



**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>January 10, 2022</b>	<b>Authority:</b> <b>Signature on File</b> <b>George M. Little</b>	<b>Effective Date:</b> <b>January 24, 2022</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> 5-ACI-6A-28

- 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 Unit** 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 inmate whose psychiatric needs exceed the treatment capability of the facility (refer to **Section 5**, **Section 7 – Special Observation and Assessment Unit**, **Section 8 – Intermediate Care Unit**, **Section 10 – Secure Residential Treatment Unit**, **Section 12 – Behavior Management Unit**, and **Section 14 – Diversionary Treatment Unit** of this procedures manual).
- 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> 5-ACI-5B-11

#### 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 led 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 Services 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 and Assessment Unit (SOAU). 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 SOAU 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> 5-ACI-5B-11

## 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.

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## VIII. SUPERSEDED POLICY AND CROSS REFERENCE

### A. Superseded Policy

#### 1. Department Policy

- a. 13.8.1, Access to Mental Health Care Policy Statement, issued December 23, 2019, by former Secretary John E. Wetzel.
- b. 13.8.1, Bulletin 03-01 to Section 3-Delivery of Psychiatric Services, issued December 10, 2018, by former Secretary John E. Wetzel.

#### 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 007, Access to Provided Legal Services
- c. DC-ADM 008, Prison Rape Elimination Act (PREA)
- d. DC-ADM 201, Use of Force
- e. DC-ADM 801, Inmate Discipline
- f. DC-ADM 802, Administrative Custody Procedures
- g. DC-ADM 803, Inmate Mail and Incoming Publications
- h. DC-ADM 812, Inmate Visiting Privileges
- i. DC-ADM 816, Inmate Compensation
- j. 2.1.1, Planning, Research, Statistics, and Grants
- k. 3.1.1, Fiscal Administration
- l. 4.1.1, Human Resources and Labor Relations
- m. 5.1.1, Staff Development and Training
- n. 6.3.1, Facility Security
- o. 6.3.12, Drug Interdiction

- p. 6.5.1, Administration of Security Level 5 Housing Units
- q. 6.5.8, Capital Case Administration
- r. 6.7.2, Special Response Teams
- s. 7.2.1, Counseling Services
- t. 7.3.1, Reentry and Transition
- u. 11.1.1, Population Management
- v. 11.2.1, Reception and Classification
- w. 11.4.1, Case Summary
- x. 11.5.1, Records Office Operations
- y. 13.1.1, Management and Administration of Health Care
- z. 13.2.1, Access to Health Care

2. ACA Standards

- a. Adult Correctional Institutions: 5-ACI-3A-18, 5-ACI-4A-04, 5-ACI-4A-07, 5-ACI-4A-10, 5-ACI-4A-11, 5-ACI-4A-12, 5-ACI-4A-13, 5-ACI-4A-16, 5-ACI-4A-21, 5-ACI-4A-22, 5-ACI-4A-24, 5-ACI-4A-25, 5-ACI-4A-26, 5-ACI-4A-27, 5-ACI-4B-01, 5-ACI-4B-02, 5-ACI-4B-04, 5-ACI-4B-09, 5-ACI-4B-10, 5-ACI-4B-11, 5-ACI-4B-12, 5-ACI-4B-15, 5-ACI-4B-28, 5-ACI-4B-30, 5-ACI-4B-31, 5-ACI-5A-02, 5-ACI-5A-05, 5-ACI-5B-11, 5-ACI-6A-04, 5-ACI-6A-07, 5-ACI-6A-08, 5-ACI-6A-28, 5-ACI-6A-29, 5-ACI-6A-30, 5-ACI-6A-32, 5-ACI-6A-33, 5-ACI-6A-34, 5-ACI-6A-35, 5-ACI-6A-37, 5-ACI-6A-38, 5-ACI-6A-39, 5-ACI-6A-41, 5-ACI-6B-12, 5-ACI-6B-13, 5-ACI-6C-04, 5-ACI-6C-06, 5-ACI-6C-07, 5-ACI-6C-08, 5-ACI-6C-12, 5-ACI-6C-13, 5-ACI-6D-03, 5-ACI-6D-05, 5-ACI-6E-01
- b. Adult Community Residential Services: None
- c. Correctional Training Academies: None

3. PREA Standards

115.42, 115.78, 115.83



**PROCEDURES MANUAL**  
Commonwealth of Pennsylvania • Department of Corrections

**Policy Subject:**

**Access to Mental Health Care**

**Policy Number:**

**13.8.1**

**Date of Issue:**

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**Authority:**

**Signature on File  
George M. Little**

**Effective Date:**

**January 24, 2022**

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 Executive Deputy Secretary for Institutional Operations/Regional Deputy Secretary and the Bureau of Standards, Audits, Assessments, and Compliance for review and approval prior to implementation. Absent such approval, all procedures set forth in this manual must be met.

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

<b>Policy Subject:</b> <b>Access to Mental Health Care Procedures Manual</b> <b>Section 1 – Psychological Services</b>		
<b>Policy Number:</b> <b>13.8.1, Section 1, Bulletin #1</b>		
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The purpose of this Bulletin is to update **Section 1, Subsection B.2.c.(2)(f)ii**, of Department policy **13.8.1**. Changes are noted in bold and italics.

**Section 1, Subsection B.2.c.(2)(f)ii**. shall now read:

- ii. ***Psychology and nursing staff will screen every new individual placed in Restrictive Housing or Special Management housing with the electronic DC-510 (i.e., Restrictive Housing and Special Management Housing-Mental Health Care Screening) and the electronic DC-510A, Restrictive Housing Health Care Screening (i.e., Restrictive Housing and Special Management Housing-Health Care Screening), respectively. Security staff will screen every new individual placed in Restrictive Housing or Special Management housing with the paper DC-510, Suicide Risk Indicators Checklist (Attachment 1-E).*** These procedures are outlined in **Section 2** of this procedures manual.<sup>1</sup>

<sup>1</sup> 5-ACI-4B-10, 5-ACI-4B-28

## Section 1 – Psychological Services

### A. Diagnostic Center

1. Every **individual** 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 **individual** upon reception. DCC will provide further assessments only for an **individual** who evidences a need for more comprehensive evaluation (e.g., those **individuals** scoring 70 or below on the intellectual screening to **access for** intellectual **disability**).
2. The purpose of this psychometric testing is to provide screening in the areas of intelligence, achievement, personality, and emotional **as well as behavioral** 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 **or a version that is read aloud** will be administered to an **individual unable to read the PAI, to an individual scoring below a 4<sup>th</sup> grade reading level on both the Test of Adult Basic Education (TABE) and Wide Range Achievement Test (WRAT) scales, to an individual who produced invalid results on the self-guided PAI, or otherwise deemed appropriate for this option of test administration.**
    - (4) **The PAI should be administered in the individual’s native language whenever possible.**
    - (5) 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. **Psychology staff should have the results of the PAI in their possession before interviewing and authoring the DCC Psychological Assessment, so that the psychology staff member can adequately address any areas of concern identified within the PAI during the DCC Psychological Assessment and clinical interview.**

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<sup>1</sup> 5-ACI-5A-02



- (6) ***The PAI Clinical Interpretive Report shall be uploaded into the Electronic Medical Record as soon as possible during the classification process.***
- b. ***DCC-PCRA: The original DCC-PCRA shall be generated and stored in DOCInfo. Additionally, a copy shall be uploaded into the electronic medical record as soon as reasonably possible, but no later than 72 hours following signoff by a Licensed Psychologist (LP).***
- c. **Revised Beta 4**
  - (1) ***The psychology staff will attempt to administer the Beta 4 to every individual received into the DCC. Exceptions are determined by the Licensed Psychologist Manager (LPM) on an individual basis.***
  - (2) ***An individual who scores 70 or below will receive additional assessment at the DCC to “rule out intellectual disability (ID)/development disabilities (DD)” if time permits. ID/DD assessment will include intelligence testing with the most recent version of the Wechsler Abbreviated Scale of Intelligence (WASI), the Wechsler Adult Intelligence Scale (WAIS), adaptive behavior testing measured by the Vineland (i.e., or other measure of adaptive behavior) as well as research of the individual’s records to determine whether ID occurred before the age of 18. This will include requesting educational records utilizing the DC-108, Authorization for Release of Information.***
  - (3) ***Once psychology staff have received an IQ score for the individual, this score shall be memorialized within the electronic medical record’s miscellaneous section within the IQ section (i.e., and within mainframe), along with the appropriate IQ category (i.e., <71 and ID is ruled out; >70 and ID is ruled out; ID Ruled In; Requires Additional Testing/Information). This task shall be completed for subsequent intelligence tests (i.e., including at permanent institutions), such that the most recent and most heavily weighted (i.e., WAIS vs. Beta) score is reflected in these sections.***
  - (4) ***If an ID has not been ruled out by the time an individual completes classification within the DCC, upon reception at the individual’s permanent institution, the site should complete all necessary testing and associated documentation of the differential diagnosis process within six months of arrival. As above, this shall include appropriate documentation and updating of all necessary systems.***
  - (5) ***Additional individualized testing results and conclusions (i.e., any intelligence testing beyond the Beta) shall be memorialized in DOCInfo, by utilizing PCRA format to report a summary of the raw data, relevant subscale scores, and conclusions regarding the differential diagnosis process associated with ID. Once this psychological report is signed off by an LP, it shall be uploaded into the electronic medical record.***

- (6) ***A custom report is available within the electronic medical record to track the IQ categories off all individuals at every State Correctional Institution (SCI). The purpose of this custom report is to assist local psychology departments with ensuring that all individuals are assigned to the appropriate IQ category as well as to ensure adherence to the six-month rule out process timeline.***
- d. ***Storage of Raw Testing Data (other than PAI) generated by Psychology Staff***
  - (1) ***Psychology staff shall store and dispose of written, electronic, and other records in a manner which insures their confidentiality.***
  - (2) ***Following the completion of the administration, scoring, and interpretation of any psychological tests, psychology staff should upload raw testing data into the Psychology Office's FileShare. This process can be accomplished by completing the following steps:***
    - (a) ***psychology staff shall scan raw data into a computer and save the raw data as a PDF to a retrievable area on the computer. The PDF shall be saved by the individual's inmate number, as it appears in DOCInfo (e.g., AB1234); and***
    - (b) ***once the raw data has been scanned and saved as above, the psychology staff member should access the Psychology Office's Statewide Psychological Testing Materials and Raw Data FileShare page (i.e., access to this area is restricted to psychology staff members only). Once on this page, the psychology staff should select the appropriate location (e.g., Beta, Vineland, WAIS, MMPI-2, Other, etc.) for the scanned and saved raw data to be completely uploaded into the FileShare site.***
- e. ***Once raw data are confirmed to be successfully scanned, saved, and uploaded into the FileShare site, the psychology staff member should dispose of the physical raw data in a manner which insures their confidentiality, at the direction of their clinical supervisor.***
- f. **More Comprehensive Assessments**
  - (1) **Mental Illness: An *individual* 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 *individual* has an SMI. This **IRP** will accompany the *individual* to the receiving facility. The *individual* shall be offered an opportunity to attend this meeting and the **IRP** will include goals in the *individual's* own words, the PRT's unique plan for the *individual* addressing**

his/her goals including sentinel behaviors (e.g., self-injurious behavior [SIB] and interventions utilized to achieve goals). **Individuals who** are not identified immediately at reception, but demonstrate evidence of mental illness, will be referred to psychiatry **by Psychology via the DC-560, Mental Health Contact Note. Upon receiving such** non-emergent referrals **from psychology staff, Psychiatry shall see the referred patient** within 14 days of the referral.

- (2) Other cases: Assessment procedures **may** be modified for juveniles adjudicated as adults, for capital cases, or for boot camp cases **based on the needs of the individual and clinical discretion of the psychology staff member.**

## 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: **(a)** group and individual therapy, as well as supervision and training in counseling and treatment for other staff members who need or request it; **(b)** serve as a resource and consultant for administrative, custodial, and other staff; **(c)** participate in the development of individualized treatment programs; and **(d)** 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 **individual** from a mental health facility. The psychology staff are responsible for advising the Regional Licensed Psychology Manager (RLPM) and the Central Office **Director** 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 provide follow-up treatment and monitor every mental health case returned to the facility from one of the Mental Health Units (MHU), SCI Waymart Forensic Treatment Center (FTC), or a Department of Human Services facility.<sup>2</sup>
2. Designated psychology staff members in the facility shall function as Mental Health Coordinators (MHC), coordinating treatment services for particular **individuals**, arranging mental health commitments, tracking 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 **typically** make referrals to the psychology department for the following reasons:

- (1) consideration for outside clearance;

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<sup>2</sup> 5-ACI-6A-28

<sup>3</sup> 5-ACI-6A-28

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- (2) difficulty adjusting to program and/or facility life;
- (3) frequent or serious disciplinary infractions;
- (4) offer of an in-person, out-of-cell assessment, of every active mental health roster **individual** involved in the disciplinary process prior to appearing before the decision maker;
- (5) potential mental health commitments;
- (6) guilty but mentally ill (GBMI) commitments;
- (7) parole evaluations in PCRA format for active mental health roster **individuals** (C and D Roster) or those convicted of violent offenses; and/or
- (8) psychosocial evaluations for use by local and Central Office **Prison Rape Elimination Act (PREA) Accommodation Committee (PAC)**.

b. Procedures

The counselor or other staff member shall refer cases to the psychology department for comprehensive evaluation and treatment on the **DC-97, Mental Health Referral Form**. Ideally, such referrals shall be discussed **by the psychology staff** 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 receive the referral, they 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 request, the information available in the record, and the **skill level of the** psychology staff. Additional **objective** testing **may** be necessary. The psychology staff performing the evaluation shall select the instruments used (**i.e., under the supervision of their clinical supervisor**), except where policy may specify **the** instruments to be used. The evaluation will be completed within **one week (i.e., five working 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 **signed DC-108** and the **signed Informed Consent for Psychology Services**;
- (2) direct observations of behavior;

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<sup>4</sup> 5-ACI-6A-33

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- (3) collection and review of additional data from individual interviews and tests assessing personality, intelligence, 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 **individuals** whose psychiatric needs exceed the treatment capability of the **current** 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-A)**.
- (2) The psychologist shall employ appropriate interview procedures and test instruments, which may include objective measures (e.g., Minnesota Multiphasic Personality Inventory [MMPI-2], PAI, and PCRA), **and** mental status exam to provide the required information. When possible, these evaluations shall be performed by a 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 an LP. The examiner and/or the reviewer's PA license number and signature shall be affixed to the report.

(a) Commutation

When possible, commutation evaluations shall be performed by an LP. If any commutation reports are prepared by other than an LP, the reports must be reviewed and signed by an LP, preferably the 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-B)** 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 **completion** of the **PCRA and Psychological Evaluation for Parole (Attachment 1-C)**. The PCRA is a list of risk factors that research suggests are related to re-offending. Specific directions for **completion** of the PCRA and format for the PCRA are presented in **Psychological Evaluation and Clinical Risk Assessment (Attachment 1-D)**.

(d) Evaluations for Mental Health Facility Placement

The psychologist may be requested to perform an evaluation on an **individual** 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 **individual** 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/**Assessment of Individuals** Confined in a Security Level 5 (SL5) Unit

- i. **Unless** psychology staff **believe more frequent visits/attention is needed, a psychology staff member** shall visit **these units at least once per day, Monday thru Friday (i.e., including Saturday and Sunday, if the site has weekend Psychology coverage), to conduct screening rounds (i.e., these visits are not intended to be clinical encounters) to ensure that each individual has access to mental health services.**<sup>5</sup> All psychology staff entering the unit shall **announce their presence upon entering the unit and shall sign** in/out on the **DC-702, SL5 Unit Log Book**.
- ii. Psychology and/or nursing staff will assess every inmate placed in an SL5 Unit for suicide potential and review the **DC-510, Suicide Risk Indicators Checklist (Attachment 1-E)**. These procedures are outlined in **Section 2** of this procedures manual. (see Bulletin #1)
- iii. All assessments and **documentation of individuals confined to SL5 Units** shall address suitability for continued placement and assess **for**

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<sup>5</sup> 5-ACI-4A-12, 5-ACI-4B-12, 5-ACI-4B-28

mental **and behavioral** deterioration or lack thereof **in an out of cell, confidential, and private setting, unless security contraindications exist**. 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 **individuals** on the C Roster out-of-cell **setting** 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 **individuals** in Administrative Custody (AC)/Disciplinary Custody (DC) status who may be released.
- v. **At a minimum**, psychology staff shall personally interview, assess, and **document progress notes** utilizing the **full DC-560** to be filed in the medical record for all A and B Roster status **individuals** monthly, **or more frequently, if clinically indicated for those individuals housed in Restricted Housing Units (RHUs)**. 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 **individuals on AC/DC** status who may be released. **If confinement continues beyond 30 days upon placement in Restrictive Housing, individuals on the inactive Mental Health (MH)/Intellectual Disability (ID) Roster (i.e., A and B), shall also be assessed at least every 30 days (i.e., with a full DC-560) and more frequently if clinically indicated. Additionally, once every 90 days (i.e., if continuously housed in Restrictive Housing or Special Management Housing) and more frequently if clinically indicated, individuals on the inactive MH/ID Roster (i.e., A and B) shall receive a mental health assessment (i.e., a full DC-560 including the memorialization/review of the embedded Suicide Risk Assessment [SRA]). This mental health assessment shall be offered to be completed in an out-of-cell setting (i.e., unless behavioral compliance contraindicates an out-of-cell contact), to ensure confidentiality. The purpose of these mental health assessments is to determine, with reasonable assurances, whether the individual poses significant risk to themselves or others and to determine whether Restrictive Housing or Special Management Housing placement is contraindicated.**<sup>6</sup>
- vi. **At a minimum**, psychology staff shall personally interview, assess, and **document progress notes** utilizing the **full DC-560** to be filed in the medical record for every C Roster **individual** monthly, **or more frequently, if clinically indicated, for those individuals housed in RHUs**. A brief ICAR entry indicating the contact occurred will also be made. Psychology staff shall make recommendations to the PRC

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<sup>6</sup> 5-ACI-4B-10, 5-ACI-4A-10

regarding **individuals on AC/DC status** who may be released. C Roster **individuals** shall be offered out-of-cell contacts with psychology on the unit at least **monthly**. The refusal and/or acceptance of these offers shall be documented **in the DC-560** in the medical record. These out-of-cell contacts are contingent on behavioral compliance from the **individual**. 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 **individual** shall be seen at the next available visit if **his/her** behavior permits. **If confinement continues beyond 30 days upon placement in Restrictive Housing or Special Management Housing, psychology staff shall complete a mental health assessment at least every 30 days and more frequently if clinically indicated. This mental health assessment will be documented with a full DC-560 and memorialization/review of the embedded SRA. This mental health assessment shall be offered to be completed in an out-of-cell setting (i.e., unless behavioral compliance contraindicates an out-of-cell contact), to ensure confidentiality. The purpose of these mental health assessments is to determine, with reasonable assurances, whether the individual poses significant risk to themselves or others and to determine whether Restrictive Housing or Special Management Housing placement is contraindicated.**<sup>7</sup>

- vii. **At a minimum, psychology staff shall personally interview, assess, and document progress notes utilizing the full DC-560 to be filed in the medical record for every D Roster individual at least once every 14 days, or more frequently, if clinically indicated, for those individuals housed in Special Management settings. A brief ICAR entry indicating the contact occurred will also be made. Psychology staff shall make recommendations to the PRC regarding individuals on AC/DC status who may be released. D Roster individuals shall be offered out-of-cell contacts with psychology on the unit at least weekly, in accordance with the offering of the minimum structured out-of-cell time for special management settings. The refusal and/or acceptance of these offers shall be documented on the DC-560 in the medical record. These out-of-cell contacts are contingent on behavioral compliance from the individual. If behavior is demonstrated that would contraindicate out-of-cell contact, this shall be documented in the DC-17X for SL5 inmates, ICAR, and the DC-560. The individual shall be seen at the next available visit if his/her behavior permits. If confinement continues beyond 30 days upon placement in Special Management Housing, psychology staff shall complete a mental health assessment at least every 30 days and**

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<sup>7</sup> 5-ACI-4B-10, 5-ACI-4A-10



**more frequently if clinically indicated. This mental health assessment will be documented with a full DC-560 and memorialization/review of the embedded SRA. This mental health assessment shall be offered to be completed in an out-of-cell setting (i.e., unless behavioral compliance contraindicates an out-of-cell contact), to ensure confidentiality. The purpose of these mental health assessments is to determine, with reasonable assurances, whether the individual poses significant risk to themselves or others and to determine whether Special Management Housing placement is contraindicated.**<sup>8</sup>

- viii. **Minimum contact requirements for psychology staff in specific units and roster codes is outlined in Section 2 of this procedures manual.**
- ix. Psychology staff shall assess an **individual** 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 **individual**. These assessments shall be documented as brief **ICAR** entries with a **full DC-560** filed in the medical record. SRTU and BMU approved **individuals** 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.
- x. An **individual** continuously confined in an **RHU, Security Threat Group Management Unit (STGMU), Special Management Unit (SMU), or Positive Outcome Restructuring Through Assessments and Learning (PORTAL)** for a period of one year shall be given, at a minimum, an annual psychological addressing the suitability of continued confinement in the unit, regardless of current MH/ID Roster status. It is the responsibility of the psychology staff to see that such an evaluation is conducted. **At a minimum, these evaluations shall include memorialization/review of the SRA, a summary of the individual's adjustment over the prior year of living in the unit, current barriers that prevent transfer to a less restrictive environment (e.g., continued assaultive misconducts), and efforts that have been or will be undertaken to overcome these barriers.** These **evaluations** shall be documented with a PCRA evaluation filed in the **electronic** medical record. If the **individual** refuses to **participate in the** assessment, procedures in accordance with Department policy **13.1.1, "Management & Administration of Health Care,"** shall be followed.

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<sup>8</sup> 5-ACI-4B-10, 5-ACI-4A-10

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- x. Psychology staff shall make recommendations to the PRC regarding **individuals on** long-term AC/DC status who may be released or possibly transferred to an SRTU, BMU, SMU, STGMU, or other specialized program.
- xii. Unless a specific need exists that the **individual** must be removed from the unit **for the psychological evaluation**, the **individual** shall be visited **and interviewed** 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.
- xiii. **Each week** the LPM/MHC will provide the Commissioned Officer-in-Charge of the unit weekly with a listing of all **individuals** 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 **with** and decision-making processes **about individuals on their unit**. These postings should stay in the secured control bubble. **No indicators of MH/ID status should be posted on cell doors or elsewhere in sight of those individuals confined to the unit.**
- xiv. The Unit Manager/Officer-in-Charge is responsible for coordinating visit/interview dates and times to ensure that security is provided during meetings, **if deemed necessary**, between **individuals** and psychology/psychiatric staff. Any requests by mental health staff to interview an **individual** out-of-cell shall be accommodated by security staff **when** possible, as they are to have unrestricted full **and confidential** access to **these individuals**. 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 **encouraged** to interview the same **individual** together. **This procedure also applies to Psychiatric Observation Cells (POCs), Diversionary Treatment Units (DTUs), SRTUs, and BMUs.**
- xv. **Should the Facility Manager or other administrative Department of Corrections (DOC) staff desire a custom report to be provided from the electronic medical record, they may request the report from the LPM/designee from the psychology department.**

- (g) Psychological Evaluation of *Individuals* Housed in *Special Management Housing*<sup>9</sup>

***Special Management Housing includes DTUs, SRTUs, BMUs, and out-of-cell treatment options. Descriptions of these alternatives that may be available to safely manage the threat posed by an individual, as well as the relationship between the threat the individual poses and the individual's actions, are included in the following policies.***<sup>10</sup>

- 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 an LPM or LP, if available, and recommendations made for treatment or referral; 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 **the** 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 **signed DC-108**. This report will be utilized by Central Office **PAC** to make informed recommendations. Further information on the Central Office **PAC** can be found in Department policy **DC-ADM 008, "PREA."**

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

This comprehensive evaluation will specifically review and address:

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<sup>9</sup> 5-ACI-4B-01

<sup>10</sup> 5-ACI-4B-01

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- 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 **that** suggests comorbid conditions not previously identified, appropriate referrals to psychiatry should be made;
  - ii. institutional adjustment, including a review of sexual behavior in prison (e.g., misconducts for sexual behavior, **incidents of being victimized, etc.**), current relations with **individual** 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 **psychological testing (e.g., the PAI) as determined appropriate and necessary to better understand the individual.**
- (3) The LPM shall ensure that a psychology staff member assesses each newly received **individual** transferred from another correctional or mental health system (*i.e., intersystem transfers including, but not limited to* county prison, the Federal Bureau of Prisons, parole supervision, or a State Hospital). The assessment shall be completed **immediately upon the individual's admission to the facility reception. If psychology staff are not available on-site upon the individual's admission to the facility, the individual shall be seen on the next business day that psychology staff are available on-site, but no later than 72 hours after reception. Following this initial encounter, for intersystem transfers received in DCCs, Psychology staff shall meet individually with all (i.e., MH/ID A, B, C, and D Rosters) intersystem transfers once every 14 days for the first month and then at least monthly thereafter while the individual remains in the DCC. For all other intersystem transfers, Psychology staff shall see these individually once every 14 days**

**for the first month and according to their MH/ID Roster, thereafter. These mental health assessments shall include, but are not limited to:**<sup>11</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, **which shall include completion of an SRA**;
- (i) assessment of violence potential and person-specific potential circumstances that increase violence potential;
- (j) assessment of drug and alcohol **use and any substance use disorder treatment**;
- (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) completing the **DC-560A, Initial Reception Mental Health Questionnaire as well as the embedded SRA. Psychology should refrain from making non-emergent referrals to Psychiatry off of the DC-560A for all intersystem transfers. Nursing staff are responsible for making these referrals to Psychiatry, as needed.**

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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 **generated and stored in DOCInfo. Additionally, an electronic copy shall be uploaded into the electronic medical record as soon as reasonably possible, but no later than 72 hours following signoff by an LP.** A notation of the fact that an evaluation was performed, the purpose, and date shall be entered in the **ICAR**. 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.

e. Psychology Response to PREA Events

- (1) Psychology staff are responsible for interviewing all reported **inmate** 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. **All PREA contacts will be offered to occur in a private and confidential setting. Contacts related to PREA incidents will not occur cell side or in a manner that is not private and confidential.**
- (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 **individual'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 **offer to have the individual sign an Informed Consent for Psychology Services, as per the procedures outlined in Section 2 of this procedures manual.**
- (4) The purpose of the interview is to evaluate and assess the **individual's** current level of cognitive, mental, and emotional functioning as well as to determine the **individual's overall** 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 **shall be** provided. **It is critical that it be clear to all that** this interview and the report are neither conducted for the purposes of an investigation nor for the purpose of documenting and illuminating the **individual'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 **at least** monthly for at least 90 days and may occur more frequently and last longer due to clinical judgment and **individual's** roster status.

## **C. Treatment**

### **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 **individual** need and reflected on **individual** IRPs. The psychology staff member is to use **evidence based** therapeutic techniques of his/her choice, unless the Department mandates a particular type of treatment model. However, if **the psychology staff consider utilizing an intervention, in which the evidence supporting its use may not be as strong as established therapeutic programs or the balance of treatment benefits and possible harms may be less favorable, or the intervention may be less applicable to the correctional setting or individuals who are incarcerated**, such plans shall be discussed with their supervisor, RLPM, and the **Director** 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. **An average of four hours of group treatment per week (i.e., per PSA/PSS on the psychology department complement) shall be offered.**

2. **Documentation of Individual and Group Progress Notes**

- a. Each therapeutic contact and the date of the contact shall be recorded in the **ICAR**. **Individual clinical** contacts shall be recorded on the **DC-560** using **either** the Simple Object Access Protocol (SOAP) format (**i.e., for a full DC-560**) **or a qualitative narrative (i.e., for a brief DC-560)** and filed in the psychology section of the **electronic** medical record, **complete with date and time**.
- b. **The treating psychology staff member shall ensure the following when completing clinical documentation in the electronic medical record:**
  - (1) **documentation is to appear in the correct individual's electronic medical record;**
  - (2) **documentation entries shall be accurate, timely (i.e., either completed during or immediately after the individual encounter and no later than the close of business on the day of the encounter), objective, concise, consistent, comprehensible, logical, descriptive, and reflective of thought process. Late entries are appropriate if the electronic medical record was unavailable, the author needs to add important information, and or if the author neglected to write notes on a particular medical record. Late entries shall be labeled Late Entry and the author shall record the time, date of entry, and the time and date of the occurrence within the text of the Late Entry; and**
  - (3) **continuity of care is provided and that information relevant to the safe and orderly operations of the facility is forwarded to unit management team members, as needed.**
- c. **The full DC-560 note should be utilized by psychology staff to document clinically significant mental health contacts that occur in a private and confidential setting, conducive to appropriately assessing all relevant areas of the DC-560. A full note may still be utilized if the clinical contact was unable to occur in a private or confidential setting due to safety, security, or other operational concerns.**
- d. **Completion of the full DC-560 may include, but is not limited to an assessment of an individual's level of cognitive abilities, appearance, emotional state, and behavioral interactions. It involves questions, observations, objective findings, impressions and clinical judgment, and commonly includes observations of appearance, level of consciousness, speech and language, emotions, thoughts, perceptual alterations, orientation, dangerousness to self and others, memory, abstract thinking, intellectual ability, judgment, and insight.**
- e. **A full DC-560 note shall include specific references to the individual's observable and measurable progress on goals as identified on their IRP, to reflect that care is measurement based. For example, the note for an individual**



**whose recovery goal is to “reduce depressive symptoms” shall include language specific to the progress or lack of progress made in reducing depressive symptoms.**

- f. Due to their nature, certain encounters may be documented utilizing the brief DC-560 note. This format option should be utilized to document casual contacts, which may occur cell-side (i.e., those that do NOT occur in a private or confidential setting), but do not include a full mental status examination completed by the psychology staff member. Additionally, a brief DC-560 may be completed to memorialize a private or confidential contact that is NOT clinically significant. Other examples of when the brief DC-560 note may be utilized include, but are not limited to, documenting an individual NO SHOW for an appointment, NO SHOW for a PRT, contact made during PRC/PRT, D Roster transfer conference call documentation, or contacts that are not face-to-face with the individual (e.g., with the individual’s family member, reentry related, etc.).**
- g. A brief DC-560 will NOT count as the individual’s minimum mental health progress note contact, if the individual is on the active MH/ID Roster. The required minimum mental health progress note MUST be a FULL note.**
- h. The utilization and selection of when a brief note or full note is completed should be monitored regularly by the site LPM and the RLPM during quarterly audits.**
- i. Given that psychology staff are regularly expected to facilitate clinical groups (i.e., related to the individual’s recovery plan in general population [GP], Residential Treatment Unit [RTU], DTU, RHU, BMU, SRTU, Intermediate Care Unit [ICU], Intermediate Treatment Unit [ITU], FTC, etc.), clinical documentation of group contacts is required on a monthly summarizing basis. A DC-472M, Psychology Group Note shall be completed each month to summarize an individual’s progress in group(s) attended as outlined by the individual’s IRP. For example, if an individual attended three of the Self-Esteem groups conducted by a psychology staff member during a month, only one DC-472M needs to be completed at the end of the month to summarize that individual’s progress in that group.**
- j. Within the DC-472M, the psychology staff member shall identify the units and or levels of care in which the individual attended groups facilitated by that psychology staff member, the various individualized goals that were addressed in group(s) for that individual, the types of groups attended for the month, the number of groups offered and attended for the month, the level of participation in group(s) based on a Likert scale, and provide a brief summarizing progress note.**
- k. A DC-472M does not count toward a C or D Roster individual’s minimum mental health contact (i.e., mandatory minimum mental health contacts may not occur**

*in a group setting).*

- l. The DC-472M is NOT to be utilized to memorialize Sex Offender Treatment group progress.*
- m. If an individual is scheduled to attend group(s) offered throughout the month but attends zero groups for the month, a DC-472M is not required to be completed. If the DC-472M is being utilized to summarize progress in more than one type of group facilitated by the same psychology staff member, the psychology staff member must provide summarizing commentary about each group within a single DC-472M (e.g., if an individual attended two Self-Esteem groups and two Depression groups, only one DC-472M is required, but commentary must specifically address progress within both groups for the month).*
- n. If an individual attends several groups facilitated by a psychology staff member and several other groups facilitated by another psychology staff member, a separate DC-472M will need to be completed by each psychology staff member (i.e., each staff member must complete a separate DC-472M to memorialize progress in the group that they facilitated).*

### 3. Monthly Reports on Treatment

*All clinical documentation related to the delivery of Psychological services is memorialized in the electronic medical record. Consequently, custom reports have been generated and are available for use by institutional administrators use, by requesting copies of these reports from the site LPM/designee. A listing of available custom reports and basic descriptions of their contents are available on the Psychology Office homepage on the Intranet. However, if an SCI administrator determines the need for a new custom report that is currently unavailable, a specific request can be made to the respective RLPM, Administrative Officer 5, and Director of the Psychology Office, for the feasibility of the development of this report. Additionally, the site LPM/designee may utilize existing productivity reports (i.e., custom reports) to monitor the quantity, quality, and timeliness of clinical documentation and service provision. The LPM/designee may generate reports from the electronic medical record at the request of Facility Managers for their administrative use, in accordance with Department policy 13.1.1, Section 10.*

- D. Clinical Supervision of Psychological Services Associate (PSA), Psychological Services Specialist (PSS), and Forensic Psychological Services Associate (FPSA) who are not licensed as Psychologists by the Commonwealth of Pennsylvania, but who work within the Pennsylvania Department of Corrections**

*Each psychology staff member (i.e., PSA/PSS/FPSA) will engage in the delivery of mental health services, both individual and group therapy, commensurate with their level of skill and training. Clinical supervision of psychological services is an essential component of quality mental health care. In such clinical supervisory*

**relationships, LPs shall establish a timely and specific process for providing feedback to supervisees. Information regarding the process is provided to the supervisee at the beginning of supervision. LPs evaluate supervisees on the basis of their actual performance on relevant and established minimum standards and requirements, as outlined below, to ensure competent professional, ethical, and responsible psychological care for incarcerated individuals with mental health concerns. These guidelines include the following listed below.**

1. **The clinical supervisor shall ensure that the employee possesses skills commensurate with the work assigned.**
  - a. **Although this must include an ongoing assessment of the employee's skills after hire, clinical supervisors (i.e., DOC LPMs/LPs) shall participate in interviews for PSA/PSS/FPSA candidates. For SCIs that do not currently have a DOC LPM, the RLPM should participate in interviews for PSA/PSS/FPSA/LP candidates. Participation in the interview by the clinical supervisor may occur via teleconference or videoconference. The DOC LPM/LP's input into the selection of their future supervisee should include strong consideration of the candidate's knowledge, skills, and credentials.**
  - b. **The clinical supervisor shall also either formally complete the supervisee's annual employee performance review (i.e., for LPMs) or provide input into the supervisee's annual employee performance review (i.e., RLPMs or contract LPMs).**
  - c. **Any clinical and professional issues requiring attention will be addressed on an individual basis as per the discretion of the clinical supervisor and remedied according to the clinical supervisor's direction.**
2. **The clinical supervisor shall plan all service delivery procedures in consultation with the employee. The supervisor shall acquire knowledge of clients/patients, through face-to-face contact when necessary, sufficient to carry out this duty effectively.**
  - a. **Clinical supervisors shall plan anticipated/recommended work assignments in consultation with the employee. For SCIs that do not currently have an LPM, the Deputy Superintendent for Centralized Services (DSCS) shall consult with the RLPM to achieve this standard. Clinical supervisors shall have face-to-face contact with individuals as needed and as requested.**
  - b. **For sites that have an LPM or contract LPM on-site, this standard shall also be achieved by, but not limited to, the LPM chairing the PRT.**
  - c. **For sites that receive their clinical supervision from an RLPM (i.e., as a temporary placeholder, until an LP can be hired on-site), this standard may also be achieved by (i.e., but not limited to) the RLPM completing quarterly audits, on-site visits, conducting rounds of specialized units during on-site visits,**

*conducting individual and or group interviews during on-site visits with individuals on the active mental health roster, consultative phone calls, as needed, and participating in PRT during on-site visits.*

3. *The supervisor shall establish and maintain a level of supervisory contact consistent with professional standards. These standards require regular face-to-face consultation with the employee, either individually or in a group. In particular, the supervisor shall acquaint the employee with the Code of Ethics found in § 41.61 (relating to Code of Ethics) and shall, under that section, be accountable for ethical violations by the employee.*
  - a. *For institutions with an LPM/contract LPM on-site, at a minimum, the LPM will host a group monthly clinical supervision meeting for all department psychology staff. These supervisory sessions will be documented by the LPM with a Monthly Clinical Skills Training/Supervision for Psychology Staff (Attachment 1-F). This monthly group clinical supervision meeting may occur in combination (i.e., before or after) with the regularly scheduled clinical skills training, at the discretion of the clinical supervisor. Annually, the LPM shall distribute and review with staff the Code of Ethics found in § 41.61 (relating to Code of Ethics).*
  - b. *For institutions with an LPM/contract LPM on-site, at a minimum, the LPM will host an individual clinical supervision meeting with each department psychology staff member, on a monthly basis. This individual clinical supervision will be documented on the Individual Clinical Supervision Workplan (Attachment 1-G).*
  - c. *For institutions without an LPM, the RLPM will, at a minimum, provide regular group monthly clinical supervision with the psychology staff, via videoconference, if available, but teleconference at a minimum. During on-site visits, at a minimum, the RLPM may participate in PRT meetings, rounds with PSA/PSS staff, be available for face-to-face consultations with the employee, as needed, conduct regular clinical chart reviews on a quarterly and annual basis, and generate summarizing quarterly and annual reports regarding the outcomes of those clinical chart reviews, as well as any plans of action (POAs) required as a result of this supervisory oversight. Group supervisory sessions will be documented by the RLPM using the Monthly Clinical Skills Training/Supervision for Psychology Staff. Annually, the RLPM shall distribute and review with staff the Code of Ethics found in § 41.61 (relating to Code of Ethics). These standards shall apply to on-site (i.e., those SCIs with LPMs) clinical supervisors, as well.*
4. *The supervisor shall be available for emergency consultation and intervention.*
  - a. *For institutions with an on-site LPM/contract LPM, all psychology staff will be informed of how and when to contact their LPM for emergency consultation and*

*intervention.*

- b. *For institutions without an LPM, all psychology staff will be informed of how and when to contact their respective RLPM for emergency consultation and intervention.*
5. *The supervisor shall maintain an ongoing record detailing the activities in which the employee is engaged, the level of competence in each, and summarizing outcomes of relevant procedures.*
  - a. *The clinical supervisor will complete (i.e., LPMs) or provide feedback (i.e., contract LPMs and RLPMs) on the standardized performance standards associated with the annual Employee Performance Review. Additionally, the clinical supervisor will maintain an electronic clinical supervisory file for each employee under his/her clinical supervision, which, at a minimum, fulfills the above.*
  - b. *For sites that receive their clinical supervision from an RLPM (i.e., as a temporary placeholder, until an LP can be hired on-site), this standard shall be achieved by providing feedback on the standardized performance standards associated with the annual Employee Performance Review as well as the maintenance of an electronic clinical supervisory file for each employee under their clinical supervision which, at a minimum, fulfills the above.*
  - c. *The clinical supervisory file shall include at least one monthly entry on the Individual Clinical Supervision Workplan for each employee receiving clinical supervision from an on-site LPM. This form will be utilized to detail the main activities in which each employee is engaged including individual contacts, group therapy and facilitation, documentation, report writing, treatment planning, crisis intervention, professionalism and ethics, responsiveness to supervision, other (e.g., awareness of multicultural and diversity issues), group supervision, and SRA. The clinical supervisor will assess the level of competence in each of the main content areas using the following descriptors, as clinically appropriate: 1-Unsatisfactory; 2-Satisfactory; 3-Outstanding; N/A-Not Applicable.*
  - d. *A rating of “unsatisfactory” generally reflects that the supervisee’s clinical skills appear to require significant improvement or appear below the level expected for experience and position. These ratings require the supervisee and clinical supervisor to develop a plan to improve the relevant clinical skills and other steps deemed necessary by the clinical supervisor. A rating of “satisfactory” generally reflects that clinical skills appear satisfactory, but require additional attention and improvement. A rating of “outstanding” generally reflects that clinical skills appear at or above a level expected for the supervisee’s experience and position. A rating of “not applicable” shall be utilized by the clinical supervisor when there is insufficient data, records, or observations to offer a rating for the rating period.*

- e. **The clinical supervisor shall provide narrative commentary to substantiate each competency rating. Additionally, each month, the clinical supervisor shall memorialize all monthly scores on the above content areas within the Summary of Supervision chart that is located at the bottom of each employee's individual clinical supervision form. These electronic forms will be retained within the electronic clinical supervisory file that shall be maintained by the clinical supervisor. Each form will be signed off (i.e., as evidenced by electronic typed name) by the clinical supervisor and an offering to sign off (i.e., as evidenced by electronic typed name) by the supervisee.**
  - f. **Competency in SRA is tracked within each employee's individual clinical supervision workplan. Competency is assessed by the clinical supervisor based on three main domains including:**
    - (1) **the timelines of when SRAs are completed (i.e., as defined in Section 2 of this procedures manual);**
    - (2) **the thoroughness of the content of the assessment; and**
    - (3) **the planned intervention taken as a result of the entire SRA.**
  - g. **RLPMs will review individual clinical supervision workplans on a quarterly basis during quarterly audits.**
6. **The supervisor shall ensure that the employee signs all reports, records, and other communications prepared by the employee for distribution or maintenance within the employment setting. Written communications prepared by the employee for distribution outside the employment setting shall be signed by the employee and countersigned by the clinical supervisor.**

**NOTE: This shall be achieved by the clinical supervisor co-signing all psychological reports and all DC-551s, Continuity of Care and Transfer Individual Treatment Plan.**

7. **The supervisor shall ensure that the employee's supervised status is made known to clients/patients and that the employee's title clearly indicates this status.**

**NOTE: This standard shall be achieved by the PSA/PSS utilizing the Informed Consent for Psychological Services for all individuals on the active mental health roster and fulfilling this disclosure appropriately, as per the individual's supervised status.**

8. **The supervisor shall inform clients/patients of the employee about the possibility of periodic meetings with the supervisor at their or the clinical supervisor's request.**

**NOTE: This standard shall be achieved by the PSA/PSS utilizing the Informed Consent for Psychological Services for all individuals on the active mental health roster.**

#### **E. 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-H)**.

#### **F. Orientation, Onboarding, Training, and Consultation**

##### **1. Orientation**

- a. ***The goal of the Psychology Office Orientation process is to introduce new psychology staff members to the mission and culture of the Pennsylvania DOC, the delivery of mental health care within this setting (i.e., including roles and responsibilities of LPMs/PSAs/PSSs), professional peers available for clinical consultative purposes, and to prepare the new staff member for internal, local, and specialized work and training related to the Psychology Office. Ideally, the Psychology Office Orientation should be completed in the first 60 days of the official start date of the new psychology staff member, though this is not always possible.***
- b. ***Psychology Office Orientation for newly hired psychology staff should be coordinated by the local DSCS/LPM. If a site does NOT have an LPM/LP on-site when a new PSA/PSS/FPSA is hired, the DSCS shall notify the respective RLPM of the new employee within the first 60 days of hire.***
- c. ***For newly hired LPMs, the DSCS/LPM shall coordinate the introduction of two closely situated LPMs (i.e., if possible, one should be from an SCI with a similar mission and mental health population) and coordinate separate site visits (i.e., or the new LPM may visit the tenured LPM's site of the tenured LPMs with the newly hired LPM). The tenured LPMs are expected to provide an overview of specific psychology-related policies, as identified with an asterisk on the Psychology Office Specific Orientation and Onboarding (Attachment 1-I) (i.e., including an overview of the contents and procedures of the Annual Psychology Office Audit, Quarterly Audits and On-site RLPM visits, Central Office Special Needs Psychiatric Review Team [COSNPRT], American Correctional Association [ACA] requirements for psychology staff, the American Psychological Association [APA] Code of Ethics, State Board of Psychology Code of Ethics, Employee Performance Standards, and issues related to Labor Relations) and other general DOC policies which affect psychology staff. The DSCS shall also coordinate an introduction of the newly hired LPM with the respective RLPM and other RLPMs for an augmentation of this process, future consultative purposes, an explanation of the RLPM roles***

*and responsibilities, etc. This introduction should occur during the RLPM's next scheduled site visit, but certainly may occur sooner via teleconference or videoconference.*

- d. *The newly hired LPM shall review identified policies before the tenured LPM visits/meetings so that the newly hired LPM may ask questions and engage in a meaningful discussion about general policy, mental health policy, procedural expectations, etc. Should any questions remain unanswered following Orientation, the newly hired LPM should seek clarification from his/her site's DSCS or RLPM.*
- e. *For newly hired Non-LPM psychology staff, the LPM/DSCS shall coordinate an introduction with the site psychology department as well as with the LPM or RLPM (i.e., until an LPM can be hired on-site), for consultative purposes, procedural and operational questions, clinical supervisory expectations and arrangements, overview of roles and responsibilities of all team members, etc. The LPM/DSCS/psychology staff volunteer should coordinate an opportunity for the newly hired Non-LPM psychology staff member to discuss identified policies as outlined in Psychology Office Specific Orientation and Onboarding (i.e., including an overview of the contents and procedures of the Annual Psychology Office Audit, Quarterly Audits and On-site RLPM visits, COSNPRT, ACA requirements for psychology staff, the APA Code of Ethics, State Board of Psychology Code of Ethics, and issues related to Labor Relations) with the LPM/RLPM/psychology staff volunteer/designee, as needed. For newly hired Non-LPM psychology staff, discussions regarding Employee Performance Standards shall occur with the DSCS/LPM/RLPM, as per DOC policy.*

## 2. Onboarding

- a. *The goal of the Psychology Office Onboarding process is to acclimate the newly hired psychology staff members to DOC electronic user systems, people, processes, and procedures with the intent of preparing the individual to contribute in their new role with the DOC. The goal is to have Onboarding completed in the first 90 days of the official start date of the new psychology staff member.*
- b. *The DSCS/LPM will ensure all areas identified in the Psychology Office Specific Orientation and Onboarding are reviewed with all newly hired psychology staff. For new LPMs, items identified with an asterisk will be reviewed both during tenured LPM visits during Orientation and with local site designee/DSCS during Onboarding (i.e., including an overview of the contents and procedures of the Annual Psychology Office Audit, Quarterly Audits and On-site RLPM visits, COSNPRT, ACA requirements for psychology staff, Employee Performance Standards, the APA Code of Ethics, State Board of Psychology Code of Ethics, and issues related to Labor Relations). For Non-LPM psychology staff hires, all policies listed in Psychology Office Specific Orientation and Onboarding will be reviewed with LPM/DSCS/designee. Should any questions remain unanswered*



*following this aspect of Onboarding, the newly hired LPM should seek clarification from their site's DSCS and/or RLPM, depending on the context of the inquiry.*

- c. *The newly hired Non-LPM psychology staff hires shall review all identified items before the arranged meeting with the LPM/DSCS/designee so that the newly hired Non-LPM psychology staff member may ask questions and engage in a meaningful discussion about general policy, mental health policy, procedural expectations, etc. Should any questions remain unanswered following Onboarding, the newly hired Non-LPM psychology staff member should seek clarification from their site's LPM, DSCS, and RLPM, depending on the context of the inquiry.*
- d. *For all newly hired psychology staff members, the site MHC/PSS/designee should also provide an overview of the identified electronic user systems as outlined in Psychology Office Specific Orientation and Onboarding, as part of the Onboarding process.*
- e. *The completed Psychology Office Specific Orientation and Onboarding shall be filed in the new psychology staff member's employee personnel file.*

### 3. **Training and Consultation**

- a. 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 DSCS department head meeting.
- b. 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.
- c. ***Each staff, inclusive of correctional staff, assigned to a multidisciplinary services team (i.e., PRT) are trained to respond to mental health related crises. This training is conducted at least annually and is established by the Mental Health Authority in cooperation with the facility or program administrator and includes instruction on: recognition of signs and symptoms of mental illness,***

**violent behavior and acute chemical intoxication and withdrawal; methods for accessing health/mental health staff during a mental health crisis; implementation of suicide/self-injurious prevention interventions; procedures for placement of patient in a level of care in accordance with his/her mental health needs. These training requirements will be delivered within the annual Suicide Prevention and Intervention and Mental Health Crisis Training.**<sup>12</sup>

- d. 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, psychology staff will provide consultations pertinent to disciplinary proceedings as per Department policy DC-ADM 801, “Inmate Discipline,” Section 1, assist health staff with individuals who have comorbid medical issues during PRTs and on an as needed basis, and even assist in the decision making for an individual’s placement in specialized programs and housing assignments via vote sheet completion, participating in unit staffings, participating in PRTs, and initiating referrals for specialized housing units.**<sup>13</sup> **Additionally,** psychology staff may consult with the Facility Manager regarding the impact of new programs upon the **incarcerated** 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 **individual** who has been exposed to traumatic events in accordance with Department policy 6.7.2, “**Special Response Teams.**”
- e. **It is essential that psychology staff engage in regular and ongoing consultation and communication with security staff, medical staff, and the individual for the purposes of ensuring cross-discipline observations and concerns are mutually known by unit management team members. For example, the PRT may request through the DSCS/Deputy Superintendent for Facilities Management (DSFM), a representative screening of an individual’s outgoing correspondences and communications (e.g., GTL messages, mail, phone calls, etc.) for the purposes of identifying any safety concerns related to suicide risk or self-harm potential. If needed, security staff will share only information pertinent to the safety screening to the DSCS/DSFM, whom may relay the information to the PRT/designee for appropriate follow-up action. In this regard, the PRT can assist with focusing and concentrating screenings of correspondences of those individuals believed to be at higher risk of suicide, but whom may be falsely denying the existence of this elevated risk. Similarly, psychology staff should ensure to appropriately direct individuals who express non-emergent medical issues to sign up for medical sick call, as well as to communicate directly and immediately with medical staff upon discovering an emergent medical crisis.**

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<sup>12</sup> 5-ACI-6A-28

<sup>13</sup> 5-ACI-6C-07

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- f. Psychology staff members are frequently asked to perform other professional duties in the facility that may not relate to the population **of the facility**.
  - (1) An LP reviews the personnel packages of Correctional Officer Trainee Candidates, and completes the **Psychological Screening Report Form (Attachment 1-J)** in accordance with the instructions found in the **Role of Psychologist in Personnel Selection of Corrections Officer Trainees (Attachment 1-K)**.
  - (2) An LP is required to evaluate a correctional officer who has worked in an 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. “Administration of Security Level 5 Housing Units.”**
  - (3) Psychology staff members may assist other staff members and make referrals in accordance with Department policy **4.1.1, “Human Resources and Labor Relations.”**
  - (4) During facility **drills and** 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. **Additionally, during “lock downs” the following minimum psychological operations should continue to occur, unless operational and institutional need dictates otherwise, as per the direction of the Facility Manager:**
    - (a) **daily psychology contacts with individuals admitted to POCs;**
    - (b) **screening of initial receptions and parole violators (PVs) into the SCI;**
    - (c) **rounds in Restrictive Housing (i.e., RHU, SMU, STGMU, etc.), Special Management Housing Unit settings (DTU, SRTU, BMU, etc.), and RTUs;**
    - (d) **screening of initial receptions into Restrictive Housing or Special Management settings; and**
    - (e) **crisis intervention contacts, as needed.**
- g. **Annually, all psychology staff (i.e., inclusive of individuals whose primary duty is to provide mental health services to individuals commensurate with their respective levels of education, experience, training, and credentials) shall receive 12 hours of continuing professional education or staff development in**

*clinical skills.*<sup>14</sup>

- (1) ***These 12 hours will be delivered via monthly training meetings facilitated by site LPM/LP. The content of each monthly training meeting is directed by the Central Office Psychology Office. Examples of monthly training topic resources include APA professional guidelines, empirical peer-reviewed journal articles of relevance (e.g., mental health needs of the correctional population; behavior management techniques; mental health issues with the female population; aging/palliative care; trauma-informed care; confidentiality of mental health records; suicide/self-injury prevention; signs and symptoms of mental illness, substance abuse/relapse and neurocognitive disorders/neurodevelopmental disabilities; assessment and diagnosis of mental disorders; crisis intervention; etc.). Selected monthly training resources will be posted on the Psychology Office File Share website, for ease of access.***
- (2) ***If a site does not have an LPM or LP currently, the psychology staff of that department may be required to teleconference in with a site that does have an LPM for their monthly department training/meeting (i.e., this training shall be facilitated by an LPM/LP/RLPM). It is the responsibility of the site without an LPM/LP to arrange for their monthly training with their RLPM or another SCI's psychology department to teleconference with and participate in the monthly meeting/training facilitated by an LPM/LP. The respective RLPM may assist with coordinating these arrangements to ensure compliance with this requirement.***
- (3) ***If a site LPM/LP desires to augment the monthly training resource with a relevant topic of interest, the LPM/LP may select applicable professional literature (i.e., preferably from a peer reviewed empirical journal article that is less than five years old). Prior to augmenting the monthly training with a newly selected resource, the LPM/LP must share the resource with the respective RLPM and receive their approval.***
- (4) ***At this (one-hour minimum) monthly meeting, the LPM/LP is expected to facilitate a discussion of the assigned topic with the psychology department staff. This discussion shall address the central topics of focus and lead to a collaborative clinical skills discussion between psychology staff and the LPM/LP. This meeting may also serve to be the department's monthly group clinical supervision meeting. If a site only has an annuitant LPM (i.e., no other LPMs on-site), it is the responsibility of the annuitant LPM to facilitate the monthly psychology department training.***
- (5) ***If a site has more than one LPM/LP, the monthly training meeting may be co-facilitated. However, this is not a requirement.***

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<sup>14</sup> 5-ACI-6B-13

- (6) ***There are several options of how this training meeting can be facilitated. The first approach is for staff to review/skim the assigned material before the meeting so that the entire hour is dedicated to facilitated discussion of the topic. However, the determination of how this discussion is facilitated and how the assigned material is reviewed shall be the responsibility and discretion of the LPM/LP. If needed, an RLPM may be consulted.***
- (7) ***LPM/LP/MHC at each site will be responsible for maintaining a monthly training sign-in sheet (refer to Department policy 5.1.1, In-Service Training Roster) for each monthly department meeting. This document shall be saved electronically and submitted to the Facility Manager, DSCS, Training Coordinator (i.e., for entry into the Commonwealth’s Learning Solution [LSO], in accordance with Department policy 5.1.1) and respective RLPM on a monthly basis. This document will be stored electronically by the site LPM/LP/MHC on the Psychology Office File Share website under the respective month and year.***
- (8) ***If a psychology staff member is unable to attend a monthly psychology department training, that training time will need to be made up by the psychology staff member by arranging for a documented session with an LPM/LP on the assigned topic material for that month. As above, this may be arranged by the psychology staff member coordinating participation with another site’s monthly training meeting.***

**G. Local Psychology Department Oversight, Quality Improvement, and Quality Assurance Activities**

***Participation in Monthly Site Quality Improvement Meeting (in accordance with Department policy 13.2.1, “Access to Health Care,” Section 16)***

1. ***In an effort for the local psychology department to monitor and improve mental health care and service delivery at the local site level, the site LPM(s)/designee shall participate in the SCI’s monthly multidisciplinary quality improvement meeting. The activities associated with this monitoring includes collecting data, evaluating defined data, identifying data trends, and analysis of data. This should be combined with planning, intervening, and reassessing services with the goal of ensuring more effective access to care, improved quality of care, and better utilization of resources. The content of psychology’s contributions to this internal review shall be appropriately maintained, protected, and comply with legal requirements on confidentiality of records, as per Department policy 13.2.1, Section 16.***
2. ***The specific data points to be presented and discussed by the LPM(s)/designee include, but are not limited to the following:***

- a. *reviewing all suicides, serious suicide attempts, and other serious incidents (e.g., use of force, assaults, restraints/involuntary medications) involving individuals identified with a serious mental illness, from the past month. This can be achieved by the LPM/designee providing an overview of institution specific data contained in the monthly COSNPRT packet, distributed from the Central Office Psychology Office. Additionally, the LPM/designee should provide an update on information discussed at the monthly suicide prevention committee meeting. Finally, the LPM/designee can provide an institution specific overview of the serious incidents (i.e., uses of force, assaults, restraints/involuntary medications) that involved D Roster individuals that occurred over the past month by reviewing relevant Extraordinary Occurrence Reports (EORs) from the institution. To accomplish this, LPM(s)/designee should receive institution specific EORs; and*
- b. *reviewing clinical issues and the implementation of measurable corrective action plans to address and resolve important problems and concerns identified specific to mental health issues, and incorporating findings of internal review activities into the department and site's educational and training activities. This can be achieved by the LPM/designee providing an update on the site's most recent results on the RLPM Quarterly Audit and Annual Audit, including any identified data trends from quarter to quarter (i.e., by reviewing the Quarterly report distributed by the Central Office Psychology Office) or year to year which present problematic findings or noted significant improvements. Furthermore, the LPM/designee shall provide an overview of the progress on the required Plans of Corrective Action developed from those Quarterly LPM audit items that were not substantially compliant and for those annual audit items that were non-compliant.*

#### H. Central Office Oversight, Quality Improvement, Quality Assurance Activities, and Peer Review

##### 1. Central Office Special Needs Psychiatric Review Team (COSNPRT)

- a. This interdisciplinary team *is chaired by the Director of Psychology, the Psychology Office's Administrative Officer 5, and RLPMs. COSNPRT meets monthly and includes, but is not limited to the Executive Deputy Secretary for Institutional Operations (EDSI)/Regional Deputy Secretaries (i.e., including staff assistants), a representative from the Office of Chief Counsel, the Major of Security, Director of the Office of Population Management, Chief Data Analyst from Planning, Research, and Statistics, Chief of Psychiatry, Mental Health/Health Care Advocate, the Corrections Treatment Services Program Administrator, and the Quality Assurance Risk Management Coordinator* 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, *which may include the following:*

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- (1) review of waiting lists for specialized programs requiring referrals (Special **Observation and Assessment** Unit [**SOAU**], ICU, BMU, SRTU, and SMU);
- (2) trends in 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 **individuals** in DTU for greater than 30 days;
- (6) review of suicides, serious attempts, and SIB for the month and year-to-date;
- (7) trending **within** regions considering location, most frequent self-injurers, etc;
- (8) review of cases due to sentinel events, difficult placements, or referral;
- (9) **review of D Roster change process;**
- (10) **review of intelligence testing progress;**
- (11) **review of quarterly RLPM audit results, annual POC audits, quarterly MHU audits, and other relevant oversight processes that require discussion and corrective plans of action;**
- (12) **review of alone reports as they pertain to suicide prevention efforts;**
- (13) distribution of COSNPRT packet to **all DOC psychology staff** members, **COSNPRT members**, Facility Managers, and the contract service provider for psychiatric services; and
- (14) the **Director** of Psychology will elevate issues to the **Deputy Secretary of Administration** that are significant or cannot be resolved.

2. RLPM Oversight

- a. **At a minimum**, RLPMs provide clinical oversight and monitoring of their assigned facilities **through the completion of on-site visits, on-site audits, remote audits, and regular consultation with SCIs**. They **may** review referral packets and monitor trending in operations through **on-site visits, on-site audits, remote audits**, and discussion with appropriate staff **on-site locally and centrally**. **During RLPM on-site visits, the RLPM shall collaborate with the site administrators (i.e., Facility Manager, DSCS, LPM, etc.), if needed, to ensure that space is available either inside the RHU/DTU or external to the unit for treatment staff consultation with**

*individuals confined to the RHU/DTU.*<sup>15</sup> Any issues of significance or those that cannot be resolved are elevated to the **Director of Psychology**.

- b. **RLPMs are also expected to observe PRTs during visits, if the audit schedule permits. Additionally, RLPMs are expected to review convenience celling (i.e., individuals housed alone without a Z-Code) practices during visits in order to assist with ensuring that those individuals who can be double celled safely, are double celled.**
  - c. At least once per quarter, the RLPM will **audit (i.e., either remotely or on-site)** their assigned sites and complete a compliance report. These reports shall be submitted to the Secretary, respective **EDSI/Regional Deputy Secretary, respective LPM/designee, respective Facility Manager and DSCS, the Director of Psychology, Psychology Office Administrative Officer 5, Corrections Treatment Services Program Administrator, and Quality Assurance Risk Management Coordinator within the Psychology 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 **audit, which may be** conducted the same day as a **Quarterly RLPM audit**.
  - d. **The minimum number of RLPM site visits per year is based on the acuity and size of the SCI's overall population, mental health population, and presence of specialized housing units or programs (e.g., RTUs, SRTUs, BMUs, DTUs, etc.). At a minimum, sites may receive either two, three, or four on-site visits per year from the RLPM. However, if in the clinical opinion of the RLPM, additional on-site visits are needed beyond these minimums, this format may allow for that service to be provided.**
  - e. Quarterly reports will be submitted in a narrative format and cover all measurable areas of the **Quarterly RLPM audit. These findings will also be presented quarterly at the Central Office COSNPRT meeting.**
  - f. **RLPMs are responsible for providing site administrators with a verbal summary of findings for each quarterly audit.**
  - g. **This quarterly report generated by the RLPM shall be utilized by the LPM/designee during the site's monthly Quality Improvement meeting, in accordance with Subsection G. above, to report on progress of quarterly audit POAs.**
3. Peer reviews for LPMs shall be completed as specified in Department policy **13.1.1**, and may include the below listed types.

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<sup>15</sup> 5-ACI-4B-04



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- a. Scheduled Peer Review – all LPMs shall have a scheduled peer review performed **annually**. 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 **clinical** care issues identified by health service providers, the Psychology Office, Contracted Health Care Provider staff, or non-medical personnel including facility staff.<sup>16</sup>

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<sup>16</sup> 5-ACI-6D-03



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

**Policy Subject:**

**Access to Mental Health Care Procedures Manual  
Section 2 – Delivery of Mental Health Services**

**Policy Number:**

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The purpose of this Bulletin is to update **Section 2, Subsection L.2.f. (5)(6)**, of Department policy **13.8.1**. Changes are noted in bold and italics. **Section 2, Subsection L.2.f. (5)(6)** shall now read:

- (5) ***Additionally, upon arrival of any reception into Restrictive Housing or Special Management Housing/Intake Unit, the ranking Corrections Officer present in the unit shall immediately notify Nursing staff and Psychology staff (i.e., if available in the institution at the time) of the reception(s) into the L-5 unit so that these staff members may respond immediately to complete the appropriate Health Care Screenings as indicated below.***
- (6) ***If Psychology or Nursing are not immediately available (i.e., within a reasonable amount of time, so as not to disrupt overall operations of the L-5 unit) to respond to the unit to complete the appropriate Health Care Screenings, or operational contraindications exist that preclude Nursing or Psychology staff from completing their screenings with the individual prior to Security staff placing the individual in a permanent L-5 cell, Security staff shall still proceed with completing the paper DC-510. The individual being admitted into the L-5 unit shall not be placed into a permanent L-5 cell until the paper DC-510 is completed by Security staff.***
- (7) ***If the results of Security's completion of the paper DC-510 suggest ongoing concerns about the individual's safety (e.g., risk of suicide) and Psychology and Nursing staff are not immediately available to screen the new reception, Security staff shall take all necessary precautions to ensure the individual's safety and well-being until Psychology or Nursing are able to appropriately screen the reception.***
- (8) ***Once completed by Security staff, the paper DC-510 shall be forwarded to medical records to be uploaded into the electronic health record.***
- (9) ***Institutional Psychology, Nursing, and Security staff shall collaborate together to ensure that the standard screening process for L-5 admissions includes completion of the electronic DC-510 or DC-510A prior to the individual being placed into a permanent L-5 cell, unless operational***

*contraindications exist, as referenced above.*

- (10) ***In addition to the paper DC-510 completed by Security staff, every individual placed into a unit identified as Restrictive Housing or Special Management shall also be assessed with the electronic DC-510 (i.e., Restrictive Housing and Special Management Housing-Mental Health Care Screening) and the electronic DC-510A (i.e., Restrictive Housing and Special Management Housing-Health Care Screening), by Psychology and Nursing staff, respectively.<sup>1</sup> These separate formal Health Care Screenings completed by Psychology and Nursing, shall replace the current practice of completing the “Clinical Staff Evaluation” section of the paper DC-510. Consequently, Psychology and Nursing staff are no longer required to provide a qualitative response within the “Clinical Staff Evaluation” section of the paper DC-510. Instead, the following procedures shall direct the completion of reception into these units, for Psychology and Nursing staff.***
- (a) ***The DC-510A shall be completed immediately by Nursing staff on the days and times when Psychology staff are not present in the institution.***
  - (b) ***Monday through Friday, 0800 to 1600 (i.e., also including other days and times Psychology staff are available in the institution), Psychology staff shall complete the electronic DC-510 on all receptions into the unit, which will include a clinical interview and completion of the embedded Suicide Risk Assessment, at a minimum. When Psychology staff complete the electronic DC-510, Nursing staff shall also complete the DC-510A.***
  - (c) ***When Psychology staff are not available to complete the DC-510 in response to an L-5 reception, Nursing staff shall complete the entire DC-510A, including the mental health portion of the screening.***
  - (d) ***In situations where Psychology does not complete a DC-510 for an admission on the same day the admission occurs, on the next working day, Psychology staff shall review the DC-510A (i.e., completed by Nursing) and the paper DC-510 (i.e., completed by Security) and document Psychology’s review within an electronic DC-510, which shall include the completion of a thorough Suicide Risk Assessment. Psychology staff will also discuss the case with unit staff as soon as possible and if clinically indicated, Psychology staff may also review additional records, gather collateral information, schedule and complete relevant psychological testing, and take any other clinical or administrative actions necessary to identify and treat an individual with Psychological needs.<sup>2</sup>***
  - (e) ***The conclusions of the electronic DC-510 and DC-510A shall be determined by the individual(s) completing the form(s). Referral options include but are not limited to, no mental health referral, routine referral to the appropriate mental health discipline, emergent or routine referrals to medical or dental, or emergent/immediate referral to the appropriate mental health discipline for emergency assessment and treatment. If the results of the screening indicate the individual is at imminent risk for serious self-harm, suicide, exhibits debilitating symptoms of a mental illness or serious mental illness, or requires emergency medical care, the appropriate health care and or mental health care discipline shall be immediately contacted for appropriate assessment and treatment.***
  - (f) ***The clinical interviews conducted by Nursing and Psychology staff to fulfill completion of the DC-510A and DC-510, shall be conducted in private and confidential locations, unless behavioral or security contraindications exist. These clinical interviews shall not be recorded.***

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<sup>1</sup> 5-ACI-4B-28, 5-ACI-4B-10

<sup>2</sup> 5-ACI-4B-10

## Section 2 – Delivery of Mental Health Services

### A. Identifying Mental Health Needs of *Individuals*

Good treatment begins with the appropriate identification of the needs of each *individual*. Thus, early and appropriate identification of needs for mental health services is the foundation for providing appropriate treatment to these individuals.

#### 1. Automated Tracking System

Tracking of an *individual* 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 *individual* 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 *individual*. 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 *individual* 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 have been diagnosed earlier with a Serious Mental Illness (SMI), but may be in remission and/or displaying adequate adjustment to facility life.
- (3) The Inactive MH/ID Roster includes any *individual* 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.

##### b. ***Criterion that requires consideration for placement on the Active MD/ID Roster includes, but is not limited to, the following:***

- (1) ***history of outpatient treatment or inpatient psychiatric hospitalization;***
- (2) ***receiving psychotropic medication – An individual who receives or is prescribed psychotropic medication shall be placed on the Active MH/ID Roster; and***
- (3) ***history of self-injury within the last two years – Recent self-injuries shall trigger review of roster placement.***

- c. The **individual's** status on the MH/ID Roster is communicated to other Department staff by means of the Mental Health Roster in the following manner:
- (1) A Roster – **individual** has no identified psychiatric/ID needs or history of psychiatric treatment;
  - (2) B Roster – **individual** has identified history of psychiatric treatment (other than SMI or ID history), but no current need for psychiatric treatment and does not require follow-up/support from Psychology on a regular basis. **Individual** is placed on Inactive MH/ID Roster;
  - (3) C Roster – **individual** is currently receiving psychological treatment, but may or may not be receiving psychiatric (psychotropic medications) treatment, and is not currently diagnosed with an SMI or functional impairment and does not have an ID or is not Guilty But Mentally Ill (GBMI). An Individual Recovery Plan (IRP) for a newly incarcerated C Roster **individual** shall be developed within 30 days of intake and **reviewed** annually, or more frequently if clinically indicated **to determine whether or not revisions or updates to the plan are required, as memorialized by completion of the DC-563, Psychiatric Review Team Summary.**<sup>1</sup> **A DC-563 is required to memorialize the occurrence of each PRT, but only when an IRP is not completed for that PRT;** and
  - (4) D Roster – **individual** is currently diagnosed with an SMI, ID, credible functional impairment, or is GBMI. The PRT shall generate an IRP for him/her.<sup>2</sup> An IRP for a newly incarcerated **individual** shall be developed within 30 days of intake. **Psychology staff** shall coordinate with the education department to ensure that any **individual diagnosed** with an ID who is 21 years of age or younger receives an Individual Education Plan (IEP).
- d. **The Mental Health Coordinator (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.**
- e. **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 security clearance through the Central Office, Psychology Office.**

## **B. Definition of Serious Mental Illness**

1. **Individuals** determined by the PRT to have a current diagnosis or a recent significant history of any of the DSM5 diagnoses (using International Classification of Diseases [ICD] 10 codes and letter tags):

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<sup>1</sup> 5-ACI-6A-07

<sup>2</sup> 5-ACI-6A-07

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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

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. **Individuals** 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. **Individuals** diagnosed by PRT with ID, a dementia, or other cognitive disorders that result in a significant impairment involving acts of self-harm or other behaviors that have a seriously adverse effect on life or on mental or physical health.
4. Any **individual** sentenced GBMI.

### C. Clinical Guidelines for Functional Impairment

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

1. whether the **individual** 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 **individual** 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 **individual** has demonstrated a pervasive pattern of dysfunctional or disruptive social interactions including withdrawal, bizarre or disruptive behavior.

### D. Intellectual Disability (ID)

**Individuals** scoring 70 or below on the BETA-4 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, health care, 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.



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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

- a. 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.
- b. Information which is not available in the system and must be entered by the mental health staff:
  - (1) ICD code;
  - (2) World Health Organization Disability Assessment Schedule (WHODAS) score; and
  - (3) suicide attempt history – means, dates, and severity of attempts.

4. Reception Officer<sup>3</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 ID. 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 Nursing staff for close observation and further evaluation.

5. Diagnostic and Classification Center (DCC)<sup>4</sup>

- a. ***Psychology staff in the DCC shall be involved in the reception process on day one (i.e., or as soon as operations permit) of an individual's arrival into the DCC for the purposes of completing a DC-560A, Initial Reception Mental Health***

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<sup>3</sup> 5-ACI-6A-33

<sup>4</sup> 5-ACI-6A-28

**Questionnaire. The embedded Suicide Risk Assessment (SRA) shall be completed with this screening for all receptions into the DCC. Psychology staff shall screen every individual received into the DCC for these purposes, according to these guidelines, with the appropriate identification of Suicide Risk and Protective factors into the Sapphire Summary screen.**

- b. Observations or concerns about any *individual* 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 **Section 1** of this procedures manual), in non-**emergent** cases. Under supervision of the Licensed Psychology Manager (LPM), Psychology staff will interview the *individual* as soon as possible after receipt of the referral, but no later than one week.<sup>5</sup> This interview will be documented using a **DC-560, Mental Health Contact Note**. The LPM/*designee* will evaluate the need for immediate psychiatric evaluation and/or Psychiatric Observation Cell (POC) placement. **Psychology staff shall adhere to the requirements outlined in Subsection D.6.b. below as to the steps necessary with making a non-emergent referral to Psychiatry staff. Once the steps outlined in Subsection D.6.b.(1) below have been followed and a non-emergent referral to psychiatry is completed by Psychology staff, if clinically necessary, after adhering to steps outlined in Subsection D.6.b. below, the individual may be scheduled to be seen by the psychiatry provider within two weeks of this referral from Psychology staff or sooner if clinically indicated. In emergent (i.e., those requiring immediate attention) cases, a phone call shall be made immediately to the Psychology Department (or the infirmary if after hours), or the individual shall be escorted to the infirmary area. Psychology staff shall document emergent referrals (i.e., those which may have occurred via telephone) on the DC-560.**<sup>6</sup>
- c. 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, ID placements, or history of drug or alcohol abuse. Every effort shall be made to obtain prior records of hospitalizations, treatment programs, or specialized placements **through medical records staff utilizing the DC-108, Authorization for Release of Information.**
- d. 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.

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<sup>5</sup> 5-ACI-6A-33

<sup>6</sup> 5-ACI-6A-33

6. Permanent Facilities

a. Receptions<sup>7</sup>

Every permanent facility shall **adhere to Department policy 13.2.1, “Access to Health Care,” Section 17 for intrasystem (i.e., State Correctional Institution [SCI] to SCI) transfers. This shall include non-emergent and emergent referrals from nursing to Psychology, as clinically indicated. Additionally, at the time of reception, all intrasystem transfers of C and D Roster individuals shall be referred by nursing to Psychology so that the individual can be seen by PRT within 30 days of arrival into the receiving facility. However, if the individual needs to be seen sooner than this time frame, nursing staff shall make the appropriate emergent or non-emergent referral to Psychology staff.**

b. General Population

Since any **individual** may report or demonstrate mental health issues whether or not they are currently receiving mental health treatment, all staff must be trained and able to recognize signs of potential mental illness, suicidality, or elevated risk of violence. Observations or concerns about any **individual** with such issues shall be relayed to the appropriate treatment staff for evaluation and follow-up using the **DC-97** to Psychology **for non-emergent situations (i.e., those that do not require immediate attention)**. Under supervision of the LPM, Psychology staff will interview the **individual** as soon as possible after receipt of the referral, but no later than one week (**i.e., five working days**).<sup>8</sup> This interview will be documented on a **DC-560**. The **LPM/Psychology staff designee** will evaluate the need for immediate psychiatric evaluation and/or POC placement.

**Prior to making a non-emergent referral to Psychiatry, Psychology staff shall complete the following:**

- (1) **review the current course of psychological and psychiatric treatment within the electronic health record;**
- (2) **review the electronic medical record to determine when the individual’s next regularly scheduled appointment is with Psychiatry;**
- (3) **consider whether the individual should instead be more appropriately referred to the PRT, to be reviewed by the entire multidisciplinary team;**
- (4) **consider consultation with the LPM/clinical supervisor to identify appropriate psychological interventions to implement with the individual;**

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<sup>7</sup> 5-ACI-6A-28, 5-ACI-6A-33

<sup>8</sup> 5-ACI-6A-33

- (5) **deploy psychological interventions (e.g., increase frequency of individual contact, enrollment into an appropriate group while monitoring the individual's response to group therapy, etc.) to ameliorate the presenting non-emergent complaint(s) or problem(s); and**
- (6) **if psychological interventions have failed to resolve the non-emergent complaint(s), a summary of the interventions taken, when they were taken, and the patient's response to the interventions shall be included on the non-emergent referral to Psychiatry, if it is determined that the non-emergent referral is still indicated.**

**Once Psychology staff determine that a non-emergent referral to Psychiatry is warranted, the individual shall be seen daily by Psychology staff until seen by Psychiatry for the referral. The purpose of this enhanced contact requirement is to support and monitor the individual that has not responded sufficiently to psychological intervention. Additionally, these enhanced daily contacts will allow Psychology staff to continue with ongoing interventions and monitoring, to determine whether the non-emergent referral continues to be necessary (i.e., thus, no longer requiring the non-emergent referral to Psychiatry).**

The **individual** shall be scheduled to be seen by the psychiatry provider within two weeks of receipt of this referral from Psychology staff or sooner if clinically indicated. **In emergent (i.e., requiring immediate attention) cases, a phone call shall be made from the staff member witnessing the potential psychological emergency to the Psychology Department (or the Shift Commander, if after hours or if Psychology staff are not available) for the purposes of explaining the details of the situation and receiving direction on next steps, which may include escorting the individual to the infirmary (after hours) and/or remaining with the patient until Psychology is able to conduct a face-to-face interview for SRA purposes. Each site's LPM (i.e., Regional Licensed Psychology Manager [RLPM], if no LPM on site) shall monitor non-emergent referrals to Psychiatry within the electronic health record and address clinical practice issues with supervisees during supervision, as needed.**

## **E. Processing**

Each facility shall provide mental health services needed by an **individual** 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/Certified Registered Nurse Practitioner-Psychiatric Services (PCRNP) shall see the individual who is on the C Roster and currently being prescribed psychotropic medications by psychiatry provider at a minimum of once every 120 days, and all D Roster individuals at a minimum of once**

every 90 days. The psychiatrist/PCRNP is encouraged to see the **individual** more frequently 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 **individual's** IRP. For C Roster patients, the psychiatry provider shall refer to PRT for roster discussion, if and when the psychiatry provider initiates psychotropic medications for an **individual**, or discontinues all psychotropic medications (**individuals** whose psychotropic medications are discontinued shall at least have one scheduled follow up psychiatric appointment within two to four weeks after the discontinuation of psychotropic medications to assess the stability), and/or no longer requires the individual to be followed by the psychiatry provider. For D Roster patients, the team shall follow **D Roster Change Protocol**.

- (2) **The treating psychiatrist/PCRNP shall continue to see individuals on the D Roster out of cell every 30 days and individuals on the MH/ID C Roster out of cell a minimum of every 90 days or more frequently based on their discretion and shall make recommendations to the Program Review Committee (PRC) regarding individuals in Administrative Custody (AC)/Disciplinary Custody (DC) status who may be released.**
  - (3) If an **individual** diagnosed with an SMI is placed in a Diversionary Treatment Unit (DTU), the treating psychiatrist/PCRNP **shall offer to** see the **individual** out of cell once every 30 days.
- b. Psychological Services – Each facility shall provide sufficient psychological staff to provide evaluation, monitoring, and treatment to those **individuals** in need of such services. **The below chart outlines the minimum psychological contacts and treatment planning required for the various levels of care and specialized units operated by the Department of Corrections (DOC). The Psychology staff member has the discretion to see the individual more frequently, if clinically indicated. All psychological contacts will be recorded on a DC-560. The below considers that daily rounds shall occur in Restricted Housing Units (RHUs), Special Management Units (SMUs), DTUs, Secure Residential Treatment Units (SRTUs), Behavioral Management Units (BMUs), and any other units identified as Special Management Housing or Restrictive Housing. Additionally, the below continuum includes that an average of four hours of group treatment per week (i.e., per Psychological Services Associate [PSA]/Psychological Services Supervisor [PSS] on the Psychology department complement) shall be offered to those individuals on the Active MH/ID Roster.**

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<b>Level of Care-Unit</b>	<b>Minimum Individual Contact Frequency</b>	<b>Minimum PRT Frequency</b>
<b>General Population C-Roster</b>	<b>Once per 90 days</b>	<b>Once per 365 days</b>
<b>General Population D-Roster</b>	<b>Once per 60 days</b>	<b>Once per 180 days</b>
<b>Residential Treatment Unit</b>	<b>Once per 30 days</b>	<b>Once per 120 days</b>
<b>Intermediate Care Unit</b>	<b>Once per 14 days</b>	<b>Once per 60 days</b>
<b>Forensic Treatment Center</b>	<b>Once per 7 days</b>	<b>Once per 30 days</b>
<b>Diversionsary Treatment Unit</b>	<b>Once per 14 days</b>	<b>Once per 120 days</b>
<b>Secure Residential Treatment Unit/ Behavioral Management Unit</b>	<b>Once per 14 days</b>	<b>Once per 120 days</b>
<b>Restricted Housing Unit (MH/ID A or B)</b>	<b>Once per 30 days</b>	<b>Not applicable</b>
<b>Restricted Housing Unit (MH/ID C)</b>	<b>Once per 30 days</b>	<b>Once per 180 days</b>
<b>Special Management Unit</b>	<b>Once per 30 days</b>	<b>PRN</b>

- c. Counselors – Each facility shall have available Corrections Counselors trained to work with an **individual** who is in need of mental health services. Counselors working with an **individual** in need of residential mental health services (i.e., Residential Treatment Units [RTUs], SRTUs, 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 an MHC on the Psychology staff and shall make appropriate use of the coordinator to assist an **individual** in receiving each of the mental health services he/she is scheduled to receive.

2. Internal Mental Health Facilities <sup>9</sup>

- a. Inpatient Regional Mental Health Units (MHUs) are available to provide mental health care for an **individual** who needs the service.<sup>10</sup>
- 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 **individuals** to the FTC and MHUs are presented in **Section 4** of this procedures manual.<sup>11</sup>
- c. Procedures for referring an **individual** to the SRTU are contained in **Section 10** of this procedures manual.
- d. Procedures for referring an **individual** to the BMU are contained in **Section 12** of this procedures manual.

<sup>9</sup> 5-ACI-6A-28

<sup>10</sup> 5-ACI-6A-39

<sup>11</sup> 5-ACI-6A-39

3. Information Flow

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 appropriate treatment personnel concerning an **individual** 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 and **Psychology staff**. Treatment staff shall share with Corrections Officers, trades instructors, and other staff the goals and direction of recovery plans developed for **individuals** in need of mental health services.

4. **Psychiatric Review Team (PRT) and Individual Recovery Plans (IRPs)**

**The PRT is a multidisciplinary treatment team chaired by an LPM)/Psychology staff member designee. More specific functions of the PRT are located throughout DOC policy, as necessary.**

a. **The PRT's complement of staff includes, but is not limited to:**

- (1) **LPM/PSS/PSA/Forensic Psychological Services Associate (FPSA);**
- (2) **Psychiatrist/PCRNP;**
- (3) **Psychiatric Nurse/medical designee;**
- (4) **Corrections Counselor;**
- (5) **Social Worker;**
- (6) **Drug and Alcohol Treatment Specialist (DATS);**
- (7) **Corrections Officer; and/or**
- (8) **Unit Manager (UM).**

b. **PRT for parole issues may also include:**

- (1) **the facility parole representative; and**
- (2) **the county MH/ID liaison may be invited.**

c. **The PRT's primary responsibilities include, but are not limited to:**

- (1) **initiating and maintaining the IRP for individuals on the Active MH/ID Roster. Recovery plans shall include the goals the team and individual intends to achieve, including symptom stabilization and elimination, and**

*recommendations regarding how staff shall interact in dealing with the individual. The individual shall be involved in the development of his/her recovery plan, shall be given the opportunity to sign-off on the completed plan, and may receive a copy of the IRP, if requested. These procedures are more fully described under Subsection G. below;*

- (2) *final review/approval for additions and removals to/from the Active MH/ID Roster (e.g., any changes to an individual's MH/ID Roster);*
- (3) *modifying and/or specifying the IRP to address sentinel events such as POC placement, RHU placement, placement in restraints, aftercare treatment planning upon discharge from the FTC and MHU including appropriate housing placement, reviewing the use of involuntary psychiatric medication and other circumstances that may alter the individual's mental status that warrants a modification in treatment;*
- (4) *community reentry planning for individuals monitored on the Active MH/ID Roster, beginning 12 months prior to their sentence complete date. This also includes discussions concerning those individuals identified as "Hard to Place;"*
- (5) *PRT makes recommendations to the PRC for level of observation for individuals housed outside of the infirmary setting;*
- (6) *responsible for coordinating treatment planning and care between inpatient and outpatient settings;*
- (7) *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], Review – IRP [Attachment 2-C]), or DC-563. The IRP documentation must show clearly that the individual 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. IRPs should reflect at least one goal for each current mental health diagnosis and depending on the version of the IRP being generated, IRPs should reflect progress made or not made toward goals. The IRP must also show that the individual was involved in the development of the plan, and the individual shall be offered the opportunity to sign the IRP. If the individual opts not to sign the IRP, refusals shall be noted;*
- (8) *the PRT must approve removal of an individual from the Active MH/ID Roster. The rationale for the removal and the date shall be recorded on the DC-563 within the electronic medical record by Psychology staff. For example, this should include documentation of the discussion to determine whether or not an individual remains functionally impaired. An individual removed from the Active Roster shall automatically be placed on*



*the Inactive MH/ID Roster and the change noted in the tracking system;*

- (9) *individuals on the D Roster that are being considered for downgrade to C Roster or upgrade to D Roster due to Functional Impairment must adhere to the D Roster Change protocol as outlined in the D Roster Change Request Form;*
- (10) *the psychiatrist/PCRNP shall participate in the development, modification, and discontinuance of each treatment plan.<sup>12</sup> However, psychiatric providers are not required to attend annual PRT meetings for C Roster patients in general population. Psychology staff shall offer annual PRT meetings for C Roster individual in general population. However, if the individual declines to attend this annual PRT meeting with Psychology, the refusal will be documented on a brief DC-560, within Sapphire, the PRT will not occur, and the individual's current IRP will continue as written, if appropriate. If the individual does attend PRT, the IRP will be reviewed and updated, if necessary. If the IRP requires no change as decided by the patient and PRT, a new IRP will not be generated by Psychology. Should PRT determine that Psychiatric participation is necessary with a particular general population C Roster individual at annual review, that request will be made by the PRT to Psychiatry staff; and/or*
- (11) *individuals shall be invited to attend PRT, so that they may contribute to the development of their IRP. Refusals to attend PRT shall be documented on the appropriate IRP or DC-563.*

#### **F. Mental Health Commitments to Inpatient Facilities** <sup>13</sup>

##### 1. General

- a. An **individual** 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>14</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 **individual** is in need of a mental health commitment, the facility shall move as expeditiously as possible to obtain such a commitment.
- 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 **considered for placement** in the FTC at Waymart or a

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<sup>12</sup> 5-ACI-6A-33

<sup>13</sup> 5-ACI-6A-28, 5-ACI-6A-33, 5-ACI-6A-37, 5-ACI-6A-39

<sup>14</sup> 5-ACI-6A-33

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Department of Human Services (DHS) Forensic Unit. A female *individual* requiring a longer-term §304 involuntary commitment shall be **considered for placement** in a DHS Forensic Unit.<sup>15</sup> Appropriate forms for each type of commitment are:

- (1) **Application for Involuntary Emergency Examination and Treatment, MH 783 (Attachment 2-D);**
  - (2) explanation of **Patient’s Bill of Rights, MH 783-A (Attachment 2-E);**
  - (3) **Application for Extended Involuntary Treatment, MH 784 (Attachment 2-F);**
  - (4) **Voluntary Application for Mental Health Treatment (Section 201) (Attachment 2-G);**
  - (5) **Explanation of Voluntary Admission Rights, MH 781-Z (Attachment 2-H);**  
and
  - (6) **Initial Evaluation, MH 781-A (Attachment 2-I).**
- 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 *individual* 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>16</sup>
  - b. Upon referral for evaluation for possible commitment, the *individual* shall be seen by the psychiatrist as soon as possible, but no later than the next working day.
  - c. The psychiatrist shall evaluate the *individual* in accordance with the criteria for commitment contained in the Mental Health Procedures Act.
  - d. If upon evaluation by the psychiatrist, the *individual* is found committable, the designated facility staff member shall prepare the petitions (**Application for**

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<sup>15</sup> 5-ACI-6A-37

<sup>16</sup> 5-ACI-6A-37

**Involuntary Emergency Examination and Treatment, MH 783**), obtain the necessary signatures, see that the **individual** is advised of the forthcoming hearing, and read the **individual'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 **individual'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 they 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 **individual** to the mental health facility. The procedures for a male **individual** are fully described in **Section 4** of this procedures manual. Such transfer shall occur as expeditiously as possible.
- j. Following transfer of an **individual** 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 **individual**. 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<sup>17</sup>

- 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 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.

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<sup>17</sup> 5-ACI-6A-08

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- 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.
- 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.
- d. If a DHS mental health facility accepts the *individual* 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 *individual* at the end of the five days.
- e. In a Department MHU, the MHU staff are responsible to notify the sending facility of changes in the *individual's* treatment status. If the *individual* is to be discharged, appropriate arrangements shall be made for the *individual'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 *individual* 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<sup>18</sup>

- a. An *individual* 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>19</sup>
- b. If upon evaluation by the psychiatrist, the *individual* is found in need of treatment, the designated facility or MHU staff member shall prepare the petition, obtain the necessary signatures, see that the *individual* 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.

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<sup>18</sup> 5-ACI-6A-28, 5-ACI-6A-33

<sup>19</sup> 5-ACI-6A-08

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- c. The designated staff member shall submit the original copy of the petition and history of the **individual**, including treatment program, and any special needs to the MHU staff.
- d. An **individual** 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>20</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 **individual** 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.3. below**.

**G. Continuity of Care Procedures for Individuals 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 **individual** in the system; this continuum ranges from outpatient services offered to an **individual** in the general population, **enhanced outpatient services on RTUs**, 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 **individual** 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 **individuals** being discharged into the community are described in **Subsection H. below**).
- b. The mechanisms which have been developed to ensure this continuity of care include the MH/ID Automated Tracking System, **an electronic health record**, enhanced teleconferencing between mental health staff who work with these **individuals**, and the sharing of treatment plans between service providers in the interfacing facilities, hospitals, and agencies.

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<sup>20</sup> 5-ACI-6A-08

2. Tracking of **D Roster Individuals and any problematic C Roster Cases** Moving from One Facility to Another (*i.e., intrasystem transfers*)
  - a. The automated tracking system shall ensure that an **individual** 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. 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 **individual** and his/her special needs.
  - c. Any additional critical clinical information shall be forwarded to the receiving facility as soon as possible.
  - d. **All intrasystem transfers (i.e., from SCI to SCI) of C and D Roster individuals shall be referred to Psychology upon reception by nursing so that Psychology staff can schedule the individual to be seen by PRT within 30 days of arrival. However, if the individual needs to be seen sooner than this time frame, nursing staff shall make the appropriate emergent or non-emergent referral to Psychology staff.**
3. Tracking of **Individuals** Returning from the FTC, Department Regional MHUs, and DHS Regional Forensic Centers returning to other Department facilities<sup>21</sup>
  - a. Shortly before the **individual** 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 multidisciplinary 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, DATS, and/or UM; and
      - (e) Lieutenant from the area.

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<sup>21</sup> 5-ACI-6C-07

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- (2) During the videoconference or teleconference, the FTC, DHS Regional Forensic Center, or MHU team shall summarize the **individual's** response to treatment at the forensic facility and offer any insights he/she might have concerning the **individual'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 **to ensure that the individual is placed in the POC upon return from the inpatient commitment and** evaluated by mental health staff immediately upon return to the facility.
  - (4) It is likely that the DHS Regional Forensic Centers may use different forms to document videoconference or teleconference treatment recommendations. FTC and MHU teams may **upload additional information as needed into Sapphire. DHS may share additional information with the DOC, if needed, to be uploaded into Sapphire.**
  - (5) The treatment teams in the FTC, DHS Regional Forensic Center, and MHU shall make recommendations for the **individual's** facility placement. This is a key component of the videoconference or teleconference.
- b. Upon return to the facility, the **individual** shall be placed in an infirmary observation cell or other appropriate setting until he/she can be evaluated by the facility psychiatrist/PCRNP who shall make placement recommendations within the facility, based on the evaluation results and the recommendations **from the inpatient treatment team**. An **individual** returning from the FTC, MHU, or DHS unit who is on AC or DC status shall not be placed in the RHU until his/her case has been reviewed by the PRT. The PRC shall be notified immediately of the **individual's** return so that the committee can review the **individual's** AC/DC status. Insofar as possible, an **individual** with an SMI 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 **individual'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 **individual** from the FTC, DHS Regional Forensic Center, SRTU, or MHU.
  - d. The PRT shall review the **individual's** case monthly for four months to monitor the success of the IRP to reintegrate the **individual** into prison life.
  - e. Several weeks after the **individual's** return to the facility from the FTC, DHS Regional Forensic Center, or MHU treatment staff from those units may request information concerning the **individual'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 **individual's** discharge.

4. Tracking of **Individuals** 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 **individual** 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 *Individual* with Mental Illness Being Discharged**

These procedures provide direction to staff in developing continuity of care services for an **individual** with mental illness following his/her release from incarceration into the community following Sentence Complete or parole.<sup>22</sup>

1. Sentence Complete **Individuals** on the MH/ID Roster <sup>23</sup>
  - a. The Psychology Department shall maintain automated procedures for Active MH/ID Roster **individuals**. Lists of the names and Department numbers of each roster **individual** 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 **individuals** with mental illness who are housed on their unit.
  - b. The LPM shall schedule special PRT reviews for an **individual** on the MH/ID Roster 12 months prior and again six months prior to the Sentence Complete to update the **individual DC-551, Continuity of Care Plan. This document shall be stored on DOCInfo for the purpose of permitting appropriate user access.**
  - c. The updated **DC-551** shall address continuity of care service needs and actions required to transition the **individual** into the community.
    - (1) Participants in the meeting shall include, but are not limited to, the LPM, MHC, psychiatrist/PCRNP, CHCA, DATS, **Social Worker/designee**, and Corrections Counselor or UM. It is desirable that the **individual** attend the meeting.
    - (2) The **DC-551** shall address the **individual's** anticipated community needs including mental health, medical treatment, substance abuse, aging services, intellectual disability services, 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 **DC-551**.

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<sup>22</sup> 5-ACI-6C-07

<sup>23</sup> 5-ACI-6A-34



**Offense based treatment (e.g., Sex Offender Treatment) shall not be included on the DC-551.**

- (3) If the **individual** did not attend the PRT meeting, this will be documented on the **DC-551**, and the staff shall meet with the **individual** to discuss the planning process. Staff shall determine where the **individual** plans/wishes to reside, ascertain his/her view of treatment and benefit needs, and secure the **individual's** participation in the planning process.
  - (4) Staff shall request that the **individual** sign the **DC-108** in accordance with Department policy **DC-ADM-003, "Release of Information,"** so that the Department staff can share treatment information including the **individual's** Social Security number, physical/medical health diagnoses, and psychiatric diagnosis, with outside agencies.<sup>24</sup> Staff shall advise the **individual** 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. **It is especially critical that every effort be made to coordinate a linkage with community providers and exchange clinically relevant information with appropriate community providers as needed for individuals diagnosed with serious mental illnesses.**<sup>25</sup>
- d. The Central Office Psychology Office shall monitor the MH/ID Roster to identify each roster **individual** 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 **individual** 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.
  - e. The **Social Worker/designee** shall contact the MH/ID Administrator in the **individual's** county of origin to advise the county staff of the **individual's** impending Sentence Complete and obtain assistance locating community resources. A list of MH/ID administrators can be obtained from the OMHSAS Forensic Liaison, Central Office Psychology Office, **or Office of Mental Health and Health Care Systems Advocate at Central Office. The Social Worker/designee shall provide the individual with a list of available community resources prior to discharge and arrange for continuity of care if the individual is on the active mental health roster and/or receiving psychotropic medication.**<sup>26</sup>
- (1) The **Social Worker/designee** shall document all contact with the MH/ID Administrator in the medical record on the **DC-472**, and shall follow-up this

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<sup>24</sup> 5-ACI-6A-04

<sup>25</sup> 5-ACI-6A-34

<sup>26</sup> 5-ACI-6A-34

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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 *individual* has signed the **DC-108**, the **Social Worker/designee** shall provide the county MH/ID agency with the *individual's* Social Security number, current ICD diagnosis, treatment being provided, and other pertinent data. The information shall be included with the **DC-551**.
  - (3) If the *individual* refused to sign the **DC-108**, the **Social Worker/designee** shall provide the MH/ID agency with information regarding the *individual's* date of release and number of MHU/FTC commitments while incarcerated. If the *individual* refused to sign the **DC-108**, the **Social Worker/designee** will not provide to the OMHSAS the *individual's* current ICD diagnosis, WHODAS score, level of treatment being provided, and other pertinent data. This confidential information shall not be included with the **DC-551** until the *individual* has signed a **DC-108**.
  - (4) The **Social Worker/designee** 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 *individual* returning to those jurisdictions. The **Social Worker** is encouraged to contact the **Office of Mental Health and Health Care Systems Advocate** with any questions regarding these arrangements.
  - (6) If the County MH/ID Administrator is non-responsive to the contact described above, the **Social Worker/designee** shall contact the Regional Office of the OMHSAS or the OMHSAS Forensic Liaison and the **Office of Mental Health and Health Care Systems Advocate**.
  - (7) Staff should also consider contacting the *individual's* family for assistance with aftercare planning, if the *individual* has agreed and signed the **DC-108**.
- f. If the *individual* is psychiatrically stable, the **Social Worker/designee** shall arrange a community intake/evaluation appointment for the *individual*. This includes the date and time of the appointment, location of the interview, and contact person. This information shall be provided to the *individual* 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

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section, and it will be shared with the county MH/ID contacts or the OMHSAS Liaison.<sup>27</sup>

- g. If the Department treatment team believes that the **individual** meets involuntary mental health civil commitment criteria outlined in the Mental Health Procedures Act, the **Social Worker/designee** shall advise the **individual's** home county 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 **Social Worker/designee** shall provide documentation of the **individual's** treatment history and current treatment needs to the County MH/ID Administrator of the county to which the **individual** shall be released, and shall request that the County MH/ID Administrator designate a community hospital to which the **individual** can be committed for the needed inpatient services.<sup>28</sup>
- h. If the Department treatment team believes that the **individual** 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 **Social Worker/designee** will provide documentation of the **individual'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 **individual** 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 **individual** completing sentence to a state hospital Regional Forensic Center.
- i. If the **individual** 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.
- j. If the **individual's** condition is such that he/she is in need of immediate treatment, but is not committable under the Mental Health Act, the **Social Worker/designee** shall contact the MH/ID agency to discuss treatment options including intervention by the county crisis services upon release.
- k. If the **individual** refuses to accept processing for community aftercare or is non-responsive to recommendations for community aftercare processing, and the staff believes that the **individual'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 **individual** does not meet inpatient commitment criteria), then the

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<sup>27</sup> 5-ACI-6A-34

<sup>28</sup> 5-ACI-6A-34

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Bureau of Health Care Services (BHCS) shall be contacted, and in consultation with the **Office of Mental Health and Health Care Systems Advocate**, 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 **individual**;
  - (2) notify local law enforcement authorities of the pending release and the **individual'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.
- I. The Medical Department shall provide the **individual** with a 60-day supply of prescribed medication, in accordance with Department policy **13.2.1** to prevent disruption of treatment until the **individual** 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. Information concerning medication shall be conveyed to the community treatment provider.
- m. In cases where an **individual** 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 **individual**, 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 **individual** may be moved to a facility closer to his/her home. In these cases the **Social Worker/designee** in the referring facility shall be responsible for continuity of care planning, and these activities should be documented on the **DC-551**.
- n. In situations in which the **individual** 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 **individual** 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 the on-line application.
  - (2) COMPASS can be reached directly at <http://www.compass.state.pa.us>.

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- (3) Staff shall submit monthly lists of the number of on-line COMPASS applications completed to the CHCA/designee.
  - o. 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 **individual** on the MH/ID Roster Being Paroled/Re-Paroled

Whenever possible, an **individual** 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 **individual** will be in accordance with Department policy **7.3.1, “Reentry and Transition.”**<sup>29</sup> 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 **individual** receiving mental health treatment.
- b. The LPM/MHC shall monitor the MH/ID Roster to identify any **individual** approaching one year to his/her parole date and schedule a PRT meeting to update the **individual’s** IRP on the **DC-551** to ensure that the **DC-551** includes objectives that are related to community reentry.<sup>30</sup> The PRT shall supplement the “Hard to Place” procedures outlined above.
  - (1) The **DC-551** shall address mental health and medical treatment needs, co-occurring disorder treatment needs, housing needs and family integration, 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, UM, and facility parole representative. The county MH/ID liaison should be invited to the meeting.

**NOTE:** Department policy **7.2.1, “Counseling Services,”** mandates that the Facility Parole Representative shall attend the PRT meeting for any MH/ID

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<sup>29</sup> 5-ACI-6C-07

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*individual* who is likely to receive facility support for parole so that the Pennsylvania Parole Board (PB) can participate in aftercare planning.

- (3) The PRT shall review every *individual* 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, **Social Worker/designee** and/or DATS shall meet with the *individual* 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 psychologist shall conduct a psychological evaluation for parole, employing the PA Clinical Risk Assessment (PCRA), 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 *individual's* minimum date. The report shall include an updated ICD diagnosis.
  - (6) The LPM and/or MHC shall be available to the PB to respond to any questions regarding the *individual's* mental health assessment or response to treatment in the facility. The LPM shall visit the facility parole office regularly to discuss referrals.<sup>31</sup>
3. Procedures for a Non-Hard to Place *Individual* on the MH/ID Roster Being Paroled/Re-Paroled
- a. The Psychology Department, UM, **Social Worker/designee**, and the Corrections Counselors and/or DATS shall monitor the MH/ID Roster to identify an *individual* approaching his/her parole date.
  - b. The LPM/MHC shall monitor the MH/ID Roster to identify any *individual* approaching one year to his/her parole date and schedule a PRT meeting to update the *individual's DC-551* to ensure that the **DC-551** includes objectives that are related to community reentry.<sup>32</sup>
    - (1) The **DC-551** 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, VA benefits, SSI, SSDI, and Income Maintenance.<sup>33</sup>

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<sup>31</sup> 5-ACI-6C-07

<sup>32</sup> 5-ACI-6C-07

<sup>33</sup> 5-ACI-6C-07

- (2) Participants at the PRT meeting shall include the LPM, consulting psychiatrist/PCRNP, **Social Worker/designee**, 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 **individual** on the Active MH/ID Roster to determine if he/she meets the referral criteria for placement in one of the Department's CCCs 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-J)**.
  - d. The psychologist shall conduct a psychological evaluation for parole employing the PCRA 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 **individual's** minimum date. The report shall include an updated ICD diagnosis and WHODAS score.
  - e. The Corrections Counselor or DATS and the **Social Worker/designee** shall arrange for a meeting with the **individual** 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 staffing. The counselor shall advise the facility parole agent of those aftercare needs at least six months prior to the **individual's** parole eligibility date.
  - f. The Corrections Counselor shall coordinate with the PB to provide whatever documentation or updated evaluations are necessary for aftercare placement.

## **I. Limits of Confidentiality**

1. All **individuals** will be offered the opportunity to sign one **DC-484, Mental Health Confidentiality Disclosure Statement** for Psychology upon admission to the DCC of the Pennsylvania DOC to indicate that they have been informed that these conditions have been explained. If the individual refuses to sign the **DC-484**, he or she shall be informed that this refusal does not change or alter the conditions explained, and will apply throughout the individual's time with the Pennsylvania DOC. Additionally, if the individual is released from DOC custody and is returned, (e.g. parole violator), Psychology shall complete a new **DC-484**. The **DC-484** shall be completed once at the time of the Initial Psychiatric Assessment or Brief Psychiatric Assessment by the psychiatrist/PCRNP.<sup>34</sup>
2. Unless the staff can be reasonably certain that the individual can read and understand the **DC-484**, the **DC-484** shall be read aloud to the **individual**; the clinician shall provide

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<sup>34</sup> 5-ACI-6A-28, 5-ACI-6C-04

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him/her with the opportunity to ask questions, and the **individual** shall be asked to sign the **DC-484**.

3. The individual shall be provided with a copy of the **DC-484**, if requested.
4. When the **individual** is seen for psychological evaluation or treatment, he/she shall be reminded of the conditions of confidentiality that were originally explained in the **DC-484** completed during the classification process.
5. If the individual refuses the offered evaluation or treatment, he/she will be cautioned that assessments by recipients of the report (staffing committees and PB) might be affected by the lack of information resulting from the refusal.
6. The individual shall be advised that he/she may later agree to sign the **DC-484**, if initially refused.
7. It shall be stressed that **DC-484** describes conditions under which information may be disclosed. This is not a 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 individuals.

**J. Informed Consent**<sup>35</sup>

**1. Informed Consent for Psychological Services**

- a. **When Psychology staff conduct an initial assessment (e.g., patient contact in response to a DC-97 for an A or B Roster individual), formal evaluation (e.g., Commutation Psychological Evaluation; PCRA; Parole Psychological etc.) of any kind and or provide treatment/therapy/counseling (i.e., as directed by an IRP) services, Psychology staff shall seek to obtain informed consent and discuss the limits of confidentiality with the individual as early as is operationally and clinically feasible.**
- b. **Psychology staff have a primary obligation and shall take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing the extent and limits of confidentiality within the DOC. If Psychology staff believe an individual may not completely understand language utilized in any version of the Informed Consent Document for Psychology, Psychology staff shall explain the contents of the electronic document to the individual, utilizing language that is reasonably understandable to that individual.**
- c. **When obtaining informed consent, Psychology staff shall directly communicate this discussion with the individual, in a face-to-face exchange, as long as institutional and security operations permit.**

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<sup>35</sup> 5-ACI-6A-28, 5-ACI-6C-04



- d. ***For individuals who are legally incapable of giving informed consent (e.g., those individuals under the age of 14), Psychology staff nevertheless complete the following:***
  - (1) ***provide an appropriate explanation;***
  - (2) ***seek the individual's assent (i.e., affirmation of a desire to participate from an individual legally incapable of giving informed consent);***
  - (3) ***consider such person's preferences and best interests; and***
  - (4) ***obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, Psychology staff take reasonable steps to protect the individual's rights and welfare.***
  
- e. ***When seeking informed consent, as long as institutional and security operations permit, the individual is legally capable of providing informed consent, and is willing to provide informed consent, individuals shall be afforded the opportunity to indicate their consent with their signature on the appropriate form. If institutional or security operations prohibit indication of consent with the individual's signature or the individual refuses to indicate informed consent with his/her signature, the reason(s) for this refusal or inability to provide informed consent will be documented on the appropriate version of the informed consent document for Psychology along with the assigned Psychology staff member's signature.***

## **2. Informed Consent for Therapy/Treatment**

- a. ***When seeking informed consent for Therapy/Treatment, Psychology staff shall inform individuals as early as is feasible in the therapeutic relationship about the nature and anticipated course of Psychological treatment, the absence of fees, the potential benefits of psychological treatment, the potential risks of psychological treatment, alternatives to psychological treatment, involvement of third parties, limits of confidentiality, supervision information, a brief overview of medical record security, medical record retention, and medical record access, and provide sufficient opportunity for the individual to ask questions and receive answers.***
  
- b. ***Informed consent to therapy/treatment shall be documented by completing the Informed Consent for Psychological Services section of the IRP. Unless it is not feasible, the discussion of informed consent and confidentiality associated with therapy/treatment shall occur at the outset of the relationship (i.e., defined as placement upon the active mental health roster) and thereafter, as new circumstances (e.g., new admission into SRTU/BMU, etc.) may warrant.***

- c. ***Any time an individual is added to the active mental health roster (i.e., from either A or B Roster), the Informed Consent for Psychological Services section of the IRP shall be completed by Psychology staff for that individual. An appropriate time to complete this is at the outset of developing the Initial IRP or Change of Status Recovery Plan. If an individual is discontinued from the active mental health roster and is subsequently placed back onto the active mental health roster in the future, at that time, the Informed Consent section of the IRP shall be completed by a Psychology staff member.***
  - d. ***If an individual is currently on the active mental health roster and does NOT have an Informed Consent Document for Psychology (i.e., Therapy/Treatment version) on file, one shall be completed at his/her next PRT review (e.g., at the annual PRT for C Roster, at the next 120-day PRT review for D Roster, or upon development of any Change of Status IRP, etc.).***
3. ***Informed Consent for Assessment/Evaluation***
- a. ***Prior to initiating a formal (i.e., a PCRA for parole purposes, a commutation psychological evaluation, etc.) or informal assessment/evaluation (i.e., assessment of an A or B Roster referred to Psychology with a DC-97) with an individual, Psychology staff shall seek to obtain informed consent, utilizing the Informed Consent Document for Psychology (i.e., Assessment/Evaluation version).***
  - b. ***Memorialization of informed consent obtained shall include an explanation of the nature and purpose of the psychological assessment/evaluation, conditions of participation, the absences of fees, involvement of third parties, the limits of confidentiality, supervision information, a brief overview of medical record security, medical record retention and medical record access, and sufficient opportunity for the individual to ask questions and receive answers.***
  - c. ***An Informed Consent for Assessment/Evaluation shall be completed prior to each time Psychology staff completes a formal assessment/evaluation (e.g., Psychological Evaluation for Parole, Commutation Psychological Evaluation, etc.) or an addendum to a formal Psychological assessment.***
  - d. ***If Psychology staff receive a DC-97 for an individual on the A or B Roster, Psychology staff shall seek to obtain informed consent from the individual as early as is feasible prior to conducting their assessment or evaluation. Psychology staff shall select the OTHER option within the Nature and Purpose of the Psychological Assessment/Evaluation section and specify that the Nature and Purpose of this assessment/evaluation is “Response to DC-97/Mental Health Referral,” and include details of the specific referral question indicated on the referral.***
  - e. ***The Assessment/Evaluation version of the informed consent document for Psychology shall also be utilized for responding to Prison Rape Elimination Act***

*(PREA) related incidents as well, regardless of whether or not the individual is referred with a DC-97. Unless it is not feasible, the discussion of informed consent and confidentiality associated with this assessment/evaluation shall occur prior to conducting the assessment/evaluation. Psychology staff shall select the OTHER option within the Nature and Purpose of the Psychological Assessment/Evaluation section and specify that the Nature and Purpose of this assessment/evaluation is “PREA,” and include other details necessary regarding the nature and purpose of the assessment/evaluation. As part of this discussion, the Psychology staff member shall explain that, if indicated for the individual’s protection, information disclosed shall be shared only on a need-to-know basis with indicated staff (i.e., Security Office, PREA Compliance Manager [PCM], UM, Counselor, Sexual Abuse Review Team, Pennsylvania State Police [PSP], etc.).*

- f. *Prior to initiating any type of formal personality, intelligence, or other testing assessment protocol, Psychology staff shall seek memorialization of informed consent being given utilizing the assessment/evaluation version of the electronic document. However, informed consent may not be required for assessments which utilize third parties (e.g., a DOC employee) as the main source of information related to the formal assessment of an individual’s adaptive functioning. If a proxy other than a DOC employee is utilized for this purpose, informed consent from the individual patient is required.*
- g. *Psychology staff using the services of an interpreter obtain informed consent from the individual to use that interpreter, ensure that confidentiality of test results and test security are maintained as a result, and include in their recommendations, reports, and diagnostic or evaluative statements, discussion of any limitations on the data obtained.*

#### **K. Guilty But Mentally Ill (GBMI) Individuals**

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.

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- (1) Category I consists of those GBMI commitments for whom:
    - (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) **individual** 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 have been notified, be placed in regular DCC housing unless contraindications to such placement are noted during the reception process.
  - g. A Category I GBMI **individual** shall not be double celled in a DCC until reviewed by the treatment team. **During this time, these individuals shall receive enhanced security observation.** This review shall be completed as soon as operations permit, but no later than 72 hours. If the treatment team find the **individual** to be neither

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seriously mentally ill, a serious threat to others, nor disruptive, double celling may be considered if approved by the treatment team. A Category II GBMI **individual** 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 reviewing treatment team.

2. Staff Contacts and Procedures

- a. Upon notification from the Records Specialist that a GBMI **individual** 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 **individual** 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 **individual** 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 **individual** 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 **individual** and shall assist in coordinating these needs.
- g. Within one working day after reception, the DCC Psychologist or PSS shall see the GBMI **individual** for an initial evaluation.

3. Psychiatric Evaluation

- a. All GBMI **individuals** shall be placed in D Roster upon arrival to the DOC.
- b. All GBMI **individuals** shall have an initial psychiatric evaluation and psychological assessment upon arrival to the DCC.
- c. All GBMI **individuals** shall have treatment follow-ups on regular intervals by Psychiatry and Psychology as per the current policy.

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- d. All GBMI **individuals** shall receive a PRT review at least once every four months, more if clinically indicated.
- e. 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 **individual** is transferred to a mental health facility.
- f. 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.
- g. 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<sup>36</sup>

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 **individual** sent to them from the Department is ready to return to the correctional system, the mental health facility shall contact the receiving facility and **establish** a return date.
- b. The receiving facility shall arrange to pick up the returning GBMI **individual**.

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 <sup>37</sup>

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

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<sup>36</sup> 5-ACI-6A-37

<sup>37</sup> 5-ACI-6A-37

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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 **individual**, 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 **individual** is being transferred to that facility.
- 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 **individual** 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 **individual** being transferred. The DCC LPM shall provide the permanent facility LPM with the name and number of the GBMI **individual**, 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 **Individuals** at Permanent Facilities

a. Reception

- (1) Upon reception of a GBMI **individual**, his/her case shall be reviewed by appropriate intake staff. This staff shall make the proper housing assignment and shall refer the **individual** 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 **individual**.

b. Programming

- (1) For the first month after reception, the counselor assigned to the case shall see the **individual** on a weekly basis. The facility Psychologist shall see the GBMI **individual** 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 **individual'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-563 by Psychology staff.**

**L. Dealing with a Potentially Suicidal *Individual* and an *Individual* who Attempts Suicide<sup>38</sup>**

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 **individual** is critically important, both for the individual in need of service and for the facility charged with his/her care. **Acute risk factors, chronic risk factors, and protective factors shall be considered.**

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 **individual**. The potential also increases when the means of the suicide identified in the plan is readily available to the **individual** and can be lethal.

b. **Housed Alone**

***The potential for suicide in a correctional setting is higher if an individual is in a cell alone (e.g., Z-Code, alone in a cell without a Z-Code, or double celled but cellmate is away).***

c. 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.

d. Stress

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

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<sup>38</sup> 5-ACI-6A-35



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- (1) difficulties in coping with legal problems;
- (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/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 **use**; and/or

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(22) transition periods within a correctional institution (i.e. release from a POC, placement into an RHU, removal from general population).

e. Prior Suicidal Behavior of Significant Other

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

f. Signs and Symptoms

The potential for suicide is greater if the individual manifests signs/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 **signs or** 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 SIBs and/or serious suicide attempts;
- (16) sudden elevated mood (“everything’s OK attitude”); and/or
- (17) psychic or somatic anxiety.

g. 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.

h. 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.

i. 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 **or when the illness is newly diagnosed or takes a significant turn for the worse.**

- j. 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 UM shall be notified, and a referral shall be made to the LPM/designee **depending on the type of referral (i.e., emergent vs. non-emergent).** In the absence of the UM, the staff person shall contact the Shift Commander. The UM or Shift Commander shall immediately contact the LPM/designee and brief him/her on the situation.
- b. The LPM/designee shall assess the **individual’s** suicidal potential in the most appropriate location depending on the **individual’s** level of agitation and security needs (**individual’s** cell, psychologist’s office, or observation area) **with efforts at achieving a confidential and private setting being the most beneficial for such assessments. All staff, including mental health staff, are prohibited from utilizing language related to “contracting for safety” (e.g., “I was able to get his**

***promise that he would not hurt himself tonight,") especially when assessing for patient suicide risk.***

- c. A suicidal ***individual*** shall be under continuous observation.<sup>39</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 ***individual*** is a danger to self and/or others, he/she shall order a watch. The watch may only be reduced or terminated by a physician or psychiatrist/PCRNP.<sup>40</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 ***individual*** be moved to the POC to be placed on constant watch.<sup>41</sup> Procedures for monitoring the watches in the POC are described in **Subsection L.3. below.**
- f. Every ***individual*** placed in Level 5 Housing Units shall be assessed on the **DC-510, Suicide Risk Indicators Checklist** (refer to **Section 1** of this procedures manual). The checklist shall also be used for every returned parole violator.<sup>42</sup> Every ***individual*** 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 ***individual*** is brought to the Level 5 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:<sup>43</sup>
    - (a) why the ***individual*** is being brought to the Level 5 Housing Unit/Intake Unit;
    - (b) if the ***individual*** is expressing suicidal thoughts/making threats to harm himself/herself;
    - (c) whether the ***individual*** shows signs of depression (crying, withdrawn, passive);
    - (d) is the ***individual*** acting/talking in a strange manner (hearing/seeing things that aren't there?);

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<sup>39</sup> 5-ACI-4A-11, 5-ACI-4B-01

<sup>40</sup> 5-ACI-4A-11, 5-ACI-4B-02

<sup>41</sup> 5-ACI-4A-11

<sup>42</sup> 5-ACI-6A-04

<sup>43</sup> 5-ACI-6A-35

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- (e) whether the **individual** appears to be under the influence of drugs/alcohol;
  - (f) whether there is any information that the **individual** may be self-destructive; and
  - (g) whether the **individual** is requesting protective custody.
- (3) The **individual** shall be asked:
- (a) whether he/she has experienced a recent family change (i.e. death of child/spouse/parent or “Dear John letter”);
  - (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 Level 5 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 **individual**; and/or
  - (f) if he/she is on any psychotropic medication.
- (4) Staff shall note whether the **individual**:
- (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 L.2.f. above** are present, the Unit Officer shall immediately phone the following staff: (see Bulletin #2 with updated language)~~
- ~~(a) between 8:00 AM and 4:30 PM, nursing and LPM or MHC. A **Psychology staff member** will immediately visit the unit to review the checklist, assess the **individual**, and discuss the case with unit staff prior to the **individual** being placed in cell. The time and results of the assessment will be recorded in the “Clinical Staff Action” section including a plan; or~~
  - ~~(b) after hours, or on weekends, the Shift Commander shall notify nursing staff and nursing staff shall immediately review the checklist, assess the **individual**, and discuss the case with unit staff prior to **the individual** being placed in cell. The time and results of the assessment will be~~

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recorded in the “Clinical Staff Action” section. Psychology staff will review the checklist, assess the **individual**, and discuss the case with unit staff upon the next available working day.

- (6) Even if no items are present, the nurse and/or **psychology staff member** will assess the **individual** 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 **individual** 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 Areas

- a. **Space is available either inside the infirmary, areas identified as restrictive housing, or external to the unit for treatment staff consultation with individuals in the POC.**
- b. **Individuals psychiatrically admitted to the POC shall be offered to be seen at a minimum:**
  - (1) **once out of cell upon admission. This can be accomplished by interviewing the individual out of cell prior to the individual being physically placed in the POC;**
  - (2) **anytime the clinical mental health team (i.e., Psychology, Psychiatry, and Psychiatric Nurse) determine an out-of-cell contact would be clinically beneficial throughout the individual’s admission; and**
  - (3) **once out of cell prior to discharge from a POC (i.e., on the day of discharge).**

**All facilities shall identify an area that is acceptable for these clinical contacts to meet privacy and security standards. All individuals that refuse an out-of-cell contact while in a POC, shall be documented by Psychology and Psychiatry in Sapphire, along with the reason(s) for the refusal.**

**Daily POC rounds shall be conducted by the clinical mental health team. The clinical mental health team shall also coordinate regular POC rounds in conjunction with the assigned Commissioned Officer(s).**

**The above mentioned out-of-cell contacts shall be monitored by the Regional LPM(s), the Executive Deputy Secretary for Institutional Operations (EDSI), Regional Deputy Secretary (RDS), and the Department’s psychiatric vendor.**

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- c. 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 **individuals** committed to the MHU. All watches will occur in accordance with Department policy **DC-ADM 008, “PREA.”**
- d. Each facility shall provide an observation area to monitor suicidal **individuals**. 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 **individual** to hang himself/herself. Observations shall be conducted in infirmary areas or other areas. At a facility without an infirmary, the POCs shall be located close to the medical area to allow for frequent observation and rapid response.
- e. If an RHU or DTU cell is temporarily utilized as a POC for a psychiatric admission, it must be a camera cell. Additionally, if an RHU or DTU cell is temporarily utilized as a POC, it is mandatory that all provisions of implementing all safeguards, levels of watch, documentation, and operational procedures as directed by **Subsection L.3. above** and **Section 3** of this procedures manual, as well as other policies directing other disciplines’ operations for this setting are followed. It is imperative that all disciplines and members of multidisciplinary teams, including security, are informed of the individual’s needs and the expectations of this temporary housing placement.
- f. 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 are available to **manage** the **individual’s risk**.
- g. 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 **individual** will destroy an item or use it to induce self-injury, the **individual** may be deprived of the item; however, every effort shall be made to provide a substitute for the item or allow the **individual** 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, **individuals** should be permitted reading materials without staples, mattresses, etc.
- h. The different levels of observation require different types of restrictions. In every case, the least restrictive measures shall be determined by the psychiatrist/PCRNP. However, every **individual** shall initially be evaluated for constant watch. If the **individual** is behind a locked door, the observing staff shall be able to open the cell door immediately.<sup>44</sup>

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<sup>44</sup> 5-ACI-4B-11

- i. **Possessions and privileges provided to individuals on suicide precautions should be individualized and commensurate with their level of risk.**
- j. **All decisions regarding the removal of an individual's clothing, bedding, and possessions (books, slippers/sandals, eyeglasses, etc.) shall be commensurate with the level of suicide risk as determined on a case-by-case basis by a psychiatric provider and documented in Sapphire DC-447, Psychiatric Observation Cell Orders. If a psychiatric provider determines that an individual's regular clothing needs to be removed for reasons of safety, the individual shall always be considered for a jumpsuit or issued at least a safety smock and safety blanket.**
- k. **All individuals on suicide precautions should be allowed access to a shower consistent with schedules in other special housing units.**
- l. **All individuals on suicide precautions shall not automatically be locked down. Rather, PRC should allow routine privileges associated with the individual's custody level (e.g., family visits, telephone calls, etc.) if recommended by PRT as beneficial to the individual's mental health care, unless such privileges are lost or curtailed as a result of a disciplinary sanction. If any privileges recommended by PRT are withheld by PRC, the PRC shall inform the PRT of the justifications for withholding the privileges.**
- m. **All individuals on suicide precautions shall be allowed to attend court/parole hearings unless exigent circumstances exist in which the individual is out of control and at immediate, continuing risk to self and others.**
- n. **A safety mattress shall be issued to all individuals on suicide precautions unless the individual utilizes the mattress in ways in which it was not intended (i.e., attempting to tamper with/destroy, utilize to obstruct visibility into the cell, etc.). Safety mattresses shall be sanitized appropriately following each use and admission, or more frequently as determined by health care staff.**
- o. 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.<sup>45</sup>

(1) Constant Watch <sup>46</sup>

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>47</sup> **Suicidal individuals shall be under constant**

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<sup>45</sup> 5-ACI-4B-11

<sup>46</sup> 5-ACI-4A-11, 5-ACI-6A-35

<sup>47</sup> 5-ACI-6A-35



**watch.**<sup>48</sup> **Observations of individuals on watch shall be documented on the DC-483, Psychiatric Observation Monitoring Form. This form shall not be made out in advance with times entered in advance i.e. 0810, 0820, 0830, 840, and 0850. Constant watch is reserved for the individual who is actively suicidal, either by threatening (with a plan) or engaging in self-injury, and considered a high risk for suicide. This individual should be observed by an assigned staff member on a continuous, uninterrupted basis.** All personal clothing shall be removed from the **individual** and an anti-suicide smock and blanket shall be provided.<sup>49</sup> The psychiatrist/PCRNP will determine what items are permitted in the cell based on security needs and the **individual's** current behavior. Any items not permitted need an explanation on the **DC-447**. Psychiatry provider shall assess if a mental health commitment is necessary and shall provide recommendations and document accordingly as soon as possible.

An officer shall be assigned to provide constant watch. The assigned officers are scheduled to rotate every two hours. The officer is required to have visual contact of the **individual** at all times. This may also be accomplished if the **individual** is located in a camera cell and has full view of the **individual** at all times. If the camera is covered, then the necessary actions must take place in order to remove the objects covering the camera. If this is not possible, then the officer shall be assigned to the cell door and must have full view of the **individual** at all times. If the **individual** is continuously covering the view into the cell, all necessary actions need to take place in removing the objects that are being used to cover the view of the **individual**, this does not require orders from Psychiatry. This must be documented in the **DC-483**. Any planned use of force shall be documented in accordance with Department policy **6.3.1, "Facility Security."**

If more than one **individual** is on constant watch at the same time, they may be placed in adjacent POCs so that one officer may watch more than one **individual**. Constant watch may not be assigned to one officer who cannot observe both **individuals** simultaneously.

(2) Close Watch<sup>50</sup>

**Close watch is reserved for the individual who is not actively suicidal, but expresses suicidal ideation (e.g., expressing a wish to die without a specific plan) and/or has a recent prior history of self-destructive behavior and would be considered a low risk for suicide. In addition, an individual who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (i.e., through actions, current circumstances, or recent history) indicating the potential for self-injury,**

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<sup>48</sup> 5-ACI-4B-11

<sup>49</sup> 5-ACI-6E-01

<sup>50</sup> 5-ACI-6A-35

**should be placed under close watch, at a minimum. Clinical discretion of when to order close watch is at the discretion of the psychiatric provider. Close watch** is less restrictive than constant watch; however, there is still potential danger for SIB. Visual checks shall be made in such a fashion that the **individual** is not aware of a pattern developing, but at least once in every ten-minute period for a total of seven entries per hour. The assigned officers are scheduled to rotate every two hours. The type of clothing and cell items permitted is based on the clinical judgment of the psychiatric provider based on the **individual's** security needs and current behavior.<sup>51</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**.<sup>52</sup>

(3) Regular Watch

**Regular watch is reserved for the individual who is not suicidal, but assessed to be in need of closer observation based upon his/her behavior and/or serious mental illness. This observation level is normally reserved for individuals displaying concerning, non-suicidal behavior, or individuals adjusting to the initiation of, or change in, psychotropic medication. It can also be utilized as a step-down from more restrictive suicide precautions. This individual should be observed by staff at staggered intervals not to exceed every 30 minutes, with documentation as the check occurs. Individuals placed on this level of observation shall always be issued regular clothing and have full access to other possessions and privileges (unless serving a disciplinary sanction).** 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 **individual** is not aware of a pattern developing, but at least within a 30-minute period (random – three entries in an hour). 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 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**.<sup>53</sup>

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 **individual** from the observation area to a follow-up plan. Double celling should be considered, particularly for **individuals** under regular or close watch. **The IRP developed for the individual on watch shall describe the signs, symptoms, and circumstances in which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient**

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<sup>51</sup> 5-ACI-6E-01, 5-ACI-4B-15

<sup>52</sup> 5-ACI-4B-11

<sup>53</sup> 5-ACI-4B-11

*and staff can take if suicidal thoughts do occur. These three components are referred to as a Safety Plan.*

#### **4. Suicide Risk Assessment (SRA) and Safety Plan**

*A comprehensive SRA includes a brief mental status examination (MSE), a review of chronic and acute risk factors for suicide, a review of any protective factors, and a treatment plan that includes methods to reduce acute risk and enhance protective factors (e.g., a safety plan). The purpose of an SRA is not to predict suicidal or self-injurious behavior, but to prevent this behavior through early identification and intervention. Monitoring for elevated risk to engage in any form of self-injury should be part of every mental health contact. When possible, a treating mental health staff member familiar with the individual should complete the SRA due to their knowledge of the individual's needs and history.*

- a. *An SRA can be completed on any individual. Completion of an SRA does not necessarily indicate that the individual should be subsequently placed on the Active MH/ID Roster.*
- b. *The SRA is not meant to be utilized daily or in rapid succession on the same individual.*
- c. *Staff should utilize as many available sources of information in gathering data for the SRA. A face-to-face interview with the patient is essential, but not sufficient. Additional relevant sources should include the patient's health record, incident reports, consultation with other team members, including Corrections Officers, any referral information, and knowledge of the patient based upon providing mental health treatment (if available). Review of documentation prior to interviewing the patient is recommended. Whenever possible, SRAs should be completed through multidisciplinary consultation (i.e., including input from Corrections Officers).*
- d. *When conducting an interview associated with an SRA, the assessor shall conduct the interview in a setting that is as private and confidential as possible (i.e., considering the security risks associated with the patient and situation).*
- e. *For Psychology's use, all features of the SRA are embedded in the DC-560; DC-560A; DC-472L, Progress Note Psychology POC; DC-472J, MHU/FTC Psychology Progress Note; and DC-575, Post Sexual Assault Interview.*
- f. *After completing any SRA, Psychology staff will ensure that all identified risk and protective factors are updated on the patient's summary page within the electronic health record. The location of this inclusion is to ensure that risk and protective factors are easily accessible to other health care staff currently involved in the patient's treatment.*

- g. Once an SRA is initially completed and risk and protective factors are reflected on the patient's summary page within the electronic health record, future SRAs shall not require the complete re-identification of all risk and protective factors. Instead, following the initial identification of risk and protective factors, future SRAs shall include a review and update (i.e., if needed) of the previously identified risk and protective factors in the patient's summary page in the electronic medical record. However, to complete an SRA on an individual who has already had an SRA previously completed, a new MSE is required, documentation of the review and/or update (i.e., if necessary) of the suicide risk and protective factors, appropriate clinical action plan based on the general estimation of suicide risk, as well as the development of a new safety plan to address the new crisis are required.**
- h. The SRA shall be completed/reviewed any time there is a concern of elevated suicide risk, including during the following intercepts and when clinically indicated:**

  - (1) to inform initial implementation or placement on suicide precautions, as well as justification for an individual's discharge from suicide precautions in POCs. For these reasons, the SRA should be completed by the assigned Psychology staff member and reviewed by the admitting psychiatrist/PCRNP. The SRA is not required to be completed/reviewed before placing an individual on a watch, but it should be completed/reviewed as soon as practical thereafter and prior to reducing watch and/or discharging someone from watch. If it is not completed to justify reducing watch or discharging someone from watch, a review of dynamic risk factors and protective factors should be undertaken to ensure the patient's risk management and treatment needs have been met and documented;**
  - (2) in response to initial screening referrals in the DCC to Psychology staff for acute suicidal/self-injury ideation, self-injury threats, or related behavior as well as for all new receptions into the DCC;**
  - (3) in response to emergent referrals to Psychology staff for acute suicidal/self-injury ideation, self-injury threats, or related behavior;**
  - (4) to accompany referrals to Psychiatry from Psychology for elevated risk of suicide or self-injury;**
  - (5) whenever the PRT determines the need to downgrade a D Roster individual to C Roster, who was previously determined to be functionally impaired as a result of any form of self-injury;**
  - (6) as part of mental health assessments associated with placements and contacts of individuals in Restrictive Housing and Special Management;**

- (7) *when asked to provide an opinion regarding an initial approval of a Z Code or to continue a Z Code; and*
  - (8) *prior to discharging an individual from an MHU that was admitted for reasons related to self-injury, suicidal ideations, threats, or related behavior.*
- i. *When conducting an SRA, the assessor should include a brief MSE, an overview/review of Chronic Risk Factors (i.e., historic and demographic), acute risk factors (i.e., within three months), Protective Factors (i.e., those factors that are likely to increase the safety), as well as a general estimate of suicide risk and an accompanying treatment plan that includes methods to reduce acute risk and enhance protective factors (e.g., a safety plan).*
- (1) *Chronic Risk Factors include but are not limited to family/close friend history of suicide; history of emotional, physical, or sexual abuse; history of major depressive disorder; history of psychotic disorder; chronic pain problem; chronic medical illness; history of substance use disorder(s); history of violence (including index offense); history of poor impulse control; perception of loss of social support; first prison sentence; longer sentence or life sentence; sex offender; Caucasian; older than 35 years of age; male; history of serious suicide attempts or any form of self-injury; or other.*
  - (2) *Acute Risk Factors (i.e., within three months) include but are not limited to suicidal ideation (i.e., including passive ideation); recent serious suicide attempt or any form of self-injury; current/recent depressive episode; current/recent psychotic symptoms; current/recent anxiety or panic symptoms; current/recent substance use/intoxication; hopelessness/helplessness; increasing interpersonal isolation; agitated or angry; current/recent violent behavior; recent serious medical diagnosis; disturbance of mood/lability; recent bad news, loss, or anniversary date; early in prison sentence; recent change in housing (e.g., RHU/DTU placement); safety concerns (e.g., security threat group dropout); recent negative staff interactions; evidence of hoarding medications; recent misconduct(s); current report of a plan to kill him/herself; current report of desire to die; or other.*
  - (3) *Protective Factors include but are not limited to family support (e.g., visits, correspondences, etc.); religious/spiritual/cultural beliefs; interpersonal social support; future orientation/plans for future; exercises regularly; positive coping skills and conflict resolution skills; children at home; spousal support; insight into problems; job or school assignment or engagement in other meaningful daytime activities; active and motivated in mental health treatment; sense of optimism/self-efficacy; or other.*

- j. **Review of Chronic, Acute, and Protective factors is not an actuarial process. While it is true that suicide risk elevates as risk factors accumulate, the simple summation of the number of risk factors versus the number of protective factors should not be interpreted to mean that if an individual has more risk factors than protective factors, that the individual is at elevated or high risk. Instead, each assessment should determine whether the totality of the risk factors outweighs the totality of the protective factors. This requires individual-specific weighted judgment.**
- k. **Chronic Risk Factors are unlikely to change, unless new information is received. Acute Risk Factors are more likely to change than Chronic Risk factors.**
- l. **Protective factors are skills (e.g., coping strategies), strengths, or other factors exhibited by the individual that can be used to help reduce risk. Some factors that are protective for one individual, may be risk factors for others.**
- m. **The Psychology staff member shall not rely exclusively on the individual's self-report of identifying Chronic, Acute, and Protective factors. The Psychology staff shall rely on at least one other source of information when identifying these factors and criteria, as outlined above.**
- n. **The judgment of estimated risk should be based on the factors indicated, but this is a matter of clinical judgment. Based on the estimated risk and clinical judgment, Psychology staff should take appropriate action (e.g., referral to PRT, referral to Psychiatry, contact Psychiatry for an emergent referral and emergency assessment for placement into POC, etc.).**
- o. **The treatment plan associated with an SRA should include methods to reduce acute risk and enhance protective factors. This treatment plan is referred to as a Safety Plan.**

### **Safety Plans**

- (1) **A Safety Plan is a collaborative strategy developed by the individual and Psychology staff member to identify those signs or symptoms that the individual may be decompensating and those specific steps the individual can take to be safe. A Safety Plan can be documented on an appropriate progress note (e.g., full DC-560, DC-560A, DC-472L, DC-472J, and DC-575), which is typically associated with the completion of an SRA or on an IRP.**
- (2) **Psychology staff have the discretion to develop a Safety Plan with an individual at any time. However, upon admission to a POC, Psychology staff shall create a Safety Plan for the individual. This Safety Plan can be included in the individual's Change of Status IRP that must be completed upon admission.**

- (3) **First, the patient and Psychology staff member should identify the warning signs and symptoms of potential safety concerns, which includes identifying those warning signs that the individual is beginning to struggle or the existing struggle is beginning to exacerbate even further. These warning signs and symptoms can include thoughts, feelings, behaviors, and or circumstances in which the risk for decompensation, suicide, suicidal ideation, violence, etc., is likely to recur.**
- (4) **Secondly, the patient and clinician should identify coping skills to ensure personal safety that the individual can utilize by themselves or with others to ensure their immediate safety. This process should include a discussion of coping skills utilized in the past to ameliorate similar stressors and new coping skills that the individual can discuss with the Psychology staff member for the purpose of deescalating one's emotions, thoughts, or behaviors, either by themselves or with someone else. Additionally, this part of the plan should also include a discussion of the obstacles that might exist to implementing these coping skills and how to overcome these obstacles. This section of the plan should include the identification of emergency contacts (i.e., correctional and professional staff) for the individual and how to access and notify correctional staff of emergencies.**
- (5) **Finally, the Safety Plan should include a section related to the identification of the service strategies to be provided from the correctional and professional support system to ensure ongoing safety. This section should include the identification of what others could do to help ensure ongoing safety, if the individual's crisis intensifies.**

**Safety Plans should generally be based on data collected and the risk factors identified on an SRA. These plans should target acute risk factors and, if possible, reinforcement of protective factors. Safety Plans should be generated collaboratively between the individual and the Psychology staff member. Safety Plans should reflect a problem-solving approach and be specific to the individual.**

#### 5. 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.<sup>54</sup> 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.

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<sup>54</sup> 5-ACI-4B-02

- 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 *individual* 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 *individual* placed on suicide observation, both inside and outside the infirmary, shall be given written notice of the reasons for AC using a **DC-141, Part 1, Other Report Form.** For an *individual* placed in observation outside of the infirmary, a hearing is scheduled according to the provisions of Department policy **DC-ADM 802.** ([see memo 1-27-2021](#))
  - (2) An *individual* placed in observation status outside the infirmary shall be given a review whereby he/she is presented with the reasons for AC 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 American Correctional Association (ACA) standards, DHS regulations for MHUs/FTCs, and Department policies and directives.

#### 6. Use of Psychiatric Restraints<sup>55</sup>

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

#### 7. Mental Health Commitment<sup>56</sup>

If the *individual* 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 *individual* is a female. Although the FTC and Forensic State Hospital are the preferred sites for long-term commitments, 304s may also be conducted in the MHUs.

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<sup>55</sup> 5-ACI-3A-18

<sup>56</sup> 5-ACI-6A-39



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- c. Voluntary (201) Commitments may be placed in a Department MHU, or in the FTC at SCI Waymart.

8. Discharge of an **individual** from a POC

- a. Staff shall be aware of the increased risk of suicide for an **individual** released from a POC and shall be conservative in discharging him/her.
- b. If the **individual** 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 **individual** shall be closely monitored by staff;
  - (2) Psychology staff will interview the **individual** in the POC on the day of discharge. Additionally, the **individual** will be interviewed by Psychology on the day of discharge on the unit he/she is 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; and
  - (4) the **individual** will be scheduled for PRT within seven days of discharge **for the purpose of reviewing the IRP and Safety Plan to determine if the goals and objectives remain current. If the IRP in place is determined to no longer be accurate, updates to the IRP shall occur to reflect the most updated risks and needs of the patient.**
- c. Release of an **individual** from POC to housing units that are not general population (RHU, SRTU, SMU, DTU, etc.):
  - (1) placement of the **individual** in a cell within close observation of Corrections Officers;
  - (2) 15-minute close observation and/or continuous video monitoring is initiated and maintained;
  - (3) the Psychology staff, in conjunction with the **individual's** counselor, shall maintain daily contact with the **individual** and review the corrections staff logs, incident reports, and any classification materials;
  - (4) the **individual** shall be scheduled for a psychiatry appointment as per the recommendations indicated in the POC discharge progress note;
  - (5) the **individual** shall be scheduled to be reviewed by PRT within seven days of discharge **for the purpose of reviewing the IRP and Safety Plan to determine if the goals and objectives remain current. If the IRP in place is**

**determined to no longer be accurate, updates to the IRP shall occur to reflect the most updated risks and needs of the patient; and**

- (6) **PRT shall continue to review the individual 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.**

9. Treatment Planning and Responsibilities

a. PRT

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

b. Continuity of Care<sup>57</sup>

An aftercare plan is developed by the PRT based on the **individual'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 **individual's** progress for at least 30 days after his/her release from observation. Monitoring may be extended, based on the **individual'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 **individual** 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 **individual** is on constant or close watch, the treating psychiatrist/PCRNP shall visit the **individual** every day he/she is in the facility.

e. Physician

The facility physician shall visit the **individual** daily.

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<sup>57</sup> 5-ACI-6A-04

f. Licensed Psychologist Manager (LPM)

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

g. Unit Manager (UM)

The UM shall provide information regarding the **individual's** current situation, and assist in the implementation of the aftercare plan after the **individual's** release from observation.

h. Nursing Staff

The registered nurse shall be the contact person for the psychiatrist/PCRNP. Nursing staff shall visit each **individual** in a POC every two hours in accordance with Department policy **13.2.1**.

**M. Suicide Prevention Committee**<sup>58</sup>

1. The Suicide Prevention Committee at each facility is a multidisciplinary, 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, Brief Chart Review** and clinical reviews. A specific plan of action (POA) 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. **Quarterly, in accordance with Department policy 5.1.1, Section 5, the Training Coordinator shall provide an update on the progress of suicide prevention training**

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<sup>58</sup> 5-ACI-6A-35

**for the facility to the LPM/designee and the Deputy Superintendent for Centralized Services (DSCS). This data should be discussed during the monthly Suicide Prevention Committee, as outlined below, to ensure compliance with annual completion deadlines.**

3. 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. ***In this regard, the Suicide Prevention Committee shall be tasked with reporting the monthly progress of achieving compliance with the annual suicide prevention training requirements, outlined in Department policy 5.1.1;***
  - b. the process by which all ***individuals*** 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 ***individual*** dedicated channel introducing mental health staff and services offered by Psychology;
  - f. developing wallet or pocket cards for dealing with ***individuals*** suffering from mental illness or intellectual disability and potentially suicidal ***individuals***;
  - g. ensuring proper submission and review of all **DC-516s**;
  - 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;
  - i. ***monitoring*** post POC ***discharge*** PRTs that are required to occur ***and developing POAs to rectify any noted deficiencies***;
  - j. ***developing specific POAs associated with suicide prevention in the facility, discussing them with the committee, implementing these POAs, and monitoring these plans following implementation***; and
  - k. ***monitoring POAs developed in response to suicides and serious suicide attempts that recently occurred at the facility and making needed adjustments and revisions to initial plans, if necessary.***

**N. Statewide Psychological Ethics Committee (SPEC)**

*The Statewide Psychological Ethics Committee (SPEC) is responsible for convening (i.e., via teleconference) quarterly to review and discuss newly proposed and/or existing policies and practices that fall within the scope of Psychological practice within the Pennsylvania DOC as outlined by the American Psychological Association and or the Pennsylvania Board of Psychology. The Administrative Officer 5 (AO5) from the Psychology Office shall chair the SPEC. Prior to each meeting, the AO5 will compile an SPEC agenda based on concerns and issues identified by field staff to be reviewed and considered by the SPEC, for determination of appropriate action. The AO5 of the Psychology Office will provide a copy of agenda items, topic discussion, and meeting minutes of the quarterly SPEC meeting to the Regional LPMs, Director of the Psychology Office, and COSNPRT on a quarterly basis. Copies of these items shall be included in the distribution of the monthly COSNPRT packet. The SPEC shall be comprised of the AO5 from the Psychology Office, a minimum of five volunteer LPMs, and the Department's Mental Health/Health Care Advocate, when available. The AO5 is responsible for reporting back to SPEC, as needed.*

**O. Mental Health Services Review Committee (MHSRC)**

The Mental Health Services Review Committee (MHSCRC) at each facility shall annually review this procedures 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, **Director of Psychology**, and the respective RLPM for review and coordination. In addition, the MHSRC shall review the facility's written procedures for screening, treating, tracking, and follow-up of **individuals** 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.

## Section 3 – Delivery of Psychiatric Services

### A. Documentation of Psychiatry Services<sup>1</sup>

This section establishes procedures for the delivery of psychiatric services. All psychiatric reports, assessments (practitioner/nursing), exams, progress notes, etc. shall be **documented in the Electronic Health Record (EHR)**.

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

A **DC-472C** shall only be used by a psychiatrist or Psychiatry Certified Registered Nurse Practitioner (PCRNP) to document psychiatric patient care provided at all locations within the Department of Corrections (DOC). Psychiatry providers at a Mental Health Unit (MHU)/Forensic Treatment Center (FTC) shall utilize **DC-472E, Inpatient Progress Note**. The Subjective Objective Assessment Plan (SOAP) format includes:

- a. S (Subjective) – Current psychiatric and medical symptoms, pertinent interval history, pertinent pharmacology or medication concerns, etc;
- b. 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;
- c. A (Assessment) – Diagnosis/rationale – need for treatments, medications/medication adjustments/change in medications/medication compliance, **and review of blood work results**; and
- d. P (Plan) – The clinician’s treatment plan, including a diagnostic component and a therapeutic component, could include:
  - (1) psychotropic medications (new or modify pre-existing) with rationales;
  - (2) laboratory test including blood levels, electrocardiogram (EKG), X-Rays, etc.;
  - (3) referrals to other disciplines such as Medical and Psychology (psychotherapy, psycho education, etc.);
  - (4) request/review of medical records from outside sources;
  - (5) administrative/security concerns to be addressed;
  - (6) Program Review Team (PRT) regarding changes to C and D Roster status;

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<sup>1</sup> 5-ACI-6D-05

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- (7) next appointment (routine and/or brief follow-up); and
- (8) statement of discussion with the **individual**.

2. Psychiatric Reports/Examinations

a. The following are examples of psychiatric examinations:

- (1) psychiatric assessments;
- (2) second opinions;
- (3) commutation;
- (4) pardon;
- (5) guilty but mentally ill (GBMI);
- (6) specialized housing units; and
- (7) other reports as requested.

b. The evaluation shall **include**:

- (1) demographic information;
- (2) current psychiatry history;
- (3) past psychiatric history;
- (4) substance **use/treatment** 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.

3. Informed Consent for Psychotropic Medication<sup>2</sup>

- 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 this form is to **document the individual is informed consent for the psychotropic medication, including the individual's understanding of the benefits, side effects, and any alternatives to the proposed medication.** A Spanish version of the **DC-452D** is available (**Attachment 3-C**).
- b. The **individual** shall be asked to document whether he/she wants, or does not want, to take the medication.
- c. Upon form completion, the **individual** shall be asked to date/time and sign the document.
- d. When an **individual** refuses to sign the form, the psychiatrist/PCRNP shall document the **individual's** refusal on the **DC-452D**. If the **individual** 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.
- e. Patient facilitator can complete this form during the Telepsychiatry session. Telepsychiatry provider shall document the medication consent process accordingly in the progress note.

**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 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

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<sup>2</sup> 5-ACI-6A-28, 5-ACI-6C-04



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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). **One psychiatrist may collaborate with no more than four PCRNPs.** At a minimum, the PCRNP and his/her collaborating psychiatrist/substitute psychiatrist shall meet, or talk by telephone, at a minimum once a month and, if needed, weekly to discuss cases, prescription practices, or other clinical practice issues. Any changes in clinical care, plan, or treatment because of the collaboration discussion shall be documented in patient's record by the PCRNP.

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 an 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 **individual**;
  - (5) **not approved to provide Decision-Making Capacity Evaluations**;
  - (6) **shall collaborate with psychiatrist or Regional Chief Psychiatrist as much as possible prior to assigning D-Roster psychiatric diagnosis for those who currently have been maintained on a C-Roster diagnosis**; and
  - (7) 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);
  - (3) admission to, and discharge from, a Psychiatric Observation Cell (POC);
  - (4) admission assessments, discharge, and routine care of patients in the FTC/**MHU** (inpatient) including psychiatric restraints with the approval from the Department of Human Services (DHS); and
  - (5) 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 **individuals**, only when less restrictive measures and techniques have proven to be less effective.
- 2. Therapeutic restraints shall only be used when an **individual** is acting in a manner as to be a clear and present danger to himself/herself, 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>3</sup>

**D. Guidelines for Psychiatric Observation Cells (POC)**<sup>4</sup>

- 1. General Procedures
  - a. The Registered Nurse Supervisor/designee shall notify the Shift Commander of every POC admission and discharge.
  - b. Every **individual** 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 where feasible.
  - c. If a Restricted Housing Unit (RHU) or Diversionary Treatment Unit (DTU) cell is temporarily utilized as a POC for a psychiatric admission, it must be a camera cell and the individual must initially be placed on a constant watch unless the psychiatry provider decides to change it based on his/her assessment. This initial constant watch

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<sup>3</sup> 5-ACI-6C-13

<sup>4</sup> 5-ACI-6A-35

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will remain in place until a face-to-face assessment is completed by the psychiatric provider. Additionally, if an RHU or DTU cell is temporarily utilized as a POC, it is mandatory that all provisions of implementing all safeguards, levels of watch, documentation, and operational procedures as directed by this section and **Section 2** of this procedures manual, as well as other policies directing other disciplines' operations for this setting are followed. It is imperative that all disciplines and members of multidisciplinary teams, including Security, are informed of the individual's needs and the expectations of this temporary housing placement.

- d. The Department discourages prolonged psychiatric admission/stay in POC, unless the inmate is being provided/receiving appropriate treatment, steadily improving, and/or awaiting discharge to an appropriate housing unit, MHU, or FTC.
  - e. In accordance with Department policy **6.3.1, a DC-141, Part 1, 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.
  - f. An **individual** shall only be discharged from a POC upon being assessed face-to-face or via Telepsychiatry by the psychiatrist/PCRNP with **proper documentation in DC-472C** and only upon a written order by the psychiatrist/PCRNP. Verbal or telephone orders for discharge are not acceptable. A **DC-474A, POC Discharge Summary Form (Attachment 3-D) shall be completed within the next working day**.
  - g. The Registered Nurse Supervisor/designee shall ensure that PRC is notified of planned POC discharges so that PRC may arrange for appropriate housing.<sup>5</sup>
2. Notification of Facility Psychiatrist/PCRNP or MHC for Psychiatric Emergencies by Facility Staff
- a. During regular working hours, the MHC/Registered Nurse (RN)/designee shall call the facility psychiatrist/PCRNP. The psychiatrist/PCRNP shall evaluate the **individual** for a POC admission. If a psychiatric emergency exists, psychiatry provider shall instruct the nursing staff to admit the **individual** to a POC for psychiatric reasons. The psychiatrist/PCRNP shall complete a **DC-447, Psychiatric Observation Cell Order (Attachment 3-E)** and document the reasons/findings in the **DC-472C**.
  - (1) If a psychiatric emergency exists and a psychiatric provider orders a POC admission, but all current POCs at the current facility are currently occupied or otherwise unavailable, collaboration of members of PRT and PRC must consider the following:

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<sup>5</sup> 5-ACI-4B-09

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- (a) whether any of the current patients in the POC can be moved to a less restrictive setting with provisions of safeguards and watches, as appropriate, and ordered and supported by the psychiatric provider;
  - (b) if the above is not possible, an RHU or DTU cell may be temporarily utilized as a POC for a psychiatric admission. This cell must be a camera cell and the individual must initially be placed on a constant watch unless the psychiatry provider decides to change the watch based on his/her assessment. This initial constant watch will remain in place until a face-to-face assessment is completed by the psychiatric provider. Additionally, if an RHU or DTU cell is temporarily utilized as a POC, it is mandatory that all provisions of implementing all safeguards, levels of watch, documentation, and operational procedures as directed by this section and **Section 2** of this procedures manual, as well as other policies directing other disciplines' operations for this setting are followed. It is imperative that all disciplines and members of multidisciplinary teams, including Security, are informed of the individual's needs and the expectations of this temporary housing placement; and
  - (c) transfers to another facility for this purpose are strongly discouraged.
- (2) If a psychiatric admission to POC is not warranted, MHC/RN/designee shall inform the Captain/Shift Commander of the clinical decision. The psychiatry provider shall document the findings in the **DC-472C** with plan and recommendations.
- (a) If concern still exists regarding keeping the **individual** safe from himself or herself that is not due to psychiatric etiology (e.g., the **individual** expresses/making threatening suicidal gestures or inflicts self-harm, but the psychiatric provider has deemed the ideations or actions to not be the result of psychiatric impairment), collaboration between members of PRT and PRC should consider alternative housing in a DTU or RHU, with provisions of implementing enhanced security measures and restrictions (e.g., Intermediate Restraint System, Restraint Chair, etc.) as appropriate and outlined in Department policies **6.3.1** and **6.5.1**, "**Administration of Security Level 5 Housing Units**," to provide a housing setting commensurate with the individual's current needs. Once an alternative location at the current facility has been identified, it is imperative that all disciplines and members of multidisciplinary teams, including Security, are informed of the individual's needs and the expectations of this placement.
  - (b) Unit psychology staff/counselor/designee shall provide support, assess for suicidality, and monitor the **individual** regularly until it is no longer deemed necessary during working days.

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- (c) Unit Certified Peer Specialist (CPS) shall also provide peer support daily as needed.<sup>6</sup>
  - (d) The **individual** will be scheduled for follow-up with psychiatry within one to three days, if deemed necessary.
- b. During non-regular working hours, the Shift Commander may bring the **individual** into a POC. The Registered Nurse Supervisor/designee shall evaluate the **individual** using a **DC-586NN, Nursing Evaluation Tool: General Psychiatric Concern** and contact the on-call psychiatrist/PCRNP to report the **individual's** condition and behavior.
- (1) If a psychiatric emergency exists, the psychiatrist/PCRNP shall order a POC admission for psychiatric reasons, 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 documentations as outlined in this procedures manual.
  - (2) If a psychiatric emergency exists and a psychiatric provider orders a POC admission, but all current POCs at the current facility are currently occupied or otherwise unavailable, members of PRC and/or Shift Commander must consider the following:
    - (a) utilizing an RHU or DTU cell temporarily as a POC for a psychiatric admission. This cell must be a camera cell and the individual must initially be placed on a constant watch unless the psychiatry provider decides to change the watch based on his/her assessment. This initial constant watch will remain in place until a face-to-face assessment is completed by the psychiatric provider. Additionally, if an RHU or DTU cell is temporarily utilized as a POC, it is mandatory that all provisions of implementing all safeguards, levels of watch, documentation, and operational procedures as directed by this section and **Section 2** of this procedures manual, as well as other policies directing other disciplines' operations for this setting are followed. It is imperative that all disciplines and members of multidisciplinary teams, including Security, are informed of the individual's needs and the expectations of this temporary housing placement; and
    - (b) transfers to another facility for this purpose are strongly discouraged.
  - (3) If a psychiatric admission to POC is not warranted (after the review by the psychiatry provider), nurse/designee shall inform the Captain/Shift Commander of the clinical decision.
    - (a) If concern still exists regarding keeping the **individual** safe from himself or herself that is not due to psychiatric etiology (e.g., the **individual**

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<sup>6</sup> 5-ACI-6B-12

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expresses/making threatening suicidal gestures or inflicts self-harm, but the psychiatric provider has deemed the ideations or actions to not be the result of psychiatric impairment), collaboration between members of PRC and/or Shift Commander should consider alternative housing in a DTU or RHU, with provisions of implementing enhanced security measures and restrictions (e.g., Intermediate Restraint System, Restraint Chair, etc.) as appropriate and outlined in Department policies **6.3.1** and **6.5.1** to provide a housing setting commensurate with the individual's current needs. Once an alternative location at the current facility has been identified, it is imperative that all disciplines and members of multidisciplinary teams, including Security, are informed of the individual's needs and the expectations of this placement.

- (b) Unit psychology staff/counselor/designee shall follow-up the next working day.
- (c) Unit CPS shall also provide peer support daily as needed.
- (d) The **individual** will be scheduled for follow-up with psychiatry within one to three working days.

3. Nurses shall be required to perform/ensure the following.<sup>7</sup>

- a. The RN 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>8</sup>
- b. The RN shall contact the psychiatric practitioner to report the **individual's** condition, and to obtain orders; if receiving verbal orders, initiate the **DC-447** and a copy of the **DC-447** shall be provided to the officer in charge of the POC to follow through all the restrictions as ordered by the psychiatry provider. Any changes to these restrictions require a new **DC-447**, and the RN shall communicate with the officer in charge of the changes by providing a copy of the new **DC-447**.

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<sup>7</sup> 5-ACI-4B-12

<sup>8</sup> 5-ACI-6A-07

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- c. Initiate and maintain the **Inpatient Area Admission/Discharge Log** (see 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, Section 10**.
  - e. The RN shall initiate a **DC-478, Inpatient Unit Nursing Care Plan** (see 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>9</sup>
  - f. Inform the Corrections Officer regarding the level of watch for the **individual**, and the items permitted to be in his or her possession.
  - g. **All** verbal orders shall be entered in the electronic **medical record**.
  - h. Procedures for psychiatric therapeutic restraints shall be followed in accordance with Department policy **6.3.1, Section 33**.
  - i. The RN shall observe **individual** behaviors, interact with the **individual** to assess the stability, and provide therapeutic support at least every two hours during the shift, and document (using the SOAP [IER] format) the findings, observations, and behaviors in the inpatient progress notes, at a minimum of twice (every four hours) per shift, unless otherwise ordered by the psychiatric/medical practitioner.
  - j. The RN shall report significant changes in the **individual’s** behavior or mental status to the psychiatric provider.
  - k. 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:<sup>10</sup>
- a. **during regular working days**, psychiatrist/PCRNP **may give verbal orders for the admission to the POC. Psychiatrist/PCRNP** shall assess the **individual face-to-face or via Tele Psych** for the need of POC admission **by the end of that working day** and document all clinical findings with respect to the need for the POC admission in the **DC-472C**, along with recommendations in relation to his/her treatment while the **individual is being admitted to POC**, and also complete the **DC-447**;

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<sup>9</sup> 5-ACI-6A-07

<sup>10</sup> 5-ACI-4B-12

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- b. POC admitted **individuals** shall be assessed daily during working hours on regular working days. Document the assessed clinical findings/progress/recommendations in the progress note;
- c. when appropriate, the psychiatric provider or psychology staff member may request an out-of-cell contact for those individuals psychiatrically admitted to the POC;
- d. team review of the restrictions must be done on a daily basis on working days, same shall be documented and if any changes to the restrictions are considered, a new **DC-447** shall be completed with all the new restrictions or lesser restrictions. This form must be completed in its entirety at all times;
- e. all POC discharge decisions shall be made during the team review. The MHC/RN/designee shall inform PRC of POC discharges;
- f. where feasible, Telepsychiatry may be utilized for POC admits/rounds/discharges, 302 commitments, and psychiatric restraints assessments;
- g. enter medication orders in the EHR eMAR;
- h. ***the psychiatry provider shall review and sign-off on all verbal orders within the next working day;***
- i. complete the **DC-474A** within 24 hours of discharge or by the end of the next working day with follow-up recommendations.<sup>11</sup> All patients who are being discharged from POC shall be referred to PRT; and
- j. complete an on-site or via Telepsychiatry (where **available**) evaluation within two hours after the application of any psychiatric restraints in the POC (psychiatrist only).<sup>12</sup>

During times of extreme weather conditions, it is expected that the psychiatrist shall communicate with site, complete the assessment over the phone, and complete the documentation in Sapphire accordingly. The psychiatrist will assess the patient face-to-face as soon as the extreme conditions abate and it is safe to drive to the site.

- 5. The facility physician shall be required to ensure the following.<sup>13</sup>
  - a. Review the annual or bi-annual physical examination.
  - b. Perform an initial examination including:
    - (1) review of the medical problem list;

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<sup>11</sup> 5-ACI-6D-05

<sup>12</sup> 5-ACI-6C-13

<sup>13</sup> 5-ACI-4B-12



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- (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>14</sup>
- c. Examine the **individual** 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.<sup>15</sup>
- a. Provide counseling and support during regular working hours (Monday – Friday). The psychology staff shall evaluate the **individual** Monday – Friday (*i.e., optionally* with the psychiatric provider). **Psychology shall document their contacts with individuals admitted Psychiatrically to POCs and/or individuals under POC status housed in a similar unit (e.g., RHU, DTU, etc.) on the DC-472L, Progress Note Psychology POC.**
  - b. Update the Individual Recovery Plan (IRP) addressing behavior warranting POC admission on the day of admission, or as soon as normal institution operations permit.<sup>16</sup>
  - c. Verbally communicate concerns about the **individual's** condition to the nursing staff and **individual's** counselor and/or DATS.
  - d. Document results of daily contacts in the progress notes.
  - e. Assign each **individual** 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>17</sup>

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<sup>14</sup> 5-ACI-6A-07

<sup>15</sup> 5-ACI-4B-10, 5-ACI-4B-12

<sup>16</sup> 5-ACI-6A-07

<sup>17</sup> 5-ACI-6A-37

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- g. Complete the following monitoring when an **individual** transfers from the POC to general population or a Residential Treatment Unit (RTU):
  - (1) the **individual** shall be seen in the POC on the discharge day, or when normal institution operations permit;
  - (2) the **individual** shall be seen on the housing block, or when normal institution operations permit;
  - (3) the **individual** shall be seen the day after discharge from the POC; and
  - (4) the **individual** shall be seen as clinically indicated until the Psychiatric Review Team (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 **individual**.
  - 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, as defined in **Section 2** of this procedures manual. All 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 the medical records department to be placed in the inpatient record;
  - b. notify the nursing staff immediately of any unusual behavior;
  - c. CPSs can be used to provide support during watches conducted by Correctional Officers; the Correctional Officer must always be present during these watches.<sup>18</sup> Under no circumstances do CPSs replace staff; they increase supportive services. CPS 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 CPSs, due to the sensitive nature of these assignments, will take considerable care in ensuring CPSs are mature, reliable, have credibility with both staff and **individuals**, are able to protect the suicidal **individual's** privacy from other **individuals**, and can perform duties with minimal need for supervision;

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<sup>18</sup> 5-ACI-6B-12

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- e. each CPS will receive a job orientation and sign the **Inmate Job Orientation Form** (see Department policy **DC-ADM 816, “Inmate Compensation,” Section 1**) maintained by the CPS 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 **individual** on watch.
- f. CPS supervisor will ensure all CPSs receive suicide prevention training. If this training is needed, CPS supervisor will coordinate the training.

**E. Involuntary Administration of Psychotropic Medications**<sup>19</sup>

1. Guidelines

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

- a. the **individual** suffers from a mental disorder and/or an organic, mental, or emotional impairment that has a substantial adverse impairment on the **individual's** cognitive/volitional function;
- b. the **individual** is an imminent threat of danger to self or others; and
- c. the **individual** 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/or
  - (3) is housed in a POC or infirmary, and shall be assessed for an involuntary commitment by a psychiatrist and if needed, it will now be initiated.

2. Procedures for Treating Acutely Mentally Ill and Unstable Inmates

- a. An **individual** showing signs of significant, impairing mental disorganization, including significant inability to care for self, and/or who possess a danger of hurting

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<sup>19</sup> 5-ACI-6C-08

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himself/herself or others **secondary to mental illness**, shall be immediately placed in a POC by Security staff.

- b. The **individual** 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 **individual** 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 **individual** and assess the need for POC admission or psychotropic medication, and/or other interventions. After conducting an assessment of the **individual**, the on-site psychiatrist/PCRNP shall document his/her findings in the progress notes with recommendations.
- 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 **individual'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 **individual** requires psychotropic medication, the **individual** shall be offered the opportunity to voluntarily accept the prescribed psychotropic medication. The **individual's** response(s) shall be recorded in the progress notes.
- f. If the **individual** 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 **individual**.
- g. **For those who may have received STAT administration of psychotropic medication for the acute emergency and/or those who may not require acute STAT administration of medications, but would benefit from standing orders of psychotropic medications over the patient's objection**, the on-site/on-call psychiatrist may then consider ordering the involuntary administration of psychotropic medication for the purpose of patient's standing **orders of psychotropic medication** treatment; 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 administration of this psychotropic medication, then the Bureau Chief of Psychiatry shall be consulted.

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- 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 **individual's** medical record, and an alternative treatment plan shall be developed in order to stabilize and ensure the health and safety of the **individual**.
- j. ***If the plan of care is to order intramuscular (IM) injection of standing psychotropic medications over patient's objections after the concurring second opinion then this treatment shall be initiated at the facility, provided it is safe and medically stable to initiate the treatment. The patient shall be referred to inpatient level of care while he/she continues to receive his/her treatments at the facility.***
- k. In the case of **acute** emergency.

***If the*** on-site/on-call psychiatrist determines that there is no less invasive means for preventing the **individual** from causing harm to himself/herself or others, the psychiatrist/PCRNP may order STAT psychotropic medication over patient's objection. ***If appropriate and needed, the patient shall be assessed*** for a mental health commitment as soon as possible.

***The on-site psychiatry provider shall examine the patient and document the rationale and need for the involuntary administration of psychotropic medication in the progress note. This documentation must include the immediate threat posed to the individual or others, all the efforts to have the individual accept the medications voluntarily, every previous unsuccessful treatment effort, and every emergency treatment that was needed to stabilize the individual.***

The **on-call** provider shall document the rationale and need for the involuntary administration of psychotropic medication in the progress note. This documentation must include the immediate threat posed to the **individual** or others, all the efforts to have the **individual** accept the medications voluntarily, every previous unsuccessful treatment effort, and every emergency treatment that was needed to stabilize the **individual**. ***Patient shall be examined by psychiatry provider during the next working day.***

3. Process for the Administration of Involuntary Psychotropic Medication

- 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.

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- b. After the administration of medication, vital signs shall be monitored by the RN every 30 minutes at a minimum, or until otherwise directed by the psychiatrist/PCRNP. Medication efficacy and side effects shall be monitored by the RN and documented in the progress note. In addition, hydration status, food intake, changes in mental status, etc. shall also be routinely assessed and documented accordingly by the RN.
- c. The RN shall contact and inform the psychiatry provider if the medication did not produce the desired results and get further recommendations with respect to the need for further medication. The same shall be documented in the progress note. The verbal nursing order(s) for the first dose of medication, and any subsequent doses, shall be cosigned by the psychiatry provider as soon as possible.
- d. The psychiatrist (not PCRNP) shall perform an evaluation face-to-face or via Telepsychiatry as necessitated by reported concerns of inadequate response to one or more doses of the medication, deterioration of the **individual's** overall condition, worsening risk of harm to self or others, or at the specific request of the site Facility Manager/Deputy/CHCA/designee at any time.
- e. Recommended plan shall be documented in the progress note by the psychiatrist.
- f. The treatment team shall begin emergency commitment procedures if indicated **and needed**. The transfer to the FTC or MHU shall be completed at the earliest possible date.<sup>20</sup> The **individual** 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 **individual'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 Deputy Superintendent for Centralized Services (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 **individual** does not have a documented/diagnosed sleep disorder, the following shall occur:

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<sup>20</sup> 5-ACI-6A-37, 5-ACI-6C-12

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1. the psychiatrist/PCRNP shall refer the **individual** to psychology for the Sleep Hygiene Enhancement Program. **Sleep log documentation should be part of monitoring improvement or lack of improvement prior to and after initiation of therapy and treatment;**
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 **individual**. The psychiatrist/PCRNP shall document the rationale for continuing/renewing the prescription in the **individual'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 **individual** 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 if they are expiring prior to the scheduled appointment with the psychiatry provider for up to ten days, so as not to have abrupt withdrawals, and the **individual** must be scheduled to have a face-to-face re-evaluation within seven days. 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.

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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.<sup>21</sup>
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.

## **H. Psychiatric Medication Monitoring<sup>22</sup>**

The Department provides clinical management of psychiatric illness and medication management through **outpatient** clinics **and inpatient care**. Medications specifically reviewed and monitored include Antipsychotics, Mood Stabilizers, and Tricyclic Antidepressants (TCA). Minimum guidelines shall be followed in order to monitor and evaluate for possible side effects of antipsychotic medications, mood stabilizers, and TCAs.

1. Antipsychotic Medication\*\*
    - a. Initial Work Up – Fasting Serum Glucose, Fasting Lipid Panel, Complete Blood Count (CBC), Complete Metabolic Panel (CMP), Prolactin level\*, Weight plus Body Mass Index (BMI), Blood Pressure, Electrocardiogram (EKG), Abnormal Involuntary Movement Scale (AIMS).
    - b. ***Thyroid Stimulating Hormone (TSH) initially and then if clinically indicated.***
    - c. Every Six Months – Fasting Serum Glucose, Cholesterol Panel, CMP, CBC, Blood Pressure, Weight plus BMI, AIMS.
    - d. Every 12 Months – EKG
- \*Prolactin level initially, at six-month mark and then only if clinically indicated.
- \*\*Pregnancy test if applicable.
- e. Documentation
    - (1) Practitioner orders

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<sup>21</sup> 5-ACI-6A-41

<sup>22</sup> 5-ACI-6A-28



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- (a) Psychiatrist/PCRNP shall order/**review** 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.

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

The AIMS shall be completed in accordance with Department policy **13.2.1, Section 3.**

2. Mood Stabilizer Medication\*

a. Lithium:

- (1) **Fasting** CMP, CBC with Platelets, 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) **Fasting** CMP, CBC with Platelets: Initially, at three months, at six months, then every six months thereafter.
- (2) **TSH initially and then if clinically indicated.**
- (3) Depakote level weekly x two at initiation or dose change, then at three months. Once stable, every six months.

c. Trileptal:

**Fasting** CMP, CBC with Platelets: Initially, at three months, at six months, then every six months thereafter.

d. Tegretol:

- (1) CMP, CBC with Platelets: Initially, at three months, at six months, then every six months thereafter.
- (2) **TSH initially and then if clinically indicated.**
- (3) Tegretol level weekly x two at initiation or dose change, then at three months. Once stable, every six months.

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\*Pregnancy test if applicable.

e. Documentation

(1) Practitioner Orders

- (a) Psychiatrist/PCRNP shall order/**review** 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 (CMP and CBC), 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/**review** 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 Antidepressant Medications**

- a. **Fasting CBC, CMP, TSH initially when clinically indicated.**
- b. **Psychiatrist/PCRNP shall order/review required labs and document any clinically significant findings on a progress note.**
- c. **Lab results within the last 120 days are acceptable. The provider shall review the lab results and follow up as deemed clinically necessary.**

5. Other Special Labs

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

I. **Psychiatric Clinic Appointment NO SHOW Process**

***If a patient is not present for Psychiatry appointment:***

1. ***the psychiatry provider will document in the patient's progress note as a no show for the scheduled appointment. In addition, the provider shall review the patient's chart including previous lab results, required lab monitoring, address any medication expirations, renewals, etc. and request a follow-up clinic appointment within a reasonable time frame;***
2. ***after the review of the chart, if the psychiatry provider is clinically concerned regarding the mental wellbeing of the individual patient who had been consistently not showing up for the appointments, the provider shall refer the patient to psychology for the Mental Health wellness check; and***
3. ***psychology shall document the Mental Health wellness check findings and address any related issues surrounding the cause of the no show for clinic appointment. Psychology shall not request an additional clinic appointment, unless the patient's condition requires the need to be seen prior to an already scheduled appointment. Psychology may consider to include that individual patient for PRT review.***

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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 Unit (RTU)<sup>1</sup>

### A. Program Mission

1. The Residential Treatment Unit (RTU) is designed to provide structure, consistency, and support to **individuals** 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 **individuals** and staff to establish a therapeutic alliance which is of the utmost importance for the recovery of the RTU **individual**. The ultimate goal of the RTU is to maximize functioning within the Department and to facilitate a successful community reentry for relevant **individuals**.
2. All “D” Roster facilities shall operate an RTU in accordance with this section. Each facility with an 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 **individuals** with current, significant psychiatric and impaired psychological functioning. These **individuals** may be experiencing or may be predicted to have difficulty adapting to general population housing in the Department. **Individuals** currently in the RTU will not meet commitment criteria according to the Pennsylvania Mental Health Procedures Act.
  - a. Only **individuals** 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 **individuals** with current, significant mental health issues. **Individuals** who **are Mental Health/Intellectual Disability (MH/ID)**, C or D and who are receiving psychiatric services may be considered for placement in the RTU even if they could be safely housed in general population. An **individual** should not be considered for RTU placement without a current significant mental health issue(s)/diagnosis. **Individuals** 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.

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<sup>1</sup> 5-ACI-6A-38



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**NOTE:** The ultimate goal for RTU *individuals* 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.

- b. An *individual* 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 *individual* as having adjustment difficulties due to a limitation.<sup>2</sup> The referral shall be made to the Psychiatric Review Team (PRT), who shall screen and evaluate the referred *individual*.<sup>3</sup> The *individual* 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 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 identify 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 *individual* 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.**” *In these situations, it is expected that the referring state correctional institution (SCI) adhere to the protocol outlined in Subsection B.2. above.*
  5. Every attempt shall be made to place any *individual* who needs RTU housing into a suitable unit within 30 days of the initial evaluation.
  6. In cases where an *individual* 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;

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<sup>2</sup> 5-ACI-5B-11

<sup>3</sup> 5-ACI-6C-06

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- c. length of time *individual* is likely to be in the RTU;
  - d. programming offered in the RTU; and
  - e. objectives of the *individual's* IRP.
7. In order to generate additional RTU bed space, the PRT shall consider the following:
    - a. double-celling an *individual*; or
    - b. discharge of a higher functioning *individual* to alternative housing (if available, step down unit or appropriate general population housing).
  8. In those cases where an *individual* is seriously disruptive within the unit, the RTU Management Team shall consider alternative but appropriate housing.<sup>4</sup>

**C. RTU Cell Assignment**

1. Ideally, RTU *individuals* are compatibly double-celled.
2. The Unit Management Team will make every effort to facilitate a double-celling agreement between compatible RTU *individuals*.
3. Individualized determinations shall be made to ensure the safety of each *individual* (refer to Department policy 11.2.1, “Reception and Classification,” Section 5). (28 C.F.R. §115.42[b]) *Individuals* may be double-celled as long as there are no compatibility contraindications present including, but not limited to, age differences, disparate physical size, history of sexual perpetration or sexual victimization, Security Threat Group (STG) affiliation, security needs, Prison Rape Elimination Act (PREA) Risk Assessment Tool (PRAT) scores, medical issues, geographic/regional differences, and/or a documented history of ethnic/religious violence.
4. *Individuals* who have engaged in sexual abuse in a confinement setting shall not be doubled-celled.
5. Involuntary double-celling of an RTU *individual* should only occur under the direct oversight and supervision of the Unit Manager.
6. The **Involuntary Double-Celling Checklist (Attachment 5-A)** shall be used prior to double-celling an RTU *individual*. Any “yes” response in the Staff Review Section stops the process, pending review by the Unit Manager.
7. 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.

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<sup>4</sup> 5-ACI-6C-06

8. RTU **individuals** will only be placed in a single cell if they meet the criteria for single-cell/Z-Code status as outlined in Department policy **11.2.1**.

#### D. Individual Recovery Plans (IRPs) and Psychiatric Review Team (PRT)<sup>5</sup>

1. An **individual** 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 **individual** shall complete an **Initial IRP** (if the **individual** does not already have one) or a **Change of Status IRP (Attachment 5-C)**.
2. All **individuals** 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 **individual's** needs and should include obtainable goals that the **individual** has helped create. The IRP should be recovery-based keeping recovery principles as the focus. The **individual'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 IRPs, as well as which type of IRP is appropriate for the **individual** 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 **individual** to complete their IRPs. The **individual's** IRP will encompass both on-unit and DAILE goals. This will ensure that treatment is cohesive between both programs and not confuse the **individual** with two separate treatment plans.
3. PRT will be held on the RTU or another appropriate location. RTU **individuals** will be permitted and encouraged to attend PRT meetings related to their treatment. If an **individual** 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 [CO], Counselor, Psychology, Unit Manager, Psychiatry, Alcohol and Other Drugs [AOD], Education, Medical, and Activities, as appropriate). Meetings shall be utilized to review IRP progress, review goals for **individuals**, review incentive programs, discuss **individual** behavior, and evaluate **individuals** and recovery-oriented programming. Attendance of the Treatment Team Meeting should be recorded and kept on file.

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<sup>5</sup> 5-ACI-6A-38

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 ten 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.

**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 **individual** participation in activities that should help the **individual** meet the goals from his/her IRP.
3. Programming shall be designed to stabilize and stimulate the recovery needs of the **individual** with the ultimate goal, where appropriate, of re-integration into a general population housing unit.
4. An **individual** in RTU housing will be permitted to participate in group activities and other programs with general population **individuals**.
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 **individuals**. Programming should focus on meeting IRP objectives to include influencing **individuals** to have frequent opportunities for social interaction and to be actively involved with recovery-oriented activities.

**NOTE:** Trained Peer Assistants and/or Certified Peer Specialists (CPS) can be utilized to assist staff in providing support programs and activities in compliance with Department policy **7.3.1, “Reentry and Transition.”** At no time will a peer assistant or a CPS be responsible for supervision of the RTU **individuals**. Peer Assistants and/or CPSs 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 **individual** who requires that level of care.<sup>6</sup>

6. A suggested menu of required and optional therapeutic groups is as follows:
  - a. Group Therapy
    - (1) \*goals group;

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<sup>6</sup> 5-ACI-6B-12

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- (2) \*coping skills;
- (3) anger management;
- (4) self-esteem;
- (5) \*medication adherence;
- (6) hygiene group;
- (7) alcohol and other drugs;
- (8) life management skills;
- (9) \*support based groups;
- (10) daily living skills;
- (11) interpersonal relations;
- (12) communication skills;
- (13) stress management;
- (14) healthy relationships;
- (15) healthy living;
- (16) human sexuality;
- (17) relapse prevention;
- (18) mental health Transitional Housing Unit (THU) workshop;
- (19) WRAP© (Wellness Recovery Action Plan); and
- (20) social skills.

b. Recreation

- (1) aerobics;
- (2) special exercise class;
- (3) recreational therapy;
- (4) art therapy;

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- (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 Psychological Services Specialist (PSS)/Psychological Services Associate (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 **individuals** who have participated in the DAILE program at SCI Muncy and the RTU at SCI Camp Hill. These resources should be considered for use during the required and optional group therapy sessions.
- f. 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. WRAPs© may be developed and used by any individual who chooses to create a

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WRAP©. If an individual chooses to develop a WRAP© he/she may do so; however, staff or CPSs who have completed WRAP© Seminar I may assist an individual in developing a WRAP©. WRAP© groups may be facilitated by a CPS or staff who have completed WRAP© Seminar II. WRAP© may be utilized to support any individual housed in any housing unit within the Department of Corrections.

(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 *individual* details;
- (b) specially designed details for mentally ill *individuals*;
- (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-G)** shall be given to each RTU *individual* by his/her counselor upon admission to the unit and reviewed with the *individual* 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

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unit. Decorative bulletin boards should be used to display **individual** 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 **individuals** and can help facilitate a sense of pride. A resident of the week should be chosen using the following consideration:

- a. an **individual** who participates in unit activities;
- b. an **individual** who has demonstrated improved behavior;
- c. an **individual** who has achieved identified IRP goal(s); and/or
- d. an **individual** 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 CO at least twice per month. Psychology staff are highly encouraged to attend. These meetings shall allow for **individual** input regarding the happenings on the unit as well as to help facilitate a sense of ownership and connectedness with other **individuals** and staff.
4. The RTU is encouraged to have at least one “game” night a week which will provide structured opportunities for the **individual** 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 **individual** 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 employee performance review (EPR). Re-assignment will be made based on approval through the Unit Manager, the staff member’s supervisor, 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 **individuals**, as assigned by the RTU Unit Manager. Such duties may include, but are not limited to, attending Commissary meetings, co-facilitating therapeutic groups, individual contacts, and supervising **individual** out-of-cell time. The Counselor shall manage the casework duties for every **individual** assigned to the unit. He/she shall complete every necessary report, staffing, assist in the development of IRPs, 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. Licensed Psychologist Manager (LPM) involvement in this decision is highly encouraged. The committee shall

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select officers who have demonstrated ongoing interest in and effective management skills working with mentally ill **individuals**. 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, **with specific attention and observation made of those individuals that are in a cell alone (e.g., Z-Code, housed alone without a Z-Code, double-celled but cellmate is away)**.
- c. **COs and Sergeants assigned to an RTU are required to wear an emergency cut-away style tool during their shift when assigned to the RTU. The cut-away tool shall be carried in a case on the officer's belt to expedite an appropriate response during suicide attempts requiring the need to remove a ligature with the tool. The cut-away tools are to be considered tools and inventoried in accordance with Department policy 6.3.1, "Facility Security," Section 7.**

4. Psychology Services Specialist (PSS)

A member of the Psychology staff shall be responsible for providing ongoing monitoring, individual and group therapy, developing IRPs with the **individuals**, 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 are required to provide a total of 20 hours of Mental Health services on the RTU a week per 75 RTU **individuals**. **The PSS shall offer private out-of-cell clinical encounters (i.e., unless behavioral or security contraindications exist) with individuals living on an RTU a minimum of once every 30 days, more if clinically indicated. It is essential that PSS staff complete Suicide Risk Assessments when clinically indicated and according to Section 2 of this procedures manual.**

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. **Given the**

**increased acuity of mental illness among individuals living on the RTU, LPMs should ensure to prioritize clinical supervision of PSSs working on RTUs.**

6. Psychiatry Staff

The Psychiatrist/Psychiatric Certified Registered Nurse Practitioner (PCRNP) will meet with RTU **individuals** 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 **individuals** 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 **individuals** 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 **individuals** on the RTU. If RTU **individuals** are participating in a recreational activity in another area of the facility, they should be able to do so at a time that other **individuals** 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 **individual** 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 **individual** in need. Services such as art, music, recreational or occupational therapy may be obtained using the 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 **individuals**. 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 **individuals** 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 **individuals** 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 **individuals** are permitted to retain issued razors, razor blades, and mirrors in their cell. Unit Officers shall thoroughly inspect each razor upon an **individual's** admission to the unit to ensure the item has not been altered. The RTU staff member conducting the inventory of the **individual's** property will ensure the **individual** only has one razor in his/her possession. RTU staff require PRT approval to restrict razor possession or shaving privileges of any RTU **individual**. 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 **individual** is placed on razor restriction, this will constitute a status change. Accordingly, the **individual'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 **individual** from razor restriction is contingent on the **individual's** performance with his/her updated IRP.

## K. Staff Training and Development <sup>7</sup>

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 an 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 **individual** 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 **individual** is becoming disruptive due to inappropriate language and/or non-compliance, etc. The BAC is not appropriate for **individuals** 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 **individual**. 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.
2. The Unit Team will use the **BAC Tracking Sheet (Attachment 5-H)** 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 **individual** movement is permitted, goals for BAC discharge, and involved Unit Team members. Note that the time of anticipated release can change at the Unit Team’s 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. **Individuals** 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 **individual** 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

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<sup>7</sup> 5-ACI-6B-13

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Team shall make an effort to work collaboratively with the **individual** in the establishment of these goals and to encourage the **individual** to achieve his/her recovery goals.

6. The PSS assigned to the RTU shall be contacted immediately upon **individual** placement in the BAC during normal business hours. If an **individual** 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) make initial contact, they will assess the **individual** 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 **individual** during his/her placement in the BAC.
7. If the PSS/designee makes initial contact with the **individual** housed in the BAC, he/she will help the **individual** to identify the origins of the problematic behavior and to encourage the **individual** to achieve his/her 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 **individual** during his/her placement in the BAC.
8. If no behavioral improvement is noted while the **individual** 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 **individual** significantly decompensates in the BAC at any time, the Unit Team/Shift Commander will reassess the **individual's** behavioral state and make alternate recommendations, which may include POC placement or Mental Health Unit (MHU) referral.

**M. Discharge and Transfer Procedures**

1. An **individual** 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 **individual** or for an **individual** who refuses to participate in stipulated IRP activity, 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 **individual** from the RTU, the PRT will meet to consider such discharge. The PRT will be held on the RTU and the **individual** 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. **Individuals** may continue to participate in the DAILE program even though they are discharged from the RTU.

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3. The recommendation for discharge of the **individual** 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 **individual's** progress, reasons for discharge and recommendations for follow-up monitoring (**i.e., transition plan**), 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 **individual** is to be returned to another facility, a transfer petition shall be submitted in accordance with Department policy **11.1.1. Individuals** 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 Observation and Assessment Unit (SOAU)**

### **A. Program Mission**

The Special Observation and Assessment Unit (SOAU) is a designated unit utilized for closer observational purposes of new Department receptions and it is also utilized as a special referral process to have clinical assessments completed at the individual's home institution or the designated SOAU.

1. When utilized for observational purposes, the SOAU is a designated unit which utilizes multiple phases that is especially helpful in providing close observation of newly received individuals into the Department. However, this designated unit may also be utilized for close observation of permanent individuals at the State Correctional Institutions (SCIs) that operate SOAUs. The reasons for closer observation may include, but are not limited to monitoring an individual's risk of mental health decompensation, monitoring adjustment to incarceration, monitoring major medication adjustments, and monitoring special custody related situations, as needed, such as newly received individuals that are Guilty But Mentally Ill, unsentenced or unclassified new commitments, or individuals identified as potentially unstable but not acutely mentally ill by the transferring institution or county. The SOAU shall not be utilized as a substitute for admission to a Psychiatric Observation Cell (POC), if admission to a POC is clinically indicated. However, if all POCs are full, an SOAU cell may be utilized as a POC and all procedures shall adhere to those outlined in **Section 3** of this procedures manual concerning guidelines for POCs, for such circumstances. When utilized for observational purposes as a designated unit, the SOAU is considered special management housing.
2. When utilized as a specialized referral process, the SOAU provides for specialized mobile mental health assessments conducted on site (i.e., at the individual's home SCI) by a regional mobile mental health team. The regional mobile mental health teams are comprised of a Regional Licensed Psychologist Manager (RLPM) and Regional Chief Psychiatrist (RCP). Based on the needs of each case, the RLPM and RCP may conduct their assessment together or independently, while the individual remains at his/her home institution. Conducting these assessments without transferring the individual to another location allows for an independent and objective assessment, removes assessment and staffing burdens on permanent locations, removes inefficiencies associated with non-centralized SOAUs, removes restrictions on only being able to complete special assessments of individuals in Administrative Custody (AC) or Disciplinary Custody (DC) status, maximizes the utilization of the electronic health record, and reduces security risks associated with transportation. However, in rare cases, an individual may require transfer to an SOAU for the purposes of conducting the above Specialized Assessment. In these situations, the local SOAU team will conduct the assessment, rather than the Regional Mobile Mental Health team. The final determination of the need to transfer an individual to an SOAU for a Special Assessment is collectively decided amongst the members of the Central Office Special Needs Psychiatric Review Team (COSNPRT).

## **B. Unit Placement for Special Observation Purposes**

1. When utilized for Special Observation purposes, the SOAU is intended to support the population of the facility at which the SOAU operates. In that regard, individuals can be referred for placement in the SOAU by any staff member at the institution operating the SOAU, via a **DC-97, Mental Health Referral Form** to the institution's Psychology department or by more immediate means (e.g., telephone call directly to SOAU Psychology staff).
2. This referral information shall be forwarded to the SOAU Psychology staff member for consultation with the Corrections Classification Treatment Manager (CCTM)/Corrections Classification Program Manager (CCPM)/designee for final placement decision. Additionally, individuals can also be placed in the SOAU per Program Review Committee (PRC) action. Similarly, during off hours, the Shift Commander may also place an individual in the SOAU. However, these individuals shall be reviewed for appropriateness on the next business day by the SOAU Psychological Services Specialist (PSS) and CCTM/CCPM/designee.
3. Upon placement into the SOAU, clear communication of AC/DC status will be disclosed to the unit staff upon intake and a card/sign will be placed on the cell door to notify staff of the individual's status, if appropriate.
4. When utilized for Special Observation purposes, the following individual circumstances will be considered for placement into the designated unit. However, this is not a universal list of those individuals or situations that may be considered for the SOAU for closer observation. Unique individual circumstances and situations may occur and should be considered for SOAU placement, when clinically or administratively indicated.
  - a. New county receptions, parole violators, or others displaying possible mental health symptoms or incarceration adjustment concerns, which do not currently meet the threshold of an admission to a POC or an inpatient Mental Health Unit (MHU).
  - b. High profile cases, in which closer initial observation may be clinically and administratively indicated.
  - c. Discharges from a POC, in which the Psychiatric Review Team (PRT) believes utilizing the SOAU as a step-down observation unit would be clinically beneficial.
  - d. Stabilization unit to assist with medication changes.

## **C. Admission and Orientation to SOAU for Observation Purposes**

1. Once admitted to the SOAU, the individual shall either receive or be provided an overview of the following:

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- a. an assigned Corrections Officer will orient the individual to the rules and regulations of the SOAU as soon as possible, but no more than three hours after arrival;
  - b. general program description and purpose of the unit;
  - c. **SOAU Basic Rules** (Example included in **Attachment 7-A** which may be modified to meet the needs of the SCI);
  - d. the process of treatment planning and the individual’s involvement in that process;
  - e. **SOAU Phase Descriptions (Attachment 7-B)**, the role of the Treatment Team, and a general overview of the expectations of each phase (i.e., as required to advance through each phase);
  - f. description of groups and treatment milieu; and
  - g. discharge and transition from the SOAU.
2. Individuals housed in an SOAU will be issued royal blue hobby jeans and a royal blue shirt with DOC printed in large white block letters on the back.
  3. Medical staff shall conduct the medical screening in accordance with Department policy **13.2.1, “Access to Health Care.”**<sup>1</sup>
  4. Upon admission, psychology staff will interview/assess the individual and:
    - a. begin to develop the Initial Individual Recovery Plan (IRP); and
    - b. screen for any acute mental health symptoms including the completion of a suicide risk assessment.
  5. Within two working days (excluding weekends), a Psychiatric Assessment will be completed.

**D. SOAU Phases for Observational Purposes**

SOAU phases are changed in accordance with the individual’s stability and treatment requirements/progress. However, phases will not be lowered by more than one step per 24-hour period. The goal of the SOAU phase program is to have the individual placed at the least restrictive setting possible, while gradually increasing privileges associated with stability and improved well-being. Additionally, placement in the SOAU is meant to be for no more than seven calendar days, though this may be extended or decreased at the discretion of the PRT.

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<sup>1</sup> 5-4A-4400

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1. The CCTM/CCPM/Unit Manager (UM) will make phase changes in conjunction with input from the Treatment Team, including the SOAU Counselor, SOAU Nurse, SOAU Psychiatrist, SOAU Psychology staff, and SOU Corrections Officers. However, in the event that the SOAU CCTM/CCPM/UM is unavailable, any member of the Treatment Team who witnesses behavior may change an individual's phase. Documentation of the need for phase change will be placed on the **Correctional Officer's Flow Sheet (Attachment 7-C)** in the comments section. These changes will remain in effect until reviewed by the CCTM/CCPM/UM. In the event of a prolonged absence of the CCTM/UM, the block officers and the unit nurse may coordinate a phase change. All team members must be in agreement for a phase change to occur. All three shifts may make phase changes as deemed necessary.
2. While in the SOAU for observational purposes, staff will endeavor to offer a minimum of ten hours of unstructured out-of-cell activity and ten hours of structured out-of-cell activity a week, for each individual on each phase.
3. During all phases, clinical contacts may be offered to occur in an out-of-cell setting. However, these out-of-cell contacts are contingent on behavioral compliance from the individual. If behavior is demonstrated that would contraindicate an out-of-cell contact, the individual will not be brought out of cell. If mental health staff believe that an out-of-cell contact would be clinically beneficial, the offering of an out-of-cell contact may occur, based on the behavioral compliance of the individual.
4. Individuals within the SOAU will be offered a minimum of 20 hours out-of-cell activity for each seven-day period the individual is housed in the SOAU (i.e., if the individual is housed in the SOAU for less than seven consecutive days, it is possible they will not be offered the minimum of 20 hours of out-of-cell time). 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 out-of-cell offerings commence the first day an individual is placed in the SOAU. 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 individuals in the SOAU.
5. Individuals in the SOAU that are AC or DC status shall receive the same security precautions for all AC/DC individuals (e.g., cuffed when escorted out of cell, cuffed to table for out-of-cell time, etc.). Individuals who are AC or DC status in the SOAU shall be offered out-of-cell time only with other individuals on AC or DC status (i.e., individuals who are cuffed should not be out of cell with individuals that are not cuffed). Individuals housed in the SOAU that are not AC or DC status shall be offered out-of-cell time with other individuals in the SOAU that are not AC or DC status, so that these individuals can congregate and socialize together out of cell. However, if an individual is not AC or DC status and security staff believe that the individual should still be cuffed when out of cell because of existing security concerns, that individual shall receive his/her out-of-cell time (i.e., based on behavioral compliance) with other individuals that are cuffed and on AC or DC status.

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6. The programming day is not considered to be Monday through Friday during daylight hours. Instead, out-of-cell time shall be scheduled seven days a week in an effort to achieve the minimum of 20 hours out of cell per week offering, including evenings, if necessary. This provision is meant to avoid any days consisting of no out-of-cell time offered.
7. Standard admission to the SOAU for Observational Purposes will be at Phase 4, unless otherwise noted by the Treatment Team.
8. Individuals on AC or DC status shall be placed on Phase 4.
9. Individuals on Phase 3, 2, or 1 that have visits outside of their cell will be strip searched before and after each visit. All medical staff will be escorted and accompanied by the floor officer during any visitation/examination.
10. In addition to these general guidelines, a short-term phase system may be incorporated into the SOAU, for observational purposes. General phase descriptions that may be used are provided below.
  - a. **Phase 4:** Escorts on the unit require cuffs and belt. Possessions to be permitted unless other contraindications exist include a flex toothbrush, toothpaste, roll of toilet paper, pair of scrubs, sheets, blankets, and pillows. Religious book or magazine/soft bound book (no staples) may be issued at the individual's request. Visits are permitted according to AC/DC status rules.
  - b. **Phase 3:** Escorts are to occur by one officer at a minimum. If an individual is escorted off the unit, cuffs and belt are mandatory. While on the unit, restraints are not required. Privileges are the same as Phase 4. Individuals may request flex pens/writing materials for use to complete a Treatment Plan goal that requires writing and/or drawing as well as envelopes/paper in order to write letters. Individuals on Phase 3 may also request magazines. Visits are permitted.
  - c. **Phase 2:** Off unit escorts by officer must be one on one, at a minimum. Privileges are the same as Phase 3 with the following exceptions: Individuals are eligible to be out for meals and dayroom and may also be out for supervised group and/or activities, as specified by the Treatment Team in conjunction with the goals identified on the IRP. Individuals are permitted a small bar of soap and cup, which they may have in their possession in their cell. Liquid soap will be used in the shower. Visits are permitted.
  - d. **Phase 1:** Prepare to return to housing unit. Privileges and out-of-cell time should be similar to those individuals in general population.

**E. Length of Stay in SOAU for Observational Purposes**

1. Any placement in the SOAU for observational purposes beyond one week must be reviewed by the SOAU PRT. During the period of observation, the PSS with the SOAU PRT should memorialize treatment planning progress as needed, either utilizing an IRP



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or **DC-563, Psychiatric Review Team Summary**. Included in the IRP development should be a team discussion to determine a housing placement based on review of the individual's mental health status and recommended level of care/services. Prior to discharge, the appropriate mental health roster code will be determined and documented.

2. Individuals will be seen in general population PRT within seven working days of release from the SOAU.
3. If the treatment needs of the individual would exceed a maximum of 14 days in the SOAU, the SOAU team will submit an appropriate updated treatment plan (i.e., or **DC-563**), if necessary, with an anticipated length of stay to PRC for approval.

**F. Process for Transfer out of SOAU following Observation Purposes**

1. Housing Unit
  - a. If PRT determines that the individual no longer requires the SOAU level of services, the individual shall be moved to an appropriate housing unit. The SOAU UM will discuss the case with the UM of the designated housing unit and agree upon a movement date, not to exceed five working days.
  - b. If PRT determines that the individual requires movement to a Residential Treatment Unit (RTU), a Vote Sheet will be circulated and a team-to-team consultation will be conducted with the RTU Treatment Team. The SOAU UM and the RTU UM will agree upon a movement date, not to exceed five working days.
2. Diversionary Treatment Unit (DTU)/Restricted Housing Unit (RHU)
  - a. If PRT/PRC determines that the individual requires movement to a DTU/RHU, the respective UMs will coordinate and agree upon a movement date, not to exceed five working days.
  - b. An SOAU individual will not be placed in the DTU or RHU without review by the SOAU PRT and PRC.

3. Parent Facility

Prior to an individual's transfer, the SOAU Treatment Team shall conduct a teleconference call with the PRT/Mental Health Coordinator (MHC) at the receiving facility. Given the acuity of individuals being placed in SOAUs for observational purposes, email notification of transfers is not sufficient. Appropriate notification of transfers occurring from SOAUs shall occur via teleconference. The SOAU counselor shall document the date, names of participants, and issues discussed in the conference call in the Inmate Cumulative Adjustment Record (ICAR).

## **G. Staffing of SOAU**

1. The CCTM/CCPM/designee is responsible for the daily operations of the SOAU as a designated unit.
2. SOAU Psychiatric Review Team (PRT)<sup>2</sup>

The SOAU PRT consists of the SOAU PSS, Licensed Psychologist Manager (LPM)/designee, psychiatric staff (i.e., including a psychiatric nurse, if available), the respective UM, Counselor, Lieutenant, Corrections Officers assigned to the SOAU, with input from the CCTM/CCPM/designee. Other staff may be included as deemed appropriate. The SOAU PRT meets weekly to review the status of each SOAU individual, review IRPs, and to determine discharge planning. Members of the RTU PRT may attend SOAU PRT for continuity of care purposes related to discharge planning. In addition, this team will discuss the general operation of the unit, as needed. These discussions will be facilitated by the CCTM/CCPM/UM and the LPM/designee and should aim to maximize officer involvement. Unit operational discussions shall not be conducted in the presence of patients on the SOAU.

### **a. Responsibilities**

#### **(1) SOAU UM shall:**

- (a) provide manager-level direction with the assistance of the Lieutenants. The UM will provide the team with daily leadership and will review and direct the activity of the individuals in his/her care; and
- (b) visit the unit daily (to conduct and document round and to sign the logbook).

#### **(2) LPM/designee shall:**

- (a) review and sign IRPs generated by the PSS;
- (b) provide clinical supervision of the SOAU PSS and services provided to individuals on the SOAU; and
- (c) chair the PRT.

#### **(3) SOAU PSS shall:**

- (a) be the liaison for institutional staff on clinical matters related to the SOAU;
- (b) work closely with custody staff and all disciplines assigned to the SOAU;

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<sup>2</sup> 5-4A-4400

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- (c) conduct daily rounds of the SOAU (i.e., on days in which Psychology staff are working in the institution) and provide appropriate documentation in the electronic medical record for all clinically significant contacts;
  - (d) coordinate the daily clinical operational functions on the unit;
  - (e) prepare the IRP developed by the SOAU PRT that identifies the reason for the placement in the unit and present problems and goals to be addressed by the individual and the SOAU PRT. The plan should encompass eventual placement into general population/Central Diagnostic and Classification Center (CDCC);
  - (f) ensure that SOAU individuals continue in the classification process and/or continue in the transfer clearance process to the CDCC, including the completion of psychological evaluations and/or coordinating inpatient commitments, as clinically indicated; and
  - (g) generate a discharge summary on a brief **DC-560, Mental Health Contact Note**, when the individual has been discharged from the SOAU.
- (4) Psychiatric provider shall:<sup>3</sup>
- (a) complete the Initial Psychiatric Evaluation (IPE) or Brief Psychiatric Exam (BPE) per current policy for any newly arrived individuals;
  - (b) Psychiatry shall complete a progress note at a minimum of once per week;
  - (c) consult with the PSS as needed to review difficult cases and possible placement in the POC, MHU, or Specialized Program referral; and
  - (d) attend to emergent crises as needed.
- (5) PRT meets weekly with each individual on an individual basis and will identify and include on the IRP:
- (a) behavior modification recommendations;
  - (b) diagnosis and Treatment Plan (i.e. medication); and
  - (c) transfer/housing recommendations.

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<sup>3</sup> 5-4A-4400

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- (6) Psychiatric Nursing staff shall:<sup>4</sup>
- (a) document the individual's SOAU placement in the Medical Chart and perform intakes on new receptions on either a **DC-479, Intra-System Transfer Reception Screening**, or **DC-471, New Reception/Parole Violator Return Screening Form-Male**;
  - (b) complete **DC-108, Authorization for Release of Information**, requesting appropriate medical records from outside medical and psychiatric providers;
  - (c) alert psychiatric and medical providers for immediate assessed needs and medication orders, to include documenting/implementing verbal orders received from psychiatric and medical providers;
  - (d) administer medication and treatments, assess individuals during medication administration rounds, and document this activity in the electronic medical record;
  - (e) document a daily observation note in the Medical Chart including behavior, response to medication, symptoms, and affect; use individual quotes for statements and specific descriptions to describe affect and behaviors; alert SOAU Treatment Team members to changes in status;
  - (f) check completeness of Medical Chart to include psychiatric documentation;
  - (g) attend SOAU PRT, provide medication list and compliance information to the psychiatric provider;
  - (h) coordinate review/order of essential medications with psychiatric and medical providers; be alert to county individuals whose medications are not yet entered into Sapphire;
  - (i) attend to medical charts and medications as individuals are released/change housing units; reinstate Keep on Person (KOP) meds as appropriate;
  - (j) ensure that individuals continue in the classification process, including medical testing and physical examinations;
  - (k) conduct rounds with psychology/psychiatric provider when requested; and
  - (l) provide briefing with nursing supervisor, dispensary nurse, or second Mental Health Nurse, as appropriate.

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<sup>4</sup> 5-4A-4400

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- (7) Counselor shall:
- (a) make daily rounds on the SOAU;
  - (b) attend PRT;
  - (c) complete daily notes on each individual and document individual status in the ICAR;
  - (d) review and sign the IRP;
  - (e) assist in completing any Specialized Program referrals;
  - (f) review and approve phone list and visiting list submissions;
  - (g) complete the Vote Sheet for individuals being discharged to the RTU, when needed; and
  - (h) prepare the **SOAU Daily Census/Roster (Attachment 7-D)** Monday through Friday and email to appropriate staff, as determined by each site.
- (8) Corrections Officers shall:
- (a) prepare a shift pass down email which will document each admission containing as much information regarding admission as available; any phase changes and/or unusual behaviors to note as per shift, which should include any information regarding why an individual's phase was not reduced, if beyond the 24-hour period;
  - (b) orient the individual to the SOAU operations, rules, and procedures;
  - (c) maintain an observation record of each individual housed in the SOAU;
  - (d) offer reading material to individuals upon admission and at every phase unless the individual is not eligible due to safety or security risk which shall be documented in the progress notes and psych observation form;
  - (e) complete the **SOAU Out-of-Cell Tracking Form (Attachment 7-E)**;
  - (f) complete appropriate sections of the **Correctional Officer's Flow Sheet** on each shift; the 10-6 shift will make a minimum of two entries in the Comments Section of the **Correctional Officer's Flow Sheet** and fill out appropriate sections of the **SOAU Out-of-Cell Tracking Form**;
  - (g) conduct rounds at a minimum of every 30 minutes, as outlined in post orders;

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- (h) document behaviors as observed on the in-cell cameras; and
  - (i) be responsible for facilitating and monitoring out-of-cell activity.
- (9) Therapeutic Activities Services (TAS) Worker shall:
- (a) develop and deliver therapeutic activities during the days, evenings, and on the weekends, when available; and
  - (b) 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 individuals and providing structured and unstructured recreational time for SOAU individuals.

3. Other Staff or Services Involved on the SOAU

a. LPM/designee

The LPM/designee is responsible for chairing any Treatment Team meetings held on the SOAU. However, in all aspects of the program, the LPM will closely collaborate with Psychiatry and the CCTM/CCPM/UM.

b. PRC

This committee is generally comprised of the Deputy Superintendent for Facilities Management (DSFM), Deputy Superintendent for Centralized Services (DSCS), and the CCPM. The PRC will review SOAU individuals as needed.

c. Social Worker

When needed, this employee will develop, implement, and provide social work, counseling, and case management services to SOAU individuals 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 in the ICAR.

d. Chaplaincy

The Facility Chaplaincy Program Director (FCPD) will conduct weekly rounds to individuals in the SOAU, providing counseling and individual consultation, as necessary.

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e. Certified Peer Specialist (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 individuals, educational group programming, recreational activities, and assistance with daily living skills. CPSs will function under the supervision of the CCTM/UM.

**H. Determination and Maintenance of Staffing Levels for the SOAU**

1. The DSFM and the Major(s)/designee shall be responsible for selecting and assigning Corrections Officer staff to the SOAU. The UM and CCTM shall have input into this selection; however, the final determination shall be made by the DSFM.
2. Staff assigned to the SOAU must exhibit the following characteristics prior to placement in SOAU positions:
  - a. willingness to work in a non-traditional corrections environment;
  - b. the ability and willingness to become an integral part of the SOAU Treatment Team;
  - c. the ability and willingness to perform non-professional counseling and crisis intervention with SOAU individuals;
  - 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 individuals exhibiting chronic disciplinary issues, self-injurious behaviors, and/or the inability to adapt to a general population setting).
3. Removal from the SOAU position may occur at any time if it is determined that the Corrections Officer is inappropriate for his/her assignment, ineffective, or detrimental to the operation of the SOAU. This determination shall be made by the DSFM with input from the Major, Shift Commander, and/or SOAU UM. In addition to custody staff, any staff member, recommended by the UM and the CCTM may be reassigned from the SOAU if that staff is deemed inappropriate for assignment to the SOAU.

### **I. Chain of Command**

1. The CCTM/CCPM and/or UM shall provide daily guidance/direction for all Corrections Officers assigned to the SOAU. The CCTM/CCPM and UM are responsible for monitoring and evaluation of staff performance.
2. The Medical Complex Lieutenant, in conjunction with the Shift Commander, is in charge of use of force situations and assumes responsibility for operation of the unit in the absence of the UM/CCTM.
3. The CCTM/UM shall have the discretion to make essential administrative, program, and operational decisions regarding unit security and individual management. Clinical direction will be made via the SOAU PRT as directed by the LPM/designee and psychiatric provider.

### **J. Staff Training**

All staff selected or assigned to the SOAU 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 SOAU 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. Corrections Officer Trainees will not be assigned to the SOAU.

### **K. Treatment Modalities**

Treatment modalities will be determined and defined according to the needs of the individual based upon the IRP. Individualized therapeutic services include, but are not limited to:

1. individual and group counseling, as clinically indicated;
2. in-cell and out-of-cell exercise program developed in conjunction with the Activities Department;
3. individual counseling to address medication compliance in conjunction with the Psychiatric nurse, as clinically indicated; and
4. CPS – groups and daily rounds.

### **L. Referrals to SOAU for Special Assessment Purposes**

The SOAU may also be utilized for Special Assessment purposes. In most cases, the Special Assessment will occur at the individual's home institution. In these instances, the regional mobile mental health team will travel to the individual's home institution to conduct



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the assessment. Special Assessments may occur for the following reasons, though this is not a universal list of reasons:

1. to determine the presence or absence of a serious mental illness or for cases requiring a differential diagnosis for program placement or treatment, but only after local second opinions have determined that diagnostic ambiguity remains and that an independent clinical assessment is likely to be clinically beneficial;
2. to determine the need for referral to a specialized program or other treatment and housing recommendations, but only after the local site's PRT and PRC have met and discussed the case and are uncertain whether a specialized program is clinically and administratively indicated or are uncertain which specialized program is appropriate;
3. to determine subsequent placement following Secure Residential Treatment Unit (SRTU)/Behavior Management Unit (BMU)/Special Management Unit (SMU) removal;
4. to determine the appropriateness of individuals potentially qualifying for a specialized program who may have lengthy or multiple admissions to the RHU, AC/DC (refer to Department policy **6.5.1, "Administration of Security Level 5 Housing Units"**) or DTU;
5. SMU or long term RHU inmate four to six months prior to sentence completion may be referred; and/or
6. an individual receiving mental health treatment in the Diagnostic and Classification Center (DCC) who has accumulated a significant amount of DC time or who has unsuccessfully adjusted to the DCC RTU with multiple admissions to the POC, the SOAU (i.e., for observation purposes) and/or the RHU for the purposes of identifying subsequent housing and or programmatic placement.

**M. Submitting Referrals to SOAU for Special Assessment Purposes**

The MHC at any SCI referring an individual to the SOAU for Assessment purposes shall submit the following information to the Office of Population Management (OPM). Once approved and placed on the waiting list, if an institution determines that removing the individual from the SOAU waiting list would be clinically beneficial, the below requirements are also required to be submitted to OPM for Central Office review and determination of removal.

1. The referral packet shall include the following:
  - a. a cover letter from the referring institution's LPM/designee explaining the reasoning for referral and evidence utilized to determine the appropriateness and justification for the SOAU referral. This referral cover letter shall include a contingency plan for consideration should the SOAU referral be denied, as well as an explanation of steps taken locally to exhaust local resources;

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- b. a brief overview of the results of local alternative providers' (i.e., second opinions completed/requested on site) assessments. This is a mandatory requirement;
- c. a Psychological evaluation (i.e., less than 90 days old) which provides an overview of the following information:
  - (1) identification of the specific referral question to be answered by the Regional Mobile Mental Health team (e.g., determine the presence of absence of a psychotic disorder; determine the appropriateness of SMU vs. BMU, etc.);
  - (2) current diagnoses, treatment history, and the individual's suitability for the specialized referral;
  - (3) any relevant Mental Health (MH)/Intellectual Disability (ID) roster changes (i.e., including associated functional impairments), diagnostic changes, and history of self-injury;
  - (4) medication compliance issues and discussion of recent medication changes, if indicated;
  - (5) relevant misconduct history or trends;
  - (6) brief discussion of relevant specialized unit placements (e.g., POC, RTU, DTU, RHU, MHU, SRTU, BMU, etc.);
  - (7) a brief and general overview of previously completed personality, intelligence (i.e., especially related to ruling out intellectual disability), and other psychological testing; and
  - (8) treatment recommendations for the specific behaviors/symptoms for which the individual is being referred and address the role, if any, of psychological problems causing the disruptive behaviors.
- d. **DC-46, Vote Sheet;**
- e. copies of prior SOAU (or Special Assessment Unit [SAU]) evaluations. If making a referral and prior SAU/SOAU evaluations have not been uploaded into the electronic medical record, they must be retroactively uploaded into the electronic medical record at the time of the specialized referral; and
- f. copies of prior psychiatric evaluations. If making a referral and prior psychiatric evaluations have not been uploaded into the electronic medical record, they must be retroactively uploaded into the electronic medical record at the time of the specialized referral.

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2. Once the SOAU referral packet is completed at the facility, it will be uploaded simultaneously to OPM via the Special Program Referral Application (SPRA). 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 Director of Psychology, Chief of Psychiatry, and Executive Deputy Secretary for Institutional Operations(EDSI)/Regional Deputy Secretary for the sending and receiving region will vote on the SOAU referral, within the SPRA located on the Intranet. If the recommendations are not unanimous, the EDSI will make the final recommendation.
4. Referrals for other specialized programs (e.g., SRTU, BMU, SMU, Intermediate Care Unit [ICU], etc.) may be changed to an SOAU referral by the Director of Psychology, Chief Psychiatrist, and EDSI/Regional Deputy Secretary within the SPRA if specialized assessment for diagnosis and program appropriateness is deemed relevant.
5. When an individual is approved or disapproved for SOAU, OPM will notify the referring facility via email with copies to the Director of Psychology, the respective RLPM, and the respective RCP. This email will include the reasons for rejections and recommendations, and, when indicated, whether the Special Assessment will be completed at the individual's home SCI or whether the individual will be transferred to an SOAU for the Special Assessment. If it is determined that the Special Assessment will be completed at the individual's home SCI, the RLPM and RCP will endeavor to complete the Special Assessment on site at the individual's home SCI within 45 calendar days of the notification from OPM. In rare cases, if it is determined that the Special Assessment requires transferring the individual to an SOAU, the relevant institutions should follow the procedures outlined **Subsection P. below**.
6. Once OPM has notified the referring facility that an individual has been approved for SOAU and the individual is placed on the SOAU waiting list, the referring facility will immediately implement the following protocol for Enhanced Mental Health Services which has been established for individuals on the SOAU waiting list:
  - a. weekly out-of-cell psychology contact, at minimum, will be offered and memorialized with a **DC-560**;
  - b. monthly review by the PRT;
  - c. monthly PRC review; and
  - d. continued weekly Correctional Counselor visits.
7. 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. Once an individual is approved for assessment by the SOAU and is receiving enhanced mental health services, an interim mental health commitment should not preclude subsequent SOAU assessment, unless decided otherwise by Central Office.

## **N. Time Frame for Completion of Special Assessment**

Once approved by COSNPRT, special assessments completed on site at the individual's home site are expected to be completed within 45 calendar days, with the vast majority being able to be completed in 30 calendar days. If an assessment remains incomplete after 45 days, the assigned RLPM and RCP will notify the Director of the Psychology Office at Central Office.

## **O. Special Assessment at the Individual's Home SCI**

1. Most specialized referrals that are approved for SOAU through the above electronic SPRA, will have the Special Assessment conducted at the individual's home SCI by the RLPM and RCP.
2. The RLPM and RCP may opt to conduct their assessments collaboratively or independently. However, both disciplines shall collaborate and discuss the case before memorializing their respective final assessments within the electronic medical record.
3. The RLPM or RCP may request additional psychological testing or other health care related screenings and medical work ups to be completed at the site before completing their Special Assessment. A variety of medical disorders can manifest severe mental health symptoms of varying durations. Consequently, when clinically indicated, requests for medical work ups may include, but are not limited to, a review of the patient's history, a physical examination, or laboratory tests to determine if symptoms are the direct physiological consequence of a specific medical condition. Appropriate laboratory tests or physical examinations may be helpful in determining the etiological role of another medical condition. These requests shall be accommodated in a timely manner to assist with the differential and Special Assessment process.
4. The RLPM and or RCP may opt to conduct their Special Assessment utilizing video conferencing capabilities.
5. The RLPM shall memorialize their Special Assessment within the electronic medical record utilizing the **Special Psychological Assessment** form. This form may also be utilized by facility LPMs to memorialize similar independent psychological assessments completed by the licensed psychologist.
6. The Regional Chief Psychiatrist shall memorialize their Special Assessment within the electronic medical record utilizing the **DC-525, Psychiatric Assessment** form.
7. Once complete, the RLPM and RCP shall communicate the memorialization of their respective Special Assessments within the electronic medical record via email to the referring site and the Director of Psychology.
8. The Director of Psychology will communicate a final decision on appropriate housing to OPM for the purpose of facilitating any needed transfers, if necessary.

**P. Transportation to SOAU for Special Assessment**

In rare circumstances, COSNPRT may determine that it is clinically and administratively necessary to transport an individual to a designated SOAU for a Special Assessment, as identified through the SPRA. Every individual received into the SOAU shall be a temporary transfer. Transfer procedures for the SOAU 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 SOAU shall be received no later than 2:00 p.m. Monday, Tuesday, and Wednesday of each week so that the individual can be observed. Staff shall be available to conduct initial assessments and provide for a period of stabilization. The individual can only bring personal property items permitted in accordance with **Section 4** of this procedures manual.
2. An initial phone conference will be initiated by SOAU staff and be held with the PRT at the referring facility to clarify the individual’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 individual will be transported alone without other individuals, unless the referring facility’s security team believes the individual can be safely transported with others. The transport date will be coordinated between the SOAU team, the referring facility, and 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 SOAU team shall determine the method and time of discharge in coordination with the referring facility.
5. When an individual is discharged from the SOAU, the individual is permitted to return to the parent facility with only personal property items permitted in accordance with Department policy **6.5.1**, and **Section 4** of this procedures manual.

**Q. Admission and Orientation to designated SOAU for Special Assessment**

The individual shall be received in the Property Room and processed for the SOAU. Once in the SOAU, security staff shall orient the inmate to the rules and regulations of the housing unit. Upon admission (i.e., no later than 72 hours following admission), the SOAU Treatment Team shall meet with the individual to discuss the following:

1. review referral packet;
2. screen for suicide (i.e., completed by nursing according to Department policy **13.2.1, Section 17**, by completing a Suicide Risk Assessment as per **Section 2** of this procedures manual) and/or assaultive potential; and

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3. create a planned assessment battery under the direction of the LPM/Licensed Psychologist (LP) to answer the referral question(s).

**R. Assessment Process within a designated SOAU for Special Assessment**

Members of the Multidisciplinary SOAU Team shall conduct an intensive clinical assessment for the purpose of answering the referral question(s). An LPM/LP shall supervise and provide oversight of all clinical psychological assessments utilized to determine the presence or absence of a serious mental illness, for further diagnostic 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(s). For example, the Million Clinical Multiaxial Inventory-3 (MCMI) may be given to clarify psychopathology and augment Personality Assessment Inventory results. Tests to address organicity or to clarify diagnosis shall be utilized to address the referral question(s). Due to the specialized clinical nature of these assessments, licensed psychology staff should conduct them or supervise staff conducting SOAU assessments.

The below includes a general overview of operations when an individual is placed in an SOAU for Special Assessment purposes:

1. Daily rounds will be conducted by psychiatry and psychology staff, similar to expectations for POC rounds. Other members of the SOAU team including nursing, counseling, and security will provide important information/observations regarding the individual's behaviors, actions, and verbalizations during team meetings.
2. The assigned LPM/LP shall memorialize their Special Assessment within the electronic medical record utilizing the **Special Psychological Assessment** form. The assigned Psychiatrist shall memorialize their Special Assessment within the electronic medical record utilizing the **DC-525**.
3. Once complete, the assigned LPM and assigned Psychiatrist shall communicate the memorialization of their respective Special Assessments within the electronic medical record via email to the referring facility and the Director of Psychology. The Director of Psychology will communicate a final decision on appropriate housing to OPM for the purpose of facilitating any needed transfers, if necessary.
4. In the event that the SOAU team recommends a specialized housing unit placement (e.g., SRTU, BMU, ICU, SMU, etc.), or non-specialized unit placement, the SOAU Team will contact OPM who, in turn, will contact the Director of the Psychology Office for direction on placement. Arrangements shall be made for direct placement from the SOAU to the recommended program when necessary and appropriate. The individual will not need to be returned to the referring facility prior to placement in the specialized housing unit, unless bed space within the specialized program dictates otherwise.
5. When both assessments are complete, the SOAU shall hold a teleconference with members of the PRT from the individual's home facility. During the teleconference, the SOAU Team shall provide a report to the PRT that shall include the assessment findings,

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an evaluation of the individual's level of functioning while in the SOAU, and recommendations for further programming.

6. When clinically indicated, the SOAU Team shall initiate inpatient commitment proceedings. While in an inpatient setting, the individual shall be monitored periodically by a member of the SOAU Team. Discharge planning shall include members of the SOAU Multidisciplinary Team and the MHU Treatment Team.
7. In those cases where continued DC time could result in further decompensation of the individual's mental status, the SOAU Team shall make recommendations to the referring facility's PRC to modify or systematically reduce that DC time per Department policy **DC-ADM 801, "Inmate Discipline."**
8. Security rounds shall be conducted once every 30 minutes, as outlined in post orders.

## **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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- 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.

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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.



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

<b>Policy Subject:</b>		
<b>Access to Mental Health Care Section 10 – Secure Residential Treatment Unit (SRTU)</b>		
<b>Policy Number:</b>		
<b>13.08.1 Section 10, Bulletin #1</b>		
<b>Original Issue Date:</b>		
<b>January 10, 2022</b>		
<b>Date of Issue:</b>	<b>Authority:</b>	<b>Effective Date:</b>
<b>December 16, 2024</b>	<b>Signature on File Dr. Laurel R. Harry</b>	<b>December 23, 2024</b>

**Bulletin #1 to Section 10 – Secure Residential Treatment Unit (SRTU)** of Department policy 13.08.1, “**Access to Mental Health Care,**” **Attachment 10-H, SRTU Property, Privileges, and Services Chart**, is hereby distributed to update language in relation to Commissary purchases while on Phase 3 and Phase 2 in the SRTU program.

**Attachment 10-H. SRTU Property, Privileges, and Services Chart**, is updated with the following text:

For Phase 5, **Commissary Privileges**, it will now read: “~~\$15~~ \$20 weekly limit, DC List Only.”

For Phase 4, **Commissary Privileges**, it will now read: “~~\$15~~ \$20 weekly limit, DC List Only.”

For Phase 3, **Commissary Privileges**, it will now read: “~~\$15~~ \$25 weekly limit, AC list only. May receive SecurePak according to DC-ADM 815.”

For Phase 2, **Commissary Privileges**, it will now read: “~~\$15~~ \$35 weekly limit, AC list only. May receive SecurePak according to DC-ADM 815.”

## Section 10 – Secure Residential Treatment Unit (SRTU)<sup>1</sup>

### A. Program Mission<sup>2</sup>

1. The Secure Residential Treatment Unit (SRTU) is designed to provide management, programming, and treatment for an **individual** 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 **individuals** 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 **individual** population. The focus of the SRTU is to convey sufficient skills in behavioral control, **emotion regulation**, coping, and compliance with recommended treatment.
2. Each **individual** in the SRTU will be scheduled and offered a minimum of 20 hours out-of-cell (OOC) activity per week; ten hours of structured activity and ten hours unstructured activity. This intensive specialized treatment program will assist an **individual** in progressing to the least restrictive environment for managing his/her demonstrated behavior. The least restrictive environment will vary among **individuals** and may include eventual return to a general population, continued placement within the SRTU, and even fulfillment of the **individual's** reentry plan upon Sentence Complete. An **individual'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 **individual** 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 **individual** 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).
3. ***An individual who is identified on the Restricted Release List (RRL) should only be referred to the SRTU if the referring institution believes that upon completion of treatment in the SRTU, the individual will be suitable for release to general population. Individuals on the RRL should only be referred to the SRTU if they are deemed to be motivated for reintegration into general population as demonstrated by an extended period of misconduct free adjustment and demonstrate an extended period of positive and pro-social interactions with the unit management team, including Corrections Officers (COs) and members of the Program Review Committee (PRC). Additionally, individuals on the RRL should not be referred to the SRTU without the support of the referring site's Facility Manager, as well. Included in this referral decision, is the knowledge that the RRL designation will be***

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<sup>1</sup> 5-ACI-4A-04

<sup>2</sup> 5-ACI-6A-28, 5-ACI-4B-31

**set aside during SRTU program participation and the individual will be permitted to participate in the SRTU program according to his or her specified program phase. This opinion should be clearly expressed in the referral packet's cover letter from the referring institution's Licensed Psychologist Manager (LPM)/designee.**

- a. **As an RRL individual is preparing to complete Phase 2, the SRTU unit team shall begin the official RRL removal process such that the individual will be permitted to participate in Phase 1 within general population. For individuals on RRL, completion of Phase 2 will result in removal from the RRL.**
- b. An **individual** may not be released to general population (i.e., Phase 1 probationary status) until he/she has been officially removed from the RRL.
- c. In the event that an RRL **individual** makes it to Phase 2 and goes on an escorted trip to a destination in general population, **that escorted trip will occur with COs and** arrangements shall be made to appropriately restrain **the individual** to maintain security of those still active on RRL.

## 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>3</sup>

### 1. SRTU Treatment Team

- a. Comprised of the LPM, Unit Manager, Unit Counselor, Psychiatrist/Certified Registered Nurse Practitioner (CRNP), full-time Psychology staff (Psychological Services Specialist [PSS]), Activities, and SRTU COs. The SRTU Treatment Team will meet with and review all SRTU **individuals** at least every **120** days. **Individuals** placed on **Recovery Phase** in accordance with **Subsection L.4.f. below** will be reviewed daily. This team follows the **individual** 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 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 **individuals** 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**

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<sup>3</sup> 5-ACI-4A-13, 5-ACI-6A-28

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**10-C).** In addition, the SRTU Treatment Team will meet **as needed** to discuss the general operation of the unit and review the recovery plans of each **individual**. 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

(1) SRTU Unit Manager

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 **individuals** in his/her care. If not permanently assigned to the SRTU, the Unit Manager will visit the unit daily and sign the logbook.

(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 meet with SRTU **individuals** as often as deemed clinically necessary, but no less than once every 30 days **while an individual is on Phases 5-2**. In addition, they will coordinate medication monitoring. Psychiatric coverage will include 30 minutes per **individual**. All Psychiatric contacts are to be OOC unless the **individual** refuses or security issues prohibit OOC contact at that time. This includes those SRTU **individuals** who may be on **Recovery Phase**. The Psychiatrist/PCRNP will also be required to participate in all scheduled **PRT** meetings.

(4) PSS

The PSS assigned to the SRTU will be responsible for developing IRPs with their assigned **individual** caseload. These IRPs will specifically identify goals and objectives designed to restore the **individual** to a stable and healthy level of functioning. The goals on the IRP, established collaboratively with the SRTU Treatment Team and the **individual** shall drive the clinically structured OOC offerings on the unit. **Given the presenting clinical concerns of individuals admitted to the SRTU, evidenced-based interventions (e.g., Cognitive Behavioral Therapy [CBT] and dialectical behavior therapy [DBT]) should be prioritized and coordinated with the LPM/Regional LPM (RLPM) as**

**needed.** The PSS will work closely with custody staff and all disciplines assigned to the SRTU. The PSS 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 (*i.e., once every 14 days or more if clinically indicated*) bi-weekly **OOC offerings documented with a full DC-560, Mental Health Contact Note and Inmate Cumulative Adjustment Record (ICAR).** *If the individual is offered and refuses OOC contact and it occurs at the cell door, this should be documented in addition to its impact on confidentiality.* At the discretion of the LPM, the PSS assigned to the SRTU may have other assigned facility duties.

***If confinement continues beyond 30 days within an SRTU, Psychology staff shall complete a mental health assessment at least every 30 days thereafter for individuals on the active Mental Health/Intellectual Disability (MH/ID) Roster (i.e., C and D) and more frequently if clinically indicated. This mental health assessment will be documented with a full DC-560 and memorialization of the embedded suicide risk assessment. This mental health assessment shall be offered to be completed in an OOC setting (i.e., unless behavioral compliance contraindicates an OOC contact), to ensure confidentiality. The purpose of these mental health assessments is to determine, with reasonable assurances, whether the individual poses significant risk to himself/herself or others and to determine whether restrictive housing or special management housing placement is contraindicated.***<sup>4</sup>

(5) Corrections Counselor (CC)

The CCs will provide professional counseling and case management activities to an **individual** caseload assigned by the Unit Manager. This will include treatment groups, individual contacts, and supervising **individual** unstructured OOC 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 **individual's** status. The CCs will work with the SRTU staff to assure that proper documentation is kept by maintaining the tracking forms for all OOC 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 **individual** is making in preparation for his/her possible graduation from the program and possible reentry into the general population.

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<sup>4</sup> 5-ACI-4A-10



(6) TAS Worker

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, occupational therapy, and vocational adjustment services. The activities would be directed at engaging self-isolated or reclusive **individuals** and providing structured and unstructured recreational time for SRTU **individuals**. The increased activity and OOC time will be assisting with improving the **individual'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 **individuals** 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 **individual** movement, showers, meals, activities, etc. Unit staffing and security measures may be reduced by the Unit Team and the PRC for an SRTU **individual** in Phases 3, 2, and 1 but, should always remain at a level to provide escort coverage for daily OOC 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 **individual's** progress with their treatment objectives. COs are expected to communicate their observations of an **individual's** activity and any interactions they may have had with the **individual**. In addition, custody staff will participate in all Treatment Team meetings, comment on, and sign the IRP.
- (c) Because the potential exists that an **individual** may become a significant danger to himself/herself and/or others, enriched custody staffing levels are required in the units to provide protection to staff and **individuals**. This modification ensures that OOC 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 OOC structured and unstructured activities, protect persons and property on the unit, and escort **individuals** 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.

- (d) **CO rounds on the SRTU shall be conducted in a continuous fashion to ensure that all cells/areas are checked a minimum of once every 15 minutes, on an irregular and intermittent schedule, by the officers assigned to the unit. Daily oversight of CO rounds by Commissioned Officers is an essential function that also must be prioritized and emphasized in order to ensure security rounds are occurring according to policy and post orders and are of the highest quality. Officers' rounds should ensure specific attention and observation of those individuals that are in a cell alone, either because of a Z-Code, being housed alone without a Z-Code, or because their cellmate is away.**
- (e) **COs, Sergeants, and Lieutenants assigned to an SRTU are required to wear an emergency cut-away style tool during their shift when assigned to the SRTU. The cut-away tool shall be carried in a case on the officer's belt to expedite an appropriate response during suicide attempts requiring the need to remove a ligature with the tool. The cut-away tools are to be considered tools and inventoried in accordance with Department policy 6.3.1, "Facility Security," Section 7.**

2. Other Staff Involved on the SRTU

a. PRC<sup>5</sup>

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 **individuals** monthly or as necessary as indicated by submissions of the **SRTU Program Review Sheet (Attachment 10-E)** by the SRTU IRP. **Individuals** in the SRTU on **Recovery Phase** will be reviewed by the PRC at least weekly.

b. AOD

Drug and Alcohol Treatment Specialists (DATS) will provide group and/or individual structured OOC contacts for SRTU **individuals** with identified AOD treatment needs. The goals/objectives of such treatment will be reflected on the **individual'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

This staff member will address the educational needs of the **individuals** 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

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<sup>5</sup> 5-ACI-4A-07

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volunteer. The goal would be to have *individuals* prepare for reentry to general population classes or reentry into society. All OOC 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])

This employee will develop, implement, and provide social work, counseling, and case management services to SRTU *individuals* to enhance their social functioning and to help them attain a more satisfactory social, economic, emotional, or physical adjustment within a Department facility. All OOC contacts will be noted on the **SRTU Accepted/Refused Structured Out-of-Cell Program Log**. This employee will be interacting with *individuals*, *individual* family members, *individual* 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 *individuals*.

e. Medical-Nursing

Any medication concerns identified will be forwarded to the Psychiatrist/CRNP, the assigned PSS, and recorded in the *individual's* medical file. All OOC 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 *individuals* in the SRTU. Structured group contact will be available at least weekly. All OOC contacts will be noted on the **SRTU Accepted/Refused Structured Out-of-Cell Program Log**.

g. CPS<sup>6</sup>

CPSs will be available on the unit to provide support for participants in the program. Duties may include individual OOC contacts with *individuals*, 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**.

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<sup>6</sup> 5-ACI-6B-12

**D. Determination and Maintenance of Staffing Levels for the SRTUs<sup>7</sup>**

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 an 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 **individuals**;
  - d. good communication skills;
  - e. good emotional stability;
  - f. interest in mental health issues;
  - 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 member is deemed inappropriate for assignment to the SRTU.

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<sup>7</sup> 5-ACI-4A-13

### **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 **individual** management. Clinical decision will be made via the SRTU Treatment Team as directed by the LPM.

### **F. Staff Training<sup>8</sup>**

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>9</sup>**

Admission criteria shall include the following:

1. a diagnosis of SMI as defined in the **Definition of an SMI Outline (Attachment 10-F)** of this policy;
2. history of multiple admissions to a Restricted Housing Unit (RHU), either Administrative Custody (AC) or DC status, a Diversionary Treatment Unit (DTU), 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 **that are attributed to a mental health** disorder;
4. a Special **Observation** Assessment Unit (**SOAU**) evaluation may be required;
5. **MH/ID C-Roster individuals** may be considered for placement in an SRTU;

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<sup>8</sup> 5-ACI-6A-30

<sup>9</sup> 5-ACI-6A-28

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6. **individual** is cleared of acute medical problems by the referring facility’s medical department; and
7. an **individual** that meets SRTU program criteria who is also currently maintained on the RRL, as a step-down process, upon PRC recommendation.

**H. Process for Transfers**

1. When an **individual** is being recommended by the PRT, Unit Management Team, or Psychology staff, for placement in an SRTU, the PRC shall review the recommendation with the **individual** 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 **individual**. The **individual** will be given the opportunity to respond to the rationale given and object to his/her placement in an SRTU, if he/she so desires. The **individual** may appeal the recommendation for transfer to the Facility Manager/designee and Central Office, as outlined in Department policy **DC-ADM 802, “Administrative Custody Procedures”** and **DC-ADM 801, “Inmate Discipline.”**<sup>10</sup>
2. The MHC/designee at the referring facility shall **upload the referral** to the Office of Population Management (OPM) **via the Special Programs Referral Application (SPRA)**. OPM is responsible for tracking the SRTU Referral Packet through the approval/rejection process.
  - a. If needed, the RLPM may be consulted to review the SRTU Referral Packet and schedule a face-to-face (on site or via videoconference) interview with the referred **individual** prior to the referring facility submitting the packet to OPM. The purpose of this interview is to facilitate an appropriate referral to the SRTU or any other specialized placement. This interview provides a focused independent assessment, upon which the RLPM 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** Director of Psychology and Chief of Psychiatry in their approval process of this packet.
  - b. The SRTU referral may be changed to an **SOAU** referral by the RLPM if a specialized assessment for diagnosis and program appropriateness is deemed necessary. **The electronic referral will include the following information:**
    - (1) **a cover letter from the referring institution’s LPM/designee explaining the reasoning and evidence utilized to determine the appropriateness and justification of the referral. This referral cover letter shall include a contingency plan for consideration, if the referral is denied, as well as an explanation of steps taken to exhaust local resources;**

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<sup>10</sup> 5-ACI-6C-12

- (2) a brief overview of the results of local alternative providers (i.e., second opinions completed/requested on site) assessments;**
- (3) a Psychological Evaluation (i.e., which is less than 90 days old) which provides an overview of the following information:**
  - (a) current diagnoses, treatment history, and the individual's suitability for the specialized referral;**
  - (b) any relevant MH/ID Roster changes (i.e., associated functional impairment(s), diagnostic changes, and suicide attempts or other self-injuries);**
  - (c) medication compliance issues and recent medication changes;**
  - (d) relevant misconduct history or trends;**
  - (e) a brief and general overview of previously completed personality, intelligence (i.e., especially related intellectual disability testing), and other psychological testing;**
  - (f) any relevant specialized unit placements (e.g., Psychiatric Observation Cell [POC], Residential Treatment Unit [RTU], DTU, RHU, MHU, FTC, SRTU, Intermediate Care Unit [ICU], Positive Outcome Restructuring Through Assessments and Learning [PORTAL], etc.);**
  - (g) treatment recommendations for the specific behaviors/symptoms for which the individual is being referred and address the role, if any, of psychological problems in causing the disruptive behaviors;**
  - (h) for SOAU Referrals only: identification of the specific referral question to be answered by the SOAU team (e.g., determine the presence or absence of a psychotic disorder; determine the appropriateness of the SRTU vs. Behavior Management Unit [BMU]);**
  - (i) DC-46, Vote Sheet;**
  - (j) copies of prior SOAU evaluations. If making a referral and prior SOAU evaluations have not been uploaded to Sapphire, they must be retroactively uploaded to Sapphire at the time of the specialized referral; and**
  - (k) copies of prior Psychiatric Evaluations. If making a referral and prior Psychiatric Evaluations have not been uploaded to Sapphire, they must be retroactively uploaded to Sapphire at the time of the specialized referral and included in the specialized referral at the time of submittal.**

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3. OPM will then electronically forward the SRTU Referral Packet to the **Director of Psychology**, Chief of Psychiatry, and the Regional Deputy Secretary for the sending and receiving region who will vote on the SRTU referral. If the recommendations are not unanimous, the Executive Deputy Secretary **for Institutional Operations (EDSI)** will make the final recommendation.
4. **Referrals for other specialized programs (e.g., SOAU, BMU, ICU, etc.) may be changed to an SRTU referral by the Director of Psychology, Chief Psychiatrist, Regional Deputy Secretary, or EDSI within the Special Program Referral Application.**
5. **When an individual is approved or disapproved for SRTU, OPM will notify the referring facility via email with copies to the Director of Psychology, the respective RLPM, and the respective Regional Chief Psychiatrist. This email will include the reasons for rejections and recommendations.**
6. Prior to an **individual'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**.
7. Once **OPM** has notified the referring facility that an **individual** has been approved for SRTU placement, and the **individual** 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 **individuals** on the SRTU waiting list. The protocol is as follows:
  - a. **if an individual is housed in a Level 5 (L5) setting at the time of SRTU approval, initiate or continue offering of ten structured and ten unstructured OOC hours per week;** a weekly OOC psychology contact, at minimum, will be conducted, with **ICAR** and **DC-560** documentation copied to the medical record;
  - b. psychological contacts **as needed**;
  - c. monthly OOC Psychiatrist/CRNP contacts;
  - d. weekly review by the PRC;
  - e. monthly PRT review; and
  - f. continued weekly CC 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.



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9. An **individual** who is on the waiting list for the SRTU can be transferred to an MHU/FTC if necessary. This does not affect his/her SRTU waiting list status, unless decided otherwise by Central Office.
10. **Additionally, once approved and placed on a waiting list, if an institution determines that removing the individual from the waiting list reflects the most appropriate level of care decision and believes the individual can be placed in a less restrictive and/or more clinically appropriate setting, the requirements noted in Subsection H.2.b.(1)-(3) above are also required to be submitted to OPM for Central Office review through the SPRA, for appropriate review and tracking purposes.**

**I. Transportation**

An **individual** 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**. Additional restrictions and/or requirements are as follows:

1. all of the **individual's** property will be transported with him/her to the SRTU;
2. an **individual** 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 **individual** shall be transported via sedan; this is the responsibility of the referring facility.

**J. Admission and Orientation**

1. All **individuals** will receive a standardized "SRTU **Individual** Handbook." This handbook will be distributed to all **individuals** upon arrival and admission to the SRTU. The 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 **individual's** involvement in that process;
  - d. overview of the Levels of Treatment/Phase System and the role of the Treatment Team;
  - e. what an **individual** needs to do to advance through the Phases/Levels of Treatment;
  - f. earning and utilizing incentive points;
  - g. property and privileges;

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- h. description of groups and treatment milieu;
  - i. discipline and “**Recovery Phase;**” and
  - j. discharge and transition from the SRTU.
2. Once admitted to the SRTU, the **individual** shall receive the SRTU **Individual Handbook** and staff will orient the **individual** to the rules and regulations of the unit, within 48 hours of arrival. The **individual** will be asked to sign the **SRTU Individual Handbook Receipt Form (Attachment 10-G)**.
  3. Staff shall complete the **appropriate DC-510, Suicide Risk Indicators Checklist** in accordance with **Section 2** of this procedures manual.
  4. **Individuals** housed in an 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 **individual** 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 **individual’s** program code in accordance with Department policies **11.2.1, “Reception and Classification,”** and **DC-ADM 008, “Prison Rape Elimination Act (PREA).”**
    - b. ***The potential for suicide in a correctional setting is higher if an individual is in a cell alone (e.g., Z-Code, alone in a cell without a Z-Code, or double celled but cellmate is away). As such, SRTU staff should remain vigilant in assessing suicide risk.***
    - c. When considering double celling Phase 2 **individuals** on the unit, the SRTU Treatment Team should make every effort to facilitate voluntary double celling agreements between SRTU **individuals**.
    - d. 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, PREA Risk Assessment Tool [PRAT] designations, and a documented history of ethnic/religious violence, or propensity for such) the SRTU Treatment Team may consider voluntary double celling.
    - e. 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 *individual* and:
  - a. review the Referral Packet; and
  - b. screen for any acute mental health symptoms, **complete DC-510, and a thorough Suicide Risk Assessment (SRA).**
8. Within **48 hours of the completion of the Initial Psychiatric Admission Summary Note**, the unit Psychology staff will **create an Initial IRP** with the *individual* and outline specific targeted goals, objectives, **and evidence-based interventions**. Documentation that the IRP was completed with the *individual* will be made in the ICAR.
9. The SRTU Treatment Team shall conduct an initial review of the *individual’s* IRP **at the next PRT. IRPs shall be reviewed at a minimum of once every 120 days, or more frequently if clinically indicated.**
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 be 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 individual progresses through Phases 5, 4, 3, and 2, the Psychiatrist/PCRNP will offer to see the individual at least monthly, more if clinically indicated. At least one session per month will be offered to occur OOC, unless behavioral or security contraindications exist.**

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

1. An *individual* 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 **Director of Psychology**. These transfers will be coordinated through the Bureau of Health Care Services (BHCS) and

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OPM. Any permanent transfer of an SRTU **individual** to a non-SRTU location will require written approval by the **EDSI**.

**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 **individual** from an SRTU to a non-SRTU facility. In these cases, the SRTU **individual** will be housed in a POC, unless written approval has been granted by the **EDSI** for placement in another setting such as a DTU or RHU. The **Director of Psychology**, BHCS, must be notified within 24 hours of any temporary transfer of an SRTU **individual**.
3. Prior to an SRTU **individual'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-563, PRT Summary**.
4. If an **individual** is committed to a Department MHU or the FTC, that **individual's** SRTU bed will be held open for a reasonable period of time, pending the **individual's** return from the MHU or FTC.

**L. Treatment Programs/Levels of Treatment<sup>11</sup>**

***The SRTU is designed to support individuals with a severe mental illness that interferes with their ability to sustain placement in a general population setting. Participation in this treatment program is based on a phase system that may include, but is not limited to, Phases 5 through 1, Recovery Phase, and Post-SRTU aftercare. Treatment planning may also include variations to the standard phases, treatment goals, and length of time in a phase, incentives, privileges, and management of problematic behavior. Modifications to the individual'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-H).***

**1. Treatment Phase Overview**

- a. Movement to a lower treatment phase is based on appropriate **individual** behavior and compliance with the IRP. The initial treatment phase shall be determined by the **individual's** present level of functioning, recent historical information, and mental status. The SRTU Treatment Team, **including mental health, custody, and unit management team staff**, shall recommend all treatment phase changes. **These will**

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<sup>11</sup> 5-ACI-4B-31, 5-ACI-6A-28

**be documented by circulating an SRTU Program Review Sheet and forwarding to the PRC. The Unit Counselor will document all status changes in the ICAR. A DC-46 is not required for phase change following placement in Recovery Phase. A DC-46 will be required to be circulated for all Phase 1 approvals. Ultimately the PRC, with input from the SRTU Treatment Team, has the final decision on awarding or terminating privileges and granting phase changes.**

**b. Phase advancement shall be based on behavior and attendance as well as participation in programming. Criteria for consideration of earning privileges, incentives, advancement from phase to phase, and cutting set-aside-disciplinary sanctions include:**

- (1) attaining goals as outlined in the IRP;**
- (2) remain free of misconducts and problematic behavior reports;**
- (3) remain free of self-injury;**
- (4) attend at least 75% of the minimum 20 hours OOC structured and unstructured programming; and**
- (5) attend at least 75% of individual sessions.**

## **2. Individual Recovery Plan (IRP)**

All **individuals** 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 **contemplates** that the treatment delivered **will** be tailored to the individual’s strengths **and** needs; 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. Steps in developing a “Recovery Model” IRP:**

- (1) identify the “person-centered” goal. Listening to the individual with empathy, acceptance, and validation will allow the goal to be expressed;**
- (2) 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;**
- (3) identify obstacles that prevent the individual from reaching *his/her* goal;**
- (4) 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 *individual* from reaching *his/her* goal. **Objectives should clearly describe pro-social behaviors that will replace the expressed/exhibited maladaptive behaviors; and**

- (5) identify treatment interventions. Treatment interventions will be chosen that are likely to increase the individual's strengths, **including their interpersonal effectiveness, distress tolerance, and emotional regulation. Treatment interventions should be evidence-based considering diagnosis and presenting concerns.**
- b. In conjunction with the SRTU Treatment Team, the Psychology staff will update the Initial/Annual IRP, using the **IRP. This will occur at a minimum every 120 days while the individual is in the SRTU program.** The IRP shall be reviewed OOC with the SRTU **individual unless security contraindications exist. The individual shall be encouraged to** have input into *his/her* goals rather than all **goals** being generated by the SRTU Treatment Team in a standardized fashion. All **individuals** will be invited to personally attend and participate in all SRTU Treatment Team meetings, **unless current security contraindications exist and are documented.** Treatment plan reviews will be documented in the **DC-563.**
- c. The goals on the IRP, established collaboratively with the SRTU Treatment Team and the **individual**, drive the clinically structured OOC offerings on the SRTU.

### 3. **Progress in Treatment**

- a. 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 OOC participation will be reviewed by the Treatment Team. Should an individual's participation in OOC offerings fall below **75%** of the minimum **of 20** hours programming, the institution's LPM/**designee** will lead the Treatment Team in collaborating with the individual to **specifically** 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. **There should also be consideration of how long an individual has remained in the SRTU program and has not advanced to higher phases. In cases such as this, consultation with the respective RLPM should occur to determine if an SRTU individual will continue to benefit from the program.**
- b. The Treatment Team will also assess whether a higher level of care is indicated. The institution's LPM/**designee** may **initiate** a videoconference/teleconference consultation **between** their Treatment Team **and** their respective RLPM, to discuss and review the Recovery Plan changes recommended by the institution's Treatment Team.

4. Phase System

a. Phase 5 (seven days)

- (1) This is the starting point for new admission to the program. The **individual** is eligible to advance to Phase 4 programming after seven days with no problematic behavior demonstrated and active participation in OOC programming. This phase includes:
  - (a) the initial assessment of the **individual**;
  - (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**; and
  - (b) escorted in restraints to all OOC activities. Restrained **individuals** will not be in mixed OOC groups/activities with unrestrained **individuals**.

b. Phase 4 (**14** days or longer based on clinical recommendation)

- (1) After seven consecutive days on Phase 5 without problematic behavior, the **individual** is eligible for transition to Phase 4. Advancing through phases depends on active participation in programming. After **14** days on Phase 4, the **individual** 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;

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- (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;
  - (e) ***all incentive points earned in a week must be used in that week to order incentives. Any points not used will NOT be carried over to the following weeks; and***
  - (f) escorted in restraints to and from all activities. Restrained ***individuals*** will not be in mixed OOC groups/activities with unrestrained ***individuals***.
- c. Phase 3 (**30** days or longer based on clinical recommendation)
- (1) An ***individual*** 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 **30** days;
    - (b) compliant with institutional regulations for at least **30** days;
    - (c) demonstrates an overall level of functioning that is consistent with general population; and
    - (d) compliant with treatment objectives as outlined in the ***individual'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;
    - (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 ***individual*** can be considered for on-unit employment based on team approval and job-availability. The Phase 3 ***individual*** may be permitted to eat meals OOC. Phase 3 ***individuals*** 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 ***individuals*** are generally unrestrained for regular movement within the unit unless out with another ***individual*** who requires restraints.



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d. Phase 2 (75 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) ***all incentive points earned in a week must be used in that week to order incentives. Any points not used will NOT be carried over to the following weeks***;
- (5) may generally move unrestrained out of cell unless out with another ***individual*** who requires restraints;
- (6) in Phase 2 the ***individual*** 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 ***individuals*** will be paid GLP for five days per week;
- (7) may exercise in a group with up to six other unrestrained ***individuals***;
- (8) ***at the discretion of the SRTU Treatment Team, during Phase 2 the individual may begin a Step-Down Plan. The plan will begin by allowing the individual to wear institutional browns and state-issued boots. A CPS will meet the individual on that unit and will then escort the SRTU individual to the mainline lunch or dinner meal. Staff will be aware of when the SRTU individual is leaving and returning to the SRTU. Upon returning to the unit, he/she will return the institutional browns and boots and will be issued SRTU clothing. As per policy, the SRTU individual will be strip-searched before leaving the unit and when returning to the unit***;
- (9) ***after Step 8 above has occurred several times, the same system may be utilized to have the CPS escort the SRTU individual to receive a haircut or commissary. The procedure will be similar to the above; staff will be aware when the SRTU individual is leaving and returning to the unit***;
- (10) ***once all SRTU Treatment Team members agree that the SRTU individual is ready for additional increased general population exposure, the SRTU individual 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 SRTU Treatment Team. The individual will be escorted by the CPS and the same procedures will be utilized as outlined above; and***

- (11) **lastly, to assist the individual with a smooth transition to Phase 1 general population, the SRTU Treatment Team should consider connecting the individual to as many general population services and resources as safely as possible. These may include, but are not limited to:**
  - (a) **continued supportive contact with a CPS;**
  - (b) **employment;**
  - (c) **expedited placement in all recommended Correctional Plan programming, if program eligible; and**
  - (d) **interfacing with RTU staff, or designated block staff.**
- e. Phase 1 (**120 days or longer based on clinical recommendation**)
  - (1) An **individual** 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 SRTU facility. This probationary phase will be **at least 120 days** in length, **but can be extended if clinically appropriate**. Should the **individual** be away from the facility for any reason, such as Authorized Temporary Absence (ATA) or a Mental Health Commitment, Phase 1 time **may** be suspended **or continued at the discretion of the SRTU Treatment Team in consultation with the temporary placement facility**.
  - (2) While on Phase 1, the SRTU Treatment Team will continue to review the individual's IRP every **120 days in collaboration with the General Population Treatment Team**. Incentive points will not be earned nor can they be used while an **individual** 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 **individual** successfully completes **Phase 1**, the SRTU Treatment Team will staff him/her for graduation from the program. Graduation from the SRTU will be completed by a **DC-46** with final approval from the Facility Manager. Since the **individual** has 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 **individual** to general population requires facility approval via the Regional Deputy Secretary.
- f. **Recovery Phase**

**Consequences for engaging in self-injurious behavior, aggressive, or other problematic behavior will be immediate with the individual being placed on Recovery Phase where the capacity to earn incentives is limited. Recovery**

**Phase is an alternative temporary placement within the unit or off-of-the unit for SRTU individuals 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.**

(1) **Purpose of Recovery Phase**

- (a) An essential part of all Behavior Management programs is the provision for an immediate **intervention** for serious negative behavior. Therefore, a **Recovery Phase** may be instituted to temporarily address an acutely aggressive, threatening, disruptive **individual** participating in SRTU programming. This ensures the **opportunity for de-escalation of the individual**, safety of staff and other **individuals**, and the smooth continuation of the program for treatment compliant **individuals**. **Remembering that the goal is to return the individual to the therapeutic regimen as soon as safely possible.**
- (b) **The SRTU individual may be held on Recovery Phase for as short a time as needed (e.g., a few hours), but is recommended to last no longer than 72 hours. If after the first 24 hours on Recovery Phase the individual's status has not stabilized, the assigned Psychology staff member will create an addendum to the IRP including specific goals relevant to the behaviors exhibited which resulted in the alternative placement. However, if the individual's status has not stabilized after the first 72 hours, the Psychology staff member will be consulted to determine the need for POC placement or consultation with Psychiatry. Following the first 72 hours, if necessary, the PRC may approve additional placement on the Recovery Phase in 24-hour increments. The SRTU Treatment Team will complete an SRTU Program Review Sheet reflecting the Recovery Phase placement and forward to the PRC for review and approval. Should the individual be maintained on Recovery Phase for longer than one week, the SRTU Treatment Team may schedule a teleconference with their respective RLPM to discuss recommendations for case management.**

(2) **Documentation of Recovery Phase Placement**

- (a) SRTU **individuals** 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 individual requires a higher level of care (e.g., POC placement). These behaviors may be reported and documented using the respective discipline's clinical documentation and, as necessary, by utilizing either the:**

- i. **DC-141, Part 1, Misconduct or Other Report;** or
  - ii. **DC-121, Part 3, Employee Report of Incident.**
- (b) Once a staff member observes a harmful, potentially harmful, or disruptive behavior, he/she will inform the Area Lieutenant, Unit Manager, and the LPM/designee. He/she 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 individual on **Recovery Phase**. The Lieutenant **or** Unit Manager will complete the **SRTU Recovery Phase Restriction Form (Attachment 10-I)**. Recommended property and privilege restrictions must relate to the behavior which prompted the **individual's** placement on **Recovery Phase**. All documentation shall be completed immediately and forwarded to the Shift Commander for initial disposition.
- (3) In general, cells utilized for **Recovery Phase** 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 **individual**.
- (4) Prior to placing the **individual** into **Recovery Phase**, he/she shall be strip searched and given property and privileges as indicated on the **SRTU Recovery Phase Restriction Form**. Once placed on **Recovery Phase**, the **individual** shall be seen by his/her assigned Psychology staff member **within 24 hours or as soon as normal facility operations permit for the purpose of determining the need to addend the individual's IRP. All other staff contacts will occur as outlined in the IRP and as directed by the PRT, including consideration of offering clinically appropriate structured and unstructured OOC time, unless behavioral compliance, institutional safety, staff safety, and/or patient safety contraindicates bringing the individual out of cell during recovery status.**
- (5) **While on Recovery Phase, the Treatment Team will reinforce with the individual the following:**
- (a) **the goals and objectives, emphasizing the expected pro-social behaviors as described on the IRP;**
  - (b) **the nature of staff contacts (who, frequency, and duration) during the Recovery Phase;**
  - (c) **the incentives for exhibiting the identified pro-social behaviors; and**
  - (d) **the anticipated duration of the Recovery Phase and return to the regular SRTU treatment milieu.**
- (6) **While on Recovery Phase, individuals will not earn any incentive points.**

- (7) To be removed from **Recovery Phase**, an **individual** must be treatment plan compliant, in behavioral control, and misconduct free. To finish **Recovery Phase**, the Treatment Team, **with approval from PRC, will** decide when an **individual** has successfully completed **Recovery Phase**. The **individual** will then be returned to the program phase deemed appropriate by the SRTU Treatment Team.

#### M. Structured Versus Unstructured Programming

1. All structured and unstructured programming will take place **OOC** upon determination by the Treatment Team. **Psychology staff will document their group contacts, according to protocols established in Section 1 of this procedures manual, using the DC-472M, Progress Note Psychology Group. All other group** facilitators of structured and unstructured programming **will** document their group contact with each individual on the **SRTU Group Participation Form (Attachment 10-J)**. Each facilitator **will** keep the **SRTU Group Participation Form** in **his/her** possession. At the end of each 30 days, the **SRTU Group Participation Form will be placed with the individual participant's DC-17X, Adjustment Record for SL5 Inmates. Upon completion of or removal from the SRTU program, this documentation will be forwarded to the individual's DC-15, Inmate Record Jacket.** At the same time, the facilitator **will** place a brief monthly summary in the **ICAR**.
2. Structured activities are those that are led/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 **individuals**, 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 **individuals**, 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 **individual**. This visual representation of their immediate objectives can be placed where the **individual** 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 **individual**. 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. **Individuals in SRTU shall be offered a minimum of one**

*hour of exercise per day outside their cells, seven days per week, unless security or safety considerations dictate otherwise.*<sup>12</sup>

4. At a minimum, ten structured and ten unstructured OOC hours of programming will be offered to all **individuals** housed in the SRTU. The number of structured OOC hours or portions of an hour of programming the **individual** 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 **SRTU Accepted/Refused Structured Out-of-Cell Program Log**. The number of unstructured OOC hours or portions of an hour of programming the **individual** 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 **individual**, document the total in the **ICAR**, and report the data on the **Weekly Structured/Unstructured Out-of-Cell Program Report (Attachment 10-K)**. 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 **Director of Psychology and respective RLPM**.
6. **The programming day is not considered to be Monday through Friday during daylight hours. Instead, OOC time shall be scheduled seven days a week to achieve the minimum of 20 hours OOC per week offering, including evenings, if necessary. This provision is meant to avoid any days consisting of no OOC time offered.**

## N. 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:

1. **Recovery Phase** for an SRTU **individual** who is celled in an area apart from the SRTU (if available) due to his/her behavior, psychiatric symptoms, and/or facility need. The **individual** may be committed to an 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

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<sup>12</sup> 5-ACI-4A-24

4. modified phase (e.g., an **individual** with previous assaults on female staff will lock up when female staff are on the unit, or a Phase 4 **individual** may be permitted uncuffed OOC time when other **individuals** are all in their cells).

## **O. Incentive Program**

1. The Incentive Program is designed to allow **individuals** 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 **individual**, 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. **Individuals** 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 **individual** 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. **Individuals** 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. **Individuals** are assigned to specific groups based on individual needs. **Individuals** 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. **Individuals'** points are aggregated each week. **Individuals** are informed, weekly, both verbally and in writing of all points earned. **Individuals** then may order items or purchase privileges using their points. Items are given point values from 5 to 50 points. **All incentive points earned within the week must be used within that week or else they will be lost. Incentive points do not accumulate week to week.** Points and privileges will be held in abeyance should the **individual** be placed in **Recovery Phase**.
  - 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);

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- (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) ***no incentive points will be earned while on Recovery Phase.***
- e. At the end of each week, the SRTU Counselor will tabulate each ***individual's*** incentive point total for the previous week using the **SRTU Weekly Point Summary (Attachment 10-L)**. The total points will be transposed to the **SRTU Monthly Point Summary (Attachment 10-M)** 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 (Attachment 10-N)** to each ***individual***. 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.

**P. Misconducts**

1. The alleged commission of a Class 1 Misconduct charge 1 to 14 will result in formal disciplinary action if found guilty and ***Recovery Phase*** 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 ***Recovery Phase*** for no more than three days.
3. An ***individual*** will not be issued misconducts for self-mutilation, however, a **DC-121, Part 3** will be generated. This may result in the ***individual's*** placement in the POC or on ***Recovery Phase***.
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 ***individual's*** mental illness or volitional. The Hearing Examiner will use this input for sanctions or modifying sanctions.
5. An ***individual*** 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.



## Q. Changes in Status

1. **Individuals** may be transferred to the SRTU in either 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 **individual's** behavior so he/she can progress to placement in the least restrictive environment, based on his/her 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 **individual** is in the SRTU. An **individual** can earn further reductions in his/her DC sanctions for appropriate behavior.
3. An **individual** who exhibits misconduct-related behavior while in the SRTU will generally serve a period of suspension on **Recovery Phase** 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.

## R. Release of SRTU *Individuals*

1. Phase 1 constitutes the release of the **individual** to a general population housing unit generally within the treating facility. The release of any Phase 1 **individual** from the SRTU to a general population RTU or appropriate housing unit requires approval of the Regional Deputy Secretary.
2. An **individual** 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 **individual's** progress in the SRTU 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 **individual** is readied for transition on the approved date;
  - b. the **individual** packs his/her property and cleans the cell;

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- c. the **individual's** property is inventoried by unit staff;
  - d. all SRTU property, clothing, etc., is returned to the SRTU inventory;
  - e. the **individual's** property is released to the **individual** and/or the Department transportation crew;
  - f. if the **individual** is being released to the SRTU facility's general population, request appropriate staff to escort the **individual** 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 **individual** movement forms for count procedures are completed; and
  - i. in a case where the **individual** is being discharged to an RTU placement at another facility with an SRTU, the SRTU Treatment Team shall conduct a videoconference or teleconference call, with the Unit Management Team of the receiving facility to discuss the **individual'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 **individual'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 **individual** arrives at his/her designated facility.
6. An **individual** being transferred to another facility as a Phase 1 SRTU **individual** on probationary status will be afforded the same privileges and services as defined in the **SRTU Property, Privileges, and Services Chart** (Phase 1) and placed in general population.
7. In the event that an **individual's** behavior deteriorates, during his/her Phase 1 probationary period, the **individual** may be returned to the SRTU. If the **individual'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 **individual** 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 **individual** 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 RLPM.

## S. Discharge Procedures

1. Discharge/Graduation of an **individual** 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. it is necessary to place an SRTU graduate in the RHU, he/she will be managed according to his/her **MH/ID Roster** and Department policy **DC-ADM 801**; or
  - c. an **individual** 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 **individual** from the SRTU for other than successful program completion shall be considered when:
  - a. the SRTU Treatment Team concludes that the **individual** remains resistant to participation in the IRP that was developed for him/her; and/or the **individual** engages in repeated negative behavior which is contrary to the mission of the SRTU, and undermines the treatment of other SRTU participants;
  - b. all **individuals** being considered for discharge from the SRTU for reasons other than successful completion shall be automatically referred to the **SOAU** for review and recommendation for subsequent placement. The **SOAU** recommendations will then be included in the Referral Packet; and
  - c. the following criteria should be met when an **individual** is being considered for removal from overall SRTU programming:
    - (1) clinician and custody consensus that the **individual'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 **individual's** progress.
3. The facility recommending an **individual** for removal from SRTU programming should send an **SOAU** referral to the **SPRA**. **This referral must only be forwarded electronically. OPM will log and track the referral as it moves through the approval/rejection process. The purpose of the SOAU referral is to determine the appropriateness of SRTU failure. The referral** should include the following information:
  - a. **DC-46** circulated through the SRTU Treatment Team and the referring facility's administrative staff;

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- b. rationale for the *individual's* removal from SRTU programming to include listing of disruptive behaviors, misconducts, and actions of self-injury; and
  - c. documented evidence of behaviors to include, but not limited to Misconduct Report(s), **DC-121s**, **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 *individual's* case will be generated.
5. If the final recommended disposition by COSN/PRT does not include placement in another SRTU, the **EDSI** will conduct the final review.
6. If removal from SRTU Programming is approved by the COSN/PRT and the **EDSI**, then a Transfer Petition will be completed by OPM. COSN/PRT will determine where the *individual* should be placed and OPM will assign a facility accordingly.
7. The receiving facility can submit the *individual* for consideration by COSN/PRT for reentry into the SRTU programming, if the *individual* 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 *individual* whose Psychiatric Evaluation is over five 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.

**T. Release via Sentence Complete (Formerly Final Discharge Maximum Expiration [FDME])**

1. If an *individual* is scheduled for release via Sentence Complete before completion of the SRTU program, the *individual* 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. The *individual* may be referred to the **SOAU** in accordance with this procedures manual for an evaluation. The *individual* may be placed on the Hard to Place Offender List in accordance with Department policy **7.3.1, "Reentry and Transition."**

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3. Any release of a highly assaultive **individual** due to sentence completion shall follow procedures set forth in Department policy **6.5.1, “Administration of Security Level 5 Housing Units,” Section 1**. Reentry services shall be offered in accordance with Department policies **6.5.1** and **7.3.1**.

**U. Unit Operation Evaluation**

1. Monday of each week, the SRTU Unit Manager/designee will provide, via email, the **Director of Psychology and respective RLPM** with an updated roster to include SRTU **individuals** on 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 **Director of Psychology and respective RLPM**, the log sheet of OOC 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 OOC programming at less than a **75%** 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 RLPM and the **Director** 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 review, consultations with the institution may occur with recommendations to modify the programming delivered to the SRTU.
4. In order to evaluate the operation of the SRTU, each Facility Manager/designee shall ensure that an **SRTU Semi-Annual Report (Attachment 10-O)** is completed and submitted to the **EDSI**, the **Licensed Psychologist Director (LPD)**, 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. This report shall include, but not be limited to, the following:
  - a. the number of **individual** receptions by month;
  - b. a list of facilities transferring **individuals** to the unit;
  - c. the name and Department number of every **individual** transferred to the unit;
  - d. the name and Department number of every **individual** promoted to Phase 1;
  - e. the average length of an **individual’s** stay in all Phases (5, 4, 3, 2, and 1);
  - f. the name and Department number of every **individual** released from the unit and the location where he/she was transferred;

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- g. the name and Department number of every **individual** with Sentence Complete expiring while in the unit;
- h. the name and Department number of every **individual** moved to **Recovery Phase** and Post SRTU;
- i. the number of grievances filed by **individuals** in the unit;
- j. the number of misconducts issued to **individuals** in the unit;
- k. the number of SRTU **individuals** 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 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 **overarching** theoretical orientation of the Department is derived from the **modern research** in the field of Sex Offender Treatment (SOT). All program components and therapeutic strategies are evidence-based on a cognitive behavioral model **of treatment**.

### 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 a **comprehensive** analysis of the inmate's dynamic risk factors.
- b. The risk assessment should be updated **if** an inmate's dynamic risk factors change, **even** 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, **particularly** those that have a stronger **correlation** with re-offending and/or those that may change rapidly, such as **affective regulation or substance use disorder, etc.**, as these may be more amenable to observation by supervising officers and service providers. **These issues** may indicate that risk has increased such that offending is **potentially** more imminent than it was previously.

#### 2. Facility Responsibilities

- a. Permanent facilities **will assign a sex offender coordinator/designee who will be** responsible for identifying, **initial** tracking, and assessing all sexual offenders received. All facilities shall use the automated Unit Management System for recommending **an** SOT Program and maintain waiting lists. A trained SOT provider shall conduct specialized assessments of a sexual offender within **three** months of

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his/her arrival at the facility, and subsequent to the assessment, ensure the appropriate program is placed on the offender's **DC-43, Correctional Plan (CP)**.

- 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 shall be completed in accordance with **Section 2** of this procedures manual.

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

- a. Every offender currently incarcerated for a sex offense shall be assessed for level of risk within **three** months of arrival at the permanent facility.
- b. For every male sexual offender, assessment shall include, but not be limited to, a case file review, and completion of the Static-99R. **For an explanation of how to score the Static-99R refer to Static-99R Coding Rules, Revised 2016 (Attachment 11-B). Relative risk tables related to the Static-99R** can be found online at [www.Static99.org](http://www.Static99.org).

***The Static-99R will be scored electronically in DOCInfo under the Assessments tab. Refer to the Coding Form Preamble (Attachment 11-C) for a paper copy of the Static-99R.***

- c. Unless the convicted sexual offender refuses **or exigent circumstances exist**, an individual interview shall also be part of the assessment process. During the interview, **the assessor may use the DC-577, Sex Offender Data Collection Instrument (Attachment 11-D). NOTE: The use of the DC-577 may assist the assessor in structuring the interview.** 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 **or juvenile** sexual offender, excluding the completion of the Static-99R as this risk assessment tool has not been cross-validated with this population.
- d. **Any inmate who refuses** to be interviewed for purposes of **sex offender** risk assessment shall **have documentation placed** in the **Inmate Cumulative Adjustment Record (ICAR)**. 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 and the DC-578, Sex Offender Program Evaluation (Attachment 11-E)**.

- e. Once the Static-99**R** has been completed, the treatment provider shall determine if the risk level gleaned from the Static-99**R** is to be adjusted based upon the following static and dynamic risk factors that have been empirically **validated** 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 **individuals under the age of 18** are not harmed by sexual activity with adults);
  - (3) indication that the offender has a primary sexual attraction to **individuals under the age of 18** and/or becomes sexually aroused by violence;
  - (4) indication that the inmate has engaged in a high degree of deviant sexual behavior **or known paraphilia** 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.
- f. In the case of the female **or juvenile** sexual offender, the treatment provider shall determine the level of risk based upon the case file review, the individual interview, and the presence (or absence) of **any of** the above-cited dynamic risk variables.
- g. In making decisions to adjust the risk level obtained from the Static-99**R** based upon identification of the above-cited static and dynamic risk factors, the following guidelines apply:
  - (1) Static-99**R** scores translated into Low and Low-Moderate risk categories shall be adjusted upward (Moderate/High Risk) in cases where the presence of the dynamic risk factor 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) **a primary attraction to individuals under the age of 18 and/or sexually aroused by violence**; or
  - (3) Static-99R 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.
- h. 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.
- i. The results of the sex offender assessment shall be summarized using the **DC-578**, which provides two levels of risk (Low **and** Moderate/High). A male offender assessed to be low risk shall be prescribed Low Intensity SOT Programming, while an offender assessed to be moderate or high risk shall be prescribed Moderate/High Intensity SOT Programming. **Prior to the individual's enrollment in group, the group facilitator will also complete the Program Enrollment Notification form. The original form will be forwarded to the inmate's counselor with a copy being given to the inmate and a copy will be placed in the individual's SOT file.** Assessment results (including copies of the completed Static-99R and the **DC-578**) **can be found on DOCNet.**
5. Assessment Protocol for a Technical Parole Violator

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

- a. **These cases shall be designated as Act 122 TPVs and will have an automatic release date. Designated staff will administer a Treatment Placement Screening (TPS). At the present time, all levels of risk as assessed on the TPS will be recommended for Parole Violator-Sex Offender Programming (PV-SOP). Programmatic recommendations shall be entered into the Transfer Petition using the Act 122 template provided by the Office of Population Management (OPM). All placement decisions (i.e. State Correctional Institution [SCI] or Contract County Jail [CCJ], and exact location) will be noted by OPM in the approved Transfer Petition.**
- b. **Upon reception, the receiving placement site will administer the PV-SOP program to these individuals.**

6. Assessment of a Convicted Parole Violator
  - a. A Convicted Parole Violator, re-incarcerated due to a sexual **offense conviction** 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**.
  - b. Convicted Parole Violators, re-incarcerated due to a non-sexual **offense conviction** shall be evaluated **accordingly**:
    - (1) ***if the offender has lived sex offense free in the community for ten or more years from the date of his/her most recent release, then there will be a "No Evaluation or Treatment" recommendation;***
    - (2) ***if the offender has lived sex offense free in the community for less than ten years from the date of his/her most recent release and he/she has previously completed the PA DOC Sex Offender program, then there will be a "No Evaluation or Treatment" recommendation; and***
    - (3) ***if the offender has lived sex offense free in the community for less than ten years from the date of his/her most recent release and he/she has not completed the PA DOC Sex Offender program, then he/she will be recommended for a "Treatment Evaluation" as described in Subsection B.4. above (using the prior sex offense as the index offense, scoring the Static-99R retrospectively if not available in prior records, and adjusting, if indicated, as described in Subsection B.4. above) and subject to programming recommendations.***
7. Assessment of a male inmate referred for evaluation by the Corrections Counselor and/or the PBPP due to a prior sex offense **conviction** who was not on parole at the time of the current, **instant** offense.
  - a. An inmate who was not on parole at the time he **was convicted of his instant offense, will be evaluated accordingly**:
    - (1) ***if the offender has lived sex offense free in the community for a total of ten or more years from the date of his most recent release, then there will be a "No Evaluation or Treatment" recommendation;***
    - (2) ***if the offender has previously completed the PA DOC Sex Offender program, then there will be a "No Evaluation or Treatment" recommendation; and***
    - (3) ***if the offender has lived sex offense free in the community for less than ten years from the date of his most recent release and he has not completed the PA DOC Sex Offender program, then he will be recommended for a "Treatment Evaluation" as described in Subsection B.4. above (using the***

**prior sex offense as the index offense, scoring the Static-99R retrospectively if not available in prior records, and adjusting, if indicated, as described in Subsection B.4. above) and subject to programming recommendations.**

### 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 **convictions**.
- 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 using the “Group Only” format and the **designated** “Point System.” **The process is described in Creating and Managing Groups in the Unit Management System (Attachment 11-F).**
- 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. **Use of the 60-day notice is required before termination/discharge from programming.**
- d. The order of presentation of the seven treatment phases **should follow the order as outlined in the program manual. Programming thus should begin with Module One, Responsibility Taking.** Programming shall be **delivered in a** standardized **fashion** with respect to content and, to a lesser extent, process. Any/all refinement and/or modification of programming must initially be approved through **Central Office Psychology**. If approved, any changes shall be incorporated into written procedure before implementation in the field.
- 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) are 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 ten points upon completion of the “Major Project”

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associated with each phase of the program. In order to accrue all ten 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 resubmit 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, ***the treatment provider may have the*** program participant 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.
  - 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 Process (Attachment 11-G)** outlines a procedure for managing the materials necessary to complete the collage.
  - 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

*originally* designed for the male sexual offender and, therefore, programs for female sexual offenders may be modified **to address gender differences**. Treatment for a Special Needs inmate includes **Intellectual/Developmental Disability, Serious Mental Illness, and/or physical disability**. A **non-English speaking** sexual offender may also be modified accordingly, with modifications based upon field research and findings pertaining to best practices for these populations. **The institution is responsible for acquiring translation services in order to provide programming to non-English speaking individuals**. These programs shall be reviewed and approved through **Central Office Psychology**.

## 2. Treatment Variables

Group therapy with sex offenders is viewed as the treatment modality of choice. Given skilled clinicians, the group therapy experience can be very **effective**.

- a. Group size - Group size shall be limited to not more than 15 participants.
- b. Group composition – **Group composition is primarily determined by minimum date. Groups are heterogeneous in make-up in regard to offense conviction, etc. Depending on institutional need, group composition may also be dictated by specialized populations as identified above.**
- 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 **Four-Stage Model of Group Development (Attachment 11-H)**.
- d. Getting Started - Documents explaining the **DC-580, Limits of Confidentiality (Attachment 11-I)** and **Conditions of Participation (Attachment 11-J)** should be thoroughly reviewed, signed by the inmate, and witnessed **by staff** 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 – ***It is recommended that*** group sessions be conducted ***once*** weekly for two consecutive hours. ***This allows time between groups for the individual to process the information discussed in group and will allow time for them to complete assigned homework.*** The total target time to complete the program as it is implemented for moderate and high risk/need level participants ***shall be no less than 18 months and no more than 24 months.*** 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 ***shall be no less than eight months and no more than 12 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.

#### D. Support Groups

***Individuals who have successfully completed treatment (i.e. either low intensity or moderate/high intensity) are eligible to also participate in voluntary support groups for sex offenders supervised by the DOC Psychology Staff. The support group will not be entered on the Correctional Plan and cumulative attendance will not be tracked. Participation in the support group will be strictly voluntary. This group should review SOP concepts and can be used to help individuals prepare for their parole interview. This group shall be offered to the inmate population at least one time per month. This SOP support group is also available to those individuals who have been evaluated and are awaiting participation in sex offender treatment. They will have the opportunity to familiarize themselves with the issues to be addressed in treatment. This will also afford them the opportunity to understand they are not alone in this difficult treatment process. Participation for this group will also be voluntary. Negative participation in the support group will be reviewed and documented by the SOP Coordinator, if needed, and result in the individual being removed from this support group.***

#### E. Delivery of Sex Offender Booster

1. ***All individuals who have successfully completed the SOT Program (i.e. either low intensity or moderate/high intensity) will be recommended to also complete the***

**Sex Offender Treatment Booster (Attachment 11-K).** This program recommendation should occur approximately four to six months prior to the individual seeing the parole board. The Sex Offender Treatment Booster is recommended for the individual regardless of whether it is mandated in the individual's paroling action or not.

2. **It is expected that the Sex Offender Treatment Booster will be completed in four to six weeks, preferably in a group setting or with one on one treatment as needed. The expectation is that two sessions per week will be conducted to allow the individual ample opportunity to appropriately complete homework assignments and readdress issues related to offending. Individuals who completed Low Intensity Sex Offender program must complete the corresponding Booster segments (1, 2, 11, and 12) and individuals who completed the moderate/high intensity Sex Offender Program must complete all Booster segments. Individuals will need to pass the Booster with a score of 80% or better and will be required to attend all scheduled sessions. Further questions are addressed in Sex Offender Booster Frequently Asked Questions (Attachment 11-L).**
3. **Upon completion of the SOT Booster, the group facilitator will complete the Unit Management Program Evaluation Document. He/she will evaluate the individual via the Sex Offender Booster Assessment (Attachment 11-M) and include that score into the Unit Management program evaluation. Completion will also be documented in the ICAR.**
4. **SOT Booster failures will be managed according to the instructions found in the Sex Offender Booster Frequently Asked Questions.**

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

Qualifications **for facilitating the DOC standardized SOT Program.**

1. Credentialing and Supervision
  - a. Staff who possess a graduate degree in the behavioral health, or social sciences.
  - b. **All group facilitators must have completed the DOC Fundamentals of Sex Offender Treatment (FSOT) prior to delivering this program.**
  - c. **Upon completing the DOC FSOT training, it is recommended that the newly trained staff co-facilitate at least one complete moderate/high treatment group.**
  - d. **They must hold the job classification of Psychological Services Specialist (PSS), Psychological Services Associate (PSA), or Social Worker.**
  - e. **Individuals with other levels of education experience and/or holding other job classifications may be approved individually by Central Office Psychology.**



2. Training

- a. Education, experience, and training are the critical qualifications associated with the provision of SOT.
- b. Every provider **must** obtain at least **six** hours annually of continuing education in the field of **sex offender assessment and treatment**. 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 Sexual Offender Assessment Board (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 their 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 **such as: Association for the Treatment of Sexual Abusers (ATSA), Midatlantic Association for the Treatment of Sexual Abusers (MARATSA – a chapter of ATSA), Massachusetts Society for a World Free of Sexual Abuse by Youth (MASOC), and Massachusetts Association for the Treatment of Sexual Abuser.**
- c. 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. **Central Office Psychology** shall periodically provide information as it becomes available.

**G. 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 **may** be involved in the treatment and/or management of sex offenders.

Every staff member involved in the treatment and management of sex offenders will become 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

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. **The Corrections Counselors will also monitor the “Green Sheet” to determine if the Parole Board has made any modifications for SOT Program recommendations. These changes will be communicated to the institution’s Sex Offender Coordinator via email.**

2. Psychologists

The Licensed Psychology Manager (LPM)/**SOT Program Coordinator** shall coordinate and oversee the SOT in each facility. For sex offenders who are also placed on the Mental Health/**Intellectual Disability** (MH/**ID**) tracking roster(s), the psychology staff shall ensure that the inmate’s Individual **Recovery Plan (IRP)** addresses sex offender assessment and treatment needs **that may fall beyond the scope of the standardized SOT Program.**

3. Psychiatrists/PCRNP’s

A Psychiatrist/PCRNP shall treat those sex offenders with co-existing Mental Health problems.

4. Unit Managers

When managing a Residential Sex Offender Unit for sex offenders, the Unit Manager **may** become involved in the monitoring and, in some cases, tracking of progress of offenders on his/her housing unit.

5. Corrections Officers

Particularly when posted on a Residential Sex Offender Unit 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.

## **H. 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. **All documentation must be completed by the individual who actually provided the services.**

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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. ***This file shall contain the record of the individual's group attendance and their points updates. Other SOT specific documents are maintained electronically in DOCNet. There is no need to reproduce and maintain these in a hard copy file. All completed homework assignments and completed major projects will be retained by the group leader for review and scoring. They will then be returned as soon as possible to the group participant.***
  
2. ***As stated above, the majority of record keeping is done electronically within DOCNet. An overview of those documents includes:***
  - a. ***DC-577 – this may be utilized by the assessor or treatment provider to assist in an initial structured interview;***
  
  - b. ***DC-578;***
    - (1) ***completed in conjunction with the Static-99R within 90 days of the individual's arrival at the programming institution;***
  
    - (2) ***evaluation is memorialized with a note in the ICAR. Documentation will note that the program evaluation was completed. The individual's attitude toward treatment will also be reflected;***
  
    - (3) ***the evaluator will modify the DC-43 by removing "Evaluation" and assigning a level of treatment; and***
  
    - (4) ***if the individual is refusing treatment, that will also be noted on the plan.***
  
  - c. ***Static-99R – will be completed in conjunction with the Sex Offender Program Evaluation within 90 days of the individual's arrival at the programming institution; and***
  
  - d. ***DC-579, Summary of Progress in Sex Offender Treatment (Attachment 11-N) – this document is to be completed on the following occasions and memorialized with a note in the ICAR. This ICAR note should briefly summarize the individual's progress in treatment. The group leader will also complete a Unit Management Program evaluation reflecting this same information.***
    - (1) ***At the successful completion of the group.***
  
    - (2) ***Prior to the individual's parole staffing with his/her unit team for inclusion in the parole staffing packet.***
  
    - (3) ***If the Parole Board would request an update at the time of his/her board hearing.***

- (4) **When the individual transfers to another institution prior to completion and at the time, an individual is terminated/discharged from the program.**
  - (5) **Upon successful completion, discharge, or failure.**
3. Upon the offender's release on parole or completion of the maximum sentence, any remaining documents in the file shall be destroyed.

#### I. Assistor/Peer Programs

Peers can be **an asset** in assisting other inmates who may be struggling with any number of programmatic/**treatment related** issues. Guidelines for selecting **peer assistors are as follows:**

1. Selection - The **SOT Program Coordinator** shall initially **identify and interview** potential assistors/peer group facilitator for inclusion in the program. Every **candidate for sex offender** assistor/peer **should** be entering the program on a voluntary basis, must have successfully completed the **appropriate** treatment program, **must** be misconduct-free for at least one year, and should be **recommended by a** consensus among **SOT providers**.
2. At facilities where there is a Residential Unit for sex offenders, the Unit Manager, **in conjunction with the** treatment provider, shall delineate assignments, times, and places where an assistor and peer groups can meet with **their** 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 **in an institution where there is no Residential Unit**.
3. 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.

#### J. Managing Program Participants who are Found Guilty of Misconduct(s)

1. When the misconduct results in three consecutive missed sessions, the offender shall be terminated from his/her current program. In a case where imposed sanctions **may** allow **program participation, i.e. cell restriction**, the offender may **continue his/her participation** with his/her group.
2. **If terminated from programming, this will be documented using the Unit Management Program Evaluation form and the ICAR.**

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

1. ***If this sexual assault results in a formal legal charge and criminal conviction in a Pennsylvania court of law, this individual will then be referred for assessment according to this policy.***
2. ***Consistent with the Prison Rape Elimination Act (PREA), all prisons shall attempt to conduct a mental health evaluation of all known inmate-on-inmate abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners. (28 C.F.R. §115.83[h]) If the facility offers SOT, the facility shall consider whether to require the offending inmate to participate in such interventions as a condition of access to programming or other benefits. (28 C.F.R. §115.78[d]) Inmates who have been found to have engaged in sexual abuse without an accompanying criminal conviction, shall be evaluated for SOT and, if deemed appropriate, offered the opportunity to participate voluntarily in SOT.***

**L. Collaborating with the Sexual Offender 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 themselves 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.



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

<b>Policy Subject:</b> Access to Mental Health Care Section 12 – Behavior Management Unit (BMU)		
<b>Policy Number:</b> 13.08.1 Section 12, Bulletin #1		
<b>Original Issue Date:</b> February 7, 2022		
<b>Date of Issue:</b> December 16, 2024	<b>Authority:</b> Signature on File Dr. Laurel R. Harry	<b>Effective Date:</b> December 23, 2024

**Bulletin #1 to Section 12 – Behavioral Management Unit (BMU)** of Department policy 13.08.1, “**Access to Mental Health Care,**” **Attachment 12-F, BMU Property, Privileges, and Services Chart**, is hereby distributed to update language in relation to Commissary purchase while on Phase 3 and Phase 2 in the BMU program.

**Attachment 12-F. BMU Property, Privileges, and Services Chart**, is updated with the following text:

For Phase 5, **Commissary Privileges**, it will now read: “~~\$15~~ \$20 weekly limit, DC list only. Incentives: No incentive purchases permitted.”

For Phase 4, **Commissary Privileges**, it will now read: “~~\$15~~ \$20 weekly limit, DC list only.”

For Phase 3, **Commissary Privileges**, it will now read: “~~\$15~~ \$25 weekly limit, AC list only. May receive SecurePak according to DC-ADM 815.”

For Phase 2, **Commissary Privileges**, it will now read: “~~\$15~~ \$35 weekly limit, AC list only. May receive SecurePak according to DC-ADM 815.”

## Section 12 – Behavior Management Unit (BMU)

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

1. The Behavior Management Unit (BMU) is designed to provide management, programming, and treatment for an **individual** 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 **individuals** 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 population. The focus of the BMU is to convey sufficient skills in behavioral control, **emotional regulation**, coping, and compliance with recommended interventions.
2. Each **individual** in the BMU will be scheduled and offered a minimum of 20 hours out-of-cell (OOC) activity per week; ten hours of structured activity and ten hours of unstructured activity. This intensive specialized treatment program will assist an **individual** in progressing to the least restrictive environment for managing his/her demonstrated behavior. The least restrictive environment will vary among **individuals** and may include eventual return to general population, continued placement within the BMU, and even fulfillment of the **individual's** reentry plan upon Sentence Complete. An **individual'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 **individual** 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 **individual** 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).
3. **An individual who is identified on the Restricted Release List (RRL) should only be referred to the BMU if the referring institution believes that upon completion of treatment in the BMU, the individual will be suitable for release to general population. Individuals on the RRL should only be referred to the BMU if they are deemed to be motivated for reintegration into general population as demonstrated by an extended period of misconduct free adjustment and demonstrate an extended period of positive and prosocial interactions with the unit management team, including Corrections Officers (COs) and members of the Program Review Committee (PRC). Additionally, individuals on the RRL should not be referred to the BMU without the support of the referring site's Facility Manager as well. Included in this referral decision, is the knowledge that the RRL designation will be set aside during BMU program participation and the individual will be permitted to participate in the BMU program according to his or her specified program phase.**

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<sup>1</sup> 5-ACI-4B-31

***This opinion should be clearly expressed in the referral packet's cover letter from the referring institution's Licensed Psychology Manager (LPM)/designee.***

- a. ***As an RRL individual is preparing to complete Phase 2, the BMU unit team shall begin the official RRL removal process such that the individual will be permitted to participate in Phase 1 within general population. For individuals on RRL, completion of Phase 2 will result in removal from the RRL.***
- b. An ***individual*** may not be released to general population (i.e., Phase 1 probationary status) until he/she has been officially removed from the RRL.
- c. In the event that an RRL ***individual*** makes it to Phase 2, and goes on an escorted trip to a destination in general population, ***that escorted trip will occur with COs and*** arrangements shall be made to appropriately restrain ***the individual*** to maintain security of those still active on RRL.

## **B. Location and Consultation**

BMUs will be located at various facilities within the Department. ***The BMU Treatment Teams located at the various BMUs in the Department shall participate in a quarterly teleconference to discuss and consider proposed policy revisions, case consultations, programmatic improvements, standardized procedures and practices, discharge procedures, potential training needs and opportunities for BMU staff, etc. The Treatment Team of each facility should ensure they seek input from all shifts working the BMU concerning any issues related to policy and procedure. This quarterly meeting shall be chaired by the Psychology Office's Administrative Officer 5 (AO5). Regional LPMs may participate in this meeting as per the discretion of the AO5 and the needs of the meeting. The AO5 will maintain quarterly meeting minutes and will provide a summary of the minutes to the COSN/PRT.<sup>2</sup>***

## **C. Staffing**

### **1. BMU Treatment Team**

- a. Comprised of the 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 COs. The BMU Treatment Team will meet with and review all BMU ***individuals*** at least every ***120*** days. ***Individuals*** placed on ***Recovery Phase*** will be reviewed daily. This team follows the ***individual*** in all phases, including probationary status in a general population Residential Treatment Unit (RTU) or other population housing unit deemed appropriate by the Treatment Team. Other staff and teams involved in the daily operation of the BMU include, but are not limited to: the PRC, staff members from ***Substance Use Disorder (SUD)*** treatment, Education, Social Worker, Therapeutic Activities Services (TAS) Worker, Medical – Nursing,

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<sup>2</sup> 5-ACI-6A-29



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Chaplaincy, and Certified Peer Specialists (CPS). Staff contacts with **individuals** 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 **once** each week to discuss the general operation of the unit. These meetings will be facilitated by the Unit Manager and the LPM/designee and should generally be held at the change of shift in order to maximize officer involvement.

c. Responsibilities

(1) BMU Unit Manager

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 **operations** and activity of the **unit**. 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 **clinically supervises** all psychological services in the facility **and the BMU**. 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/**designee** 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

All Psychiatric contacts are to be OOC unless the **individual** refuses or security issues prohibit OOC contact at that time. The Psychiatrist/PCRNP will meet with BMU **individuals** as often as deemed clinically necessary, but no less than once **a month**. The Psychiatric provider will also be required to participate in all scheduled Treatment Team meetings.

(4) PSS/PSA

For BMUs 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 BMU will be responsible for developing IRPs with their assigned caseload. These IRPs will specifically identify goals and objectives designed to restore the **individual** to a stable and healthy level of functioning. The goals on the IRP established collaboratively with the BMU

Treatment Team and the *individual* shall drive the clinically structured OOC 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. ***When necessary, they will also be responsible for creating and delivering a Behavior Management Plan (BMP) as described below.*** All contacts will be noted on the **BMU Accepted/Refused Structured Out-of-Cell Program Log**, at a minimum (*i.e., more if clinically indicated*) **every 14 days. OOC offerings shall be documented with a full DC-560, Mental Health Contact Note and Inmate Cumulative Adjustment Record (ICAR) entry.** The PSS/PSA will offer ***clinically appropriate*** contacts for the duration of the **Recovery Phase** placement ***as outlined on the IRP.*** At the discretion of the LPM, the PSS/PSAs assigned to the BMU may have other assigned facility duties.

***If confinement continues beyond 30 days within a BMU, Psychology staff shall complete a mental health assessment at least every 30 days thereafter and more frequently if clinically indicated. This mental health assessment will be documented with a full DC-560 and review/memorialization of the embedded suicide risk assessment as per Section 2 of this procedures manual. This mental health assessment shall be offered to be completed in an OOC setting (i.e., unless behavioral compliance or security concerns contraindicate an OOC contact), to ensure confidentiality. The purpose of these mental health assessments is to determine, with reasonable assurances, whether the individual poses significant risk to themselves or others and to determine whether special management housing placement is contraindicated.***<sup>3</sup>

(5) Corrections Counselor (CC)

The CCs will provide professional counseling and case management activities to an *individual* caseload assigned by the Unit Manager. This will include treatment groups, individual contacts, and supervising *individual* unstructured OOC 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 *individual's* status. The CCs will work with the BMU staff to ensure that proper documentation is kept by maintaining the tracking forms for all OOC 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 *individual* is making in preparation for his/her possible graduation from the program and possible reentry into the general population.

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<sup>3</sup> 5-ACI-4A-10

(6) TAS Worker

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 **individuals** and providing structured and unstructured recreational time for BMU **individuals**. The increased activity and OOC time will be assisting with improving the **individual'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 **individuals** 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 **individual** 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 **individual** in Phases 3, 2, and 1, but should always remain at a level to provide escort coverage for daily OOC contacts.
- (b) 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 **individual's** progress with their treatment objectives. COs are expected to communicate their observations of an **individual's** activity and any interactions they may have had with the **individual**. 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 **individual** may become a significant danger to himself/herself and/or others, enriched custody staffing levels are required in the units to provide protection to staff and **individuals**. This modification ensures that OOC 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 OOC structured and unstructured activities, protect persons and property on the unit, and escort **individuals** in and out of cells throughout

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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 *individuals* monthly or as necessary as indicated by submissions of the **BMU Program Review Sheet (Attachment 12-D)** by the BMU Treatment Team.

b. **SUD**

Drug and Alcohol Treatment Specialists (DATS) will provide group and/or individual structured OOC contacts for BMU *individuals* with identified **SUD** treatment needs. The goals/objectives of such treatment will be reflected on the *individual'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

This staff member will address the educational needs of the *individuals* 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 *individuals* prepare for reentry to general population classes or reentry into society. All OOC 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

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

e. Medical-Nursing

All OOC contacts will be noted ***within the electronic medical record on the appropriate nursing form and memorialized*** on the **BMU Accepted/Refused Structured Out-of-Cell Program Log**.

f. Chaplaincy

The Facility Chaplaincy Program Director (FCPD)/***designee*** will provide structured individual and group religious services to ***individuals*** in the BMU. Structured group contact will be available at least weekly. All OOC 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 ***individuals*** in the program. Duties may include individual OOC contacts with ***individuals***, 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 ***individuals***. 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<sup>4</sup>**

1. The DSFM and the Major(s)/designee shall be responsible for selecting and assigning CO/***COII*** staff to ***the*** BMUs. ***Each facility can determine the operational need for a COII to be assigned to the Unit.*** 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 ***individuals***;
  - d. good communication skills;

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<sup>4</sup> 5-ACI-4A-12, 5-ACI-4A-13

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- 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 **individuals** exhibiting chronic disciplinary issues, self-injurious behaviors (SIB), 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.
  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 member 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 **unit** 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

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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);
3. presenting behaviors that may include significant difficulties such as self-injury, overtly aggressive behavior, and/or impulse control disorder;
4. a Special **Observation and Assessment Unit (SOAU)** evaluation may be required;
5. an **individual** who exhibits severe Personality Disorder with functional impairment, chronic disciplinary issues, and demonstrates an inability to adapt to a general population setting;
6. he/she is cleared of acute medical problems by the referring facility's medical department; and
7. an **individual** that meets BMU program criteria who is also currently maintained on the RRL, as a step-down process, upon **local** PRC recommendation **in addition to the factors identified in Subsection A.3. above.**

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

1. When an **individual** 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 **individual** 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 **individual**. The **individual** 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 **individual** 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 **upload the referral** to the Office of Population Management (OPM) **via the Special Programs Referral Application (SPRA)**. This **referral** must only be forwarded electronically. OPM **will log and track the referral as it moves** through the approval/rejection process.

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- a. If needed, the Regional LPM may be consulted to review the BMU referral and schedule a face-to-face (on site or via videoconference) interview with the referred **individual** prior to the referring facility submitting the **referral** to OPM. The purpose of this interview is to facilitate an appropriate referral to the BMU **or any other specialized placement**. 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** Director of Psychology and Chief of Psychiatry in their approval process of this **referral**.
- b. The BMU referral may be changed to an **SOAU** referral by the Regional LPM if a specialized assessment for diagnosis and programs appropriateness is deemed necessary. **The electronic referral will include the following information:**
  - (1) **a cover letter from the referring institution's LPM/designee explaining the reasoning and evidence utilized to determine the appropriateness and justification of the referral. This referral cover letter shall include a contingency plan for consideration if the referral is denied, as well as an explanation of steps taken to exhaust local resources;**
  - (2) **a brief overview of the results of local alternative providers' (i.e., second opinions completed/requested on site) assessments;**
  - (3) **a Psychological Evaluation (i.e., which is less than 90 days old) which provides an overview of the following information:**
    - (a) **current diagnoses, treatment history, and the individual's suitability for the specialized referral;**
    - (b) **any relevant mental health (MH)/intellectual disability (ID) roster changes (i.e., associated functional impairment(s), diagnostic changes, and suicide attempts or other self-injuries);**
    - (c) **medication compliance issues and recent medication changes;**
    - (d) **relevant misconduct history or trends;**
    - (e) **a brief and general overview of previously completed personality, intelligence (i.e., especially related to ID testing), and other psychological testing;**
    - (f) **any relevant specialized unit placements (e.g., Psychiatric Observation Cell [POC], RTU, Diversionary Treatment Unit [DTU], RHU, MHU, FTC, Secure Residential Treatment Unit [SRTU], BMU, Intermediate Treatment Unit [ITU], Positive Outcome Restructuring Through Assessments and Learning [PORTAL] Unit, etc.); and**



- (g) ***treatment recommendations for the specific behaviors/symptoms for which the individual is being referred and address the role, if any, of psychological problems in causing the disruptive behaviors.***
  - (4) ***DC-46, Vote Sheet;***
  - (5) ***copies of prior SOAU evaluations. If making a referral and prior SOAU evaluations have not been uploaded to Sapphire, they must be retroactively uploaded to Sapphire at the time of the specialized referral; and***
  - (6) ***copies of prior Psychiatric Evaluations. If making a referral and prior Psychiatric Evaluations have not been uploaded to Sapphire, they must be retroactively uploaded to Sapphire at the time of the specialized referral and included in the specialized referral at the time of submittal.***
3. The ***Director of Psychology***, Chief of Psychiatry, and the Executive Deputy Secretary for Institutional Operations (EDSI)/Regional Deputy Secretary for the sending and receiving region will vote on the BMU referral, ***within the SPRA located on the Intranet***. If the recommendations are not unanimous, the ***EDSI*** will make the final recommendation.
  4. ***Referrals for other specialized programs (e.g., SRTU, SOAU, Special Management Unit [SMU], Intermediate Care Unit [ICU], etc.) may be changed to a BMU referral by the Director of Psychology, Chief Psychiatrist, or EDSI/Regional Deputy Secretary within the SPRA.***
  5. ***When an individual is approved or disapproved for BMU, OPM will notify the referring facility via email with copies to the Director of Psychology, the respective Regional LPM, and the respective Regional Chief Psychiatrist.*** This email will include the reasons for rejections and recommendations.
  6. Once ***OPM*** has notified the referring facility that an ***individual*** has been approved for BMU and the ***individual*** 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 individuals on the BMU waiting list:
    - a. ***initiate the offering of ten structured and ten unstructured OOC hours per week;***
    - b. monthly review by the PRT;
    - c. ***monthly*** PRC review; and
    - d. continued weekly Correctional Counselor visits.
  7. 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. **Once an individual is approved for BMU and is receiving enhanced mental health services, an interim mental health commitment should not preclude subsequent BMU placement.**

8. Following final approval, **OPM** will coordinate with the sending and receiving facilities. If space is not available **in an appropriate BMU**, OPM shall retain the **individual's** name on a waiting list.
9. **Additionally, once approved and placed on a waiting list, if an institution determines that removing the individual from the waiting lists reflects the most appropriate level of care decision and believes the individual can be placed in a less restrictive and/or more clinically appropriate setting, the requirements noted in Subsection H.2.b.(1)-(6) above are also required to be submitted to OPM for Central Office review through the SPRA, for appropriate review and tracking purposes.**
10. 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, Counselor File** and on the **brief DC-560, Progress Note**.
11. An **individual** who is on the waiting list for the BMU can be transferred to an MHU/FTC if necessary. This does not affect his/her BMU waiting list status, unless decided otherwise by Central Office.

#### I. Transportation

An **individual** 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 **individual's** property will be transported with him/her to the BMU;
2. an **individual** 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 **individual** shall be transported via sedan; this is the responsibility of the referring facility.

#### J. Admission and Orientation

1. All **individuals** will receive a standardized "BMU Inmate Handbook." This handbook will be distributed to all **individuals** upon arrival and admission to the BMU. This handbook will address and include at a minimum the following:

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- a. general program description and purpose of the unit;
  - b. BMU rules and regulations;
  - c. the process of behavior management planning and the *individual's* involvement in that process;
  - d. Overview of the Levels of Treatment/Phase System and the role of the Treatment Team;
  - e. what an *individual* 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 “**Recovery** 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 *individual* shall receive the BMU Inmate Handbook and staff will orient the *individual* to the rules and regulations of the unit within 48 hours of arrival.<sup>5</sup> The *individual* will be asked to sign the **BMU Inmate Orientation Handbook Receipt Form (Attachment 12-E)**.
  3. Staff shall complete the **appropriate DC-510A, Restrictive Housing Health Care Screening** (refer to **Section 1** of this procedures manual).
  4. **Individuals** 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 *individual may* be housed in a single cell for Phases 5, 4, and 3 of the BMU program. Suitability for double celling *may* be considered in **all** Phases and will be contingent upon the *individual's* program code in accordance with Department policy **11.2.1, “Reception and Classification.”**
    - b. When considering double celling *individuals* on the unit, the BMU Treatment Team should make every effort to facilitate voluntary double celling agreements between BMU *individuals*.

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<sup>5</sup> 5-ACI-5A-05

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- 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.
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 *individual* and:
    - a. review the referral; and
    - b. screen for any acute mental health symptoms including potential suicide risk **by completing the DC-510, immediately upon admission into the unit.**
  8. Within seven working days, a Psychiatric Admission Summary Note with treatment recommendations shall be completed. Summary of the BMU admission shall include at a minimum, but not limited to the following information:
    - a. history of present illness/reasons for BMU 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.
  9. Within 48 hours **of the completion of the initial Psychiatric Admission Summary Note**, the unit Psychology staff will **create an Initial IRP** with the *individual* and outline specific targeted goals and objectives.
  10. The BMU Treatment Team shall conduct an initial review of the *individual’s* IRP **at the next team meeting following completion of the Initial IRP.**

## K. Transfers of *Individuals* in the BMU System

1. An *individual* who is participating in the BMU program may be permanently transferred between BMUs, 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 EDSI/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 *individual* to a non-BMU location will require written approval by the EDSI.

**NOTE:** Transfers between BMUs will be coordinated with an exchange of transfer packet and a **DC-46** including a transfer rationale.

2. At times it may be necessary to temporarily transfer an *individual* from a BMU to a non-BMU facility. In these cases, the BMU *individual shall* be housed in an **RHU/DTU unless he/she is Phase 1. While temporarily housed in the RHU/DTU, the BMU individual shall be offered a minimum of 20 hours of OOC time per week.** 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 *individual'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 **brief DC-560**.
4. If an *individual* is committed to a Department MHU or the FTC, that *individual's* BMU bed will be held open for a reasonable period of time, pending the *individual's* return from the MHU or FTC. At the time of discharge, alternative placement into an SRTU may be recommended and considered. Should this be recommended, the BMU will generate a formal SRTU referral **as outlined in Subsection H.2. above**.

## L. Treatment Programs/Levels of Treatment

The BMU is designed to support *individuals* with a severe personality disorder exhibiting functional impairment **that interferes with their ability to sustain placement in a general population setting. Participation in this treatment program is based on a phase system that may include, but is not limited to, Phases 5 through 1, Recovery Phase, and Post-BMU aftercare.** Treatment planning may also include variations to the standard phases, treatment goals, and length of time in a phase, **incentives**, privileges, and management of problematic behavior.<sup>6</sup> Modifications to the *individual'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-F)**.

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<sup>6</sup> 5-ACI-6A-07

## 1. Treatment Phase Overview

- a. 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 **individual's** present level of functioning, recent historical information, and mental status. The BMU Treatment Team, **including mental health, custody, and unit management team staff**, shall recommend all treatment phase changes. **These will be documented by circulating a BMU Program Review Sheet, and forwarding to the PRC. The Unit Counselor will document all status changes in the ICAR. A DC-46 is not required for phase change following placement in Recovery Phase. A DC-46 will be required to be circulated for all Phase 1 approvals.** Ultimately the PRC, with input from the BMU Treatment Team, has the final decision on awarding or terminating privileges and granting phase changes.
- b. Phase advancement shall be based on behavior and attendance as well as participation in programming. Criteria for consideration of **earning privileges, incentives**, advancement from phase to phase, and cutting set-aside disciplinary sanctions include:
  - (1) **attaining goals as outlined in the IRP;**
  - (2) remain free of misconducts and problematic behavior reports;
  - (3) remain free of self-injury;
  - (4) attend at least 60% of the minimum 20 hours OOC structured and unstructured programming; and
  - (5) attend at least **60%** of individual sessions.

## 2. Individual Recovery Plans (IRP)

- a. All **individuals** 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 **contemplates** that the treatment delivered will be tailored to the individual’s strengths and needs; 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, violence, and self-harm.
- b. **Steps in developing a “Recovery Model” IRP:**
  - (1) identify the “person-centered” goal. Listening to the individual with empathy, acceptance, and validation will allow the goal to be expressed;

- (2) 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;
  - (3) identify obstacles that prevent the individual from reaching his/her goal;
  - (4) 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 **individual** from reaching his/her goal. **Objectives should clearly describe prosocial behaviors that will replace the expressed/exhibited maladaptive behaviors;**
  - (5) identify treatment interventions. Treatment interventions will be chosen that are likely to increase the individual's strengths, **including their interpersonal effectiveness, distress tolerance, and emotional regulation.**
- c. In conjunction with the BMU Treatment Team, the Psychology staff will update the initial IRP, using the **Individual Recovery Plan – Psychology. This will occur at a minimum every 120 days** while the **individual** is in **the BMU program**. The IRP shall be reviewed OOC with the BMU **individual unless security contraindications exist**. The **individual shall be encouraged to** have input into **their** goals rather than all **goals** being generated by the BMU Treatment Team in a standardized fashion. All **individuals** will be invited to personally attend and participate in all BMU Treatment Team meetings **unless current security contraindications exist and are documented**. Treatment plan reviews will be documented in the **DC-563, PRT Summary**.
- d. The goals on the IRP, established collaboratively with the BMU Treatment Team and the **individual**, shall drive the clinically structured OOC offerings on the BMU.

### **3. Progress in Treatment**

- a. 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 OOC participation will be reviewed by the Treatment Team. Should an individual's participation in OOC offerings fall below 60% of the minimum of 20 hours programming, the institution's LPM/**designee** will lead the Treatment Team in collaborating with the individual to **specifically** 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.
- b. The Treatment Team will also assess whether a higher level of care is indicated. The institution's LPM/designee may **initiate** a videoconference/teleconference consultation **between** their Treatment Team **and** their respective LPM to discuss and

review the Recovery Plan changes recommended by the institution's **Treatment Team**.

4. Phase System

a. Phase 5 (seven days)

- (1) This is the starting point for new admission to the program. The **individual** is eligible to advance to Phase 4 programming after seven days with no problematic behavior demonstrated and active participation in OOC programming. This phase includes:
  - (a) the initial assessment of the **individual**;
  - (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**; and
  - (b) escorted in restraints to all OOC activities. Restrained **individuals** will not be mixed in with unrestrained **individuals in OOC settings**.

b. Phase 4 (**14** days or longer based on clinical recommendation)

- (1) After **seven** consecutive days on the Phase 5/Stabilization Phase without problematic behavior, the **individual** is eligible for transition to Phase 4. Advancing through phases depends on active participation in programming. After **14** days on Phase 4, the **individual** 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;
  - (e) ***all incentive points earned in a week must be used in that week to order incentives. Any points not used will NOT be carried over to the following week(s)***; and
  - (f) escorted in restraints to all **OOC** activities. Restrained **individuals** will not be mixed in with unrestrained **individuals in OOC settings**.
  
- c. Phase 3 (**30** days or longer based on clinical recommendation)
  - (1) An **individual** 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 **30** days;
    - (b) compliant with facility regulations for at least **30** days;
    - (c) demonstrates an overall level of functioning that is consistent with general population; and
    - (d) compliant with treatment objectives as outlined in the **individual'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 **50** points per week;
    - (e) ***all incentive points earned in a week must be used in that week to order incentives. Any points not used will NOT be carried over to the following week(s)***;

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- (f) in Phase 3 the **individual** can be considered for on-unit employment based on team approval and job-availability. The Phase 3 **individual** may be permitted **and encouraged** to eat meals out of cell. Phase 3 **individuals** will be paid General Labor Pool (GLP) for five days per week; and
  - (g) 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 **individuals** are generally unrestrained for regular movement within the unit unless out with another **individual** who requires restraints.
- d. Phase 2 (**75** 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;
  - (3) any incentive point value may be used for any incentive point menu item including food up to a total of **50** points per week;
  - (4) **all incentive points earned in a week must be used in that week to order incentives. Any points not used will NOT be carried over to the following week(s)**;
  - (5) may generally move unrestrained out of cell unless out with another **individual** who requires restraints;
  - (6) in Phase 2 the **individual** 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 **individuals** will be paid GLP for five days per week;
  - (7) may exercise in a group with up to six other unrestrained **individuals**;
  - (8) at the discretion of the BMU Treatment Team, during Phase 2 the **individual** may begin a Step-Down Plan. The plan will begin by allowing the **individual** to wear institutional browns and state-issued boots. A CPS will meet the **individual** on that unit and will then escort the BMU **individual** to the mainline lunch or dinner meal. Staff will be aware of when the **BMU individual** is leaving and returning to the BMU. Upon returning to the unit, he/she will return the institutional browns and boots and will be issued BMU clothing. As per policy, the BMU **individual** will be strip-searched before leaving the unit and when returning to the unit;
  - (9) after Step **8** above has occurred several times, the same system may be utilized to have the CPS escort the BMU **individual** to receive a haircut or commissary.

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The procedure will be similar to the above; staff will be aware when the **BMU individual** is leaving and returning to the unit;

- (10) once all BMU Treatment Team members **agree** that the **individual** is ready **for increased general population exposure**, the BMU **individual** 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;
  - (11) once all BMU Treatment Team members **agree** that the **BMU individual** is ready **for additional increased general population exposure**, the BMU **individual** 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 **individual** will be escorted by the CPS and the same procedures will be utilized as outlined above; and
  - (12) **lastly, to assist the individual with a smooth transition to Phase 1 general population, the BMU Treatment Team should consider connecting the individual to as many general population services and resources as safely as possible. These may include but are not limited to:**
    - (a) **continued supportive contact with a CPS;**
    - (b) **employment; and**
    - (c) **expedited placement in all recommended Correctional Plan programming, if program eligible.**
- e. Phase 1 (**120** days or longer)
- (1) An **individual** 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 **120** days in length with an option to extend probation for another **60** days through the Vote Sheet process. However, the maximum amount of time this phase will last is 180 days. Should the **individual** be away from the facility for any reason such as Authorized Temporary Absence (ATA), or a Mental Health Commitment, Phase 1 time **may** be suspended **or continued at the discretion of the BMU Treatment Team in consultation with the temporary placement facility.**
  - (2) While on Phase 1, the BMU Treatment Team will continue to review the individual's IRP every **120** days. Incentive points will not be earned nor can they be used while an **individual** 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 **individual** successfully completes **Phase 1**, the BMU Treatment Team will staff him/her for graduation from the program. Graduation from the BMU will be completed by Vote Sheet with final approval from the Facility Manager. Since the **individual** has 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 **individual** to general population requires facility approval via the **EDSI/Regional Deputy Secretary**.

f. **Recovery Phase**

Consequences for engaging in **SIB**, aggressive, or other problematic behavior will be immediate with the **individual** being placed on **Recovery Phase** where the capacity to earn incentives is limited. **Recovery Phase is an alternative** temporary placement within the unit or off-of-the unit for BMU **individuals** 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.

(1) Purpose of **Recovery Phase**

An essential part of all Behavior Management programs is the provision for an immediate **intervention** for serious negative behavior. Therefore, **a Recovery Phase** may be instituted to temporarily address an acutely aggressive, threatening, disruptive **individual** participating in BMU programming. This ensures the **opportunity for de-escalation of the individual**, safety of staff and other **individuals**, and the smooth continuation of the program for treatment compliant **individuals**. **The goal is to return the individual to the therapeutic regimen as soon as safely possible.**

The BMU **individual** may be held on **Recovery Phase** for as **short a time as needed (e.g., a few hours)**, **but is recommended to last** no longer than 72 hours. **If after the first 24 hours on Recovery Phase, the individual's status has not stabilized, the assigned Psychology staff member will create an addendum to the IRP including specific goals relevant to the behaviors exhibited which resulted in the alternative placement. However,** if the individual's status has not stabilized after the first 72 hours, the **Psychology staff member** will be consulted to determine the need for POC placement or **consultation with Psychiatry. Following the first 72 hours, if necessary, the PRC may approve additional placement on the Recovery Phase in 24-hour increments. The BMU Treatment Team will complete a BMU Program Review Sheet reflecting the Recovery Phase placement and forward to the PRC for review and approval. Should the individual be maintained on Recovery Phase for longer than one week, the BMU Treatment Team may schedule a teleconference with their respective Regional LPM to discuss recommendations for case management.**

(2) **Documentation for Recovery Phase Placement**

BMU **individuals** 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 **individual** requires a higher level of care (e.g., POC placement). These behaviors may be reported and documented **using the respective discipline's clinical documentation and, as necessary**, by utilizing **either** the:

- (a) **DC-141, Part 1, Misconduct or Other Report**; or
- (b) **DC-121, Part 3, Employee Report of Incident.**

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 individual on **Recovery Phase**. The Lieutenant or Unit Manager will complete the **BMU Recovery Phase Restriction Form (Attachment 12-G)**. Recommended property and privilege restrictions **MUST** relate to the behavior that prompted the **individual's** placement on **Recovery Phase**. All documentation will be completed immediately and forwarded to the Shift Commander for initial disposition. **Should placement on Recovery Phase occur on the weekend, the Lieutenant will send an email to the Unit Manager, Counselor, LPM, and assigned PSS informing them of the placement.**

In general, cells utilized for **Recovery Phase** 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 **individual**.

(3) **Recovery Phase Process**

Prior to placing the individual into **Recovery Phase**, he/she will be strip searched and given property and privileges as indicated on the **BMU Recovery Phase Restriction Form**. Once placed on **Recovery Phase**, the **individual** will be seen by his/her assigned Psychology staff member within 24 hours or as soon as normal facility operations permit for the purpose of **determining the need to addend the individual's IRP**.

All other staff contacts will occur as **outlined in the IRP and as directed by the PRT, including consideration of offering clinically appropriate structured and unstructured OOC time, unless behavioral compliance, institutional**

**safety, staff safety, and/or patient safety contraindicates bringing the individual out of cell during Recovery status.**

**While on Recovery Phase, the Treatment Team will reinforce with the individual the following:**

- (a) the goals and objectives, emphasizing the expected prosocial behaviors as described on the IRP;**
- (b) the nature of staff contacts (who, frequency and duration) during the Recovery Phase;**
- (c) the incentives for exhibiting the identified prosocial behaviors; and**
- (d) the anticipated duration of the Recovery Phase and return to the regular BMU treatment milieu.**

**While on Recovery Phase, individuals will not earn any incentive points.**

To be removed from **Recovery Phase**, an **individual** must be treatment **plan** compliant, in behavioral control, and misconduct free. The Treatment Team **with approval from the PRC** will decide when an **individual** has successfully completed **Recovery Phase**. The **individual** will then be returned to the program phase deemed appropriate by the BMU Treatment Team.

#### **M. Behavior Management Plan (BMP)**

- 1. BMPs use a structured sequence of incentives to reinforce positive behavior change and reduce identified problems. BMPs are not appropriate for every individual with behavioral problems. Because development, implementation, and monitoring of BMPs are resource intensive, in the PA Department of Corrections, BMPs are used to address individuals with recurrent SIBs who have not responded to other treatment efforts. A BMP is a separate specialized strength-based treatment plan that is created in addition to the individual's IRP. BMPs should be added to the IRP in the electronic health record as one of the methods being used. Additional interventions used in BMPs include psychoeducation, cognitive-behavioral interventions including Dialectical Behavior Training skills, and consistent staff communication with the individual.**
- 2. BMPs are created by the institution's LPM, the assigned Psychology staff member, and by collaborative effort with the rest of the BMU team and the individual patient. Collaboration and ongoing consultation with facility administration, correctional staff, medical staff, mental health staff, and Central Office psychology will ensure several important concepts. These concepts include: ensuring patient safety, ensuring that objective and complete data are collected during the development of the plan, that proposed interventions are realistic and practical, that staff take**

**“ownership” of the interventions, and that implementation of the plan is consistent across all disciplines and shifts.**

3. **BMPs do not supplant safety/crisis interventions or the disciplinary process as outlined in other Department policy.**
4. **Procedure**

**Should an individual exhibit recurrent SIBs that have not responded to other forms of intervention, the BMU Treatment Team will schedule a meeting to discuss the need for a BMP. This team meeting will also discuss the risks and benefits of a BMP to the individual. The result of this meeting will be documented in the electronic health record within the DC-563. The recommendation for a BMP will be forwarded to the PRC and, in turn the Facility Manager. The institution’s LPM will then review the recommendation for a BMP with their respective Regional LPM. Together, the LPM, the Facility Manager/designee, and the Regional LPM will make the final determination to initiate a BMP and resolve any barriers that may exist to implement a behavioral change program. This decision will be communicated back to the Treatment Team.**

- a. **Data Gathering – This step involves the careful identification of the specific problem behaviors to be extinguished and the prosocial replacement behaviors to be reinforced. Target behaviors must be described in objective, nonjudgmental, and behavioral terms such that all staff working with the individual can recognize and agree when these behaviors are occurring. At this stage, inferences regarding intent and motivation of problem behaviors should be deferred. Data measuring the frequency and severity of the problem behaviors for the six months prior to the implementation of a BMP is necessary for comparison to the data collected after a BMP is implemented. Data will also include a summary of the resources utilized over the same six months.**
- b. **Sources of Information – The individual’s assigned psychology staff member, under the supervision and close collaboration with the LPM, will be responsible for compiling a comprehensive report of relevant information/data. All available data sources need to be used in the development of a BMP. Sources of information that should be used include: medical records; mental health records; court and parole records; institutional records including classification, disciplinary reports, requests for services, grievances, visitation/telephone logs, etc.; interviews with the individual; information from collaterals, such as family, friends, or other community sources (when available); interviews with COs, program supervisors/teachers, facility clergy, medical and mental health care providers; and consultation with facility administrators. During the data collection process, the information compiled should be shared and discussed with the Treatment Team. This will allow the integration of differing perspectives and resolve any contradictory data.**

- c. **Functional Assessment** – *The individual's assigned psychology staff member, under the supervision and close collaboration of the LPM, will complete the functional assessment. Functional assessment requires that a chronology of the problem behaviors, their antecedents, and their consequences are developed. Baseline frequency and severity of the behavior need to be clearly identified. The collected data will be organized such that it can describe warning signs, triggers, and conditions under which the problem behaviors are more likely; conditions under which the problem behaviors are less likely; the sequence of problem behaviors as they unfold; and consequences of the behavior that appear to be reinforcing. Development of detailed Antecedent-Behavior-Consequence chains is required to reach viable hypothesis regarding the function of the problem behaviors. The functional assessment should be reviewed with the entire Treatment Team and any alternative hypotheses should be identified and explored. The assigned psychology staff and LPM shall review the results of the completed functional assessment with their respective Regional LPM.*
  
- d. **Risk Assessment** – *The risks for specific behavior problems must be thoroughly understood in order to identify appropriate interventions and ensure that incentives and privileges are provided in a safe manner.*
  
- e. **Behavior Management Plan (BMP)** – *The assigned psychology staff member, under the clinical supervision of the LPM, will complete the BMP using form Individualized Behavior Management Plan, which is embedded within the IRP. The BMP is a structured series of phases or levels that identify increasing levels of privileges and incentives in response to the individual achieving identified behavioral goals. Each phase should be well defined to enable staff and the individual to anticipate consequences of behavioral relapses as well as positive behavioral change. Individuals who engage in self-injury following implementation of the BMP are returned to the initial, most restrictive, phase for purpose of reestablishing safety. BMPs will also require:*
  - (1) *identification of a set of replacement behaviors and treatment goals that are observable, measurable, realistic, and protect the individual from engaging in the problem behaviors. These are often described in “mini” goals or stepping stones that must be achieved to meet the ultimate goal;*
  - (2) *identification of the individual's strengths;*
  - (3) *identification of any skills deficits or special needs that need to be addressed to support the individual's progress;*
  - (4) *identification of communication strategies that are most likely to be well received and effective with the individual. This step may also include development of a “staff response plan” that guides staff behavior and the tone of communication when responding to a crisis; and*



- (5) **identification of a sequence of structured incentives, including the frequency and duration to be used in providing these incentives; and the behavioral objectives that must be achieved to earn incentives.**
- f. **Informed Consent – Prior to implementation of the BMP, informed consent from the individual shall be sought. Informed consent includes explaining the procedures to be used and the behavioral goals to be obtained in language easily understood by the individual. Risks and benefits associated with implementing the plan as well as those associated with not implementing a plan should be discussed with the individual. Informed consent is documented through the patient's signature on the BMP. Should the individual refuse to consent, the BMP will not be implemented. The individual should be informed completely about the staff interventions that will be put into place to support a decrease in self-injury and increase the patient's safety. Attempts to obtain consent should be ongoing, if initially refused.**
- g. **Monitoring and Measuring – Ongoing monitoring of the BMP to support consistent implementation is required. Measurement of the frequency and severity of the problem behaviors for six months following the implementation of the BMP is necessary to assess the effectiveness of the interventions. In order to maximize the measurement of behaviors, custody staff and others working the unit will utilize the Behavior Tracking Sheet (Attachment 12-H) in order to document observed behaviors. This form will be kept alongside the DC17X, Adjustment Record for Security Level 5 Inmates. The individual's assigned psychology staff member will be responsible for monitoring implementation and progress. They will also be responsible for compiling data on the Resource Utilization Log, contained within the DC-516, Brief Chart Review.**
  - (1) **Staff Training – All staff, including custody, working in locations with individuals who have the need for behavioral interventions should be trained in basic principles of behavior change as well as de-escalation skills. Training mental health and security staff simultaneously is preferred to improve collaboration.**
  - (2) **In order for a formal BMP to be put in place according to the above guidelines, the site must have a licensed psychologist and other psychology staff member(s) (e.g., PSA, PSS, Forensic Psychological Services Associate [FPSA]) on site that have received the full Behavior Management training delivered by the Psychology Office. The training developed for this purpose is two days in length. Custody staff and administrators of the site receive day 1 of the training. Clinical staff and unit management staff receive both days. As employees are transferred in and out of the BMU, additional annual refresher trainings may be needed. These can be delivered by the site's licensed psychologist who has received the full training.**

- (3) ***A central component of the Behavior Management training delivered to all individuals (i.e., including COs and administrators) determined to need this training is Professionalism and Ethics, which includes the following concepts regarding the development and implementation of a BMP:***
- (a) ***relying on scientific knowledge;***
  - (b) ***maintaining competence through ongoing education;***
  - (c) ***maintain integrity, responsibility, lawfulness, and confidentiality;***
  - (d) ***use understandable language;***
  - (e) ***do not discriminate on basis of age, gender, race/ethnicity, socioeconomic status, sexual orientation, or national origin;***
  - (f) ***avoid conflicts of interest, dual relations;***
  - (g) ***conducting a functional assessment before building a plan;***
  - (h) ***collect and graphically display data to support plan development;***
  - (i) ***obtain informed consent for interventions and involve patient in planning;***
  - (j) ***use least restrictive interventions;***
  - (k) ***avoid harmful incentives;***
  - (l) ***individualize plan; and***
  - (m) ***measure outcomes.***

#### **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. ***Psychology staff will document their group contacts according to protocols established in Section 1 of this procedures manual using the DC-472M, Progress Note Psychology Group. All other group*** facilitators of structured and unstructured programming will document ***their*** group contact with each individual on the ***BMU Group Participation Form (Attachment 12-I)***. Each facilitator will keep the ***Group Participation Form*** in his/her possession. At the end of each 30 days, the ***Group Participation Form*** will be ***placed with the individual participant's DC-17X. Upon completion of or removal from the BMU program, this documentation will be forwarded to the individual's DC-15, Inmate Record.*** 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, **SUD**, 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 **individuals**, 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 **individuals**, 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 **individual**. This visual representation of their immediate objectives can be placed where the **individual** 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 **individual**. 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. **Individuals in the BMU shall be offered a minimum of one hour of exercise per day outside their cells, seven days per week, unless security or safety considerations dictate otherwise.**<sup>7</sup>
4. At a minimum, ten structured and ten unstructured OOC hours of programming will be offered to all **individuals** housed in the BMU. The number of structured OOC hours or portions of an hour of programming the **individual** 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 **BMU Accepted/Refused Structured Out-of-Cell Program Log**. The number of unstructured OOC hours or portions of an hour of programming the **individual** 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 **individual**, document the total in the **ICAR**, and report the data on the **Weekly Structured/Unstructured Out-of-Cell Program Report (Attachment 12-J)**. 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 **Director of Psychology and respective Regional LPM**.
6. **The programming day is not considered to be Monday through Friday during daylight hours. Instead, OOC time shall be scheduled seven days a week to achieve the minimum of 20 hours OOC per week offering, including evenings, if**

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<sup>7</sup> 5-ACI-4A-24

*necessary. This provision is meant to avoid any days consisting of no OOC time offered.*

## 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. **Recovery Phase** for a BMU **individual** who is celled in an area apart from the BMU (if available) due to his/her behavior, psychiatric symptoms, and/or facility need. The **individual** may be committed to an 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 **individual** with previous assaults on female staff will lock-up when female staff are on the unit, or a Phase 4 **individual** may be permitted uncuffed OOC time when other **individuals** are all in their cells).

## P. Incentive Program

1. The Incentive Program is designed to allow **individuals** 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 **individual**, 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. **Individuals** 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 **individual** 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. **Individuals** earn two points for each hour of structured activity and one point for each hour of unstructured activity they attend.

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Structured and unstructured programming will occur daily. **Individuals** are assigned to specific groups based on individual needs. **Individuals** 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. **Individuals'** points are aggregated each week. **Individuals** are informed weekly, both verbally and in writing, of all points earned. **Individuals** then may order items or purchase privileges using their points. Items are given point values from five to 60 points. **All incentive points earned within the week must be used within that week or else they will be lost. Incentive points do not accumulate week to week.** Points and privileges will be held in abeyance should the inmate be placed in **Recovery Status**.
- d. The following is an overview of the incentive points that may be earned in each week:
- (1) **one point** daily **earned** for no disciplinary reports or information reports (maximum to be earned **per week** is seven);
  - (2) **one point** daily for Good/Fair ratings for Cell Cleanliness and Hygiene (maximum to be earned **per week** 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) **no incentive points will be earned while on Recovery Status.**
- e. At the end of each week, the BMU Counselor will tabulate each **individual's** incentive point total for the previous week using the **BMU Weekly Point Summary (Attachment 12-K)**. After tabulating the weekly point totals, the BMU Counselor will then distribute the **BMU Incentive Order Form (Attachment 12-L)** to each **individual**. 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 a Class 1 Misconduct charge 1 to **25** will result in formal disciplinary action if found guilty and **consideration of Recovery Phase placement**.

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2. If a misconduct is eligible for informal resolution, staff will complete the **BMU Informal Resolution Action Form (Attachment 12-M)** to document his/her sanction for that misconduct.
3. An **individual** will not be issued misconducts for self-mutilation, however, a **DC-121, Part 3** will be generated. This may result in the **individual's** placement in the POC or on **Recovery Phase**.
4. The assigned Psychology staff will provide input to the Hearing Examiner for all formal hearings. The Hearing Examiner will use this input for sanctions or modifying sanctions.
5. An **individual** on 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. **Individuals** 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 **individual's** behavior so he/she can progress to placement in the least restrictive environment, based on his/her 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 **individual** is in the BMU. An **individual** can earn further reductions in his/her DC sanctions for appropriate behavior.
3. 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 Individuals**

1. Phase 1 constitutes the release of the **individual** to a general population housing unit, generally within the treating facility. The release of any Phase 1 **individual** from the BMU to a general population housing unit requires approval of the **EDSI/Regional Deputy Secretary**.
2. An **individual** 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 general population shall be requested via memo to the office of the effected EDSI/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 **individual's** progress in the BMU program.

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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 **individual** is readied for transition on the approved date;
  - b. the **individual** packs his/her property and cleans the cell;
  - c. the **individual's** property is inventoried by unit staff;
  - d. all BMU property, clothing, etc., is returned to the BMU inventory;
  - e. the **individual's** property is released to the **individual** and/or the Department transportation crew;
  - f. if the **individual** is being released to the BMU facility's general population, request appropriate staff to escort the **individual** 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 **individual** movement forms for count procedures are completed; and
  - i. in a case where the **individual** is being discharged to a general population placement at another facility, the BMU Treatment Team shall conduct a videoconference or teleconference call, with the Unit Management Team of the receiving facility to discuss the **individual's** response to treatment. The referring facility shall document in the **ICAR** and on the **brief DC-560** the date, name of participants, and issues discussed in the conference call. At a minimum, the following issues shall be addressed:
    - (1) the **individual'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 **individual** arrives at his/her designated facility.
6. An **individual** being transferred to another facility as a Phase 1 BMU **individual** 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 **individual's** behavior deteriorates during his/her Phase 1 probationary period, the **individual** may be returned to the BMU. If the **individual'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 **individual** 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 **individual** may require a short time stay in the RHU and/or a mental health inpatient setting. If there is a 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 **individual** 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. it is necessary to place a BMU graduate in the RHU, he/she will be managed according to his/her Stability Rating and Department policy **DC-ADM 801**; or
  - c. an **individual** successfully completing Phase 1 probationary period and graduating from BMU programming may be eligible for transfer to **another** facility by submission of a permanent transfer petition utilizing the purpose: Other, and Comments: BMU Graduate.
2. Discharge of an **individual** from the BMU for other than successful program completion shall be considered when:
  - a. the BMU Treatment Team concludes that the **individual** remains resistant to participation in the IRP that was developed for him/her; and/or the **individual** engages in repeated negative behavior which is contrary to the mission of the BMU, and undermines the treatment of other BMU participants, e.g., evidence of both disruptive actions and detrimental impact on valid BMU **individuals'** progress; and
  - b. all **individuals** being considered for discharge from the BMU for reasons other than successful completion shall be automatically referred to the **SOAU** for review and recommendation for subsequent placement. The **SOAU** recommendations will then be included in the referral.
3. The facility recommending an **individual** for removal from BMU programming should send an **SOAU referral to the SPRA. This referral must only be forwarded electronically. OPM will log and track the referral as it moves through the approval/rejection process. The purpose of the SOAU referral is to determine the appropriateness of BMU failure.** The referral should include the following information:



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- a. **DC-46** circulated through the BMU Treatment Team and the referring facility's administrative staff;
  - b. rationale for the **individual's** removal from BMU programming to include listing of disruptive behaviors, misconducts, and actions of self-injury; and
  - c. documented evidence of behaviors to include, but not limited to Misconduct Report(s), **DC-121s**, **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 **individual's** case will be generated **by the Psychology Office**.
  5. If the final recommended disposition by COSN/PRT does not include placement in another BMU, the **EDSI** will conduct the final review.
  6. If removal from BMU Programming is approved by the COSN/PRT and the **EDSI**, then a Transfer Petition will be completed by OPM. COSN/PRT will determine where the **individual** should be placed and OPM will assign a facility accordingly.
  7. Prior to discharge or transfer to another BMU, 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 BMU;
    - c. BMU discharge treatment recommendations; and
    - d. any **individual** whose Psychiatric Evaluation is over five years old shall have an updated Summary Psychiatric Assessment at the time of his/her discharge from the BMU which shall include the above information.

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

1. If an **individual** is scheduled for release via Sentence Complete before completion of the BMU program, the **individual** 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. The **individual** may be referred to the **SOAU** in accordance with this procedures manual for an evaluation. The **individual** may be placed on the Hard to Place Offender List in accordance with Department policy **7.3.1, "Reentry and Transition."**

3. Any release of a highly assaultive **individual** due to sentence completion shall follow procedures set forth in Department policy **6.5.1**. Reentry services shall be offered in accordance with Department policies **6.5.1** and **7.3.1**.

## **V. Unit Operation Evaluation**

1. Monday of each week, the BMU Unit Manager/designee will provide, via email, the **Director of Psychology and respective Regional LPM** at Central Office with an updated roster to include BMU **individuals** 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 **Director of Psychology** at Central Office, the effected Regional LPM, the effected EDSI/Regional Deputy Secretary/Inspection Team, the log sheet of OOC 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 order to evaluate the operation of the BMU, each Facility Manager/designee shall ensure that a **BMU Semi-Annual Report (Attachment 12-N)** is completed and submitted to the **EDSI**, the Licensed Psychologist Director (LPD) at Central Office, the effected Regional LPM, and the effected **EDSI/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 **individual** receptions by month;
  - b. a list of facilities transferring **individuals** to the unit;
  - c. the name and Department number of every **individual** transferred to the unit;
  - d. the name and Department number of every **individual** promoted to Phase 1;
  - e. the average length of an **individual's** stay in all Phases (5, 4, 3, 2 and 1);
  - f. the name and Department number of every **individual** 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 **individual** with Sentence Complete expiring while in the unit;
  - h. the name and Department number of every **individual** moved to **Recovery** Status and Post BMU;
  - i. the number of grievances filed by **individuals** in the unit;
  - j. the number of misconducts issued to **individuals** in the unit;

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- k. the number of BMU *individuals* 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 Unit (DTU)<sup>1</sup>

### A. General

The Department strives to avoid prolonged placement of **individuals** with a Serious Mental Illness (SMI) and/or Intellectual Disability (ID) in **Restrictive Housing or Extended Restrictive Housing**. However, due to **immediate and present danger to others or the safety and/or security of the institution (i.e., as determined by the Psychiatric Review Team [PRT] and Program Review Committee [PRC])**, an **individual** with an SMI or ID may need to be placed in a secure housing unit **or setting** where he/she will continue to receive mental health care commensurate with his/her treatment needs **and not be exposed to Restrictive Housing or Extended Restrictive Housing**.<sup>2</sup> **Individuals** being considered for placement into the DTU will not meet commitment criteria according to the Pennsylvania Mental Health Procedures Act. **Each individual placed in the DTU must have an active individualized recovery plan that includes bi-weekly (i.e., a minimum of once every 14 days, more frequently, if clinically indicated) monitoring by Psychology staff, treatment as necessary, and steps to facilitate the transition of the individual back into general population.**

### B. Admission Criteria

Admission criteria shall include the following:

1. a diagnosis of an 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 **individual** 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 PRC with the recommendation of the 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 **individual** (5B transfer) may be placed in the DTU if clinical judgment indicates it as an appropriate placement; and

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<sup>1</sup> 5-ACI-4A-04

<sup>2</sup> 5-ACI-4B-30, 5-ACI-4B-31

7. any **individual** being placed in restricted housing who is under the age of 18, at the State Correctional Institution (SCI) **Camp Hill**, 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 **individuals** 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) space for **individuals** 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 **individual** 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 **individual** 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. **Psychology and nursing staff will screen every new individual placed in the DTU with the electronic DC-510 (i.e., Restrictive Housing and Special Management Housing-Mental Health Care Screening) and the electronic DC-510A (i.e., Restrictive Housing and Special Management Housing-Health Care Screening), respectively. Security staff will also screen every new individual placed in the DTU with the paper DC-510, Suicide Risk Indicators Checklist. These procedures are outlined in Section 2 of this procedures manual.**
4. All DTU **individuals** 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 **individual** 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 **individuals** in the DTU to achieve the minimum offering of OOC activity. Individual Recovery Plan (IRP) goals established collaboratively with the PRT and **individual** shall drive structured OOC programming offerings on the unit.

The number of structured OOC hours or portions of an hour of programming that the **individual** 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 *individual* 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 *individual* and shall cover the reporting period from Monday to Sunday.

5. DTU *individuals* will be handcuffed in the front using a security belt with two COs escorting. Tethers and leg shackles are optional and only used with *individuals* whose demonstrated behavior warrants their use.
6. Weekly, the DTU Counselor will compile the total hours of programming for each *individual*, 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 **Director of the Psychology Office** and the respective Regional Licensed Psychology Manager (RLPM).
7. 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 may coordinate a videoconference/**teleconference consultation** 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.
8. Each DTU unit team, in conjunction with PRT and PRC, will introduce an incentive system to encourage prosocial behavior and participation in OOC offerings.

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9. The programming day is not considered to be Monday through Friday during daylight hours. **Instead, OOC time shall be scheduled seven days a week** to achieve the minimum of 20 hours OOC per week offering, **including evenings, if necessary. This provision is meant to avoid any days consisting of no OOC time offered.**
10. All **individuals** 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, **unless security or safety considerations dictate otherwise.**<sup>3</sup>
11. **Individuals** 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.
12. The PRC shall review each **individual** 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 **brief DC-560, Mental Health Contact Note, which should include assessment for** continued appropriateness for DTU placement. The LPM/designee must make a recommendation to PRC regarding **the appropriateness of continued placement in the DTU at every PRC meeting.** The LPM/designee can also report to PRC on the **individual's** adherence to medication regime.<sup>4</sup>
13. If an **individual** refuses to attend PRC, the committee will go to the **individual's** cell.
14. 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 **individual** should be removed from the DTU or if exceptional circumstances exist allowing PRC to continue to hold the **individual** in the DTU. Exceptional circumstances include:
  - a. release would pose a substantial risk to the safety of the **individual** 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 **individual's** best interest based on his/her mental condition and that removing the **individual** and placing him/her in a general population RTU or Secure Residential Treatment Unit (SRTU) would be detrimental to his/her mental condition.
15. Any D Roster **individual** 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 Director **of** the Psychology Office. These cases will

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<sup>3</sup> 5-ACI-4A-16, 5-ACI-4A-24

<sup>4</sup> 5-ACI-4A-07

then be reviewed by the Central Office Special Needs Psychiatric Review Team (COSNPRT).

16. If a D Roster **individual** is deemed to meet the criteria in **Subsection C.13.a. & b. above**, PRC, in conjunction with PRT, will consider initiating a referral to an SRTU if warranted and appropriate.
17. **Upon reception into the DTU, the patient's IRP should be reviewed (i.e., from the existing IRP) and or updated within seven days of reception.** Psychology staff will create an IRP in collaboration with the **individual**, to present at the first PRC meeting. This plan shall address the behaviors that brought the **individual** to the DTU **and the steps necessary to facilitate the transition of the individual back into general population.** A discussion shall be conducted in regard to the behaviors (e.g., participation in OOC programming without being disruptive), the **individual** has to demonstrate to earn early release from the DTU and **or to** earn **additional** privileges **while housed in the DTU.** The goals of this IRP drive the clinical structured OOC offerings on the unit (e.g., if an **individual's** goal is to control anger, then he/she shall be in an anger management group, or if an **individual** wants to address managing anxiety related to trauma, he/she shall be in a seeking safety group).
18. IRPs are to be completed every **120** days<sup>5</sup> 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.
19. The **individual** 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 **individuals.** If an **individual** refuses to attend PRT, he/she will be seen cell side and encouraged to attend OOC PRTs.
20. A member of the Psychology staff shall be assigned to the DTU, **have an office on the unit,** and offer a **bi-weekly (i.e., once every 14 days)** OOC individual contact with each **individual, or more frequently if clinically indicated and documented with a full DC-560 and ICAR.** In the event that the **individual** is offered and refuses OOC contact and it occurs at the cell door, this should be documented in addition to its impact on confidentiality **on a brief DC-560.**
21. **If confinement continues beyond 30 days within a DTU, Psychology staff shall complete a mental health assessment at least every 30 days thereafter for individuals on the active Mental Health/Intellectual Disability (MH/ID) Roster (i.e., C and D) and more frequently if clinically indicated. This mental health assessment will be documented with a full DC-560 and memorialization of the embedded suicide risk assessment. This mental health assessment shall be offered to be completed in an OOC setting (i.e., unless behavioral compliance contraindicates**

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<sup>5</sup> 5-ACI-4B-31

*an OOC contact), to ensure confidentiality. The purpose of these mental health assessments is to determine, with reasonable assurances, whether the individual poses significant risk to themselves or others and to determine whether restrictive housing or special management housing placement is contraindicated.*<sup>6</sup> Psychology shall have a current copy of the IRP during all psychology contacts.

22. Psychology staff shall make rounds daily on the DTU, Monday through Friday excluding weekends and holidays. ***If Psychology staff are present in the institution on the weekend or holiday, rounds shall be made in the DTU.*** The ***individual*** can be removed from his/her cell for OOC contact if it is required in the clinical opinion of the Psychological Services Specialist (PSS). An ***individual*** 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.<sup>7</sup>
23. The assigned Counselor shall see every ***individual*** weekly. Each ***individual'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.
24. 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.<sup>8</sup>
25. 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.
26. Commissary purchases are limited to approved items from the AC commissary catalogue. Outside purchases are prohibited.
27. ***Individuals*** 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

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<sup>6</sup> 5-ACI-4A-10

<sup>7</sup> 5-ACI-4A-12

<sup>8</sup> 5-ACI-6B-12

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or behavior dictate otherwise. The default presumption should not be that privileges or possessions are contraindicated.<sup>9</sup>

28. DTU **individuals** 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.”**<sup>10</sup>
29. DTU **individuals** are permitted to maintain the equivalent of one records center box of any combination of personal property in their cell. Additional boxes of legal materials may be granted for open and active cases through the Corrections Superintendent’s Assistant (CSA).
30. 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 **individual’s DC-17X**.
31. 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 **individual** 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.<sup>11</sup>
32. If a determination is made that the DTU is not the least restrictive environment for an **individual** due to his/her being a threat in the DTU or a less secure environment, an SRTU or Behavior Management Unit (BMU) referral may be made. When an **individual** is being recommended for a transfer to the SRTU or BMU, the PRC, with input from PRT, shall review the recommendation and inform the **individual** of the reasons for proposed recommendation. The **individual** shall be given the opportunity to respond to the rationale given and object to the **individual** 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 **individual**. The **individual** may appeal the recommendation for SRTU or BMU to the Facility Manager and to the Chief Hearing Examiner’s Office at Central Office.
33. Any **individual** 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.
34. When an **individual’s** service of consecutive DC in the DTU is interrupted, for example the **individual** goes out on WRIT/ATA to a county facility, or non-Department facility,

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<sup>9</sup> 5-ACI-4A-25, 5-ACI-4A-26, 5-ACI-4A-27

<sup>10</sup> 5-ACI-4A-22

<sup>11</sup> 5-ACI-4A-21

his/her remaining DC imposed time is tolled during the ATA. At the time of the **individual's** return from ATA, the receiving facility shall determine if, and to what extent, the **individual's** owed DC time should be credited because while ATA, the **individual** 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 **individual's** status upon return to the facility.

35. ***Ideally, DTU individuals are compatibly double celled, unless they have a Z-Code. The Unit Management Team will make every effort to facilitate a double celling agreement between compatible DTU individuals.***
36. ***CO rounds on the DTU shall be conducted in a continuous fashion to ensure that all cells/areas are checked a minimum of once every 15 minutes, on an irregular and intermittent schedule, by the officers assigned to the unit. Daily oversight of CO rounds by Commissioned Officers is an essential function that also must be prioritized and emphasized in order to ensure security rounds are occurring according to policy and post orders and are of the highest quality. Officers' rounds should ensure specific attention and observation of those individuals that are in a cell alone, either because of a Z-Code, being housed alone without a Z-Code, or because their cellmate is away.***
37. ***CO, Sergeants, and Lieutenants assigned to a DTU are required to wear an emergency cut-away style tool during their shift when assigned to the DTU. The cut-away tool shall be carried in a case on the officer's belt to expedite an appropriate response during suicide attempts requiring the need to remove a ligature with the tool. The cut-away tools are to be considered tools and inventoried in accordance with Department policy 6.3.1, "Facility Security," Section 7.***

#### **D. Staff Training<sup>12</sup>**

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 **Director of the Psychology Office** at Central Office and the respective RLPM with an updated roster to include DTU **individuals** on MH commitment, WRIT, etc., using the

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<sup>12</sup> 5-ACI-6A-30



**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 **Director of the Psychology Office** 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. 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, **Director of the Psychology Office** 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 **individual** receptions by month;
  - b. the amount of DC time reductions per **individual** (names and numbers) who have received time cuts;
  - c. unit classifications transferring **individuals** to the unit and the number of **individuals** 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 **individual** transferred to the unit;
  - e. the average length of an **individual's** stay in the DTU;
  - f. the name and Department number of every **individual** released from the unit and the location where he/she was transferred;
  - g. the name and Department number of every **individual** with Sentence Complete (SC) expiring while in the unit;
  - h. the number of grievances filed by **individuals** in the unit;
  - i. the number of misconducts issued to **individuals** in the unit;
  - j. the number of DTU **individuals** 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.



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

**Policy Subject:**

**Access to Mental Health Care Procedures Manual  
 Section 15 – Certified Peer Specialist (CPS) Program**

**Policy Number:**

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The purpose of this Bulletin is to update **Section 15 – Certified Peer Specialist (CPS) Program** of Department policy **13.8.1, “Access to Mental Health Care.”**

**Subsection B.3.b.** has been deleted and shall now read:

- b. ***H and Z Codes are not automatically ineligible for employment as CPSs solely based on these codes. CPS suitability in general, shall be reviewed and evaluated as part of the DC-46, Vote Sheet process with input from the CPS Committee, with specific consideration given as to the reason(s) why the Z or H Code was/were assigned and whether those reasons conflict with the person working as a CPS;***

## Section 15 – Certified Peer Specialist (CPS) Program

### A. General Considerations

1. The purpose of the Certified Peer Specialist (CPS) **program** is to train select individuals from the **Department of Corrections (DOC)** population to serve as CPSs.<sup>1</sup>
2. **The Pennsylvania Certification Board (PCB) is responsible for certifying individuals as qualified to provide CPS services.**
3. The certification process will afford all successful participants the opportunity to become a recognized CPS by the Pennsylvania Department of Human Services (DHS), **PCB**, 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.
4. **Upon completion of the CPS training course, the CPS Supervisor will submit the required information to the PCB by utilizing the CPS Application (Attachment 15-A). The CPS Supervisor may act as the designated staff who may sign the CPS Application. The packet does not require notary signature. The PCB requires recertification every two years. Information regarding recertification is located on the following website: [www.pacertboard.org](http://www.pacertboard.org).**
5. **While being trained as a CPS, the wage is .42 cents per hour. Only after completing the CPS training and only when functioning as a CPS will he/she be paid .51 cents per hour.** The workday 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.
6. CPS training will provide selected candidates with the skills required to act as mentors/role models for other **incarcerated individuals** in specialized units and other places within a state correctional facility, such as:
  - a. visiting room;
  - b. Residential Treatment Unit (RTU);
  - c. Special Needs Unit (SNU);
  - d. Secure Residential Treatment Unit (SRTU);
  - e. Therapeutic Community (**Substance Use Disorder [SUD] TC**);
  - f. Restricted Housing Unit (RHU);

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<sup>1</sup> 5-ACI-6B-12

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- g. Diversionary Treatment Unit (DTU);
  - h. Behavior Management Unit (BMU);
  - i. Psychiatric Observation Cell (POC);
  - j. General Population housing units;
  - k. Diagnostic and Classification;
  - l. library;
  - m. Transitional Housing Unit/Reentry Service Office (THU/RSO);
  - n. infirmary (to include the oncology and hospice wards);
  - o. chapel;
  - p. med lines;
  - q. education center;
  - r. commissary;
  - s. dietary section;
  - t. Veteran Service Unit (VSU);
  - u. recovery units;
  - v. Mental Health Unit (MHU);
  - w. **Intermediate Treatment Unit (ITU) and Intermediate Care Unit (ICU);**
  - x. **Step-Down Unit (SDU);**
  - y. Capital Case Unit (CCU); and
  - z. Forensic Treatment Center (FTC).
7. **A CPS may provide services on different housing units if the CPS assigned to that housing unit is unavailable. Approval shall be determined by the Shift Commander.**
8. A CPS can be utilized to augment staff's efforts to effectively support **incarcerated individuals** with mental health or emotional concerns, thus enhancing their own recovery and wellness. In addition to promoting recovery skills, such as personal wellness and positive coping skills, a CPS can:

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- a. utilize his or her first-hand knowledge about mental health recovery to help his/her peers in their recovery;
  - 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 short and long-term goals and to subdivide those goals into manageable steps;
  - d. provide his/her peers with an opportunity to evaluate the choices and decisions that they make/have made;
  - e. demonstrate the value of self-determination and personal responsibility;
  - f. 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;
  - g. demonstrate the power of resilience;
  - h. assist assigned **other incarcerated individuals** in understanding the grievance process; and
  - i. assist his/her peers with shifting their focus from symptom management to recognizing and developing their wellness, their accomplishments, and their abilities.
9. **All interactions with a CPS and his/her peer shall be meaningful and confidential. A reasonable distance and adequate time shall be maintained to allow for a confidential discussion.**
10. CPSs are trained in the Copeland Center’s Wellness Recovery Action Plan (WRAP©) Seminar I and should introduce WRAP© to those they support as a CPS. WRAP© is an evidenced based wellness practice to assist a person in his/her daily wellness and to prevent a crisis. When assisting an individual who chooses to develop a WRAP©, notebook paper, outlining the sections of a WRAP© may be used.
11. **Select CPSs may be offered the WRAP Seminar II Facilitator course. If a facility has CPSs certified as WRAP facilitators, CPSs may facilitate the WRAP I seminar in a two-day or eight-week format. Two certified CPS WRAP facilitators shall facilitate all WRAP seminars. Determination of a Seminar I format will be determined by the facility administration.**
12. In addition to providing individual services, a CPS may also facilitate **other** workshops and didactic groups. The workshops provided by a CPS shall be periodically monitored by **uniformed or non-uniformed staff. CPS Supervisors must monitor all group curricula to ensure the content is in the scope of CPS knowledge and practice.**

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13. The Unit Manager will post a notice of CPS facilitated workshop/group schedules on the bulletin board in his/her housing unit. An **incarcerated person** interested in attending these sessions will submit a **DC-135A, Inmate's Request to Staff Member** in order to be scheduled for attendance.
14. CPSs selected by the CPS Committee may act as mentors to newly certified CPSs, CPSs who are on suspension or probationary status, and CPSs who are experiencing difficulty in their CPS capacity. **A CPS Supervisor shall coordinate** identification of mentors/mentees. CPSs serving as mentors must limit this role to CPS-related activity.
15. In addition to providing peer support, a CPS may be asked to address specific concerns assigned by his/her supervisor(s). The Licensed Psychology Manager (LPM)/**designee**, CPS Supervisor(s), or Unit Manager will be available to the CPS for consultation and assistance as needed.
16. Each facility shall develop an identification (ID) badge that acknowledges the **person** is a CPS. This ID badge shall be worn/carried along with the **person's** ID at all times while performing CPS services. The **recommended** badge is the cell door card and will state that the **individual** is a CPS, work assignments, and will be signed by the Deputy Superintendent for Centralized Services (DSCS)/designee.
17. **A CPS may be issued a Kelly green t-shirt. The decision to utilize t-shirts is at the discretion of the Facility Manager.**
18. Photos of CPSs shall be placed in the control center on the housing unit so staff are aware of which CPSs are assigned to a particular unit.
19. Photos of CPSs shall be placed on the unit so that residents of the unit are aware of who the CPS is for that particular unit.
20. **Each State Correctional Institution's (SCI) CPS program shall be audited annually by the Central Office Psychology Office. The annual audit of the SCI's CPS program will occur on the same date as the SCI's Annual Psychology Department audit.**

**B. Certified Peer Specialist (CPS) Candidate Selection**

1. A candidate shall be selected via a **DC-46, Vote Sheet** process.
2. **All staffing packets must be completed at least one week prior to the start of a training class in order to ensure all candidates meet the eligibility criteria.**
3. To be considered for selection as a CPS candidate, he/she must meet specific criteria:
  - a. must be a custody level 2 or 3;

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- b. ***not be designated as H Code or Z Code. A person with a current H Code or Z Code shall not be a CPS;*** (Refer to Bulletin #1 for updated language)
- c. must be misconduct free for a minimum of one year (misconducts will be reviewed by the CPS Committee);
- d. have no misconducts for assaultive behavior in the last two years;
- e. have no history of substantiated allegations of institutional sexual abuse or sexual harassment; and not found to be at high-risk of being sexually abusive via the Department's risk screening pursuant to Prison Rape Elimination Act (PREA) Standard §115.41. PREA Standard §115.42 requires that information from the risk screening process inform housing, bed, work, education, and programming assignments with the goal of keeping separate ***incarcerated individuals*** at high risk of being sexually victimized from those at high risk of being sexually abusive. Any individual identified at high risk of being sexually abusive through the most recent risk screening score shall disqualify an individual from serving as a CPS;
- f. a history of mental health treatment/services while incarcerated and/or in the community. B Roster candidates may be considered only if a mental health diagnosis during incarceration or while in the community has been validated. Steps to obtain community information are required prior to selecting a candidate identified as B Roster stability; it is the ***CPS candidate's*** responsibility to obtain this information and present it to the CPS Supervisor;
- g. program compliancy. If a candidate has refused to participate in programming, he/she is ineligible. ***A potential CPS candidate will have priority placement in his/her mandatory programming when available;***
- h. ***be reviewed*** by the Psychiatric Review Team (PRT) ***for stability and to ensure the individual's Mental Health/Intellectual Disability (MH/ID) roster is accurate;***
- i. if the candidate is on the ***SUD*** TC waiting list, his/her potential start date for ***SUD*** TC may not begin before the conclusion of his/her CPS training. ***While enrolled in a TC program, a CPS will be on temporary leave from CPS duties in order to give full attention to his/her recovery;***
- j. have more than three years remaining on his/her minimum release date, unless he/she qualifies under the Long-Term Offender (LTO)/lifer criteria listed below. ***Depending on the candidate selection needs of the institution, a request may be made to the Director of the Psychology Office for CPS candidates with two years remaining on their minimum release date;***
- k. have a high school diploma or General Education Diploma (GED);
- l. if the candidate is an LTO/lifer with positive adjustment records, he/she may be given consideration and the requirement for high school diploma/GED may be waived; and

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- m. each SCI shall determine the number of LTOs, but should not have a majority of LTOs as CPSs.
4. 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 30 CPSs. Non-D Roster facilities should have a minimum of 20 CPSs.
5. The CPS complement shall be supervised by staff that are designated by the Facility Manager/designee. If a facility determines there is an increased need for additional CPSs, a request shall be made to **the Director of the Psychology Office**.
6. Staff designated by the Facility Manager/designee will review **relevant** records to identify potential participants in the program.
7. When a CPS worker is transferred to another SCI, the sending SCI CPS Supervisory staff should inform the CPS Supervisory staff at the receiving SCI of any information pertaining to his/her status as a CPS and any other important information, including security concerns. **Information shall include training hours and topics, certification documentation, and employment status.**
8. Parole Violators (PVs) returning to an SCI who have a valid CPS certification may request employment. The CPS Supervisor(s)/designee shall verify the certification and continuing education requirements prior to approving CPS employment status. CPS employment for PVs is determined on a case-by-case basis; employment as a CPS will not begin until 60 days after a return to an SCI and approval from the CPS Committee.

**C. Certified Peer Specialist (CPS) Training Program<sup>2</sup>**

1. The CPS Training Program is designed to provide basic educational training on the following topics:
  - a. mental health 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 misuse;

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<sup>2</sup> 5-ACI-6B-12



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- h. conflict resolution;
  - i. **cardiopulmonary resuscitation (CPR)**;
  - j. **interpersonal communication skills (IPC)**;
  - k. **anger management**;
  - l. suicide prevention;
  - m. working with other professionals; and
  - n. trauma informed approach to peer support.
2. Select Department staff who are certified by an approved vendor through the DHS Office of Mental Health and Substance Abuse Services **and the PCB may** deliver the CPS core certification training. All requests for training shall be routed through **the CPS training coordinator and the Director of the Psychology Office**.
  3. A selected candidate may not miss more than six hours of the CPS certification training and may only miss six hours if approved by the instructor and/or CPS Supervisor(s) prior to the date of the anticipated absence. The CPS candidate must make up any missed work under the direction of the CPS training facilitator(s). All selected candidates must participate in classroom activities and must successfully complete **and receive a passing score on** the final exam.
  4. The CPS training instructor has the discretion to disqualify 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.
  5. Any student observed cheating on the exam will be disqualified from the class and unable to continue. He/she may apply to be a CPS candidate at a later date, but not less than one year of removal from the original class. Approval to be considered for future CPS certification training will be determined by designated facility staff.
  6. A candidate who receives the certification and signs the **CPS Confidentiality Acknowledgment Form (Attachment 15-B)** may be utilized as a CPS at an assigned facility.
  7. Once certification is completed, all CPSs will sign the **CPS Orientation Checklist (Attachment 15-C)** which will be maintained by the CPS Supervisors.
  8. All CPSs must earn at least 18 continuing education hours per year to maintain their state certification. Training topics must primarily focus on wellness, life skills, boundaries, and other related topics. Code of Ethics and PREA Level 2 Contractors/Volunteers training is mandatory for all CPSs. In accordance with Department policy **DC-ADM 008, "PREA"** the **Contractors/Volunteers/Public Visitors/Non-Department Employee PREA**

**Training Acknowledgment of Understanding and Duty to Report** shall be utilized for this training, which shall be documented under the “Other” group of the **PREA Training and Understanding Verification Form**. Weekly or monthly meetings **shall** not be counted as education hours.

9. Continuing education will be facilitated by facility staff or volunteer facilitators as approved by the facility staff and will include:
  - a. review of modules from the original certification training annually;
  - b. wellness topics, life skills; and
  - c. recovery topics.
10. CPS Supervisor(s)/designee should be present during continuing education workshops as often as possible.
11. Training facilitated by external facilitators must be supervised at all times by facility staff.
12. A CPS must report for the scheduled workshops/groups during the designated time.
13. All CPSs completing the annual education requirements will receive a **CPS Continuing Education Certificate (Attachment 15-D)** at the end of the calendar year verifying completion of the requirement.
14. A CPS may receive a **Letter of Recommendation (Attachment 15-E)** from the multi-disciplinary team and/or the immediate supervisor for use upon release for employment purposes.

#### **D. Supervisory Staff**

1. All SCIs will convene a CPS Committee ***in conjunction with the Suicide Prevention Committee which*** will consist of, but is not limited to ***CPS Supervisor***, Unit Management, Psychology, Security, ***DSCS***, Training Sergeant/Lieutenant, ***Officers***, and Counselors.
2. ***The LPM/designee shall be a member of the CPS Committee to provide input and guidance on CPS roles within the institution and to establish and monitor the boundaries of CPS services as compared to clinical services delivered by DOC professional staff. The LPM/designee shall discuss current CPS’s wellbeing and determine whether current CPSs require additional support from institutional Psychology staff. As clinically indicated, Psychology staff will report to the committee with any identified concerns upon following up with the CPS.***
3. ***The LPM/designee shall provide input into the need for appropriate staff referrals when CPS limitations are reached.***

4. ***The LPM/designee shall be available within the committee to review and approve all CPS delivered groups/workshops, to ensure clinical boundaries are not broached.***
5. ***The LPM/designee shall be available within the committee to provide guidance and support to other committee members, in their responsibilities with the CPS program.***
6. All SCIs will have a minimum of two certified CPS Supervisors. CPS Supervisors shall:
  - a. provide guidance, support, and supervision of CPS workers; and
  - b. ***coordinate and*** oversee daily operations of the CPS program ***with members of the CPS Committee.***
7. ***A full-time equivalent CPS Supervisor shall not supervise more than seven full-time equivalent CPSs. Supervisory staff time for part-time peer specialist supervisors shall be at least proportionate to the ratio of one full-time supervisor to seven CPSs.***
8. ***Supervisors shall conduct a minimum of one meeting with the CPSs per week with additional support as needed or requested. Meetings may be held as a group.***
9. ***Supervisors shall maintain a log of supervisory meetings which documents:***
  - a. ***date of the supervision meeting; and***
  - b. ***summary of the points addressed during the meeting.***
10. ***CPS Supervisors shall ensure newly trained and certified CPSs receive mentoring with CPS mentors before working independently.***
11. ***The immediate supervisor of a CPS shall determine the need for additional supervision or mentoring prior to allowing a CPS to work independently.***
12. ***A CPS Supervisor(s) or a designated committee member shall function as the primary CPS Coordinator who develops all CPS schedules and on call schedules/needs, work assignments, and attends and reports at Suicide Prevention meetings. The DSCS shall designate the primary CPS Coordinator.***
13. ***A CPS Supervisor(s)/designee will track the 18 required continuing education hours on the CPS Training Tracking Form (Attachment 15-F) to include the CPS's name and number, his/her CPS state certification number which appears on his/her training certificate, the topic of the training, how many hours the session spanned, and the date the session was facilitated. Continuing education hours correlate to the calendar year, January through December. The CPS Training Tracking Form shall be forwarded to the Director of the Psychology Office each year by December 31.***

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14. The facility CPS Supervisor/designee will provide an informational overview of the CPS program, titled “**CPS Defined Power Point**” (**Attachment 15-G**) to all staff **during block training**. This overview will include familiarization with the roles, responsibilities, and expectations of a CPS to include specific training received by a CPS in suicide prevention. Other benefits of the program, such as providing support to **incarcerated individuals living** with mental illness and assistance in de-escalating situations, will be addressed during the overview as well as identifying the facility CPS Supervisor for staff to contact with any additional questions or concerns.
15. **CPS overview (“CPS Defined Power Point”) shall be included in the new employee orientation checklist.**
16. **A supervisor of CPSs shall meet one of the following qualifications:**
  - a. **a mental health professional who has completed the Department-approved peer specialist supervisory training;**
  - b. **a person who has a bachelor’s degree in sociology, social work, psychology, gerontology, anthropology, political science, history, criminal justice, theology, counseling, education, or a related field from a program that is accredited by an agency recognized by the United States Department of Education (USDOE) or the Council for Higher Education Accreditation (CHEA), or an equivalent degree from a foreign college or university approved by the USDOE; and two years of mental health direct service experience that may include peer support services; and has completed the peer specialist supervisory training curriculum approved by the Department; or**
  - c. **a person who has a high school diploma or GED and four years of mental health direct service experience that may include peer support services, and has completed the peer specialist supervisory training curriculum approved by the Department.**

**E. General Conduct**

1. When providing one-on-one peer support, a **CPS Time Sheet (Attachment 15-H)** may be maintained by the CPS and will be turned into the CPS Supervisor(s) at the end of the **month** that the peer support takes place. **A CPS will be responsible for bringing the time sheet to every supervision meeting.**
2. All information shared in peer sessions is to remain confidential except when threats of suicide or expressions of intent to harm others are verbalized and/or witnessed, when there is a threat to the security of the SCI, and disclosure and/or witnessing of sexual abuse or harassment.
3. The CPS statewide certification includes CPSs as para-professionals who have a “duty to warn.” In these circumstances, the CPS shall report such threats and expressions to staff

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immediately. (The CPSs are informed of this duty during their training and confirm their agreement to do so by signing the **CPS Confidentiality Acknowledgment Form**.)

4. ***If a CPS encounters suicide risk factors such as isolation, hygiene concerns, recent diagnosis of a serious physical illness, giving away belongings, troubling phone calls from home, parole hit, or any other risk factors which indicate concern, he/she will alert a member of the unit team immediately. Information will inform staff of the name, unit, and suicide risk factors which may be present or may contribute to suicidal ideation.***
5. Abuse of position/privileges by a CPS shall be reason for suspension/termination from the program.
6. A CPS may be terminated for a breach of confidentiality.
7. ***Any CPS who is suspended or terminated will surrender his/her CPS t-shirt.***
8. Every CPS is subject to random urinalysis testing, in accordance with Department policy **6.3.12, “Drug Interdiction.”** If a CPS refuses to random urinalysis, he/she may be terminated from CPS employment.
9. A CPS and the ***incarcerated individuals*** attending such workshops/groups are subject to monitoring at any time by Department staff. Staff will provide intervention as needed.
10. A CPS may be suspended or placed on probationary status at the discretion of the CPS Committee or subject to termination if he/she receives any Class 1 misconduct (assault, fighting, sexual misconduct, possession of drugs) and/or is a threat to the security of the SCI.
11. Termination of CPS employment will result in the ***person*** being rendered ineligible for rehire as a CPS and ***DOC facilitated*** training opportunities related to maintaining CPS certification.
12. ***There may be periods when a CPS is experiencing an increase in symptoms or incurring emotional difficulties. When this occurs, the CPS Supervisor will meet with the CPS and determine if a leave of absence is warranted. A leave of absence does not imply suspension or termination as a CPS. This period is intended to allow the CPS time to work on his/her recovery and develop goals that would support a return to CPS employment. The length of time a CPS is on leave of absence is at the discretion of the CPS Supervisor. The CPS may be permitted to attend any training offered to the other CPSs depending on the topic. The CPS Supervisor has discretion in determining if the CPS may participate in the training. A decision to preclude a CPS who is on a leave of absence shall be based on the CPS’s mental health. Any CPS who is on a leave of absence will surrender his/her CPS t-shirt until he/she resumes CPS employment.***

13. ***A CPS who engages in self-harming behavior, suicidal ideation, or a suicide attempt will be automatically placed on a leave of absence. A leave of absence does not imply suspension or termination as a CPS. This period is intended to allow the CPS time to work on his/her recovery and develop goals that would support recovery and a return to CPS employment. The leave of absence should be for a period up to 12 months with a review at the three, six, and nine-month intervals.***
  - a. ***During the initial three-month review period, the CPS will not work but will be permitted to attend any training offered to the other CPSs depending on the topic. The CPS Supervisor has discretion in determining if the CPS may participate in the training. A decision to preclude a CPS who is on a leave of absence from continuing education shall be based on the CPS's mental health.***
  - b. ***The CPS may resume employment as a CPS on a part time basis after the three-month review if the CPS Supervisor and PRT approve. During the six-month and nine-month reviews, an increase in hours may be approved if the CPS Supervisor and PRT approve. A return to full time employment may occur between nine and 12 months upon approval from the CPS Supervisor and PRT.***

#### **F. CPS Guidelines for Level 5 Housing**

1. When assigning a CPS to ***any level 5 housing unit***, a CPS should be informed of the assignment and that he/she will be required to be strip searched upon entering the unit and at any time there is a security or safety concern. If a CPS refuses to follow this procedure, he/she is ineligible to work on these units and may be subject to CPS status review.
2. CPSs who work on a level 5 housing unit should be rotated periodically. Rotation should be determined by the CPS Supervisor(s)/designee.
3. CPSs shall provide services on the RHU/DTU during all three shifts daily and shall be informed of new receptions so they can conduct a check in with the new reception. It is a priority to have a CPS on second and third shifts.
  - a. A CPS shall provide services on the RHU/DTU throughout the 6:00 AM-2:00 PM shift.
  - b. A CPS shall make rounds during the 2:00 PM-10:00 PM and 10:00 PM-6:00 AM shift and visit each person who has arrived within the last seven days as soon as possible. The CPS should make contact with every individual regardless if there has been indication of suicidal ideation or not. It is not the expectation that a CPS be assigned for the duration of second and third shifts.
  - c. ***A CPS will sign into the designated logbook on the unit. Staff will ensure that all CPS rounds/visits are documented in the designated logbook and shall include date, time in, and time out.***

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4. CPSs shall be on call to provide services to **individuals housed** in a level 5 unit.
5. CPSs will be visually supervised by level 5 staff at all times, **while allowing spacing for a confidential discussion**.
6. CPSs will not give or receive any item to/from **another incarcerated person** without staff permission.

**G. CPS Guidelines for Psychiatric Observation Cells (POCs)**

1. CPSs shall provide services in the POC area during all three shifts daily and shall be informed of new receptions so they can conduct a check in with the new reception. It is a priority to have a CPS on second and third shifts.
2. A CPS shall provide services in the POC area throughout the 6:00 AM-2:00 PM shift.
3. A CPS shall make rounds during the 2:00 PM-10:00 PM and 10:00 PM-6:00 AM shift and visit each person who has arrived as soon as possible. It is not the expectation that a CPS be assigned for the duration of shifts.
4. **A CPS will sign into the designated logbook on the unit. Staff will ensure that all CPS rounds/visits are documented in the designated logbook and shall include date, time in, and time out.**
5. CPSs shall be on call to provide services to **individuals housed** in a POC **and the infirmary, if needed**.
6. CPSs shall be visually supervised by staff at all times.
7. CPSs shall not give or receive any item to/from **another incarcerated individual**.

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**Glossary of Terms**

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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 screening and appraisal of data, direct

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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 ***Belted Wrist Restraints (BWR), 2, 4, or 5-point*** restraints, ***which are ordered by the psychiatric provider.*** 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 ***psychiatric provider***, 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, **psychiatric provider**, 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.

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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.