex offense who was not on parole at the time of the current, non-sex offense.
  - a. In the case of an inmate who was not on parole at the time he committed the nonviolent offense for which he is currently incarcerated, the protocol described in **Subsection B. 5.** above shall be implemented, in this case recommending the “no treatment” option if the **Table for Adjustment in Risk Based on Time Free** yields a sexual re-offense risk less than 12% over a 10-year post-release follow up period. Results of the evaluation and the programming recommendation shall be reported on the **Assessment Results for Inmates Referred for Evaluation for Sex Offender Treatment Due to a Technical Parole Violation or a Prior Sex Offense** form, with copies distributed to the Corrections Counselor and Facility Parole Agent.
  - b. In the case of an inmate who was not on parole at the time he committed the violent offense for which he is currently incarcerated, the risk assessment protocol described in **Subsection B. 4.** above, using the prior sex offense, provided it did not occur more than 10 years prior to the current offense, as the index offense and scoring the *Static 99* retrospectively. Results of the evaluation and the programming recommendation

shall be reported on the **DC-578**, with copies distributed to the Corrections Counselor and Facility Parole Agent.

- c. In cases where the inmate had been offense-free in the community 10 or more consecutive years prior to the current non-sexual, non-violent or non-sexual, violent offense, the *Static 99* shall not be completed and a “no treatment” recommendation shall be made. This recommendation shall be made using the **Assessment Results for Inmates Referred for Evaluation for Sex Offender Treatment due to a Technical Parole Violation or a Prior Sex Offense** form, with copies distributed to the Corrections Counselor and the Facility Parole Agent.

### **C. Sex Offender Treatment (SOT) Programming**

#### 1. Standardized Treatment Model

- a. A program of sex offender-specific treatment is made available to every inmate convicted of a sexual offense, and in cases where specialized assessment indicates, treatment shall also be made available to an inmate who has a history of prior sexual offenses.
- b. Every facility that offers sex offender-specific treatment shall use the “*Responsible Living: A Sex Offender Treatment Program.*” The program shall be implemented as written using the “Group Only” format and the “Point System.”
- c. Initially, a denier shall be accepted into the program, but he/she shall be re-evaluated at intervals specified by the program, and ultimately terminated if satisfactory progress is not evidenced. No more than 20% of the initial group composition shall consist of deniers.
- d. Per Julie Medlin, Ph.D., the program developer, order of presentation of the seven treatment phases need not necessarily be fixed, and therefore facilities are afforded flexibility about the order of presentation, at least until such time as experience demonstrates clear superiority of one order over another. Programming shall be standardized with respect to content and, to a lesser extent, process, with refinements and/or modifications occurring over time based upon our experience, new research and related changes in general practice. Any/All refinement and/or modification of programming must initially be approved through the SOT Committee. If approved, any changes shall be incorporated into written procedure before implementation in the field is expected.
- e. Point System - Program participants must accrue 85% of the total possible points in order to “graduate” from the program. (Note: The total number of possible points may vary as a function of several factors, including group size and the speed at which the facilitator(s) is able to work through the material.)
  - (1) Using the “Group Only” format, each participant shall be able to accrue a total of six points per session, two for attendance, two for participation in the group

- session, and two for completion of the week's homework assignment.
- (2) A participant may be given a score of one rather than a score of two for participation and/or homework completion, if the group facilitator finds either or both marginal rather than satisfactory.
  - (3) A participant can accrue 10 points upon completion of the "Major Project" associated with each phase of the program. In order to accrue all 10 points, the quality of the participant's work shall be excellent. Nine points are awarded for good work, and eight for satisfactory work. If the facilitator does not find the participant's Major Project worthy of at least an "eight," the work shall not be accepted and the offender shall be advised of the reasons for rejection and performance expectations, and asked to re-submit the project after revisions have been completed.
  - (4) A program participant shall be issued a completed Points Update form (located on page 96 of the "*Getting Started*" facilitator's manual) at the completion of each treatment phase. The treatment provider shall complete Points Updates along with the Therapist's Ratings on Treatment Goals form (located at the end of the facilitator's manual for each phase), which also shall be given to the program participant.
  - (5) At this time, a program participant shall also complete the Self Rating on Treatment Goals and Review of Progress on Treatment Goals forms (located at the end of the facilitator's manual for each phase), and shall submit these to the treatment provider. This exchange of assessments shall permit the program participant, as well as the therapist, opportunity to check the extent to which the program participant's ratings agree with the treatment provider's. The treatment provider shall ensure that copies of Points Update, Therapist's Ratings on Treatment Goals, Self Rating on Treatment Goals and Review of Progress on Treatment Goals forms are maintained in the sex offender-specific treatment record.
- f. Modifications For Correctional Setting - Use of Phallometry and Polygraphy as outlined in *Responsible Living* shall be omitted due to unavailability of equipment and trained personnel. Aversive therapy techniques requiring use of ammonia shall also be omitted, and a written script shall be required instead of audiotapes for the Major Project (Covert Sensitization) in the Behavioral Techniques phase. Showing of the movie *Shadowlands* (Sex Education Phase) will be initiated once the film is made available through the Director of SOT.
- g. Procedure for implementing completion of the Major Project for the Victim Empathy Phase of *Responsible Living: Victim Scrapbook* - completing this project requires that the inmate create a series of collages depicting victim impact. **Procedure for Implementing Victim Scrapbook (Attachment 11-H)** outlines a procedure for managing the materials necessary to complete the collage.

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- h. A Moderate-High and High Risk offender, as assessed by the assessment protocol outlined in **Subsection B.** above shall receive all seven phases of *Responsible Living: A Sex Offender Treatment Program*.
- i. A Low and Low-Moderate Risk offender, as assessed by the assessment protocol outlined in **Subsection B.** above shall receive *Responsibility Taking, Sex Education and Relapse Prevention* phases.
- j. Special Populations - *Responsible Living: A Sex Offender Treatment Program* was designed for the male sexual offender and therefore programs for female sexual offenders may be modified as needed. Treatment for a Special Needs inmate (includes Mental Retardation/Developmental Disability, Mental Illness, and/or physical disability such as deafness) and a Hispanic sexual offender may also be modified accordingly, with modifications based upon field research and findings pertaining to best practices for these populations of sex offenders. These programs shall be reviewed and approved through the Sex Offender Treatment Committee (SOTC). Staff members may submit recommendations for SOTC review to the Director of SOT who will ensure these are placed on the next meeting's agenda.

2. Treatment Variables

Group therapy with sex offenders is viewed as the treatment modality of choice. It is cost effective in that a maximum number of clients receive treatment with the use of minimal resources. Given skilled clinicians, the group therapy experience can be very powerful.

- a. Group size - Group size shall be limited to not more than 15 participants.
- b. Group composition - Treatment teams may make decisions regarding whether to separate offenders based upon the nature of their offense (aggressive/violent vs. manipulative-coercive) or the age of victims (child vs. adult), or rather combine offenders with a variety of offenses and types of victims. Group composition is left to the discretion of the treatment team until such time as research reveals data indicating one type of group composition is superior to the other with regard to treatment outcome, at which time the committee shall disseminate the recommended group composition.
- c. Group process - Any ongoing group is in a continuous process of development. There have been several models outlining group development. A 4-stage model of group development summarizing the work of Corey (1995) can be found in **Attachment 11-I**.
- d. Getting Started - Documents explaining the **DC-580, Limits of Confidentiality (Attachment 11- J)** and **Conditions of Participation (Attachment 11-K)** should be thoroughly reviewed, and signed by the inmate and witnessed prior to the inmate's involvement in programming.
- e. Levels of Treatment and Adding Group Participants

- (1) *Responsible Living: A Sex Offender Treatment Program*, as it is implemented for a sexual offender whose level of risk and need fall into moderate and high categories, consists of seven treatment phases. Once a treatment phase has been initiated, the group composition is “set” and no new group members shall be added. At the discretion of the treatment team, new members may be added when a new treatment phase is initiated. However, such decisions should be carefully considered and based upon the treatment team’s assessment of the impact of these variables on the group and each participant. Close and accurate record keeping shall be very important in managing changes in group composition as well as variations in the sequential ordering of individual participant’s progression through the seven treatment modules.
  - (2) *Responsible Living: A Sex Offender Treatment Program*, as it is implemented for low risk offenders, shall generally be a “closed” group. That is, once the group composition is decided upon and the program is initiated, no new group members shall be added. The only exception to this shall be the case in which attrition has resulted in a Low Intensity group consisting of fewer than five program participants. In such case, this group may be joined with another Low Intensity group at the onset of a new treatment phase, provided the resulting larger group could ultimately complete the entire Low Intensity Program concurrently.
- f. Frequency/Duration - Group sessions shall be conducted weekly for two consecutive hours. Although the total target time to complete the program as it is implemented for moderate and high risk/need level participants is approximately two years, the overall number of sessions required shall be determined by the rate of the group’s progress through the required components. The total target time to complete the program as it is implemented for low risk offenders is approximately eight months; however, this also shall be a function of the group’s rate of progress through the program material.
  - g. Facilitation - Groups may be co-facilitated depending upon availability of staff resources. Given availability of adequate resources, co-facilitation by male-female pairs is optimal and recommended.
  - h. Responsivity Issues - An adult learns in a variety of ways using a variety of teaching techniques. These techniques comprise the most effective methods of incorporating his/her emotional, physical, intellectual and social characteristics into the learning process. For the treatment process to foster a learning climate, treatment providers need to be aware of the **Principles of Adult Learning (Attachment 11-L)**.

#### **D. Staff Qualifications and Minimum Training**

Qualifications and training requirements shall be as consistent as possible, given staffing patterns, with those standards outlined by the ATSA.

##### **1. Credentialing and Supervision**

- a. Staff who possess a graduate degree in the behavioral, health, or social sciences that had been regularly providing sex offender-specific treatment for at least two years prior to the issuing of this policy shall be considered “credentialed” providers. Staff who do not possess a graduate degree in the behavioral, health or social sciences shall be considered credentialed providers in cases where he/she possesses a Bachelors Degree or equivalent, in the Behavioral and Social Sciences, and are able to document a minimum of 2,000 hours of face-to-face clinical contact with sexual offenders. Face-to-face clinical contact includes group and individual contacts including contacts for the purpose of assessment. The Licensed Psychologist Manager (LPM) shall be responsible for maintaining a complete list of credentialed providers, and for tracking provider’s face-to-face clinical contact hours, updating these annually. Each provider shall be responsible for tracking his/her hours of face-to-face clinical contact and submitting these to the LPM annually.
- b. A credentialed provider may provide clinical supervision to any provider who does not meet the criteria for credentialing. Supervision may occur through co-facilitation of groups and/or sessions. Supervision may occur individually or in groups and should consist of weekly sessions, affording the supervisee(s) opportunity to review and discuss any concerns related to group process and/or problematic cases.

## 2. Training

- a. Education, experience and training, and NOT job classification, are the critical qualifications associated with the provision of SOT.
- b. Any/All new providers (providers beginning work subsequent to the effective date of this procedure) of SOT shall complete the *Fundamentals of Sex Offender Treatment* training offered through the Department’s Training Academy within six months of beginning to treat sexual offenders.
- c. Any SOT provider must complete the Fundamentals of Sex Offender Treatment training within six months of the effective date of this policy if he/she has not completed coursework or training in the following areas:
  - (1) assessment (including risk assessment);
  - (2) psychopathology;
  - (3) counseling and psychotherapy;
  - (4) Cognitive Therapy;
  - (5) Megan’s Law;
  - (6) relapse prevention;



- (7) sexual arousal control;
  - (8) relationship and social skills training;
  - (9) victim awareness and empathy; and
  - (10) pharmacological therapy.
- d. Every provider should obtain at least nine hours annually of continuing education in the field of sexual abuse. Continuing education includes courses, conferences, workshops, and other training experiences including self-directed literature review. A provider may request out-service trainings through his/her facility administrators. A provider may also take advantage of trainings made available by the SOAB. These six-hour trainings are typically offered quarterly and free of charge.
3. Consultation and professional affiliations
- a. Providers, regardless of degree and years of experience in the field of sexual abuse, should supplement his/her education and professional experience with informal consultation with other providers of SOT in the Department.
  - b. Providers should consider affiliations with other professional organizations, agencies, or groups involved in the assessment, treatment and management of sexual abusers.
  - c. Each facility shall ensure that at least one sex offender treatment provider maintains membership in the ATSA.
  - d. Every provider should make a good faith effort to remain informed of all applicable statutory and regulatory requirements to warn, report, and notify the appropriate persons or entities of information learned during the course of providing clinical services. The Director of SOT shall periodically provide information as it becomes available.

## **E. Multidisciplinary Treatment and Management of the Sex Offender**

The Department supports a multidisciplinary approach to the treatment and management of sex offenders. A variety of professionals including, but not limited to, Corrections Counselors, Psychologists, Psychiatrists, Certified Registered Nurse Practitioners – Psychiatric Services (PCRNPs) Unit Managers, and Corrections Officers shall be involved in the treatment and management of sex offenders.

Every staff member involved in the treatment and management of sex offenders will be come familiar with the cognitive distortions or “thinking errors” commonly used by sex offenders, as this may assist in therapeutic confrontations and/or monitoring the extent to which the offender is internalizing and practicing pro-social attitudes and behaviors addressed in the group treatment setting.

1. Counselors

- a. The Corrections Counselor shall be the primary case manager for the sexual offender, ensuring he/she has been identified, has completed his/her risk/needs assessment, and has either been placed in programming subsequent to this assessment, or, if necessary, been placed on a waiting list for future involvement in programming. Corrections Counselors shall use the **DC-97, Psychology Referral Form** to refer every newly received sexual offender, including those with prior but not instant sex offenses, to the LPM for risk assessment.
- b. Given the appropriate level of education, training, and experience, and, if indicated, clinical supervision, Corrections Counselors may also complete assessments and conduct group treatment with sex offenders, completing the **DC-578** and progress reports, when indicated (inmate is in need of an assessment, inmate is being reviewed for parole, inmate has successfully completed programming).

2. Psychologists

The LPM/designee shall coordinate and oversee the SOT in each facility. Given the appropriate level of training, experience, and, if indicated, supervision, Psychologists, Psychological Services Specialists (PSSs) and Psychological Service Associates (PSAs) may conduct group treatment with sex offenders. They may also conduct assessments for programming needs, parole, commutation, or other purposes. For sex offenders who are also placed on the Mental Health/Mental Retardation (MH/MR) tracking roster(s), the psychology staff shall ensure that the inmate's Individual Treatment Plan (ITP) addresses sex offender assessment and treatment needs

3. Psychiatrists/PCRNP's

A Psychiatrist/PCRNP shall treat those sex offenders with co-existing Mental Health problems, and on rare occasion may attempt to treat the sex offender's deviant sexual arousal or extreme sexual compulsivity using anti-androgens and/or Selective Serotonin Reuptake Inhibitors (SSRIs).

4. Unit Managers

- a. Particularly when managing a Residential Sex Offender Unit or a Therapeutic Community for sex offenders, the Unit Manager shall become involved in the monitoring and, in some cases, tracking of progress of offenders on his/her Housing Unit.
- b. Given the appropriate level of education, training, experience and, when indicated, clinical supervision, a Unit Manager may also become involved in the assessment and treatment of sex offenders.

5. Drug and Alcohol Treatment Specialists (DATS)

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- a. Particularly when maintaining an office with a Residential Sex Offender Unit or a Therapeutic Community for sex offenders, the DATS shall become involved in the monitoring and, in some cases, tracking of progress of offenders on his/her housing unit.
- b. Given the appropriate level of education, training, experience, and, when indicated, clinical supervision, a DATS may also become involved in the assessment and treatment of sex offenders.

6. Corrections Officers

- a. Particularly when posted on a Residential Sex Offender Unit or a Therapeutic Community for sex offenders, Corrections Officers can become involved in the tracking and monitoring of the offender's progress in treatment. Because an Officer tends to observe the inmates more than the treatment providers in settings outside of groups, he/she can be an invaluable source of information with regard to gauging the extent to which there is "transfer of learning" outside the group setting.
- b. Every Corrections Officer assigned to a Residential Sex Offender Unit or a Therapeutic Community for sex offenders shall complete Day 1 of the Fundamentals of Sex Offender Treatment training within six months of his/her assignment to the post.

**F. Record Keeping**

Record keeping is essential to maintaining documentation of offense-related data, risk assessments, program participation, progress in treatment, relapse prevention plans and successful program completion. Good record keeping assists the provider in remaining organized and provides a handy resource for those working with large numbers of program participants.

1. A file shall be developed for all inmate program participants. This file shall be a separate file developed and securely maintained by the treatment provider solely for maintenance of documents associated with sex offender-specific treatment.
2. Original and/or copies of all documents associated with and generated by assessment and treatment staff shall be maintained in the inmate program participant's file. As the participant progresses in treatment, record of his/her program evaluation, group attendance, completed homework assignments, major project completion, Self Ratings on Treatment Goals, Therapist's Ratings on Treatment Goals, Review of Progress of Treatment Goals, Points Updates, adjunctive individual sessions and progress reports shall be added to the file. Any existing psychological and/or psychiatric evaluations shall also be incorporated.
3. Excluding the **DC-579, Summary of Progress in Sex Offender Treatment** form, official documents (those identified with a Department number) generated through treatment shall be copied and distributed to the Corrections *Counselor* and Facility Parole Agent.

The **DC-579** shall be completed by the treatment provider prior to the offender's parole review and shall be copied and submitted to the PBPP along with the offender's Pennsylvania Clinical Risk Assessment (P-CRA). The original **DC-579** document shall be filed in the Medical Record, with copies distributed to the Corrections Counselor and Facility Parole Agent. In cases of successful program completers, a copy of the **DC-579** shall also be given to the inmate, and he/she shall be instructed to provide this summary to his/her outpatient provider of sex offender-specific treatment. All sex offender-specific assessment and treatment records, excluding the **DC-579**, shall be copied to the **ICAR** only, and shall not be maintained on file in either the Medical Record or the **DC-15**.

4. All files shall be maintained in a secure area, which is readily accessible to the treatment provider.
5. Upon the offender's successful completion of programming, he/she may be provided any/all program-related homework assignments and/or projects that have been maintained in the sex offender-specific record. Upon the offender's release on parole or completion of the maximum sentence, any remaining documents in the file shall be destroyed.

#### **G. Assistor/Peer Programs**

Peers can be invaluable in assisting other inmates who may be struggling with any number of programmatic issues. Sometimes a peer can reach an inmate faster than a service provider. However, because of the potential for problems in situations where one inmate is mentoring another, guidelines for selecting and maintaining assistors are needed.

1. Selection - The treatment team shall initially staff potential assistors/peer group facilitator for inclusion in the program. Every assistor and peer group facilitator must be entering the program on a voluntary basis, must have successfully completed the treatment program, and be in the Maintenance Phase of treatment. An assistor should be misconduct-free for at least one year and typically there should be consensus among team members before making the offender an assistor. Department policy **7.2.1, "Counseling Services," Section 8, Vote Sheet**, shall be used in the staffing process.
2. At facilities where there is a Residential Unit or Therapeutic Community for sex offenders, the Unit Manager or treatment provider shall delineate assignments, times and places where an assistor and peer groups can meet with his/her assigned inmate(s). The Unit Manager or treatment provider shall determine the number of assignments a particular assistor or peer group facilitator can manage as well as the duration of his/her sessions. All mentoring sessions shall take place in a day room or conference room, which shall be intermittently monitored by correctional staff. The Unit Manager or treatment provider shall also be responsible for the management of inmate movement in those cases where the assistor is no longer housed in the Residential Sex Offender Unit or Therapeutic Community.
3. A treatment provider in collaboration with the Unit Manager shall coordinate any/all assistor and/or peer group activities at facilities where sex offenders are treated on an "outpatient" basis. In these facilities, the treatment provider shall be responsible for

determining the number of assignments a particular assistor or peer group leader can manage as well as the duration of his/her sessions. The treatment provider shall also be responsible for the management of inmate movement associated with assistor and/or peer group activities.

4. Treatment providers shall meet with the assistors and/or peer group leaders at least once monthly to process any concerns or problems as well as any positive feelings associated with the mentoring process.

#### **H. Managing Program Participants who Accrue Misconduct(s)**

1. When the accrued misconduct is clearly non-sexual in nature and results in three consecutive missed sessions, the offender shall be terminated from his/her current program phase and shall be required to re-take the phase when it is again made available. In a case where imposed sanctions allow, however, the offender may begin the next program phase with his/her group.
2. When the accrued misconduct is clearly sexual in nature, the offender shall be terminated from the program and permitted to restart the program (as it is made available) no sooner than six months subsequent to the misconduct. In these cases, the inmate shall be required to re-start the program from the beginning.

#### **I. Managing Inmates without a Sexual Conviction who Sexually Assault during Incarceration.**

In cases where an inmate is identified as a perpetrator of a sexual assault during a period of incarceration, he/she shall be considered for placement in SOT. Such programming shall be routinely recommended in cases where allegations lead to convictions as well as in cases where, through the internal investigative process, a decision is made to issue a sexual misconduct charge and the inmate is found guilty.

#### **J. Collaborating with the Sexual Offenders Assessment Board (SOAB)**

Collaboration requires agencies to share resources and work together to enhance capacity toward attainment of a common goal. Because of the importance of collaboration in attaining goals of reduced recidivism and increased public safety, staff involved in the treatment and management of sexual offenders shall routinely exchange available pertinent information with the SOAB. Treatment staff shall apprise himself/herself of available SOAB evaluations, and shall be receptive to arranging times to answer the SOAB evaluators' questions upon request. Responses to questions may be communicated verbally or via available written reports and/or email. The SOAB will make their assessment reports available to treatment staff.

## Section 12 – Behavior Management Unit (BMU)

### A. Program Mission

1. The Behavior Management Unit (BMU) is designed to provide management, programming, and treatment for an inmate who exhibits severe Personality Disorder with functional impairment, chronic disciplinary issues, and demonstrates an inability to adapt to a general population setting. This is a secure diversionary unit for mentally ill inmates who are not acutely mentally ill and do require a secure setting due to their demonstrated problematic behavior in less secure environments. The unit is intended to provide focused staff interaction, programming, and behavior management for this select inmate population. The focus of the BMU is to convey sufficient skills in behavioral control, coping, and compliance with recommended interventions.
2. Each inmate in the BMU will be scheduled and offered a minimum of 20 hours out-of-cell activity per week; ten hours of structured activity and ten hours of unstructured activity. This intensive specialized treatment program will assist an inmate in progressing to the least restrictive environment for managing his/her demonstrated behavior. The least restrictive environment will vary among inmates and may include eventual return to general population, continued placement within the BMU, and even fulfillment of the inmate's reentry plan upon Sentence Complete. An inmate's custody level will be suspended while in the BMU but their Disciplinary Custody (DC) sanctions, if they have any, will run concurrent to their time in the BMU until the sanction expires or until placed in Phase 1 of the program. This occurs so the inmate may still participate in and benefit from treatment to the maximum extent possible and be returned to the least restrictive setting as soon as possible. An inmate who is unable to transition from the BMU, complete the BMU program, or requires a therapeutically recommended transfer to another BMU, will be processed for alternative placement by review of the Central Office Special Needs/Psychiatric Review Team (COSN/PRT).

### B. Location

BMUs will be located at various facilities within the Department.

### C. Staffing

1. BMU Treatment Team
  - a. Comprised of the Licensed Psychology Manager (LPM), Unit Manager, Unit Counselor, Psychiatrist/Certified Registered Nurse Practitioner (CRNP), full-time Psychology staff (Psychological Services Specialist [PSS] and/or Psychological Services Associate [PSA]), Activities, and BMU Correctional Officers. The BMU Treatment Team will meet with and review all BMU inmates at least every 30 days. Inmates placed on Accountability Status will be reviewed **daily**. This team follows the inmate in all phases, including at least three months of probationary status in a general population **Residential Treatment Unit** (RTU) or other population housing unit deemed appropriate by the Treatment Team; this probation can be extended for

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an additional three months if indicated. However, the duration of Phase 1 must not exceed six months' time, irrespective of any off unit placements. Other staff and teams involved in the daily operation of the BMU include, but are not limited to: the Program Review Committee (PRC), staff members from Alcohol and Other Drug (AOD) treatment, Education, Social Worker, **Therapeutic Activities Services (TAS) Worker**, Medical – Nursing, Chaplaincy, and Certified Peer Specialists (CPS). Staff contacts with inmates participating in the BMU will be noted on the **BMU Accepted/Refused Structured Out-of-Cell Program Log (Attachment 12-A)** and the **BMU Accepted/Refused Unstructured Out-of-Cell Program Log (Attachment 12-B)**.

b. In addition, the BMU Treatment Team will meet at least twice each week to discuss the general operation of the unit and review the **recovery** plans of each inmate. These meetings will be facilitated by the Unit Manager and the LPM and should generally be held at the change of shift in order to maximize Officer involvement.

c. Responsibilities and Ratios

(1) BMU Unit Manager (1:60 inmates)

The Unit Manager will provide manager-level direction with the assistance of the lieutenants. The Unit Manager will provide the team with daily leadership and will review and direct the treatment and activity of the inmates in his/her care. If not permanently assigned to the BMU, the Unit Manager will visit the unit daily and sign the log book.

(2) LPM

The LPM is not solely assigned to the BMU, but also oversees all psychological services in the facility. The LPM functions as the administrative and clinical supervisor of all psychological staff on the BMU. The LPM also provides clinical oversight, via the Treatment Team and the **Individual Recovery Plan (IRP)**, to the entire BMU Treatment Team. The LPM is responsible for chairing any Treatment Team meetings held on the BMU. However, in all aspects of the program, the LPM will closely collaborate with Psychiatry and the Unit Manager.

(3) **Psychiatric provider**

The **Psychiatric provider** will be responsible for interviewing all BMU cases weekly. Psychiatric coverage will include 30 minutes per inmate per week. All Psychiatric contacts are to be out-of-cell unless the inmate refuses or security issues prohibit out-of-cell contact at that time. This includes those BMU inmates who may be on Accountability Status. The Psychiatric provider will also be required to participate in all scheduled Treatment Team meetings.

(4) PSS/PSA (1:30 inmates)

For BMUs who have more than one full-time equivalent PSS/PSA assigned, a portion of those additional hours will be assigned to a 12-8 work shift. The PSS/PSA's assigned to the BMU will be responsible for developing IRPs with their assigned inmate caseload. These IRPs will specifically identify goals and objectives designed to restore the inmate to a stable and healthy level of functioning. ***The goals on the IRP established collaboratively with the BMU Treatment Team and the inmate shall drive the clinically structured out-of-cell offerings on the unit.*** The PSS/PSA will work closely with custody staff and all disciplines assigned to the BMU. The PSS/PSA will be responsible for delivering individual and group therapy directed at addressing the issues outlined in the IRP. All contacts will be noted on the **BMU Accepted/Refused Structured Out-of-Cell Program Log**, at a minimum weekly **Inmate Cumulative Adjustment Record (ICAR)**, and **DC-560, Mental Health Contact Note** entries are required. The PSS/PSA will ***offer daily AM and PM out-of-cell contacts for the duration of the Accountability Status placement.*** At the discretion of the LPM, the PSS/PSAs assigned to the BMU may have other assigned facility duties.

(5) Corrections Counselor (CC 1:60 inmates)

The CC(s) will provide professional counseling and case management activities to an inmate caseload assigned by the Unit Manager. This will include treatment groups, individual contacts, and supervising inmate unstructured out-of-cell time. All contacts will be noted on the **BMU Accepted/Refused Structured Out-of-Cell Program Log** and **BMU Accepted/Refused Unstructured Out-of-Cell Program Log**, and at a minimum weekly **ICAR** entries will also be made to document the inmate's status. The CC(s) will work with the BMU staff to ensure that proper documentation is kept by maintaining the tracking forms for all out-of-cell structured and unstructured activity. In addition, the CC(s) will ensure that all incentive tracking charts are up to date on a weekly basis with results reported as an **ICAR** entry. Thus, charting the progress each inmate is making in preparation for their possible graduation from the program and possible reentry into the general population.

(6) TAS Worker (1:60 inmates)

The **TAS** Worker will develop and deliver **therapeutic** activities during the days, evenings, and on the weekends. The **TAS** Worker will implement, monitor, and evaluate the therapeutic recreational segments of IRPs including instructing, directing, and providing support in a variety of activities relating to therapeutic recreation, occupational therapy, and vocational adjustment services. The activities would be directed at engaging self-isolated or reclusive inmates and providing structured and unstructured recreational time for BMU inmates. The increased activity and out-of-cell time will be assisting with improving the inmate's emotional control. All contacts will be noted on the **BMU Accepted/**



**Refused Structured Out-of-Cell Program Log** and the **BMU Accepted/Refused Unstructured Out-of-Cell Program Log**. This employee may also be assigned to work with inmates on the general population RTU as supervised by the **Unit Manager on the BMU/RTU**.

- (7) Custody Staff
  - (a) Appropriate security staffing levels and security measures for inmate movement, showers, meals, activities, etc., shall be conducted in accordance with Department policy **6.5.1, “Administration of Security Level 5 Housing Units,” Section 1**. Unit staffing and security measures may be reduced by the Unit Team and PRC for a BMU inmate in Phases 3, 2, and 1, but should always remain at a level to provide escort coverage for daily out-of-cell contacts.
  - (b) Corrections Officers (COs) assigned to the unit will provide daily input for the BMU Treatment Team decisions through regular contact with treatment staff and via documentation utilizing the **BMU Shift Pass Down Form (Attachment 12-C)**. This form is utilized in order to ensure accurate communication between shifts and the Treatment Team. In addition, it is important for custody staff’s observations to be included in the Treatment Team’s review of the inmate’s progress with their treatment objectives. COs are expected to communicate their observations of an inmate’s activity and any interactions they may have had with the inmate. In addition, custody staff will participate in all Treatment Team meetings, comment on, and sign the Treatment Plan.
  - (c) Because the potential exists that an inmate may become a significant danger to him/her and/or others, enriched custody staffing levels are required in the units to provide protection to staff and inmates. This modification ensures that out-of-cell mental health programming can be provided as well. The Deputy Superintendent for Facilities Management (DSFM) shall ensure that CO coverage is maintained and sufficient to permit the unit to conduct out-of-cell structured and unstructured activities, protect persons and property on the unit, and escort inmates in and out of cells throughout the day, even during count time. The DSFM shall meet regularly with the Major of the Guard and Unit Manager to discuss custody staffing needs.

## 2. Other Staff Involved on the BMU

### a. PRC

This committee is generally comprised of the DSFM, the Deputy Superintendent for Centralized Services (DSCS), and the Corrections Classification Program Manager (CCPM). The PRC will review all BMU inmates monthly or as necessary as indicated by submissions of the **BMU Program Review Sheet (Attachment 12-D)** by the BMU

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Treatment Team. Inmates in the BMU on Accountability Status will be reviewed by the PRC at least weekly.

b. AOD

Drug and Alcohol Treatment Specialists (DATS) will provide group and/or individual structured out-of-cell contacts for BMU inmates with identified AOD treatment needs. The goals/objectives of such treatment will be reflected on the inmate's Treatment Plan. All contacts will be noted on the **BMU Accepted/Refused Structured Out-of-Cell Program Log**.

c. Education/Adult Basic Education (ABE) Teacher (1:60 inmates)

This staff member will address the educational needs of the inmates participating in the BMU. He/she would provide educational opportunities for those who are mandated to participate in education to meet guidelines and also those who wish to volunteer. The goal would be to have inmates prepare for reentry to general population classes or reentry into society. All out-of-cell contacts will be noted on the **BMU Accepted/Refused Structured Out-of-Cell Program Log**. This team member will be supervised by the School Principal in collaboration with the Unit Manager.

d. Social Worker (MSW 1:60 inmates)

This employee will develop, implement, and provide social work, counseling, and case management services to BMU inmates to enhance their social functioning and to help them attain a more satisfactory social, economic, emotional, or physical adjustment with a Department facility. All out-of-cell contacts will be noted on the **BMU Accepted/Refused Structured Out-of-Cell Program Log**. This employee will be interacting with inmates, inmate family members, inmate guardians, and community agency staff to plan, provide, or coordinate needed social work services upon release to the community. This employee will work primarily within the BMU, however, at the direction of the LPM; the Social Worker will also assist the general population Mental Health Coordinator (MHC) with reentry services to general population inmates.

e. Medical-Nursing

Any medication concerns identified will be forwarded to the **Psychiatrist/CRNP**, the assigned PSS/PSA and recorded in the inmate's medical file. All out-of-cell contacts will be noted on the **BMU Accepted/Refused Structured Out-of-Cell Program Log**.

f. Chaplaincy

The Facility Chaplaincy Program Director (FCPD) will provide structured individual and group religious services to inmates in the BMU. Structured group contact will be available at least weekly. All out-of-cell contacts will be noted on the **BMU Accepted/Refused Structured Out-of-Cell Program Log**.

g. CPS

CPSs will be available on the unit to provide support for participants in the program. Duties may include individual out-of-cell contacts with inmates, educational group programming, recreational activities, and assistance with daily living skills. CPSs will function under the direct supervision of the Unit Manager. CPSs will not facilitate a group on their own and will not supervise inmates. Contacts will be noted by supervising staff on the **BMU Accepted/Refused Unstructured Out-of-Cell Program Log**.

**D. Determination and Maintenance of Staffing Levels for the BMUs**

1. The DSFM and the Major(s)/designee shall be responsible for selecting and assigning CO staff to BMUs. The Unit Manager and LPM shall have input into this selection; however, the final determination shall be made by the DSFM.
2. BMU assignments shall be made from COs who have submitted a written request to the Major(s)/designee to be considered for placement in a BMU position.
3. Volunteers for these assignments must exhibit the following characteristics prior to placement in BMU positions:
  - a. willingness to work in a non-traditional corrections environment;
  - b. the ability and willingness to become an integral part of the BMU Treatment Team;
  - c. the ability and willingness to perform non-professional counseling and crisis intervention with BMU inmates;
  - d. good communication skills;
  - e. good emotional stability;
  - f. interest in mental health issues;
  - g. Crisis Intervention Team and Mental Health First Aid (MHFA) trained or willing to obtain the training; and
  - h. any other attributes considered important, but not listed above (e.g., willingness and interest to work with inmates exhibiting chronic disciplinary issues, self-injurious behaviors, and/or the inability to adapt to a general population setting).
4. A CO assigned to the BMU shall be reviewed for rotation out of the BMU at least annually by the DSFM and Major(s)/designee.

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5. A CO assigned to a BMU beyond one year shall be interviewed by the facility LPM/designee to determine his/her fitness for the BMU assignment. Reports shall be confidential and shared only with appropriate personnel.
6. Removal from the BMU position may occur at any time if it is determined that the CO is inappropriate for his/her assignment, ineffective, or detrimental to the operation of the BMU. This determination shall be made by the DSFM with input from the Major, Shift Commander, and/or BMU Unit Manager. In addition to custody staff, any staff member, recommended by the Unit Manager and the LPM may be reassigned from the BMU if that staff is deemed inappropriate for assignment to the BMU.

**E. Chain of Command**

1. The Unit Manager shall provide daily guidance/direction for all COs assigned to the BMU. The Unit Manager and Shift Commander are responsible for monitoring and evaluation of staff performance.
2. The Shift Commander is in charge of use of force situations and assumes responsibility for operation of the unit in the absence of the Unit Manager.
3. The Unit Manager shall have the discretion to make essential administrative, program, and operational decisions regarding unit security and inmate management. Clinical decision will be made via the BMU Treatment Team as directed by the LPM.

**F. Staff Training**

All staff selected or assigned to the BMU to provide programming and supervision will be required to complete certain Department training. Within six months of placement into the unit, staff will be required to have completed the Department's Crisis Intervention Training (CIT) and the Department's MHFA Training. If it is necessary to assign a staff member to the BMU who has not completed this training, the facility shall, within two weeks, advise the **CIT Training Program Coordinator** of the need. **The facility's Training Coordinator shall also communicate such training needs to the CIT Training Program Coordinator to ensure that sufficient training is conducted to meet the needs of the facility.** CO Trainees (COTs) will not be assigned to the BMU.

**G. Admission Criteria**

Admission criteria shall include the following:

1. a determination of functional impairment not a result of serious mental illness as defined in **Definition of a Serious Mental Illness (SMI) Outline** (refer to **Section 10** of this procedures manual);
2. history of multiple admissions to a Restricted Housing Unit (RHU) either Administrative Custody (AC) or DC status, a Mental Health Unit (MHU), and/or the Forensic Treatment Center (FTC);

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3. presenting behaviors that may include significant difficulties such as self-injury, overtly aggressive behavior, and/or impulse control disorder;
4. a Special Assessment Unit (SAU) evaluation may be required;
5. an inmate who exhibits severe Personality Disorder with functional impairment, chronic disciplinary issues, and demonstrates an inability to adapt to a general population setting; and
6. he/she is cleared of acute medical problems by the referring facility's medical department.

#### **H. Process for Transfers**

1. When an inmate is being recommended by the PRT, Unit Management Team, or Psychology staff for placement in a BMU, the PRC shall review the recommendation with the inmate and inform him/her of the reason(s) for the transfer recommendation. The recommendation shall be documented on the **DC-141, Part 4, Facility Manager's Review**, with a copy to the inmate. The inmate will be given the opportunity to respond to the rationale given and object to his/her placement in a BMU, if he/she so desires. The inmate may appeal the recommendation for transfer to the Facility Manager/designee and Central Office, as outlined in Department policy **DC-ADM 802, "Administrative Custody"** and **DC-ADM 801, "Inmate Discipline."**
2. The MHC/designee at the referring facility shall simultaneously submit a completed referral packet to the Office of Population Management (OPM) mailbox (**CR, CEN OPM Special Program Referrals**) dedicated to the Special Programs Referral and to the respective Regional LPM. OPM is responsible for tracking the BMU Referral Packet through the approval/rejection process. This packet must only be forwarded electronically.
  - a. The Regional LPM will review the BMU referral packet and schedule a face-to-face (on site or via video conference) interview with the referred inmate. The purpose of this interview is to facilitate an appropriate referral to the BMU. This interview provides a focused independent assessment, upon which the Regional LPM can make further recommendations to the facility regarding the referral process if needed. Additionally, this focused interview process will provide guidance to the Department's Chief Psychologist and Chief of Psychiatry in their approval process of this packet. The Regional LPM will notify OPM when the referral packet is ready to be forwarded to the Chief Psychologist and Chief of Psychiatry. The findings and recommendations of the Regional LPM will be communicated to the Chief Psychologist and OPM electronically, with a copy to the referring facility's LPM/designee.
  - b. The BMU referral may be changed to a SAU referral by the Regional LPM if a specialized assessment for diagnosis and programs appropriateness is deemed necessary.

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- c. The referral packet will include the following information:
- (1) a completed **Special Program Referral Approval/Rejection Form (Attachment 2-C)** of Department policy **11.1.1, “Population Management,” Section 2)** will serve as the face sheet when forwarding a BMU referral packet. In the Requested Action Section, the Program/Unit Admission box should be checked;
  - (2) **DC-46, Vote Sheet;**
  - (3) a current **IRP** (refer to **Section 5** of this procedures manual);
  - (4) **Integrated Case Summary or Pre-Sentence Investigation (PSI)** (if available);
  - (5) the most recent **Psychological Report;**
  - (6) a copy of the **Special Assessment Unit (SAU) Discharge Summary** if one is available;
  - (7) **DC-14, Cumulative Adjustment Record** (past 12 months, unless significant details predate the cutoff);
  - (8) **DC-487, Transfer Health Information Form**, including Medication Compliance Record;
  - (9) **DC-17X, RHU Conduct Record** for prior month, and PRC notes from the past three reviews;
  - (10) if appropriate, a copy of the last six months of the Mental Health Section of the inmate’s medical record;
  - (11) a copy of the last six months of the misconduct history from DOCInfo;
  - (12) a mental health report prepared within the last three months by the psychology staff or Psychiatrist/CRNP which identifies a current diagnosis and assesses the inmate’s suitability for placement in the BMU. This report should delineate the specific diagnosis criteria utilized to support the given diagnosis. If a current diagnosis is not available or clearly established, the referring facility should consider a referral to the SAU prior to submission of a BMU Referral Packet;
  - (13) a copy of the inmate’s cell history, obtained from DOCInfo; and
  - (14) a list of separations.

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3. The OPM will then electronically forward the BMU Referral Packet to the Chief Psychologist, Chief of Psychiatry, and the Regional Deputy Secretaries for the sending and receiving region who will vote on the BMU referral. If the recommendations are not unanimous, the Executive Deputy Secretary will make the final recommendation.
4. The approved and/or rejected BMU Referral Packet will then be sent to the OPM. The OPM will record the disposition of the Referral Packet in the Transfer Petition System. OPM notifies, via email, the referring facility with copies to the Chief of Psychological Services, Bureau of Health Care Services (BHCS), and Diagnostic and Classification Coordinator, Bureau of Treatment Services (BTS). This email will include the rationale for the rejection and recommendations.
5. The OPM will return any disapproved Referral Packets to the referring facility's LPM/designee.
6. Following final approval, the BHCS will coordinate, with the sending and receiving facilities and the OPM, the inmate's transfer to the designated BMU. If space is not available, the OPM and BHCS shall retain the inmate's name on a waiting list. If an inmate is placed on the approved BMU waiting list and his/her circumstances change and there is no longer a need for program placement, the referring facility must obtain written approval from the Regional Deputy Secretary to remove the inmate from the BMU waiting list. This approval shall be obtained by sending a written memo with justification to the Regional Deputy Secretary. If the Regional Deputy Secretary grants this change, the written memo with the Regional Deputy Secretary's approval will be forwarded to the requesting facility and copied to BHCS.
7. Prior to an inmate's transfer, the transferring facility's PRT shall conduct a videoconference or teleconference call, with the BMU Treatment Team at the receiving facility. The sending facility shall document the date, names of participants, and issues discussed in the conference call in the **ICAR/DC-14** and on the **DC-472, Progress Notes**.
8. Once BHCS has notified the referring facility that an inmate has been approved for BMU placement, and the inmate is placed on the BMU waiting list, the referring facility will immediately implement the following Protocol for Enhanced Mental Health Services which has been established for inmates on the BMU waiting list. The protocol is as follows:
  - a. a weekly out-of-cell psychology contact, at a minimum, will be conducted, with **ICAR** and **DC-560** documentation copied to the medical record;
  - b. additional psychological contacts, if requested by the inmate or a staff member, will be provided by the assigned psychologist during his/her scheduled daily psychology RHU rounds;
  - c. monthly out-of-cell Psychiatrist/CRNP contacts;

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- d. weekly review by the PRC;
  - e. monthly PRT review; and
  - f. continued weekly CC visits.
9. If the referring facility cannot fully provide the above protocol for enhanced mental health services, the facility should contact OPM as soon as possible so that OPM can expedite transfer to the nearest facility which is able to provide this protocol.
  10. An inmate who is on the waiting list for the BMU can be transferred to an MHU/FTC if necessary. This does not affect their BMU waiting list status, unless decided otherwise by Central Office.
  11. If an inmate is not being followed for mental health concerns, the Enhanced Protocol does not have to be implemented. Contacts shall be in accordance with Department policy **6.5.1**.

**I. Transportation**

An inmate received into the BMU will be sent as a permanent transfer. Transport procedures for the BMU shall be in accordance with Department policy **6.3.1, “Facility Security.”** Additional restrictions and/or requirements are as follows:

1. all of the inmate’s property will be transported with him/her to the BMU;
2. an inmate transferred to the BMU shall be received no later than 2:00 PM Monday, Tuesday, or Wednesday. This schedule allows staff to be available to conduct an initial assessment and provides for a stabilization period; and
3. the inmate shall be transported via sedan; this is the responsibility of the referring facility.

**J. Admission and Orientation**

1. All inmates will receive a standardized “BMU Inmate Handbook.” This handbook will be distributed to all inmates upon arrival and admission to the BMU. This handbook will address and include at a minimum the following:
  - a. general program description and purpose of the unit;
  - b. BMU rules and regulations;
  - c. the process of behavior management planning and the inmate’s involvement in that process;
  - d. Overview of the Levels of Treatment/Phase System and the role of the **Treatment Team**;



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- e. what an inmate needs to do to advance through the Phases/Levels of Treatment;
  - f. earning and utilizing Incentive Points;
  - g. property and privileges;
  - h. description of groups and treatment milieu;
  - i. discipline and “Accountability Status;”
  - j. discharge and transition from the BMU; and
  - k. Prison Rape Elimination Act (PREA) contacts and reporting information.
2. Once admitted to the BMU, the inmate shall receive the BMU Inmate Handbook and staff will orient the inmate to the rules and regulations of the unit within 48 hours of arrival. The inmate will be asked to sign the **BMU Inmate Orientation Handbook Receipt Form (Attachment 12-E)**.
  3. Staff shall complete the **DC-510, Suicide Risk Indicators Checklist** (refer to **Section 1** of this procedures manual).
  4. Inmates housed in a BMU will be issued royal blue hobby jeans and a royal blue shirt with DOC printed in large white block letters on the back.
  5. BMU Cell Assignments
    - a. An inmate shall be housed in a single cell for Phases 5, 4, and 3 of the BMU program. Suitability for double celling will be considered in Phases 2 and 1 and will be contingent upon the inmate’s program code in accordance with Department policy **11.2.1, “Reception and Classification.”**
    - b. When considering double celling Phase 2 inmates on the unit, the BMU Treatment Team should make every effort to facilitate voluntary double celling agreements between BMU inmates.
    - c. If no compatibility contraindications are present (these include, but are not limited to: age differences, disparate physical size, gang affiliations, security needs, custody level, medical issues, geographical/regional differences, and a documented history of ethnic/religious violence, or propensity for such) the BMU Treatment Team may consider voluntary double celling.
    - d. BMU double celling after normal working hours is prohibited, except in extenuating circumstances, and only with authorization from the Shift Commander. The double celling assignment will be reviewed by the BMU Treatment Team the next working day.

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6. Medical staff shall conduct the medical screening in accordance with Department policy **13.2.1, “Access to Health Care.”**
7. Upon admission, psychology staff will interview/assess the inmate and:
  - a. review the Referral Packet; and
  - b. screen for any acute mental health symptoms including potential suicide risk.
8. Within 48 hours, the unit Psychology staff will review the **BMU Initial Recovery Treatment Plan (Attachment 12-F)** with the inmate and outline specific targeted goals and objectives. Documentation that the IRP was completed with the inmate will be made in the **ICAR**.
9. The BMU Treatment Team shall conduct an initial review of the inmate’s IRP within three working days.
10. Within **seven** working days, a Psychiatric Assessment will be completed.
11. While the inmate progresses through Phases 5, 4, 3, and 2, the Psychiatrist/CRNP will see the inmate weekly. At least one session per week will be held out-of-cell.

**K. Transfers of Inmates in the BMU System**

1. An inmate who is participating in the BMU program may be permanently transferred between BMU’s, only when the BMU Treatment Team believes it would be of therapeutic benefit and then only with the approval of both the receiving and sending facility’s Regional Deputy Secretary with input from the Director of the Psychology Office. These transfers will be coordinated through the Psychology Office and OPM. Any permanent transfer of a BMU inmate to a non-BMU location will require written approval by the Executive Deputy Secretary.

**NOTE:** Transfers between BMUs will be coordinated with an exchange of transfer packets, a **DC-46** including a transfer rationale, and a copy of the most recent Psychiatric Assessment.

2. At times it may be necessary to temporarily transfer an inmate from a BMU to a non-BMU facility. In these cases, the BMU inmate may be housed in a **Psychiatric Observation Cell (POC)**, unless written approval has been granted by the Executive Deputy Secretary. The Director of the Psychology Office must be notified within 24 hours of any temporary transfer of a BMU inmate.
3. Prior to a BMU inmate’s temporary or permanent transfer, a member of the transferring facility’s BMU Treatment Team shall communicate, with a member of the BMU Treatment Team or PRT at the receiving facility. The sending facility shall document the date, names of participants, and issues discussed in the conference call in the **ICAR** and on the **DC-472**.

4. If an inmate is committed to a Department MHU or the FTC, that inmate's BMU bed will be held open for a reasonable period of time, pending the inmate's return from the MHU or FTC. At the time of discharge, alternative placement into a Secure Residential Treatment Unit (SRTU) may be recommended and considered. Should this be recommended, the BMU will generate a formal SRTU referral packet and send to Central Office for review.

#### **L. Treatment Programs/Levels of Treatment**

1. The program components in the BMU include a multidisciplinary treatment environment.
2. All inmates in the BMU will have an IRP. These IRPs will be created using the "Recovery Model" of treatment. The Recovery Model has the goal of enhancing the individual's quality of life. It supposes that the treatment delivered will be tailored to the individual's strengths, needs, and directions; and treatment decisions are made in partnership with the individual. In adopting the recovery model, we understand that the focus is on a path of recovery, not just goals. We also understand that recovery is an ongoing process and does not mean there is an absence of symptoms. Overall, this person centered approach can reduce therapeutic disruption, noncompliance, de-compensation, and violence and self-harm.
  - a. The first step in developing a "Recovery Model" IRP is to identify the "person-centered" goal. Listening to the individual with empathy, acceptance, and validation will allow the goal to be expressed. Second, identify the individual's strengths. This will *indicate* what is already working that can be amplified, supported, and used as a resource to facilitate change. Third, identify obstacles that prevent the individual from reaching their goal. Fourth, identify treatment objectives. These treatment objectives need to be measurable, concrete, and clear. It is important that the treatment objectives are relevant to the individual's stated recovery goal and to the obstacles that are hindering the inmate from reaching their goal. Fifth, identify treatment interventions. Treatment interventions will be chosen that are likely to increase the individual's strengths.
  - b. Treatment planning may also include variations to the standard phases, treatment goals, and length of time in a phase, privileges, and management of problematic behavior. Modifications to the inmate's level of security related to restraints and escort will also be noted on the IRP. These security modifications will also be clearly noted in the Unit Control Booth. An overview of property and privileges associated with each Phase of treatment is found in the **BMU Property, Privileges, and Services Chart (Attachment 12-G)**.
  - c. In conjunction with the BMU Treatment Team, the Psychology staff will update the initial IRP, using the **BMU Recovery Treatment Plan Review (Attachment 12-H)**, every 30 days while the inmate is in Phases 5 through 1. The IRP shall be reviewed out-of-cell with the BMU inmate at a minimum of every 30 days. The inmate must have input into the goals rather than all of them being generated by the BMU Treatment Team in a standardized fashion. All inmates will be invited to personally

attend and participate in all BMU Treatment Team meetings. Treatment plan reviews will be documented in the **ICAR**.

- d. ***The goals on the IRP, established collaboratively with the BMU Treatment Team and the inmate, shall drive the clinically structured out-of-cell offerings on the BMU.***
3. Participation in treatment programs is based on a phase system. Movement to a lower treatment phase is based on appropriate inmate behavior and compliance with the IRP. The initial treatment phase shall be determined by the inmate's present level of functioning, recent historical information, and mental status. The BMU Treatment Team shall recommend all treatment phase changes. Ultimately the PRC, with input from the BMU Treatment Team, has the final decision on awarding or terminating privileges and granting phase changes.
4. The BMU treatment program includes a progressive phase system that may include, but is not limited to, Phases 5 through 1, plus Accountability Status and Post-BMU aftercare. The length of time spent in each phase is dependent on the inmate's demonstrated level of adjustment. The specific time parameters for each phase movement will be defined in the inmate's IRP.
5. Changes in status from phase to phase shall be accomplished through staff action by the BMU Treatment Team and documented by circulating a **BMU Program Review Sheet**, with final approval by the Facility Manager. All status changes will be documented in the **ICAR** by the Unit Counselor. A **DC-46** is not required for phase change following placement on Accountability Status. A **DC-46** will be required to be circulated for all Phase 1 approvals.
6. The BMU is designed to support inmates with a severe personality disorder exhibiting functional impairment in achieving the highest level of functioning within a safe environment. The phase system is designed to provide incentives for inmates who are able to remain free of self-injury, aggression, and other problematic behaviors as well as engage in appropriate behavior. Incentives may be purchased weekly via the points system and points are deducted at the time they are redeemed.
7. ***The BMU Treatment Team is aware that from time to time participation in programming may be difficult for some individuals. They may exhibit a lack of meaningful participation in the milieu offered. It is the goal of the BMU that all participants receive the maximum benefit from treatment. Therefore, the BMU Treatment Team will closely monitor program participation. Each month, every participant's IRP and out-of-cell participation will be reviewed by the Treatment Team. Should an individual's participation in out-of-cell offerings fall below 60% of the minimum of 20 hours programming, the institution's LPM will lead the Treatment Team in collaborating with the individual to discuss goals/objectives/barriers to out-of-cell participation. Part of that review will include a discussion of the programming offered in order to ensure that it addresses the individual's expressed needs.***

8. ***In addition, as part of the Treatment Team, the Psychiatric provider will review the individual's medication and ensure there are no medication side effects which may be hindering program participation. The Psychiatric provider will also assess the individual for possible inpatient treatment if clinically indicated. The institution's LPM will forward the updated IRP for review to the institution's Regional LPM and the Chief of Psychology at Central Office. The institution's LPM will coordinate a video conference with their Treatment Team, their respective LPM, and the Mental Health Advocate at Central Office, to discuss and review the Recovery Plan changes recommended by the institution's LPM and their treatment plan.***
9. Consequences for engaging in self-injurious, aggressive, or other problematic behavior will be immediate with the inmate being placed on Accountability Status where the capacity to earn incentives is limited.
10. Phase advancement will be recommended by the BMU Treatment Team, which includes mental health staff, security staff, and unit team staff. Phase advancement shall be based on behavior and attendance as well as participation in programming. The BMU is an incentive-based program, meaning that as behavioral stability is demonstrated, more privileges are earned. Inmates who engage in problematic behavior will not be afforded these privileges until they demonstrate they are able to function more independently. Overriding goals include no disciplinary reports, treatment compliance, and active program participation.
11. Criteria for consideration of cutting set-aside-disciplinary sanctions and for advancement from phase to phase include:
  - a. remain free of misconducts and problematic behavior reports;
  - b. remain free of self-injury;
  - c. attend at least **60%** of ***the minimum 20 hours out-of-cell structured and unstructured programming;***
  - d. attend at least 90% of individual sessions; and
  - e. other individualized recommendations on the IRP made by the BMU Treatment Team.
12. Phase System
  - a. Phase 5 (**seven** days)
    - (1) This is the starting point for new admission to the program. The inmate is eligible to advance to Phase 4 programming after **seven** days with no problematic behavior demonstrated and active participation in out-of-cell programming. This phase includes:
      - (a) the initial assessment of the inmate;

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- (b) working with staff to develop an IRP to identify behavioral and clinical needs and goals;
  - (c) attending initial BMU Treatment Team session and orientation to the unit;
  - (d) introduction to incentive plan;
  - (e) rules of the unit;
  - (f) behavioral expectations;
  - (g) overview of the phase system;
  - (h) group descriptions; and
  - (i) unit schedule of activities and programs.
- (2) Phase 5 privileges and restrictions include the following:
- (a) as outlined in the **BMU Property, Privileges, and Services Chart**;
  - (b) may earn up to 50 incentive points per week. Incentive points may be used on Phase 5 for items approved on the **BMU Incentive Order Form (Attachment 12-I)**; and
  - (c) escorted in restraints to all out-of-cell activities. Restrained inmates will not be in mixed out-of-cell groups/activities with unrestrained inmates.
- b. Phase 4 (60 days or longer based on clinical recommendation)
- (1) After 14 consecutive days on the Phase 5/Stabilization Phase without problematic behavior, the inmate is eligible for transition to Phase 4. Advancing through phases depends on active participation in programming. After 60 days on Phase 4, the inmate is eligible to move to Phase 3.
  - (2) Phase 4 privileges and restrictions include the following:
    - (a) as outlined in the **BMU Property, Privileges, and Services Chart**;
    - (b) may earn up to 50 incentive points per week;
    - (c) **15** incentive points may be used for food items;
    - (d) 30 additional earned points may be used for Phase 4 incentive point menu items; and

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- (e) escorted in restraints to and from all activities. Restrained inmates will not be in mixed out-of-cell groups/activities with unrestrained inmates.
- c. Phase 3 (60 days or longer based on clinical recommendation)
- (1) An inmate may be considered appropriate for transition from Phase 3 to Phase 2 when the following is evident:
    - (a) demonstrates the ability to maintain safe behavior for at least 60 days;
    - (b) compliant with facility regulations for at least 60 days;
    - (c) demonstrates an overall level of functioning that is consistent with general population; and
    - (d) compliant with treatment objectives as outlined in the inmate's IRP.
  - (2) Phase 3 privileges and restrictions include the following:
    - (a) as outlined in the **BMU Property, Privileges, and Services Chart**;
    - (b) may earn up to 50 incentive points per week;
    - (c) **30** incentive points may be used for food items;
    - (d) any incentive point value may be used for incentive point menu items other than food items up to a total of 70 points per week;
    - (e) in Phase 3 the inmate can be considered for on-unit employment based on team approval and job-availability. The Phase 3 inmate may be permitted to eat meals out-of-cell. Phase 3 inmates will be paid General Labor Pool (GLP) for five days per week; and
    - (f) restraints – upon placement on Phase 3 the Treatment Team may approve reduced restraints during escort to and from therapeutic modules for groups, recreation, and showers. However, Phase 3 inmates are generally unrestrained for regular movement within the unit unless out with another inmate who requires restraints.
- d. Phase 2 (30 days or longer based on clinical recommendation) privileges and restrictions include the following:
- (1) as outlined in the **BMU Property, Privileges, and Services Chart**;
  - (2) may earn up to 50 incentive points per week;

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- (3) any incentive point value may be used for any incentive point menu item including food up to a total of 70 points per week;
  - (4) may generally move unrestrained out-of-cell unless out with another inmate who requires restraints;
  - (5) in Phase 2 the inmate can be considered for on-unit employment based on team approval and job-availability and may be permitted to consume meals out-of-cell. Phase 2 inmates will be paid GLP for five days per week;
  - (6) may exercise in a group with up to six other unrestrained inmates;
  - (7) ***at the discretion of the BMU Treatment Team, during Phase 2 the inmate may begin a Step-down Plan. The plan will begin by allowing the BMU inmate to wear institutional browns and state-issued boots. A CPS will meet the BMU inmate on that unit and will then escort the BMU inmate to the mainline lunch or dinner meal. Staff will be aware of when the inmate is leaving and returning to the BMU. Upon returning to the unit, he will return the institutional browns and boots and will be issued BMU clothing. As per policy, the BMU inmate will be strip-searched before leaving the unit and when returning to the unit;***
  - (8) ***after Step 7 above has occurred several times, the same system may be utilized to have the CPS escort the BMU inmate to receive a haircut or commissary. The procedure will be similar to the above; staff will be aware when the inmate is leaving and returning to the unit;***
  - (9) ***once all BMU Treatment Team members believe that the inmate is ready, the BMU inmate may be escorted by the CPS to another supervised activity such as, but not limited to, Chapel or Library, following the same procedure as above; and***
  - (10) ***once all BMU Treatment Team members believe that the inmate is ready, the BMU inmate may be escorted to the yard or gym utilizing the same system. The RTU yard/gym may be considered given that it is a smaller, less crowded environment. However, another suitable location may be utilized at the discretion of the BMU Treatment Team. The inmate will be escorted by the CPS and the same procedures will be utilized as outlined above.***
- e. Phase 1 (90 days or longer)
- (1) An inmate attaining this phase is considered ready to begin reintegrating into a housing unit deemed appropriate by the Treatment Team at the current treating facility or another BMU facility. This probationary phase will be 90 days in length; with an option to extend probation for another 90 days through the Vote Sheet



process. However, the maximum amount of time this phase will last is 180 days. Should the inmate be away from the facility for any reason such as Authorized Temporary Absence (ATA), or a Mental Health Commitment, Phase 1 time will be suspended until such time as the inmate returns to the facility.

- (2) **While on Phase 1, the BMU Treatment Team will continue to review the individual's IRP every 30 days.** Incentive points will not be earned nor can they be used while an inmate is on Phase 1. The focus of this phase will be to continue to address treatment goals while adjusting to the general population setting. Thus, acclimating and blending into the general population routine is vital. Incentive points should be used prior to earning Phase 1. Once promoted to Phase 1, any unused points will be lost.
- (3) When an inmate successfully completes the probationary status after 90 or 180 days without any significant incidents of behavioral or mental health regression, the BMU Treatment Team will staff him/her for discharge/**graduation** from the program. **Graduation from the BMU will be completed by vote sheet with final approval from the Facility Manager.** Since the inmate has completed/**graduated from** the program, the Treatment Team may consider transferring him/her to another facility, or permit him/her to remain at the current facility. The graduation of any Phase 1 inmate to general population requires facility approval via the Regional Deputy Secretary.

## M. Accountability Status

Accountability Status is a temporary placement within the unit or off-of-the unit for BMU inmates whose behavior is acutely dangerous to self or others or whose behavior is threatening and disruptive to programming and the operational functioning of the unit. The inmate on Accountability Status will be evaluated daily with a plan for their timely return to the program.

### 1. Purpose of Accountability Status

- a. It is the goal of the BMU to provide quality out-of-cell programming to inmates who can benefit from treatment, but who, because of their behavior, have been restricted to units where intensive therapy is difficult to provide. An essential part of all Behavior Management programs is the provision for an immediate consequence for serious negative behavior. Therefore, Accountability Status **may** be instituted to temporarily **address** an acutely aggressive, threatening, disruptive inmate **participating in** BMU programming. This ensures the education of the inmate, safety of staff and other inmates, and the smooth continuation of the program for treatment compliant inmates.
- b. The BMU inmate may be held on Accountability Status for as little as one day, but no longer than **72 hours. Additional placement on Accountability Status may be approved by the Facility Manager in 24-hour increments up to an additional 72 hours. If the individual's status has not stabilized after the first 72 hours, the Psychiatrist will be consulted to determine the need for POC or inpatient**

*placement. In addition, upon reaching the initial 72-hour timeframe, the institution's LPM will forward the BMU Change of Status IRP to the institution's Regional LPM and the Chief of Psychology for review. Also, the BMU Treatment Team will schedule and conduct a videoconference with the Department's Mental Health Advocate. Recommendations for case management will be made in conjunction with Central Office.*

2. Indicators for Accountability Status Process

- a. BMU inmates who are exhibiting acutely aggressive and/or threatening behavior toward themselves or others or are exhibiting extremely disruptive behavior that interferes with the safe and orderly functioning of the program will be immediately (i.e., when appropriate) assessed by a psychology staff member, if the behavior(s) occur(s) during normal business hours, or by a nursing staff member, if during off business hours, to determine whether or not the inmate requires a higher level of care (e.g., POC placement). These behaviors may be reported and documented by utilizing the:
  - (1) **DC-141, Part 1, Misconduct or Other Report**; or
  - (2) **DC-121, Part 3, Employee Report of Incident**.
- b. Additionally, once a staff member observes a harmful, potentially harmful, or disruptive behavior, they will inform the Area Lieutenant, Unit Manager, and the LPM/designee. They will also complete one of the above noted documents. In consultation with the LPM/designee or a nursing staff member, the Area Lieutenant will notify the Shift Commander of the noted behavior and recommendation, if appropriate, to place the inmate on Accountability Status. The Lieutenant, Unit Manager, or LPM will complete the **BMU Accountability Status Restriction Form (Attachment 12-J)**. Recommended property and privilege restrictions must relate to the behavior which prompted the inmate's placement on Accountability Status. All documentation will be completed immediately and forwarded to the Shift Commander for initial disposition.
- c. In general, cells utilized for Accountability Status should be away from the routine activity of the BMU program. However, cells should be outfitted to ensure the maximum ability to observe and ensure the safety of the inmate.
- d. Prior to placing the inmate into Accountability Status, he/she will be strip searched and given property and privileges as indicated on the **BMU Accountability Status Restriction Form**. Once placed on Accountability Status, the inmate will be seen by their assigned psychology staff member within 24 hours or as soon as normal facility operations permit for the purpose of collaboratively completing the **BMU Accountability Status – Recovery Treatment Plan (Attachment 12-K)**. This treatment plan will specifically address the inmate's goals related to why he/she is on Accountability Status and his/her return to regular programming. Placement in Accountability Status and subsequent treatment planning will be documented in the

**ICAR. After being reviewed by the institution's LPM, the BMU Accountability Status – Recovery Treatment Plan will then be scanned to the institution's Regional LPM for review.** They will then be scheduled for the next Treatment Team meeting. All other staff contacts will occur as described in the Accountability Status Monitoring Protocol as follows:

- (1) **the assigned psychology staff member will offer daily 30-minute AM and PM out-of-cell contacts for the duration of the Accountability Status placement. Contacts will be documented with ICAR and DC-560** documentation copied to the medical record;
  - (2) additional psychological contacts, if requested by the inmate or a staff member, will be provided by the assigned psychologist during his/her scheduled daily psychology unit rounds;
  - (3) one **30-minute daily** out-of-cell Psychiatrist/CRNP contact;
  - (4) **one 30-minute daily out-of-cell Therapeutic Recreation Specialist contact,**
  - (5) **one 30-minute daily out-of-cell Social Worker contact,**
  - (6) **one 30-minute daily out-of-cell CPS contact,**
  - (7) **one hour of yard daily,**
  - (8) **PRC review during the Accountability Status placement,**
  - (9) BMU Treatment Team review **at the initiation of the Accountability Status placement,** including review of treatment compliance and property and privileges permitted with recommendations forwarded to PRC on a new **BMU Accountability Status Restriction Form;** and
  - (10) continued **30-minute daily out-of-cell** CC visits.
- e. While on Accountability Status, the Treatment Team will make the final decision as to when and whether the inmate may have more property privileges or qualify for ending Accountability Status. While on Accountability Status, inmates may earn one incentive point for each day without exhibiting acute aggressive and/or threatening behavior toward themselves or others or are exhibiting extremely disruptive behavior to the safe and orderly functioning of the program.
- f. To be removed from Accountability Status, an inmate must be treatment compliant, in behavioral control, and misconduct free to finish Accountability Status. The Treatment Team will decide when an inmate has successfully completed Accountability Status. The inmate will then be returned to the program phase deemed appropriate by the BMU Treatment Team.

## N. Structured Versus Unstructured Programming

1. All structured and unstructured programming will take place in therapeutic modules and Restart Chairs upon determination by the Treatment Team. **Each facilitator of structured and unstructured programming will document their group contact with each individual on the BMU Group Participation Form (Attachment 12-L). Each facilitator will keep the Group Participation Form in their possession. At the end of each 30 days, the Group Participation Form will be forwarded to Medical Records for filing. At the same time, the facilitator will place a brief monthly summary in the ICAR.**
2. Structured activities are those that are lead/facilitated by a Department or contracted staff member or a Volunteer. These may include: Morning Meetings, Mental Health groups, the HELPING: Multimodal Self-Change Approach, **Carey Guides**, Relapse Prevention Plan, AOD, chaplaincy, Thinking for a Change groups, Taking a Chance on Change groups, Start Now program, groups run by activities staff, education, Reentry groups and modules on accepting mental illness, activities for challenged inmates, body basics, staying healthy on your medications, exploring the United States, handle anger better, personal hygiene, planning for a better life, self-esteem, social skills for challenged inmates, and substance abuse treatment introduction and other treatment interventions. Staff may also choose to use the “Traffic Light” Tool in order to illustrate targeted goals and objectives for each inmate. This visual representation of their immediate objectives can be placed where the inmate may review and have immediate feedback concerning appropriate and inappropriate behavior. This intervention will be utilized in a way that protects the confidentiality of the inmate. These resources and activities may be acquired from the LPM assigned to the region.
3. Unstructured activities are defined as activities occurring outside the cell but not conducted by Department staff members. For example, law library, recreation, visits, viewing movies, eating in small groups, and reading out-of-cell. They do not include activities of daily living like showers, however, eating meals in a small group would be considered unstructured.
4. At a minimum, ten structured and ten unstructured out-of-cell hours of programming will be offered to all inmates housed in the BMU. The number of structured out-of-cell hours or portions of an hour of programming the inmate participates in will be logged by the staff member who provides the structured out-of-cell contact. The staff member will log the completed time on the **BMU Accepted/Refused Structured Out-of-Cell Program Log**. The number of unstructured out-of-cell hours or portions of an hour of programming the inmate participates in will be logged by a CO assigned to the unit. The CO will log the completed time on the **BMU Accepted/Refused Unstructured Out-of-Cell Program Log**.
5. Weekly, the BMU Counselor will compile the total hours of programming for each inmate, document the total in the **ICAR**, and report the data on the **Weekly Structured/Unstructured Out-of-Cell Program Report (Attachment 12-M)**. Completed logs will be

forwarded to the BMU Unit Manager for filing. The **Weekly Structured/Unstructured Out-of-Cell Program Report** will be forwarded to the Chief of Psychological Services.

## O. Phase Modification

The BMU treatment program will tailor individualized phase modifications/alternatives when necessary. The modifications will be documented on the IRP with the rationale and goals for the modification and the steps to be taken to reach those goals. These alternatives include, but are not limited to:

1. Accountability Status for a BMU inmate who is celled in an area apart from the BMU (if available) due to his/her behavior, psychiatric symptoms, and/or facility need. The inmate may be committed to a MHU, or other appropriate housing unit.
2. temporary phase change *and/or phase demotion*;
3. phase freeze (a hold in one phase for various reasons, where privileges may be modified); and
4. modified phase (e.g., an inmate with previous assaults on female staff will lock-up when female staff are on the unit, or a Phase 4 inmate may be permitted uncuffed out-of-cell time when other inmates are all in their cells).

## P. Incentive Program

1. The Incentive Program is designed to allow inmates in the BMU the opportunity to earn incentive points that may be redeemed for items on a regularly scheduled basis. Incentive points are earned based on individual performance and for positive and pro-social behaviors.
2. Incentives are a proven method for increasing pro-social behavior and reducing problematic (target) behaviors. Once the target behaviors and goals are identified with the inmate, incentives are used as a reward for achieving identified goals. Within the incentive program design is also life skill opportunities such as basic math and reading, learning to save and plan, and facilitating positive social communications.
3. Program Design
  - a. Inmates who follow facility rules and regulations evidenced by not receiving a misconduct report or demonstrating any problematic behavior will earn a point for the day. A notation in the **ICAR** will be written as supporting documentation for an inmate who does not earn his/her point for the day. This will be noted by the Unit Counselor.
  - b. Treatment points are earned based on treatment attendance and participation without problematic disruptive behavior. Inmates earn two points for each hour of structured activity and one point for each hour of unstructured activity they attend. Structured and unstructured programming will occur daily. Inmates are assigned to specific

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- groups based on individual needs. Inmates who do not have an excused absence, who ask to leave group before it is finished, or who are escorted out due to disruptive behavior do not earn points for that group.
- c. Inmates' points are aggregated each week. Inmates are informed, weekly, both verbally and in writing of all points earned. Inmates then may order items or purchase privileges using their points. Items are given point values from five to 60 points. Unused points may be carried over from week to week and month to month, but an inmate may not use more than the total stated for each phase in a given week. Once a point or privilege is earned, it cannot be taken away. Points and privileges will be held in abeyance should the inmate be placed in Accountability Status.
- d. The following is an overview of the incentive points that may be earned in each week:
- (1) seven daily points for no disciplinary reports or information reports (maximum to be earned is seven);
  - (2) seven daily points for Good/Fair ratings for Cell Cleanliness and Hygiene (maximum to be earned is seven);
  - (3) two points for each hour of attendance and participation in structured programming (maximum to be earned is 20);
  - (4) one point for each hour of attendance and participation in unstructured programming (maximum to be earned is ten);
  - (5) six bonus points for attending and participating in all groups and meeting **recovery** plan requirements for one week; and
  - (6) seven daily points for no disciplinary reports or information reports while under Accountability Status (maximum to be earned is seven).
- e. At the end of each week, the BMU Counselor will tabulate each inmate's incentive point total for the previous week using the **BMU Weekly Point Summary (Attachment 12-N)**. The total points will be transposed to the **BMU Monthly Point Summary (Attachment 12-O)** in order to track the total incentive points earned and redeemed over time. After tabulating the weekly point totals, the BMU Counselor will then distribute the **BMU Incentive Order Form** to each inmate. They will then complete and return the forms by the end of the day. Incentives earned will then begin to be distributed no later than the week following when they are redeemed.

## Q. Misconducts

1. The alleged commission of Class 1 Misconduct charge 1 to 14 will result in formal disciplinary action if found guilty and Accountability Status for no **more** than **three** days.
2. The alleged commission of a Class 1 Misconduct charge 15 to 25 **may** result in formal disciplinary action if found guilty and placement in Accountability Status for **no more than three days**.
3. ***If a misconduct is eligible for informal resolution, staff will complete the BMU/SRTU Informal Resolution Action Form (Attachment 12-P) to document his/her sanction for that misconduct.***
4. An inmate will not be issued misconducts for self-mutilation, however, a **DC-121, Part 3** will be generated. This may result in the inmate's placement in the POC or on Accountability Status.
5. ***The assigned psychology staff*** will provide input to the Hearing Examiner for all formal hearings in regard to whether the infraction was due to the inmate's mental illness or volitional. The Hearing Examiner will use this input for sanctions or modifying sanctions.
6. An inmate on probationary status in Phase 1 in a general population RTU does not automatically need to be returned to the BMU. This decision will be made by the PRC with input from the BMU Treatment Team.

## R. Change in Status

1. Inmates may be transferred to the BMU in either AC or DC status. DC sanctions should not be cut by the sending facility. The major goal of the BMU program is to stabilize the inmate's behavior so they can progress to placement in the least restrictive environment, based on their demonstrated behavior. Any remaining DC time will be addressed by the PRC at the BMU facility.
2. While in the BMU, DC status is set aside. As stated above, the DC sanction time continues to expire while the inmate is in the BMU. An inmate can earn further reductions in their DC sanctions for appropriate behavior.
3. An inmate who exhibits misconduct-related behavior while in the BMU will generally serve a period of suspension on Accountability Status with a phase change (reduction in privileges level) based on the recommendation of the BMU Treatment Team and approval of PRC.
4. All changes in status in regard to phase progression will be completed via the **BMU Program Review Sheet**. Once the unit team makes a recommendation to PRC to advance a phase, and PRC approves, an **ICAR** entry will be made by the counselor indicating such.

## **S. Release of BMU Inmates**

1. Phase 1 constitutes the release of the inmate to a general population housing unit, generally within the treating facility. The release of any Phase 1 inmate from the BMU to a general population housing unit requires approval of the Regional Deputy Secretary.
2. An inmate who is being considered for release to general population as a result of placement on Phase 1 must have completed all requirements of his/her IRP for Phase 2.
3. Approval to move to Phase 1 and release to a general population RTU shall be requested via memo to the Office of the effected Regional Deputy Secretary. Documentation should include the BMU Treatment Team's approval, PRC action, Facility Manager's approval, and submission of appropriate rationale concerning the inmate's progress in the BMU program. The release is usually to the general population RTU of the treatment facility.
4. If approval is granted for transition to Phase 1 and ultimate discharge to the designated facility, the Unit Manager/designee shall verify the status and move date.
5. The Unit Manager shall ensure that the following are completed:
  - a. the inmate is readied for transition on the approved date;
  - b. the inmate packs his/her property and cleans the cell;
  - c. the inmate's property is inventoried by unit staff;
  - d. all BMU property, clothing, etc., is returned to the BMU inventory;
  - e. the inmate's property is released to the inmate and/or the Department transportation crew;
  - f. if the inmate is being released to the BMU facility's general population, request appropriate staff to escort the inmate to the newly assigned housing unit;
  - g. review all documentation to ensure proper log entries, forms, location boards, and BMU paperwork is completed accurately and in a timely manner;
  - h. notify the facility's Control Center to ensure inmate movement forms for count procedures are completed; and
  - i. in a case where the inmate is being discharged to a general population placement at another facility with a BMU, the BMU Treatment Team shall conduct a videoconference or teleconference call, with the Unit Management Team of the receiving facility to discuss the inmate's response to treatment. The referring facility shall document in the **ICAR** and on the **DC-560** the date, name of participants, and issues discussed in the conference call. At a minimum, the following issues shall be addressed:



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- (1) the inmate's progress toward meeting the goals of his/her IRP;
  - (2) the extent to which he/she has achieved maximum benefit from treatment available at the BMU;
  - (3) any ongoing resistance to program participation; and/or
  - (4) any treatment needs to be addressed when the inmate arrives at his/her designated facility.
6. An inmate being transferred to another facility as a Phase 1 BMU inmate on probationary status will be afforded the same privileges and services as defined in the **BMU Property, Privileges, and Services Chart** (Phase 1) and placed in general population.
7. In the event that an inmate's behavior deteriorates during his/her Phase 1 probationary period, the inmate may be returned to the BMU. If the inmate's behavior deteriorates after he/she has completed Phase 1, return to the BMU is an option, but is not mandated. If a decision has been made to place the inmate back into BMU programming, a new referral packet will be generated and the packet submitted for review as stated in this policy. Depending on the nature of the deterioration, the inmate may require a short time stay in the RHU and/or a mental health inpatient setting. If there is question regarding the preferred option, cases in this status can be reviewed with the COSN/PRT and the Regional LPM.

#### **T. Discharge Procedures**

1. Discharge/**Graduation** of an inmate from BMU programming after successful completion of the Phase 1 **probationary period** shall be considered when:
  - a. the IRP goals have been satisfied with successful reintegration into a general population unit for three to six months in a permanent facility;
  - b. when it is necessary to place a BMU graduate in the RHU they will be managed according to their Stability Rating and Department policy **DC-ADM 801**; or
  - c. ***an inmate successfully completing Phase 1 probationary period and graduating from BMU programming may be eligible for transfer to a facility in their home region by submission of a permanent transfer petition utilizing the purpose: Other, and Comments: BMU Graduate.***
2. Discharge of an inmate from the BMU for other than successful program completion shall be considered when:
  - a. the BMU Treatment Team concludes that the inmate remains resistant to participation in the IRP that was developed for him/her; and/or the inmate engages in repeated negative behavior which is contrary to the mission of the BMU, and undermines the

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treatment of other BMU participants, e.g. evidence of both disruptive actions and detrimental impact on valid BMU inmates' progress; and

- b. all inmates being considered for discharge from the BMU for reasons other than successful completion shall be automatically referred to the SAU for review and recommendation for subsequent placement. The SAU recommendations will then be included in the referral packet.
3. The facility recommending an inmate for removal from BMU programming should send a Referral Packet to the OPM for review at COSN/PRT. The Referral Packet should include the following information:
    - a. a completed **Special Program Referral Approval/Rejection Form**, which will serve as the face sheet. In the Requested Action Section, the Program/Unit Removal box should be checked;
    - b. **DC-46** circulated through the BMU Treatment Team and the referring facility's administrative staff;
    - c. rationale for the inmate's removal from BMU programming to include listing of disruptive behaviors, misconducts, and actions of self-injury;
    - d. the review and recommendations as prepared by the SAU; and
    - e. documented evidence of behaviors to include, but not limited to Misconduct Report(s), **DC-121's**, **ICAR** entries from BMU Treatment Team, and PRT notes.
  4. If the COSN/PRT determines that removal from the BMU programming is not appropriate, all options will be reviewed and a decision as to the disposition of the inmate's case will be generated.
  5. If the final recommended disposition by COSN/PRT does not include placement in another BMU, the Executive Deputy Secretary will conduct the final review.
  6. If removal from BMU Programming is approved by the COSN/PRT and the Executive Deputy Secretary, than a Transfer Petition will be completed by the OPM. COSN/PRT will determine where the inmate should be placed and the OPM will assign a facility accordingly.
  7. The receiving facility can submit the inmate for consideration by COSN/PRT for reentry into the BMU programming, if the inmate displays behaviors consistent with BMU admission criteria.

**U. Release via Sentence Complete (Formerly Final Discharge Maximum Expiration)**

1. If an inmate is scheduled for release via Sentence Complete before completion of the BMU program, the inmate shall be referred to the facility Psychology Department 12

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months prior to release for continuity of care/release planning, in accordance with **Section 2** of this manual.

2. Any release of a highly assaultive inmate due to sentence completion shall follow procedures set forth in Department policy **6.5.1**.

**V. Unit Operation Evaluation**

1. Monday of each week, the BMU Unit Manager/designee will provide, via email, the Licensed Psychologist Director (LPD) at Central Office with an updated roster to include BMU inmates on Mental Health (MH) commitment, WRIT, etc. This roster shall include phases, effective date of current phase, and date admitted to the BMU.
2. Also, on Monday of each week, the BMU Unit Manager/designee will submit via email, to the LPD at Central Office, the effected Regional LPM, the effected Regional Deputy Secretary/Inspection Team, the log sheet of out-of-cell hours on the **BMU Accepted/Refused Structured Out-of-Cell Program Log** and the **BMU Accepted/Refused Unstructured Out-of-Cell Program Log**.
3. ***In conjunction with this review, the BMU Unit Manager/designee will submit a list of BMU individuals who participated in out-of-cell programming at less than a 60% average for the previous month. This list will be reviewed by the institution's LPM who will ensure that all listed individual's IRPs have recovery goals/objectives related to program participation and overcoming obstacles to treatment. This list will be forwarded to the institution's Regional LPM and the Chief of Psychology. The type and content of programming offered will be evaluated as to its efficacy in engaging the individuals in the therapeutic process. Upon Central Office review, consultations with the institution may occur with recommendations to modify the programming delivered in the BMU.***
4. The BMU Unit Manager/designee shall provide, via email, a summary of the monthly **Treatment Team meetings** to the LPD at Central Office on the first of each month.
5. In order to evaluate the operation of the BMU, each Facility Manager/designee shall ensure that a **BMU Semi-Annual Report (Attachment 12-Q)** is completed and submitted to the Executive Deputy Secretary, the LPD at Central Office, the effected Regional LPM, and the effected Regional Deputy Secretary/Inspection Team by July 31 (reporting period 1/1 to 6/30) and January 31 (reporting period 7/1 to 12/31) of each calendar year. This report shall include, but not be limited to, the following:
  - a. the number of inmate receptions by month;
  - b. a list of facilities transferring inmates to the unit;
  - c. the name and Department number of every inmate transferred to the unit;

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- d. the name and Department number of every inmate promoted to Phase 1;
- e. the average length of an inmate's stay in all Phases (5, 4, 3, 2 and 1);
- f. the name and Department number of every inmate released from the unit (i.e., including BMU graduates) and the location where he/she was transferred;
- g. the name and Department number of every inmate with Sentence Complete expiring while in the unit;
- h. the name and Department number of every inmate moved to Accountability Status and Post BMU;
- i. the number of grievances filed by inmates in the unit;
- j. the number of misconducts issued to inmates in the unit;
- k. the number of BMU inmates at the beginning and end of the reporting period;
- l. any recommendations to facilitate the operation of the unit; and
- m. any concerns regarding the operation of the unit.

## Section 13 – Special Needs Unit (SNU)

### A. Facility Responsibilities

1. **Facilities shall operate a Special Needs Unit (SNU) in accordance with this section.**
2. **At facilities that operate a Residential Treatment Unit (RTU), the SNU shall be located on a separate housing unit when feasible.**
3. **If it is not operationally feasible to physically separate the distinct “units” (i.e., if the RTU and the SNU are located on the same housing unit), the following shall apply:**
  - a. **in general, an SNU inmate shall not occupy space on the housing unit at the expense of an inmate who is in need of RTU placement;**
  - b. **an inmate who is determined to need RTU placement shall not wait to be placed in an RTU because bed space is taken by an SNU inmate; and**
  - c. **staff making housing unit and bed assignments shall consider any vulnerabilities that may exist in order to ensure appropriate placement of all inmates.**

### B. Admission Guidelines and Process for Transfer

1. The SNU is for an inmate with physical, mental, emotional or other vulnerabilities, which may make it difficult for him/her to adjust in general population. **Any adult inmate, age 18 or older**, custody level (except custody level 5), program code, and sentence structure is eligible. The following factors are among those that can be considered to determine appropriate placement:<sup>1</sup>
  - a. **A, B, C, and D Roster inmates (“functional Cs or Ds” or mental health cases not more appropriately placed in a RTU and active mental health cases who have vulnerabilities not related to mental illness);**
  - b. **physical disabilities or illness;**
  - c. **sensory impairment;**
  - d. **intellectual disability;**
  - e. **age-related vulnerability; and/or**
  - f. **other relevant risk factors or vulnerabilities.**

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<sup>1</sup> 4-4305, 4-4399

**NOTE: Functionally impaired “C” and “D” Roster inmates should be considered for housing on a RTU, not a SNU. A SNU is no longer considered appropriate housing for inmates who are mentally ill and are functionally impaired.**

2. Referrals

a. **Referrals of inmates who are identified as “C” and “D” Roster (and as further defined in Subsection B.1.a. above)** from within the facility may be made by the Unit Management Team, medical or psychology staff, Program Review Committee (PRC), or any other staff member who perceives an inmate as having adjustment difficulties due to a limitation.<sup>2</sup>

- (1) The referral shall be made to the Psychiatric Review Team (PRT), **through the Licensed Psychology Manager (LPM), who shall screen and evaluate the referred inmate.**<sup>3</sup>

**NOTE: The referring Unit Management Team as well as the SNU Unit Management Team shall be present for the review.**

- (2) **Following the evaluation, the referring Counselor participating on the PRT during the screening/evaluation shall prepare a DC-46, Vote Sheet recommending for or against SNU placement. The referring Unit Management Team shall consult with the SNU Unit Management Team when preparing the DC-46. The DC-46 must contain information for consideration regarding how or if the inmate is expected to benefit from the SNU placement.**
- (3) **The recommendation shall be forwarded for administrative staff review and action through the Major for Unit Management, the Corrections Classification and Program Manager (CCPM), the Deputy Superintendent for Centralized Services (DSCS), and the Deputy Superintendent for Facility Management (DSFM). The Facility Manager must review any split votes regarding SNU program admission or rejection.**

b. **Referrals of non-mental health cases (refer to Subsections B.1.b.-f. above) may be made by the Unit Management Team, medical or psychology staff, PRC, or any other staff member who perceives an inmate as having potential adjustment difficulties due to a limitation.**

- (1) **The referral shall be made to the assigned Counselor for Unit Management Team consideration.**
- (2) **The Unit Management Team shall screen and evaluate the referred inmate.**

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<sup>2</sup> 4-4305

<sup>3</sup> 4-4399

- (3) *If deemed an appropriate referral, the case shall be forwarded to the SNU Unit Management Team for screening.*
  - (4) *After consulting with the SNU Unit Management Team, the referring Counselor shall then prepare a DC-46 recommending for or against SNU placement. The referring Unit Management Team shall work closely with the SNU Unit Management Team when preparing the DC-46. The DC-46 must contain information for consideration regarding how or if the inmate is expected to benefit from the SNU placement.*
  - (5) *The recommendation shall be forwarded for administrative staff review and action through the Major for Unit Management, the CCPM, the DSCS, and the DSFM. The Facility Manager must review any split votes regarding SNU program admission or rejection.*
- c. *New receptions and others may be placed immediately, but temporarily, on the SNU by a Unit Manager or higher-ranking staff member (e.g., Shift Commander/Captain, in the absence of other administrative staff) pending review by the SNU Unit Management Team. The review shall be completed on the next business day.*
- (1) *The Counselor participating in the SNU Unit Management Team review shall prepare a DC-46 recommending for or against SNU placement. The DC-46 must contain information for consideration regarding how or if the inmate is expected to benefit from the SNU placement.*
  - (2) *The recommendation shall be forwarded for administrative staff review and action through the Major for Unit Management, the CCPM, the DSCS, and the DSFM. The Facility Manager must review any split votes regarding SNU program admission or rejection.*
  - (3) *If the case is determined to be inappropriate for continued SNU placement, the inmate shall be discharged to another general population housing unit.*
- d. *Staff shall make detailed and appropriate ICAR entries in order to document the status of the referral.*
3. A referral from a facility where there is no SNU, from a facility that has an inmate whose special needs it cannot accommodate, or where a separation is required, may be considered. ***The inmate will be placed and reviewed in accordance with Subsection B.2. above.*** Transfer requests shall be made via the transfer petition process as outlined in Department policy 11.1.1, “Population Management.”
  4. In cases where an inmate has been approved for SNU placement and space is not available, ***the facility must augment their current SNU bed capacity (i.e., designate additional appropriate housing space) to meet the demands of the population needs.***

5. Every attempt shall be made to place any inmate who needs SNU housing into a suitable unit within 30 days of the initial evaluation.<sup>4</sup>
6. In those cases where an inmate is seriously disruptive within the unit, the SNU Unit Management Team shall determine the appropriate housing.<sup>5</sup>

### C. SNU Cell Assignment

1. ***SNU inmates shall be single or double-celled (double-celling shall be considered the standard) in accordance with Department policy 11.2.1, "Reception and Classification," Section 5, Single Celling and Double Celling Housing.***
2. ***The Involuntary Double-Celling Checklist (refer to Section 5, Attachment 5-A) shall be used prior to involuntary double celling an SNU inmate. Any "yes" response in the Staff Review section of the Checklist stops the process, pending review by the Unit Manager.***
3. ***Involuntary SNU double-celling which occurs after normal working hours is prohibited except in the event of extenuating circumstances, and only with authorization from the Shift Commander.***
4. ***All SNU beds shall be appropriately filled. Examples of other populations that can be housed on the unit without causing negative consequences to the SNU population are peer assistants, Certified Peer Support Specialists, etc.***

### D. Staffing

***The staffing of SNUs shall be in accordance with established guidelines for staffing general population housing units (i.e. SNUs will be staffed no differently than other comparable general population housing units).***

### E. SNU Yard and Activities

1. ***A SNU shall have a separate yard, or yard period, as is operationally feasible.***
2. ***Each facility that operates a SNU shall have an On-Unit Activities Schedule appropriate for the population (refer to Attachment 13-A for a sample schedule).***

### F. Discharge and Transfer Procedures

1. An inmate shall be considered for discharge by the SNU Unit Management Team when he/she no longer needs the security or support provided by the unit, and/or when ***there is***

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<sup>4</sup> 4-4399

<sup>5</sup> 4-4399



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***a need to prioritize others for SNU placement.*** This process is also to be used when alternate housing may be appropriate for a seriously disruptive inmate.

2. The recommendation for discharge of the inmate to general population or to other housing shall be done via a **DC-46** by the SNU Unit Management Team. Included in the body of the **DC-46** shall be information that documents the inmate's adjustment and level of functioning, and whether any vulnerabilities continue to exist, and reason(s) for discharge. The **DC-46** shall be sent through the Major for Unit Management, the CCPM and Deputy Superintendents for final action. The Facility Manager must review every split vote.
3. In those cases where the inmate is to be returned to another facility, a transfer petition shall be submitted in accordance with Department policy **11.1.1**.

## **Section 14 – Diversionary Treatment Units (DTU)**

### **A. General**

The Department strives to avoid prolonged placement of inmates with a Serious Mental Illness (SMI) and/or Intellectual Disability (ID) in Restricted Housing Units (RHU). However, due to safety and/or security concerns, an inmate with a SMI or ID may need to be placed in a secure housing unit where he/she will continue to receive mental health care commensurate with his/her treatment needs. Inmates being considered for placement into the DTU will not meet commitment criteria according to the Pennsylvania Mental Health Procedures Act.

### **B. Admission Criteria**

Admission criteria shall include the following:

1. a diagnosis of a SMI/ID (i.e. D Roster) as defined in the **Definition of a SMI/ID Outline** (refer to **Section 10** of this procedures manual);
2. the inmate currently presents safety and/or security needs that cannot be accommodated by a less restrictive housing unit operated by the Department;
3. general population Residential Treatment Unit (RTU) participants who are in Administrative Custody (AC) or Disciplinary Custody (DC) may be considered for placement in the DTU by the Program Review Committee (PRC) with the recommendation of the Psychiatric Review Team (PRT);
4. a discharge from the Mental Health Unit (MHU) may be considered for placement in the DTU with recommendation from the MHU and the treating PRT;
5. a Psychiatric Observation Cell (POC) discharge may be considered for placement in the DTU with the recommendation of PRT and approval by PRC;
6. an unsentenced county inmate (5B transfer) may be placed in the DTU if clinical judgment indicates it as an appropriate placement; and
7. any inmate being placed in restricted housing who is under the age of 18, at the State Correctional Institution (SCI) Pine Grove, SCI Muncy, or any other facility shall be offered all the procedures and provisions as listed in **Subsection C. below**.

### **C. General Procedures and Provisions**

1. Each facility that houses SMI/ID inmates shall make provisions to designate secure pods to function as a DTU. In the absence of bed capacity to dedicate a full pod/unit to a DTU, the facility shall designate a range of cells to function as the DTU. These units shall be painted brightly with murals including recovery-based language and focus on the mental health treatment of those confined there. There should be sufficient out-of-cell (OOC)

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space for inmates to receive treatment in individual or congregated settings depending on the mental health and security needs displayed. These cells shall be designated as “DTU” cells in the bed management system.

2. If an exceptional circumstance exists preventing a D Roster inmate from being housed on the DTU (e.g., separation, bed space, etc.) he/she shall receive all DTU services, as per Department policy **DC-ADM 801, “Inmate Discipline,” Section 4, Disposition of Charges and Misconduct Sanctions**. He/she shall be moved to the DTU within 13 days, as per Department policy **DC-ADM 801, Section 4**. If circumstances prohibit the inmate from being moved into a DTU within the 13 day time period, notifications will be made to the Executive Deputy Secretary, Regional Deputy Secretary, Office of Population Management (OPM), Office of Psychology, and the Office of Chief Counsel.
3. All DTU inmates will be scheduled and offered a minimum of 20 hours OOC activity weekly. Ten of these hours are structured (e.g., run by appropriately credentialed staff) and ten of these hours will be unstructured (e.g., yard/exercise, contact with peer specialists, etc.). These OOC offerings commence the first day an inmate is placed in the DTU. All disciplines (e.g., psychology staff, psychiatric providers, counselors, treatment specialists, education, chaplaincy, drug and alcohol treatment specialists, medical staff, activities staff, social workers, therapeutic activities services workers) and departments are expected to offer services to the inmates in the DTU to achieve the minimum offering of OOC activity. Individual Recovery Plan (IRP) goals established collaboratively with the PRT and inmate shall drive structured OOC programming offerings on the unit.

The number of structured OOC hours or portions of an hour of programming that the inmate participates in will be logged by the staff member who provides the structured OOC contact. The staff member will log the completed time on the **DTU Accepted/Refused Structured Out-of-Cell Program Log (Attachment 14-A)**. The number of unstructured OOC hours or portions of an hour of programming that the inmate participates in will be logged by a Corrections Officer (CO) assigned to the unit. The CO will log the completed time on the **DTU Accepted/Refused Unstructured Out-of-Cell Program Log (Attachment 14-B)**. The cumulative offering, acceptance, and refusal shall be entered into the **Inmate Cumulative Adjustment Record (ICAR)** on a weekly basis by a designated Corrections Counselor for each inmate and shall cover the reporting period from Monday to Sunday.

4. ***DTU inmates will be handcuffed in the front using a security belt with two COs escorting. Tethers and leg shackles are optional and only used with inmates whose demonstrated behavior warrants their use.***
5. Weekly, the DTU Counselor will compile the total hours of programming for each inmate, document the total in the **ICAR**, and report the data on the weekly **Structured/Unstructured Out-of-Cell Program Report (Attachment 14-C)**. Completed logs will be forwarded to the DTU Unit Manager for filing. The weekly **Structured/Unstructured Out-of-Cell Program Report** will be forwarded to the Chief of Psychological Services and the respective Regional Licensed Psychology Manager (RLPM).

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6. The DTU treatment team is aware that from time to time participation in programming may be difficult for some individuals. They may exhibit a lack of meaningful participation in the milieu offered. It is the goal of the DTU that all participants receive the maximum benefit from treatment. Therefore, the DTU treatment team will closely monitor program participation. Each month, every participant's IRP and OOC participation will be reviewed by the treatment team. Should an individual's participation in OOC offerings fall below 60% of the minimum 20 hours programming, the facility's Licensed Psychology Manager (LPM)/designee will lead the treatment team in collaborating with the individual to discuss goals/objectives/barriers to OOC participation. Part of that review will include a discussion of the programming offered in order to ensure that it addresses the individual's expressed needs. In addition, as a part of the treatment team, the Psychiatric provider will review the individual's medication and ensure there are no medication side effects which may be hindering program participation. The Psychiatric provider will also assess the individual for possible inpatient treatment if clinically indicated. The facility's LPM/designee will forward the updated IRP for review to the facility's RLPM and the Chief of Psychology at Central Office. The facility's LPM/designee may coordinate a videoconference with their treatment team, their respective RLPM, and the Mental Health Advocate at Central Office, to discuss and review the Recovery Plan changes recommended by the facility's LPM/designee and their treatment team if needed.
7. ***Each DTU unit team, in conjunction with PRT and PRC, will introduce an incentive system to encourage prosocial behavior and participation in OOC offerings.***
8. The programming day is not considered to be Monday through Friday during daylight hours. Activities shall be scheduled during evenings and on weekends to achieve the minimum of 20 hours OOC per week offering.
9. All inmates in the DTU will be offered two hours of exercise per day, at least five days per week and shall be permitted to shower daily and shave three days per week.
10. Inmates housed in the DTU will be issued royal blue hobby jeans and a royal blue shirt with DOC printed in large block letters on the back. They will be provided appropriate footwear. Outerwear for exercise shall be provided as needed.
11. The PRC shall review each inmate in the DTU weekly in conjunction with the LPM/designee. This OOC contact shall be offered in a private, confidential area. This contact shall be documented in the **ICAR** and on a **DC-560, Mental Health Contact Note** filed in the medical record. The **DC-560** must assess continued appropriateness for DTU placement and likelihood of suicidality to include risk and protective factors. The LPM/designee must make a recommendation to PRC regarding removal from the DTU at every PRC meeting. The LPM/designee can also report to PRC on the inmate's adherence to medication regime.
12. If an inmate refuses to attend PRC, the committee will go to the inmate's cell.

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13. During the first PRC review, an orientation to the unit will explain the purpose, expectations, etc., of the DTU. During this first review, an administrative review will be conducted to determine if the inmate should be removed from the DTU or if exceptional circumstances exist allowing PRC to continue to hold the inmate in the DTU. Exceptional circumstances include:
  - a. release would pose a substantial risk to the safety of the inmate or others;
  - b. placement in a general population RTU would pose a substantial threat to the security of the facility; or
  - c. the PRC, in concert with the PRT, determines DTU confinement is in the inmate's best interest based on his/her mental condition and that removing the inmate and placing him/her in a general population RTU or Secure Residential Treatment Unit (SRTU) would be detrimental to his/her mental condition.
14. Any D Roster inmate who cannot be released to general population from the DTU within 30 days of being in AC status after completion of DC Status, will have his/her name, case synopsis, updated IRP and a plan for release forwarded to the appropriate Regional Deputy Secretary and the Licensed Psychologist Director for the Office of Psychology. These cases will then be reviewed by the Central Office Special Needs Psychiatric Review Team (COSNPRT).
15. If a D Roster inmate is deemed to meet the criteria in **Subsection C.13.a. & b. above**, PRC, in conjunction with PRT, will consider initiating a referral to a SRTU if warranted and appropriate.
16. Psychology staff will create an IRP in collaboration with the inmate, to present at the first PRC meeting. This plan shall address the behaviors that brought the inmate to the DTU. A discussion shall be conducted in regard to the behaviors, including participating in OOC programming without being disruptive, the inmate has to demonstrate to earn early release from the DTU and earn privileges. The goals of this IRP drive the clinical structured OOC offerings on the unit, e.g. if an inmate's goal is to control anger, then they shall be in an anger management group, or if an inmate wants to address managing anxiety related to trauma, they shall be in a seeking safety group.
17. IRPs are to be completed every 30 days after the initial change of status IRP, unless there is a sentinel event (e.g., POC placement, serious suicide attempt, self-injurious behavior, etc.) which requires the IRP to be updated sooner. An IRP will also be completed when an inmate is released from the DTU back to general population.
18. PRT shall convene monthly to review IRP progress. The inmate will be invited to attend this structured OOC programming in a private area ensuring confidentiality. Psychology staff shall document the meeting in the **ICAR**. PRT shall review IRPs collectively and determine what groups shall be offered on the unit and also review overall participation rates to determine if the groups being offered are effective in regard to attendance by the

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inmates. If an inmate refuses to attend PRT, they will be seen cell side and encouraged to attend OOC PRTs.

19. A member of the psychology staff shall be assigned to the DTU and offer a weekly OOC individual contact with each inmate. The offering of this contact and its acceptance shall be documented on the **ICAR** and on the **DC-560**. In the event that the inmate is offered and refuses OOC contact and it occurs at the cell door, this should be documented in addition to its impact on confidentiality. Psychology shall have a current copy of the IRP during all psychology contacts.
20. Psychology staff shall make rounds daily on the DTU, Monday through Friday excluding weekends and holidays. Each inmate will be spoken to every day. The inmate can be removed from his/her cell for OOC contact if it is required in the clinical opinion of the Psychological Services Associate (PSA)/Psychological Services Specialist (PSS). An inmate may request OOC contact and psychology staff, in conjunction with the unit team, will decide if it is warranted. If OOC contact is denied upon request, a reason will be entered on the **DC-17X, Adjustment Record for Security Level 5 Inmates**, and on the **ICAR**. Rounds do not have to be documented in the **ICAR** with a **DC-560** to the medical record, but rather are documented in the unit log book. The **ICAR** and the **DC-560** are required documentation for meaningful contacts but not for rounds. Meaningful contacts should include but are not limited to OOC contacts, cell-side contacts following refused OOC offering, contacts indicating clinically indicated need for OOC contact, or contacts that precipitate non-emergent and/or emergent referrals to psychiatry.
21. The assigned Counselor shall see every inmate weekly. Each inmate's Unit Management Team will review his/her case weekly. The Counselor's weekly interview and the Unit Management Team's weekly review are to be documented in the **ICAR**. The Unit Management Team shall forward a recommendation to the PRC for early release, if appropriate.
22. Certified Peer Specialists (CPS) are expected to provide supportive services on the DTU. Only those CPS services offered OOC may be counted towards unstructured OOC offerings.
23. Basic issue items shall be provided in accordance with Department policy, **6.5.1, "Administration of Security Level 5 Housing Units" Section 1**. Three pairs of personal undergarments are permitted.
24. Inmates in the DTU are prohibited from using, purchasing, or possessing tobacco products while confined in the DTU. Commissary purchases are limited to approved items from the AC commissary catalogue. Outside purchases are prohibited.
25. Inmates in the DTU shall have privileges determined by PRC with input from PRT including radio, television, telephone calls, and commissary purchases. Privileges, especially the possession of certain property, should be provided unless circumstances or behavior dictate otherwise. The default presumption should not be that privileges or possessions are contraindicated.

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26. DTU inmates shall be provided access to the facility law library and may request other law library books by requesting legal materials and/or by using the mini law library in accordance with Department policy **DC-ADM 007, “Access to Provided Legal Services.”**
27. DTU inmates are permitted to maintain the equivalent of one records center box of any combination of personal property in his/her cell. Additional boxes of legal materials may be granted for open and active cases through the Corrections Superintendent’s Assistant (CSA).
28. In case of a verified emergency, the Unit Manager or a Commissioned Officer may approve a telephone call. Every approved emergency telephone call shall be logged in the DTU Log Book and in the inmate’s **DC-17X**.
29. Visits initially are limited to one non-contact visit per month, which may be limited to weekdays only, with immediate family. Legal visits shall be permitted. The inmate may be permitted one non-contact visit per month with his/her religious advisor, as per Department policy **DC-ADM 812, “Inmate Visiting Privileges.”** However, visits can be increased in frequency or considered on weekends by PRC with input from PRT depending on non-disruptive OOC participation and demonstrated appropriate behavior and progress toward the IRP.
30. If a determination is made that the DTU is not the least restrictive environment for an inmate due to his/her being a threat in the DTU or a less secure environment, a SRTU or Behavior Management Unit (BMU) referral may be made. When an inmate is being recommended for a transfer to the SRTU or BMU, the PRC with input from PRT shall review the recommendation and inform the inmate of the reasons for proposed recommendation. The inmate shall be given the opportunity to respond to the rationale given and object to the inmate placement in the SRTU/BMU if he/she so desires. The recommendation shall be documented on the **DC-141, Part 4, Facility Manager’s Review** with a copy to the inmate. The inmate may appeal the recommendation for SRTU or BMU to the Facility Manager and to the Chief Hearing Examiner’s Office at Central Office.
31. Any inmate assigned to the DTU who goes to another facility on WRIT/Authorized Temporary Absence (ATA) will continue to be offered everything outlined in this procedures manual.
32. When an inmate’s service of consecutive DC in the DTU is interrupted, for example the inmate goes out on WRIT/ATA to a county facility, or non-Department facility, his/her remaining DC imposed time is tolled during the ATA. At the time of the inmate’s return from ATA, the receiving facility shall determine if, and to what extent, the inmate’s owed DC time should be credited because while ATA, the inmate was housed in a custodial or housing arrangement similar to DTU in a Department facility. After credit, if any is awarded, any remaining Department DC time shall be served until completed. The PRC shall be responsible to review placement while ATA, determine credit and the inmate’s status upon return to the facility.

#### D. Staff Training

All staff selected or assigned to the DTU to provide programming and supervision will be required to complete Crisis Intervention Team Training (CITT) within six months of placement into the unit. If it is necessary to assign a staff member to the DTU who has not completed this training, the facility shall, within two weeks, advise the CITT Program Coordinator. The facility's Training Coordinator shall also communicate such training needs to the CITT Program Coordinator to ensure that sufficient training is conducted to meet the needs of the facility. CO Trainees (COTs) will not be assigned to the DTU.

#### E. Unit Operation Evaluation

1. Every Monday, the DTU Unit Manager/designee will provide, via email, the Licensed Psychologist Director at Central Office and the respective RLPM with an updated roster to include DTU inmates on MH commitment, WRIT, etc., using the **Structured/Unstructured Out-of-Cell Program Report**. This roster shall include date admitted to the DTU.
2. Every Monday, the DTU Unit Manager/designee will submit, via email, to the Licensed Psychologist Director at Central Office and the respective RLPM, the log sheet of OOC hours on the **DTU Accepted/Refused Structured Out-of-Cell Program Log** and the **DTU Accepted/Refused Unstructured Out-of-Cell Program Log**.
3. The DTU Unit Manager/designee shall provide, via email, a summary of the monthly PRTs to the Licensed Psychologist Director at Central Office and the respective RLPM on the first of each month.
4. In order to evaluate the operation of the DTU, each Facility Manager/designee shall ensure that a **DTU Semi-Annual Report (Attachment 14-D)** is completed and submitted to the Executive Deputy Secretary, appropriate Regional Deputy Secretary, Licensed Psychologist Director at Central Office, and the RLPM by July 31 (reporting period 1/1 to 6/30) and January 31 (reporting period 7/1 to 12/31) of each calendar year. Only facilities that operate DTUs are required to complete this report. This report shall include, but not be limited to, the following:
  - a. the number of inmate receptions by month;
  - b. the amount of DC time reductions per inmate (names and numbers) who have received time cuts;
  - c. unit classifications transferring inmates to the unit and the number of inmates transferred to the DTU from those units (e.g., three for General Population, two from the RTU, and one from the POC);
  - d. the name and Department number of every inmate transferred to the unit;



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- e. the average length of an inmate's stay in the DTU;
- f. the name and Department number of every inmate released from the unit and the location where he/she was transferred;
- g. the name and Department number of every inmate with Sentence Complete (SC) expiring while in the unit;
- h. the number of grievances filed by inmates in the unit;
- i. the number of misconducts issued to inmates in the unit;
- j. the number of DTU inmates at the beginning and end of the reporting period;
- k. any recommendations to facilitate the operation of the unit; and
- l. any concerns regarding the operation of the unit.

## **Section 15 – Certified Peer Specialist (CPS) Initiative**

### **A. General Considerations**

1. The purpose of the Certified Peer Specialist (CPS) initiative is to train select individuals from the offender population to serve as CPSs.
2. The certification process will afford all successful participants the opportunity to become a recognized CPS by the Pennsylvania Department of Human Services (DHS) and the Pennsylvania State Civil Service Commission (SCSC). Certification will provide the potential for employment in a peer support setting after release from a state correctional facility.
3. The CPS employment wage is a minimum of .51 cents per hour. The work day can be between six to eight hours, dependent upon the needs of the facility. A CPS can be employed full or part time and does not have to give up his/her existing employment to work as a CPS. However, he/she must provide CPS services a minimum of 10-15 hours per week in order to maintain his/her CPS position.
4. CPS training will provide selected offenders with the skills required to act as mentors/role models for other offenders in specialized units and other places within a state correctional facility, such as:
  - a. visiting rooms;
  - b. Residential Treatment Units (RTUs);
  - c. Special Needs Units (SNUs);
  - d. Secure Residential Treatment Units (SRTUs);
  - e. Therapeutic Communities (Alcohol and Other Drug [AOD] TC);
  - f. Restricted Housing Units (RHUs);
  - g. Psychiatric Observation Cells (POCs);
  - h. general population housing units;
  - i. the library;
  - j. Transitional Housing Units/Reentry Service Offices (THUs/RSOs);
  - k. the infirmary (to include the Oncology and Hospice wards);
  - l. the chapel;

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- m. the med line;
  - n. the education center;
  - o. the commissary;
  - p. the dietary section;
  - q. Veteran’s Service Units (VSUs);
  - r. recovery units;
  - s. Mental Health Units (MHUs);
  - t. the capital case unit; and
  - u. the Forensic Treatment Center (FTC).
5. A CPS can be utilized to augment staff’s efforts to effectively support special needs offenders thus enhancing their own recovery and wellness. In addition to teaching specific skills, such as communication and conflict resolution, a CPS can:
- a. utilize his or her first-hand knowledge about mental health recovery to help his/her peers recover;
  - b. demonstrate recovery in a way that inspires his/her peers and helps them to see their own potential for recovery;
  - c. assist his/her peers with the identification of their long-term goals and to subdivide those goals into manageable steps;
  - d. assist his/her peers with shifting their focus from symptom management to recognizing and developing their wellness, their accomplishments, and their abilities;
  - e. provide his/her peers with an opportunity to evaluate the choices and decisions that they make/have made;
  - f. demonstrate the value of self-determination and personal responsibility;
  - g. assist in establishing/maintaining a recovery environment within the facility setting that empowers others to succeed in accomplishing goals, reconnecting to themselves, reconnecting with others, and having purpose in life;
  - h. demonstrate the power of resilience; and
  - i. assist assigned offenders in understanding the grievance process.

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6. In addition to providing individual services, a CPS may also facilitate workshops and didactic groups. The workshops provided by a CPS shall be periodically monitored by a member of the Unit Management Team and/or the Psychology Department.
7. The Unit Manager will post a notice of CPS facilitated workshop/group schedules on the bulletin board in his/her housing unit. An offender interested in attending these sessions will submit a **DC-135A, Inmate's Request to Staff Member** in order to be scheduled for attendance. An offender interested in receiving information on a specific related topic will address the request to the Unit Manager.
8. A CPS is to address issues assigned by his/her supervisor. The Licensed Psychology Manager (LPM) or Unit Manager will be available to the CPS for consultation and assistance as needed.
9. Each facility shall develop an identification (ID) badge that acknowledges the offender is a CPS. This ID badge shall be worn/carried along with the offender's inmate ID at all times while performing CPS services.

**B. Offender Selection**

1. An offender shall be selected via a **DC-46, Vote Sheet** process. To be considered for selection as a CPS candidate, offenders must meet specific criteria:
  - a. must be a custody level two or three;
  - b. must be misconduct free for a minimum of one year;
  - c. have no misconducts for assaultive behavior in the last two years;
  - d. a history of mental health treatment/services while incarcerated and/or in the community;
  - e. program compliancy;
  - f. recommended by the LPM and/or Psychiatric Review Team (PRT);
  - g. if the offender is on the AOD TC waiting list, his/her potential start date for AOD TC may not begin before the conclusion of his/her CPS training and he/she must be permitted to provide CPS services while in the TC;
  - h. have more than two years remaining on his/her minimum sentence, unless he/she qualifies under the Long-Term Offender (LTO)/lifer criteria listed below;
  - i. have a high school diploma or General Education Diploma (GED); and
  - j. if the offender is a LTO/lifer with positive adjustment records, he or she may be given consideration and the requirement for high school diploma/GED may be waived.

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2. The Facility Manager/designee shall designate the maximum number of LTO/lifers on the CPS roster at his/her facility. D Roster facilities should have a minimum of 15 CPSs with a target of 25. Non-D Roster facilities should have a minimum of 15 CPSs.
3. Staff designated by the Facility Manager/designee will review offender records to identify potential participants in the program.
4. All potential participants must be interviewed by the LPM in regard to criteria listed in **Subsections B.1-3. above**. Veterans shall be given special consideration.

**C. CPS Training**

1. The CPS Training Program is designed to provide selected offenders with basic educational training on the following topics:
  - a. the definition of recovery;
  - b. the philosophy and practice of the power of Peer Support;
  - c. the development of self-esteem and managing self-talk;
  - d. community, culture, and environment;
  - e. emotional intelligence;
  - f. employment as a path to recovery;
  - g. substance abuse;
  - h. conflict resolution; and
  - i. working with other professionals.
2. Trained Department staff will deliver the CPS training. All requests for training shall be routed through the Office of Mental Health Advocate at Central Office.
3. Selected offenders shall be trained to provide support to other offender(s) regarding recovery wellness.
4. An offender who receives the certification and signs the **CPS Confidentiality Acknowledgement Form (Attachment 15-A)** may be utilized as a CPS at an assigned facility.
5. A selected offender may not miss more than six hours of training and must make up any missed work under the direction of the CPS training facilitator. All selected offenders must also participate in classroom activities and must successfully complete the mid-term and final exam.

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6. The CPS training instructor has the discretion to remove a CPS student if there are indications that the student is unable to fulfill the requirements of the course, such as classroom exercises, homework assignments, and fidelity to the CPS model.
7. Any student observed cheating on the exam will be removed from the class and unable to continue. An offender may apply to be a CPS candidate at a later date. Approval will be determined by designated facility staff.
8. A CPS must report for the scheduled workshops/groups during his/her designated time.

**D. Supervisory Staff**

1. Supervision of the CPS program should be facilitated as a committee whose members, including treatment and security staff, are united and equal in their decision-making authority. All decisions concerning the CPSs should be made by this committee. A designated staff member shall function as the primary CPS Coordinator who develops all CPS schedules and on-call schedules and coordinates CPS Committee meetings. Other designated committee members will be responsible for the direct supervision of the CPSs. At least one committee member shall have training specific to CPS supervision. Assigned supervisory staff will be responsible for providing the following:
  - a. technical support to the CPS;
  - b. recovery wellness literature to CPS for use in continuing education;
  - c. identifying designated time frames for the CPS complement to convene for recreational time and for training (Continuing Education Unit [CEU]) time;
  - d. a CPS must earn at least 18 continuing education hours per year to maintain his/her state certification. The *Keeping Recovery Skills Alive* curriculum should be used for this purpose. The curriculum is to be purchased by each facility on a one-time basis and is included on the order form that is used for purchasing the CPS training manuals. Other training topics may be used but must primarily focus on wellness, life skills, and other related topics. CEUs can be facilitated by facility staff, CPS, a member of the Department Training Team, or volunteer facilitators approved by the facility's CPS Supervisory Team; and
  - e. the CPS Coordinator shall track all CEUs on an Excel spreadsheet to include the offender's name and number, his/her state certification number which appears on his/her training certificate, the topic of the CEU, how many hours the session spanned, and the date the session was facilitated. CEUs correlate to the calendar year, January through December. The spreadsheet shall be forwarded to the Office of Mental Health Advocate at Central Office each year by December 15.
2. The CPS complement shall be supervised by staff that are designated by the Facility Manager/designee. In addition, the CPS shall also be supported by a multi-disciplinary team to include Psychology, Medical, Treatment, and Security staff.

## E. General Conduct

1. All information shared in peer sessions is to remain confidential except when threats of suicide or expressions of intent to harm others are verbalized. The CPS statewide certification includes CPSs as para-professionals that have a “duty to warn.” In these cases, the CPS shall report such threats and expressions to staff immediately. (The CPSs are informed of this duty during their training and confirm their agreement to do so by signing the **CPS Confidentiality Acknowledgement Form.**)

***NOTE: A CPS may be terminated for a breach of that confidentiality.***

2. When providing one-on-one peer support, a **Daily Contact Record (Attachment 15-B)** will be maintained by the CPS and will be turned into the CPS Supervisor at the end of the day that the support takes place.
3. Every CPS is subject to random urinalysis testing, in accordance with Department policy **6.3.12, “Drug Interdiction.”**
4. A CPS and the offenders attending such workshops/groups are subject to monitoring at any time by Department staff. Staff will provide intervention as needed.
5. Abuse of privileges by a CPS shall be reason for suspension/termination from the program.
6. ***A CPS may be terminated from the program if he/she receives any Class 1 misconduct (assault, fighting, sexual misconduct, possession of drugs, etc.)***
7. A CPS may receive a **Letter of Recommendation (Attachment 15-C)** from the multi-disciplinary team and/or the immediate supervisor for use upon release for employment purposes.
8. ***Termination of CPS employment will result in the offender being rendered ineligible for rehire as a CPS and training opportunities related to maintaining CPS certification.***

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**Acute Dynamic Risk Factor** - A risk factor that may change rapidly and/or have a stronger temporal association with re-offending (negative mood, intoxication).

**Adjusted Actuarial Approach** – A risk assessment strategy, involving initially the use of an actuarial tool to determine a baseline level of static risk, proceeding with adjustment based upon the number and intensity of dynamic risk factors (criminogenic needs) present for an individual inmate.

**Chief Psychologist’s Office** – Refers to the office of Chief of Psychological Services, which provides professional supervision to the Psychology Departments in the state correctional facilities. The Chief Psychologist’s Office is responsible for tracking the transfers of inmates with mental illness.

**Comprehensive Assessment Plan** – A plan that provides for extensive assessments of the inmate. It identifies an inmate’s strengths, needs and reason(s) for admission to the unit. It also identifies inmate and staff responsibilities in the assessment process.

**Corrections Classification and Program Manager (CCPM)** – Responsible for planning, organizing, and directing a broad program of classification, treatment, and program activities for inmates in a correctional facility.

**Corrections Health Care Administrator (CHCA)** – The on-site administrator responsible for monitoring on-site contractual compliance and/or directing the daily operations of the Medical Department at the facility and providing supervision and direction to Department medical personnel.

**Court-Ordered Involuntary treatment or 304 Commitment** – Refers to long-term treatment for (a) individuals who are determined to be a danger to self or others or (b) persons who are already subject to involuntary treatment.

**Department** – The Pennsylvania Department of Corrections.

**Department of Public Welfare (DPW) Forensic Mental Health Units** – Refers to the forensic mental health units operated by the Office of Mental Health and Substance Abuse Services (OMHSAS), Department of Welfare. These units are located at Norristown State Hospital, Mayview State Hospital, and Warren State Hospital.

**Department Regional Mental Health Units (MHUs)** – Refers to forensic mental health units that are housed within Department facilities and are approved annually by the Office of Mental Health (OMH) in the Department of Public Welfare. The operation of the MHUs is guided by the Regulations for Inpatient Forensic Psychiatric Programs, Chapter 5320 of the Title 55, published by the Office of Mental Health.

**Deputy Superintendent for Centralized Services (DSCS)** – The facility staff member responsible for coordinating efforts between facility and the Medical Department. As the Facility Manager’s representative, he/she has joint responsibility with the Bureau of Health Care Services to address those issues outlined in this policy.



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**Deputy Superintendent for Facility Management (DSFM)** – A management level employee directly responsible for the uniformed corrections officers, Unit Management (housing), counseling services, facility maintenance, facility safety, and the facility Security Office.

**Diagnostic and Classification Center/Facility (DCC)** – A correctional facility, which assesses custody, security levels, programmatic and special needs, of inmates who are newly received into the Department, returned as parole violators, or temporarily transferred for presentence assessment.

**Diagnostic and Classification Center/Facility Initial Orientation Group** – These groups are provided to help orient new commitments to the programs and services available at housing facilities, and offer information on how to access these programs and services.

**Diagnostic and Classification Center/Facility Mental Health Staff** – The counseling, substance abuse, psychological and psychiatric staff that provides mental health services to inmates in reception status.

**Diagnostic and Classification Center/Facility Staff** – All staff in the Diagnostic and Classification Center/Facility including the mental health staff, officer, and ancillary staff.

**Disciplinary Custody (DC Status)** – The maximum restrictive status of confinement to which inmates found guilty of a Class I misconduct may be committed.

**DSM** – The American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

**Dynamic Risk Factor** – A risk factor that is considered changeable through intervention, also referred to a criminogenic need.

**Extended Involuntary Emergency Treatment or 303 Commitment** – Refers to the court ordered extension of the 302 application for a period not to exceed 20 days.

**Facility** – A State Correctional Facility, State Regional Correctional Facility, Motivational Boot Camp, Training Academy, Community Corrections Center, and the Central Office Complex as a group and/or individually.

**Facility Manager** – The Superintendent of a State Correctional Facility, State regional Correctional Facility, or Motivational Boot Camp, Director of a Community Corrections Center or Director of the Training Academy.

**Forensic Treatment Center** – Refers to the forensic psychiatric hospital operated by the Department. The unit is located at SCI-Waymart, and its operation is guided by the Regulations for Inpatient Forensic Psychiatric Hospitals, Chapter 5333 of Title 55, Published by the Office of Mental Health.

**General Population Housing Unit** – A general housing unit within which an inmate may engage in various educational, vocational, and treatment programs.

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**Guilty But Mentally Ill (GBMI)** – Sentencing provisions established by Act 286-81, 18 PA C.S.A. §§314, 315, 42 PA C.S.A. §9727 for persons found or pleas of guilty but also having a mental illness at the time of commission of their offense. Persona adjudicated as GBMI were determined by the court to be mentally ill, but not legally insane, at the time they committed their offense. They may or may not be mentally ill at the time of sentencing or reception. This is a legal, not a psychiatric diagnosis, classification.

**Hard Cell** – A secure cell usually located in a Mental Health Unit, Infirmary, or Special Needs Unit that is free of breakable objects, protrusions, screens, and other features which an inmate might harm him/herself. The area is also structurally reinforced so that the inmate will have difficulty damaging the cell. Window and doors are located and the cell is configured in such a manner as to allow custody and treatment staff provide constant observation of, and immediate access to, the resident, to prevent self-harm. Some hard cells may be equipped with medical restraints and/or observation cameras.

**Housing Unit Officer** – A corrections officer who is assigned to the living quarters where inmates are housed.

**Individual Treatment Plan (ITP)** – A series of written statements specifying the particular course of treatment and the roles of staff in carrying it out. It is based on an assessment of the inmate's needs, and it includes a statement of short and long-term goals as well as the methods by which these goals will be pursued. When clinically indicated, the treatment plan gives inmates access to the range of supportive and rehabilitative services (such as physical therapy, individual or group counseling, and self-help groups) that the treatment plan deems appropriate. To the extent feasible, the inmate shall participate in the development of his/her ITP.

**In-House Regional Mental Health Unit (MHU)** – A Department of Public Welfare Office of Mental Health Certified mental health unit housed within a Department facility. Vendors under contract to the Department operate these units. The Regulations for Inpatient Forensic Psychiatric Programs, Chapter 5320 of the Title 55, published by OMH, guide the operation of the MHUs.

**Initial Assessment Plan** – A plan developed by the Special Assessment Unit (SAU) Team that identifies the reason(s) for admission to the unit, and presents problems and goals to be addressed by the inmate and members of the Multidisciplinary Team.

**Intermediate Care Unit (ICU)** – A 50-bed unit at SCI Waymart designed to provide mental health treatment to inmates who, due to their psychiatric condition, have demonstrated an inability to function in general population, have not been successful in adapting to a Special Needs Unit (SNU), and have not evidenced behaviors necessitating commitment to the Forensic Treatment Center.

**International Classification of Diseases, Current Edition, Clinical Modification (ICD-CM)** – The official coding used in the publication of the DSM-IV. The Department requires the psychiatrist to assign ICD diagnoses to all inmate patients.

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**Involuntary Emergency Examination and Treatment or 302 Application** – Refers to a brief emergency commitment to a licensed psychiatric unit of an individual who is severely mentally ill and a danger to self or others. The 302 application shall not exceed five days.

**Licensed Psychology Manager** – A Civil Service title for the Chief Psychologist within a facility.

**Mental Health Commitment** – The procedure to commit an inmate to a Regional Mental Health Unit, Forensic Treatment Center, or DPW Forensic Mental Health Unit in accordance with the Mental Health Procedures Act. This is the same procedure applicable to civil commitments in the community.

**Mental Health Coordinator** – Refers to staff member in the Facility Psychology Department who coordinates the mental health services provided to the inmates with mental illness in the facility. If the facility does not have a MHC, then another member of the psychology staff shall assume the mental health coordination duties.

**Mental Health Procedures Act** – Refers to legislation 50 P.S. §7101 of 1976, Act #143 as amended by Act #324 of 1978, which governs the mental health procedures employed in Pennsylvania and provides for treatment and rights of mentally disabled persons, as well as for voluntary and involuntary examination and treatment.

**Mental Health Service Review Committee (MHSRC)** – A committee chaired by the Facility Chief Psychologist, which is composed of all key mental health figures in the facility including the facility psychiatrist, CHCA, CCPM, Special Needs Unit manager (if appropriate), Mental Health Unit Director (if appropriate), and any other staff members assigned by the Facility Manager. The MHSRC meets regularly to review the mental health procedures in the prison and completes an annual review of the Department and facility mental health policy and operations submitted to the BHCS.

**Mental Health Unit (MHU)** – A housing area or group of cells designated for inmates confined in a facility-based mental health unit licensed by the Pennsylvania Department of Welfare, Office of Mental Health.

**Mentally Retarded** – Refers to individuals whose general intellectual functioning is sub-average and exists concurrently with deficits in adaptive behavior with onset before age 18. Sub-average intelligence is defined as a score on a standard intelligence test of 69 or below.

**Military Experience Scale** – An instrument used to record an individual's level of experience in military service.

**Military Veterans Scale** – A self-report scale regarding physical and emotional feelings currently being experienced.

**Multi-Disciplinary Team** – *This team is chaired by the Corrections Health Care Administrator and consists of the Medical Director/designee, the inmate counselor, psychiatrist, psychologist, Unit Manager, and nursing supervisor. This team addresses the mental and medical health treatment needs of referred inmates. This shall include*

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***screening and appraisal of data, direct observation of behavior, diagnostic review of personality issues; mental health history and treatment plan referral.***

**Parenteral Medication** – Medication administered intramuscularly or intravenously.

**Patient** – For the purpose of this policy/procedures manual, when an inmate is admitted to a Mental Health Unit he/she shall be referred to as a patient who is undergoing mental health treatment.

**Post-Traumatic Stress Disorder (PTSD)** – The development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of usual human experience. The characteristic symptoms involve re-experiencing the traumatic event; numbing of responsiveness to, or reduced involvement with, the external world; and a variety of autonomic; dysphonic; or cognitive symptoms.

**Preventive Mental Health Services** – Services designed to maintain or improve the mental health of inmates before they develop emotional problems or reach a crisis. Programs include, Anger Management, Assertiveness, General Adjustment Groups, and Therapeutic Recreational Activities.

**Program Review Committee (PRC)** – A committee consisting of three staff members that conduct Administrative Custody Hearings, periodic reviews, makes decisions regarding continued confinement in the Restricted Housing Unit (RHU) and/or Special Management Unit (SMU), and hears all first level appeals of misconducts. The committee shall consist of one staff member from each of the following staff classifications: Deputy Superintendent, who shall serve as the chairperson, Corrections Classification Program Manager, Unit Manager, School Principle, Drug and Alcohol Treatment Specialist Supervisor, or Inmate Records Officer Supervisor and a Commissioned Officer. The Facility Manager may designate other staff as committee members, however, if such designations are made, they must be in writing and the Facility Manager must maintain a list of all designees. Whenever a PRC is convened, at least one member of the committee must be a staff member who is not directly involved in the administration of the RHU/SMU in which the inmate is currently housed.

**Psychiatric Observation Cell (POC)** – A cell located in the Infirmary area of the facility that is used to hold inmates who are mentally decompensating to the point where they are considered a danger to themselves, other inmates, and/or property. These cells provide a means of retraining the inmate, if necessary, and allow for constant supervision of the inmate to be maintained in order to treat the inmate.

**Psychiatric Restraints** – Physical devices such as leather four-point and two-point restraints, belted wrist restraints, helmets, etc. used for controlling behavior which is self-injurious or threatening toward others. These restraining devices do not include security restraints used for confinement purposes or facilitating inmate movement.

**Psychiatric Review Team (PRT)** – A team, chaired by the facility's Chief Psychologist/designee, including the Consulting Psychiatrist, Unit Manager, and other staff as designated by the Facility Manager. The Psychiatric Review Team reviews the cases of those inmates who

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experience adjustment or behavioral difficulties related to emotional problems and who require more in-depth evaluation, closer monitoring and support.

**Psychiatric Review Team Roster** – This roster includes that subset of inmates on the mental health/mental retardation roster who suffer from a serious mental illness, who are having severe difficulty adjusting to institutional life, and whose cases require closer, regular monitoring by the multi-disciplinary Psychiatric Review Team.

**Psychological Services Staff** – Those individuals working in a facility and who are in positions of Psychological Services Associate-Corrections, Psychological Services Specialist-Corrections, Psychologist (licensed) and Licensed Psychologist Manager (Chief Psychologist, generic). Staff provides a range of psychological assessment. Treatment and mental health services to the various units. Staff may be assigned to one or more units and are expected to visit the units to interact with the unit staff and inmates on a regular basis.

**Psychologist** – The term “psychologist” used herein shall mean any psychologist or psychological services associate.

**Psychotropic Medication** – Drugs that affect the mental state.

**Qualified Mentally Ill** – Refers to inmates who are determined to be mentally ill in accordance with the Mental Health Procedures Act.

**Qualified Personnel** – Staff licensed as psychiatrists or psychologist, or meet the State civil Service classification for corrections counselor I or II or corrections casework supervisor, psychological services associate I or II, psychological services associate supervisor, psychological services specialist, registered nurse, or licensed practical nurse.

**Receiving Officer** – The corrections officer responsible for receiving new commitments into the facility.

**Reception Committee** – Those members of the unit/facility team who meet with and review the cases of inmates newly assigned to the unit/facility or housing unit.

**Restricted Housing Unit (RHU)** – An area or group of cells housing inmates assigned to disciplinary or administrative custody status pursuant to Department policy **DC-ADM 801**, “**Inmate Discipline**” or **DC-802**, “**Administrative Custody Procedures.**”

**Serious Mental Illness** – A substantial disorder of thought or mood, which significantly impairs judgment, behavior, capacity or recognize reality, or cope with the ordinary demands of life.

**Sex Offender Treatment Committee (SOTC)** – An advisory committee comprised primarily of Department of Corrections’ providers of sex offender-specific treatment.

**Social Security disability Insurance (SSDI)** – SSDI comprises a number of disability benefits for workers and their dependents and survivors. Entitlement is based on contributions to the Social Security trust funds through Federal Insurance Contribution Act (FICA) taxes. Individuals who qualify for SSDI benefits are entitled to receive medical benefits from the federal Medicare

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program generally after they have been entitled to benefits for 24 months. SSDI benefits include Disability Insurance Benefits, Widow's Insurance Benefits, and Child's Insurance Benefits.

**Special Assessment Unit** – A program located in the SCI Waymart RHU, designed to provide independent assessment of inmates who, because of mental illness, have demonstrated an inability to function successfully in general population and have been confined to a Restricted Housing Unit for a lengthy period.

**Special Assessment Unit Team** – A team assigned to operate and provide extensive assessments on the Special Assessment Unit. The team will consist of the Zone Lieutenant and/or his/her designee, a psychologist, consulting psychiatrist, registered nurse, corrections counselor and any other staff designated by the Chief Psychologist with input from the Corrections Classification Program Manager. This team is responsible for security, risk management and the delivery of mental health services to inmates identified as being seriously mentally ill and housed on this unit.

**Special Needs Unit (SNU)** – A housing unit established to provide a safe and secure setting and specialized treatment services for those inmates identified as being unable to function in a general population-housing unit. Inmates in this category may include those diagnosed as mentally ill, emotionally unstable, mentally retarded, and physically or developmentally challenged. Placement does not require the mental health commitment process.

**Stable Dynamic Risk Factor** – A risk factor that is considered changeable through intervention, but tends to be more stable in the inmate's life (personality disorder, sexual preference for children).

**Static Risk Factor** – a risk factor that is predominantly historical and cannot be changed through intervention.

**Supplemental Security Insurance (SSI)** – SSI is a means-tested program that provides a basic floor of income for individuals with limited incomes and resources. SSI benefits are paid to aged (age 65 and older), blind, and disabled individuals who have limited means. Individuals under age 65, including children (individuals under age 18) must be blind or disabled to qualify for benefits.

**Training Coordinator** – An employee assigned by each facility, CCC region and center, Central Office, and Training Academy who is responsible for supervising the planning, coordinating, facility and ACA training record maintenance, and on-site monitoring of training.

**Unit Management Team** – The individuals assigned to operate a housing unit with the responsibilities for security, risk management, and program delivery. The team is composed of, at a minimum, a Unit Manager, Corrections Officers, and a counselor. Other staff may be assigned to the team or provide supportive services to the unit.

**Unit Manager** – The staff person responsible for managing the staff and programs in a Unit(s). The individual who is responsible for the supervision of all members of the Unit Management Team and the delivery of security and program services.

**13.8.1, Access to Mental Health Care Procedures Manual**  
**Glossary of Terms**

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**Unit Staff** – Staff who are assigned specifically to the unit, including but not limited to correction officers, and counselors, full time and who provide services and programs in a unit under the direction of the Unit Manager.

**Voluntary Application for Examination and Treatment or 201 Application** – Refers to the procedures whereby an inmate who believes he/she is mentally ill and understands the nature of voluntary treatment may apply to be treated in one of the Department Mental Health Units.