Arizona Department of Corrections
Rehabilitation and Reentry

Technical Manual

ACCESS

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CHAPTER: 1100 **Inmate Health Services**	**TECHNICAL MANUAL:** **TM 1103 - Mental Health Technical Manual (MHTM)**
DEPARTMENT ORDER: **1103 – Inmate Mental Health Care, Treatment and Programs**	**EFFECTIVE DATE:** **February 15, 2024**
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Ryan Thornell, Director

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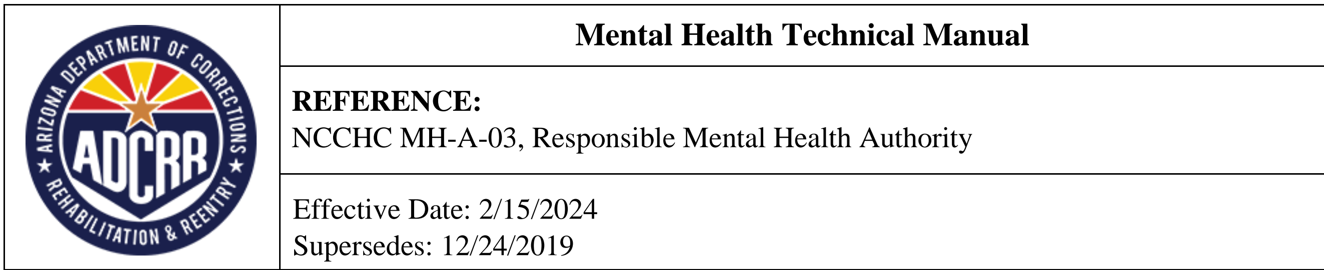

Mental Health Technical Manual

REFERENCE:
NCCHC MH-A-03, Responsible Mental Health Authority

Effective Date: 2/15/2024
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Chapter 1, Section 1.0 Administration of Mental Health Services

PURPOSE: The Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) mental health services shall be provided by a Contractor to include the provision of all mental health services for patients housed in any of the Arizona State Prison Complexes (ASPC) or private prison complexes. These services shall be monitored by the Healthcare Services Division (HSD).

RESPONSIBILITY: The responsibility of the day-to-day operation of mental health services is assigned to the Contract Mental Health Lead for each complex, who operates within ADCRR's Department Orders and under the provisions of the Mental Health Technical Manual (MHTM).

1.0 The Contractor (where applicable) shall designate individuals within their staff to perform the following roles:

1.1 Clinical Director – The psychologist designated to coordinate the day-to-day operation of the licensed mental health facilities.

1.2 Director of Nursing (DON) – The person designated to provide supervision of nursing services, including psychiatric nursing services, at each complex.

1.3 Facility Health Administrator (FHA) – The person designated to provide day-to-day direction of all health services at each complex.

1.4 Mental Health Clinician – a psychologist or psychology associate who provides clinical interventions to the patient population.

1.4.1 An individual who has an unrestricted, valid License from the Arizona Board of Behavioral Health Examiners: Licensed Associate Counselor, Licensed Professional Counselor, Licensed Master Social Worker, Licensed Clinical Social Worker, Licensed Associate Marriage and Family Therapist or Licensed Master Family Therapist.

1.4.2 An individual who has an unrestricted, valid license from the Arizona Board of Psychologist Examiners as a psychologist.

1.5 Mental Health Duty Officer - A licensed psychologist or psychiatric provider.

1.6 Mental Health Lead – The licensed psychologist or psychology associate designated to coordinate the day-to-day operation of all mental health services at each complex under his/her responsibility.

1.7 Mental Health Provider – a Psychiatrist, Psychiatric Nurse Practitioner or Psychiatric Physician's Assistant (P/PNP/PPA) who prescribes psychotropic medications.

1.7.1 Psychiatrists shall be board certified in psychiatry, or board eligible if within seven (7) years of their completion of an ACGME approved residency in psychiatry with the following exceptions: 1) supervising psychiatrists shall be board certified at hiring and during employment; 2) psychiatrists who are currently employed and are not board eligible may remain employed for no longer than one year from April 7, 2023.

1.7.2 Psychiatric Nurse Practitioner (P/PNP) or Psychiatric Physician's Assistant

1.8 Mental Health Staff – Includes QMHPs, as well as administrative and support staff (e.g., behavioral health technicians, mental health clerks, nursing, and medical assistants).

1.9 Mental Health Charge Registered Nurse (RN) – The person designated to provide supervision of psychiatric nursing services.

1.10 Primary Therapist (PT) – Psychologist or psychology associate who serves as the single point of contact and coordination for providing care to all patients designated as MH-3 and above.

1.11 Qualified Mental Health Professional (QMHP) – Includes psychiatrists, psychiatric nurse practitioners, psychiatric physician's assistants, psychologists, social workers, licensed professional counselors, psychiatric nurses, or others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients.

1.12 Regional Director of Nursing (RDON) – The person designated to plan and direct nursing services provided to all patients located in the ASPCs.

1.13 Regional Director of Psychiatry – The person designated to provide clinical supervision to staff psychiatrists and Psychiatric Nurse Practitioners (P/PNP), or any other provider prescribing psychotropic medications who work in the ASPCs.

1.14 Regional Mental Health Director (MHD) – The person designated to plan and direct mental health services provided to all patients located in the ASPCs.

1.15 Regional Release Planning Manager – The person designated to provider oversight for all medical and mental health release planning services at the ASPCs.

2.0 Local administration of mental health services shall be the responsibility of the Mental Health Lead, and shall include at a minimum:

2.1 Establishing and monitoring compliance with facility mental health procedures that assure a cohesive team approach to the provision of mental health services on every unit.

2.2 Ensuring that there exists a procedure for a monthly meeting (minimum) of all mental health staff assigned to provide services on each unit.

2.3 Ensuring that mental health services and status decisions such as SMI status, mental health scores, and treatment planning are done in accordance with current policy.

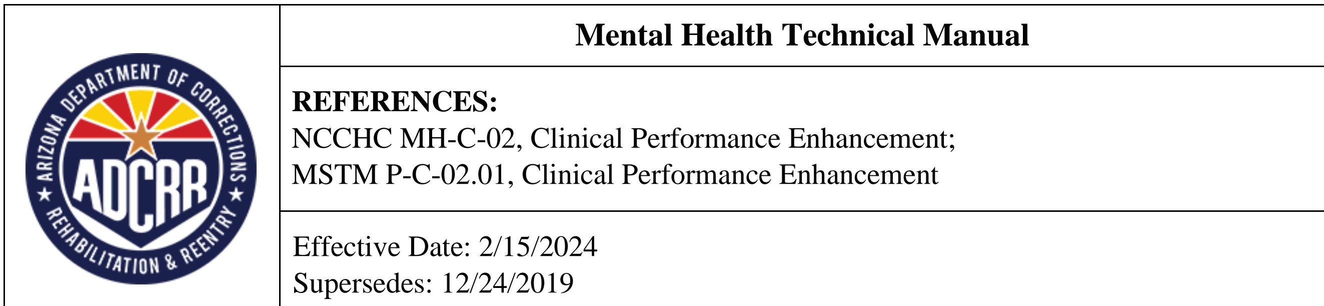
2.4 Developing programs and services and establishing facility protocols for the delivery of required services to address the identified needs in keeping with ADCRR and divisional direction.

2.5 Reviewing situations involving the delivery of mental health services to specific patients that have not been satisfactorily resolved at a lower level and/or require a higher level of care than is locally available.

2.5.1 These reviews can occur, but are not limited to, Mental Health Admissions Committee Meetings, Mental Health Treatment Team Meetings and Mental Health Staffing for individuals on mental health watch.

2.6 Responding to recommendations, directives, and requests from the local Administration as they relate to mental health services and issues.

2.7 Attend all Complex-level and Regional meetings that address the provision of mental health services.



	Mental Health Technical Manual
	REFERENCES: NCCHC MH-C-02, Clinical Performance Enhancement; MSTM P-C-02.01, Clinical Performance Enhancement
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Chapter 1, Section 2.0 Psychiatric and Mental Health Peer Review

PURPOSE: To provide a standardized peer review procedure for the assurance of the quality of care and content of records for each mental health clinician or psychiatric provider.

RESPONSIBILITY: It is the responsibility of each Mental Health Lead to ensure that all mental health clinicians and psychiatric providers receive an annual peer review that is kept on site in a NCCHC folder.

1.0 Psychologist and Psychology Associate Peer Reviews

1.1 Each psychologist and psychology associate shall have a thorough review of the mental health section of five (5) patient's medical records for whom they provided services to. This review shall be conducted by a peer (i.e., same position title).

1.2 The records being reviewed shall include at least three (3) chosen at random from the provider's caseload, and may include up to two (2) chosen at the supervisor's discretion.

1.3 The review should focus on the preceding ninety (90) to one-hundred and eighty (180) days if possible.

1.4 The mental health section shall be reviewed completely, to include the:

1.4.1 Quality of service delivery

1.4.2 Thoroughness of assessment

1.4.3 Adherence to documentation timeframes (i.e., late notes entered within twenty-four (24) hours of encounter, scanned documents within forty-eight (48) hours of receipt)

1.4.4 Quality of documentation (format, inclusiveness, appropriateness of notes, etc.) shall be noted and discussed with supervisee

1.4.5 A review of the patient's Electronic Health Record (EHR) including treatment plan, HNRs for the six (6) month period prior to the review, recent crisis and/or disciplinary infractions

1.4.6 The length of time spent face-to-face with the patient

1.4.7 A subjective report from the patient

1.4.8 A complete assessment of the individual's Activities of Daily Living (ADL), mental health symptoms and risk of danger to self, danger to others and victimization.

1.4.9 An assessment of the congruence/incongruence of the patient's reported symptoms, their diagnosis and the clinician's observations

1.4.10 Documentation of evidence based interventions utilized to treat patient's mental illness/presenting symptoms

1.4.11 Assessment of the patient's progress in meeting their treatment goals as stated in their current treatment plan

1.4.12 A documented plan for the patient to follow between sessions to manage mental health symptoms

1.4.13 Documentation of appropriate coordination of care with psychiatry/medical/custody/ release planning etc.

1.5 Additionally, the record as a whole shall be reviewed for elements such as: SMI determination, MH score, informed consents, etc.

1.6 A formal peer review or case review may be requested relative to patient mental health care by the HSD or the Contract Administrator.

2.0 Psychiatric Provider Peer Reviews

2.1 Each psychiatric provider shall have a thorough review of the psychiatric portion of the health record of five (5) patient's medical records for whom they provided services to. This review shall be conducted by a peer (i.e., same position title).

2.2 The mental health section shall be reviewed completely, to include the:

2.2.1 Psychiatric S.O.A.P.E notes:

2.2.1.1 Quality of service delivery

2.2.1.2 Thoroughness of assessment

2.2.2 Adherence to documentation timeframes (i.e., late notes entered within twenty-four (24) hours of encounter, scanned documents within forty-eight (48) hours of receipt)

2.2.3 Quality of documentation (format, inclusiveness, appropriateness of notes, etc.) shall be noted and discussed with supervisee

2.2.4 A review of the patient's EHR including treatment plan, HNRs for the six (6) month period prior to the review, recent crisis and/or disciplinary infractions

2.2.5 The length of time spent face-to-face with the patient

2.2.6 A subjective report from the patient

2.2.7 A complete assessment of the individual's Activities of Daily Living (ADL), mental health symptoms and risk of danger to self, danger to others and victimization

2.2.8 An assessment of the congruence/incongruence of the patient's reported symptoms, their diagnosis and the clinician's observations

2.2.9 Documentation of evidence based interventions utilized to treat patient's mental illness/presenting symptoms

2.2.10 Assessment of the patient's progress in meeting their treatment goals as stated in their current treatment plan

2.2.11 A documented plan for the patient to follow between sessions to manage mental health symptoms

2.2.12 Documentation of appropriate coordination of care with psychiatry/medical/ custody/release planning etc.

2.2.13 Medication orders

2.2.14 Lab work/reports

2.2.14.1 Timely AIMS (abnormal involuntary movement scale) assessments for patients on antipsychotic medication

2.2.14.2 Timely metabolic assessments for patients on antipsychotic medication

2.2.15 Consultations

2.3 The review should focus on the preceding ninety (90) to one-hundred and eighty (180) days if possible.

2.4 The records being reviewed shall include at least three (3) chosen at random from the provider's caseload and may include up to two (2) chosen at the supervisor's discretion.

2.5 For each medical record reviewed, information gathered shall be recorded on the appropriate Peer Review Form.

2.6 A formal peer review or case review may be requested relative to patient mental health care by the HSD or the Contract Administrator.

2.7 In those complexes which do not have a supervising psychiatrist, peer reviews shall be completed by the Director of Psychiatry.

Chapter 1, Section 3.0 Movement of Mental Health Patients

PURPOSE: To facilitate the timely transfer of patients, in a manner consistent with their mental health needs.

RESPONSIBILITY: This is a shared responsibility, with the sending and receiving complexes, Mental Health Leads, and the Mental Health Director (MHD).

1.0 Transfer to/from Residential or Inpatient Mental Health Programs

1.1 A regularly scheduled weekly teleconference shall be held with the Mental Health Leads from each ASPC and the MHD. The purpose of the teleconference is to discuss:

1.1.1 The appropriate program placement for each patient who has been submitted for an admissions referral to a residential or inpatient program, or a recommendation for a program discharge.

1.1.2 In a consultative manner, the provision of mental health care services and/or mental health care programming options with regards to difficult cases.

1.1.3 A record of the patients discussed during the teleconference shall be kept by the MHD, or designee.

1.1.3.1 Each patient discussed during this teleconference shall have a brief note entered into the EHR indicating their potential movement was discussed and what the outcome of the discussion was.

1.2 The MHD, or designee, will also chair a weekly teleconference that includes the Deputy Warden of Operations (DWOPs) from each ASPC and the HSD Mental Health Director to discuss the recommendations.

1.2.1 A list of all patients who have been determined to be appropriate for movement into, or out of, any mental health program shall be emailed to the HSD Mental Health Director and complex DWOPs at least two (2) business days prior to the teleconference.

1.2.2 The MHD, or designee, shall review any medical or mental health holds that would prevent movement prior to sending a movement request to Central Office Count Movement.

1.2.2.1 Requests for movement shall be emailed to Central Office Count Movement, and any special housing or transportation needs shall be clearly indicated.

2.0 Transfers from Non-Corridor Complexes

2.1 Movement of patients from non-corridor to corridor complexes (e.g., because of a change in mental health score or the presence of mental health needs that exceed the capacity of the non-corridor complex) shall be requested by the Mental Health Lead responsible for the non-corridor complex.

2.2 The sending Mental Health Lead shall contact Central Office Count Movement to confirm the receiving unit has a bed available.

2.3 The requests for movement from non-corridor to corridor complexes shall also be copied to relevant Offender Operations staff (e.g., Deputy Warden, Captain, or COIV), the receiving Mental Health Lead, and the FHA at the sending and receiving complexes.

3.0 Transfers from Private Prisons

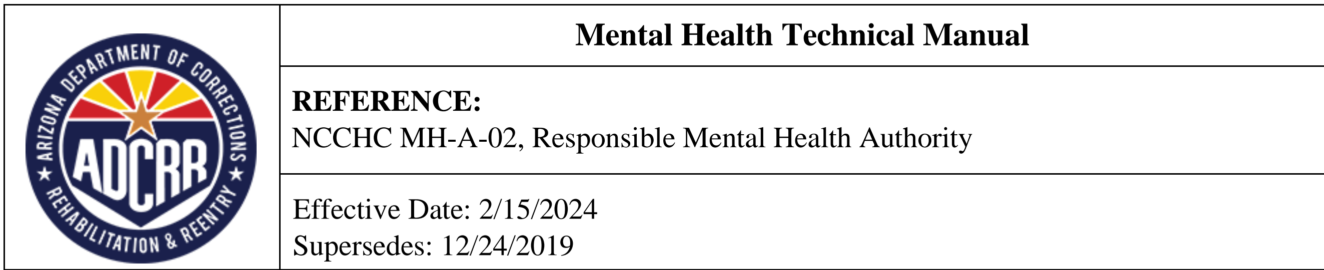
3.1 The Mental Health Lead at the private prison complex shall email the MHD, or designee, requesting the transfer of the patient and copy the HSD and Central Office Count Movement.

3.2 The MHD, or designee, shall respond within twenty-four (24) hours indicating approval or denial of the transfer.

3.3 If the transfer is approved, the MHD, or designee, shall indicate to which facility the patient is to be transferred.

3.3.1 The Mental Health Lead from the private prison complex shall then arrange through their respective Operations Administration for the patient to be moved.

3.4 In the event that the MHD, or designee, does not agree with the transfer of the patient to one of the ASPCs, then a conference call shall occur with the private prison mental health staff, the MHD, and the HSD Mental Health Director.



	Mental Health Technical Manual
	REFERENCE: NCCHC MH-A-02, Responsible Mental Health Authority
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Chapter 1, Section 4.0 Mental Health Duty Officer Protocols

PURPOSE: To provide guidance and procedure regarding the Mental Health Urgent Response during after hours, nights, and holidays.

RESPONSIBILITY: All Mental Health Duty Officers are responsible for the duties outlined in the below policy.

1.0 Mental Health Duty Officer

1.1 A Mental Health Duty Officer shall be available at all times when facility mental health staff is not available.

2.0 Mental Health Urgent Response Procedure

2.1 When a Mental Health Duty Officer is contacted from any complex, the Mental Health Duty Officer shall respond within ten (10) minutes.

2.2 The call shall be placed by an on-duty nurse (RN) after a face-to-face encounter with the patient in crisis.

2.2.1 The nurse shall document the crisis, the reason for the watch, and the name of the Mental Health Duty Officer who was contacted, along with the Mental Health Duty Officer's recommendations.

2.2.2 In the event that a nurse is unavailable to make the call, security staff shall place the patient on a temporary constant security watch until a nurse can be located.

2.3 The Mental Health Duty Officer shall obtain all available relevant information regarding the corresponding situation.

2.4 If a placement on a watch is indicated, the Mental Health Duty Officer shall place the patient on a Continuous Mental Health Watch.

2.4.1 The Mental Health Duty Officer shall write a detailed S.O.A.P.E note for each patient who was evaluated within twenty-four (24) hours of the encounter.

2.5 If the situation is regarding an alleged PREA event, the Mental Health Duty Officer shall speak directly to all patients allegedly involved in the event and complete the following:

2.5.1 Assess for danger to self or others

2.5.1.1 Place on constant watch if individual is a danger to themselves or others

2.5.2 Assess risk for victimization

2.5.2.1 Make appropriate recommendations to custody if individual is at risk for victimization

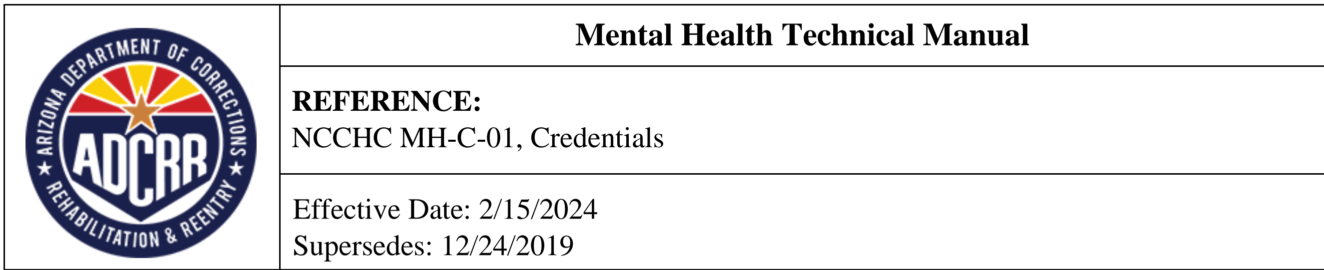
2.5.3 Offer follow-up mental health services and schedule accordingly

2.5.4 Upon returning to work on his/her next usual work day, the Mental Health Duty Officer shall write a detailed S.O.A.P.E note for each patient who was evaluated.

2.6 If a placement on a watch is ordered by the Mental Health Duty Officer, the on-duty nurse shall complete the Mental Health Watch Order (Form #807-1) with the instructions provided by the Mental Health Duty Officer.

2.7 The Mental Health Duty Officer shall contact the psychiatric prescriber if psychotropic medication intervention, or the use of therapeutic restrains for a patient, is required.

2.8 In the event that the on-duty nurse is unable to contact or does not receive a response from the Mental Health Duty Officer within ten (10) minutes, then the patient is to be placed on a Continuous Mental Health Watch until a Mental Health Duty Officer is reached.



	Mental Health Technical Manual
	REFERENCE: NCCHC MH-C-01, Credentials
	Effective Date: 2/15/2024 Supersedes: 12/24/2019

Chapter 1, Section 5.0 Supervision of Mental Health Staff

PURPOSE: To provide direction and procedure regarding mental health staff not licensed to practice independently. Outlined in this policy are elements pertaining to the clinical supervision of such individuals by licensed mental health staff to ensure mental health care requirements are met.

RESPONSIBILITY: It is the responsibility of the Mental Health Lead to ensure that all mental health clinicians who supervise unlicensed mental health staff abide by the clinical supervision requirements outlined in the below policy.

1.0 Definitions

1.1 Psychologist means an individual independently licensed within the state of Arizona who can use the title psychologist as defined in A.R.S. 32-2061 and A.A.C. Title 4, Chapter 26.

1.2 Psychology Associate means a mental health clinician who is either unlicensed or licensed at the master's level.

1.2.1 Licensed individuals can be either licensed at the associate level, independent level, or with a temporary license.

1.2.2 Unlicensed mental health clinicians must be in the process of obtaining a license in their field, and obtain a license within twelve (12) months of their start date. If the license is not obtained within twelve (12) months of April 7, 2023, or within twelve (12) months of their start date, whichever is later, they become ineligible for continued employment. They may be rehired once they obtain a license.

2.0 Supervision Requirements

2.1 Supervision means face-to-face, videoconferencing, or telephonic direction, provided by a qualified individual, and with the intention to evaluate, guide, and direct all mental health services, including psycho-educational programming. It also is to assist a clinician in increasing the knowledge, skills, techniques, and abilities needed to provide behavioral health services ethically, safely, and competently.

2.2 Psychologists shall provide clinical supervision for eight (8) or fewer psychology associates in outpatient.

2.3 Psychologists shall provide clinical supervision for six (6) or fewer Psychology Associates in an inpatient setting and residential settings.

2.4 All unlicensed clinicians (including practicum and intern students) who do not have an active Arizona license shall obtain a countersignature by an independently licensed clinician on all clinical encounters (group notes, individual notes, etc.).

2.4.1 Unlicensed clinicians are required to participate in a minimum of once weekly clinical supervision under the direction of an independently licensed clinician approved by their respective state licensing board.

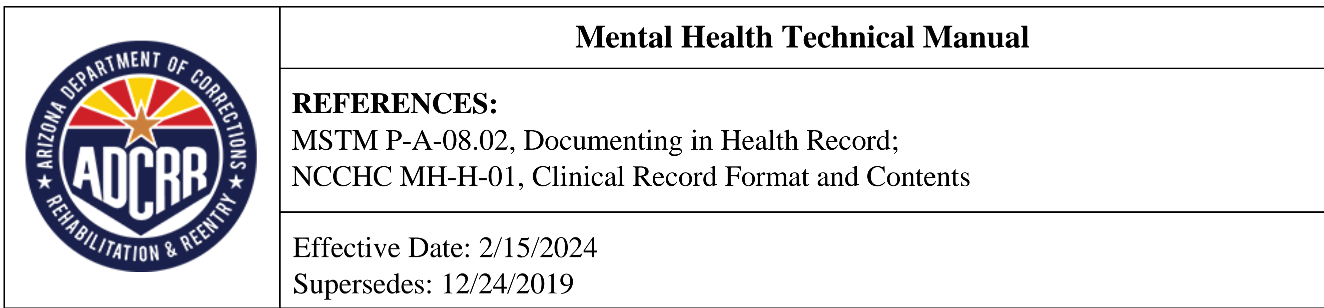
2.4.2 The unlicensed clinician shall notify the patient that he/she is unlicensed and receiving clinical supervision, and shall document such in the education section of the encounter.

2.5 Psychologists and licensed clinicians, not required by statute or licensure board, may be required to participate in clinical supervision if deemed necessary by the Mental Health Lead or MHD.

2.5.1 Other mental health staff (e.g., Behavioral Health Technicians, Recreational or Occupational therapists, etc.) shall receive at least one (1) hour of weekly supervision, individually or in a group with other similarly licensed staff.

2.6 The duration and type of clinical supervision provided to each unlicensed clinician shall be conducted in accordance with their respective board or regulatory agency.

2.7 Clinical supervision shall be documented and retained by the supervisor.



	Mental Health Technical Manual
	REFERENCES: MSTM P-A-08.02, Documenting in Health Record; NCCHC MH-H-01, Clinical Record Format and Contents
	Effective Date: 2/15/2024 Supersedes: 12/24/2019

Chapter 1, Section 6.0 Documenting in the Health Record

PURPOSE: To ensure documentation made in the mental health record is consistent and that it meets all necessary health records requirements.

RESPONSIBILITY: The accuracy of the information entered into the mental health record is the responsibility of all professionals authorized to document in the health record. Each individual making an entry must reference and follow Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) policies.

PROCEDURE:

1.0 Documentation of all encounters with patients is completed in accordance with Department Order #1103, Inmate Mental Health Care, Treatment and Programs.

2.0 Required format for the progress note:

2.1 All progress note entries will be made in accordance with the following format including but not limited to:

2.1.1 Subjective (S): Patient's report of current complaints, symptoms, and other relevant information, including direct patient quotes.

2.1.2 Objective (O): Clinician's observation of behavioral and/or physical symptoms, appearance, orientation, and congruence of mood/affect.

2.1.3 Assessment (A): Clinician's impression and interpretation of the subjective and objective information above; may include diagnosis.

2.1.4 Plan (P): Describe interventions utilized during the encounter and list the next steps related to the treatment plan.

2.1.5 Education (E): Education given to the patient to assist in managing symptoms of mental illness.

3.0 All mental health encounters shall include the following but not limited to:

3.1 A review of the patient's EHR including treatment plan, recent crisis and/or disciplinary infractions.

3.1.1 The clinician shall comment on their findings regarding each of these areas in the comment section of the note.

3.2 The length of time spent face-to-face with the patient.

3.3 A subjective report from the patient.

3.4 A complete assessment of the individual's Activities of Daily Living (ADLs), mental health symptoms and risk of DTS/DTO and victimization.

3.5 An assessment of the congruence/incongruence of the patient's reported symptoms, their current diagnosis and the clinician’s observations.

3.6 Documentation of evidence based interventions utilized to treat patient’s mental illness/presenting symptoms.

3.7 Assessment of the patient's progress in meeting their treatment goals as stated in their current treatment plan.

3.8 A documented plan for the patient to follow between sessions to manage mental health symptoms.

3.9 Documentation of appropriate coordination of care with psychiatry/medical/custody/release planning etc.

4.0 Timeline for Documentation:

4.1 Entries

4.1.1 Documentation will be made the same day as the encounter and completed at or as close to the actual time of the encounter as possible.

4.1.2 Late Entry:

4.1.2.1 Entries are considered late when they are not documented on the same day as the encounter

4.1.2.2 Late entries are to be made as soon as possible after the encounter within twenty-four (24) hours of the encounter.

4.1.2.3 The author clinician will document the date and time of the late entry and on the first line of Subjective Self-Report state: "Late Entry", on (actual date/time of the occurrence or encounter,) the following occurred (and then proceed with the Progress Note), complete the entry with the signature of the writer.

5.0 Utilizing Paper Records

5.1 Handwritten entries must be legible and clear and can be in cursive or print style and written in black ink. Blue ink is acceptable if the writing is dark enough to be copied.

5.2 To make a correction to an entry, the author must:

5.2.1 Draw a single line through the incorrect entry (the original entry must be visible and legible).

5.2.2 Make the correct entry; initial the correction and entry.

5.2.3 At no time is it acceptable to remove any entry, which has been placed in a health record, either individual entries or whole pages that then are re-written to exclude the original entry.

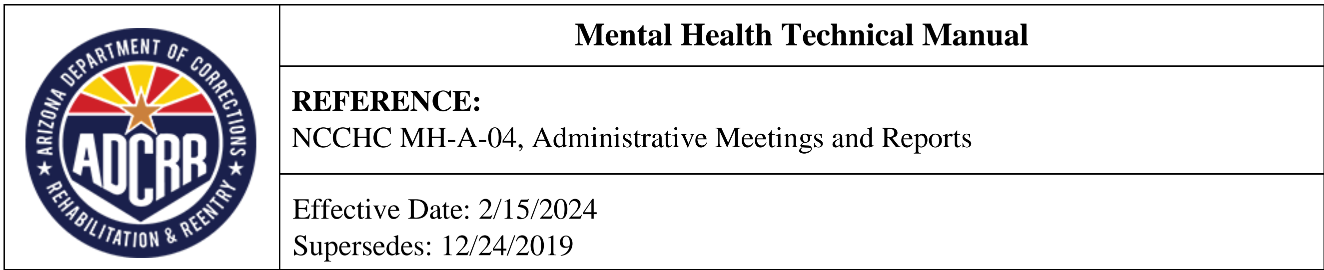
6.0 Scanned Documents

6.1 All scanned documents shall be scanned into the patient's EHR chart within two (2) business days.

6.2 All scanned documents shall be scanned right side up in a clear and usable manner.

6.3 All scanned documents shall be accurately labeled with meaningful titles/file names (i.e., not labeled as miscellaneous or other).

6.4 All scanned documents are dated (and appear in any programmed or ad hoc list according to this date) based on the clinically relevant date of the document, not the date scanned.



	Mental Health Technical Manual
	REFERENCE: NCCHC MH-A-04, Administrative Meetings and Reports
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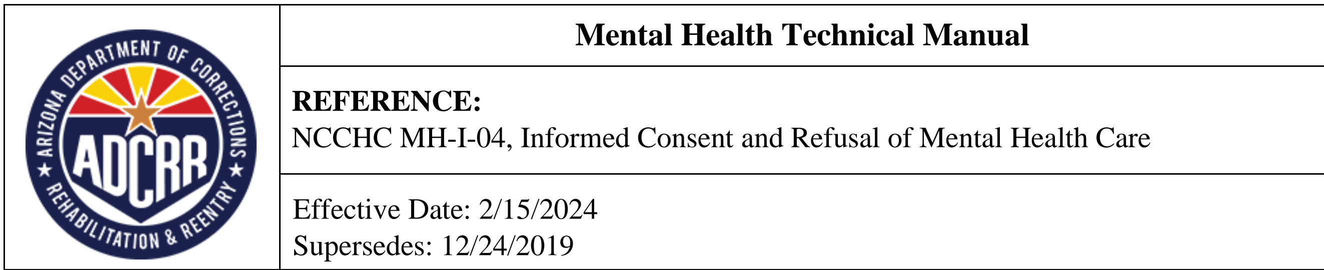
Chapter 2, Section 1.0 Monthly Reporting of Mental Health Statistics

PURPOSE: To describe how mental health statistics shall be collected and reported on a monthly basis.

RESPONSIBILITY: The Mental Health Lead at each complex is responsible for completing, compiling, and forwarding the monthly mental health statistics.

1.0 At the end of each month, every mental health staff member shall compile information requested by ADCRR and submit this to the Mental Health Lead. The Mental Health Lead shall compile complex-wide information and submit this to the FHA, or designee. This information shall be forwarded to the HSD by the 5th day of the following month.

2.0 The mental health lead and staff shall ensure that all the required reports and statistics are completed and submitted before the established due date as required by the Contract and in accordance with ADCRR Department Orders.



	Mental Health Technical Manual
	REFERENCE: NCCHC MH-I-04, Informed Consent and Refusal of Mental Health Care
	Effective Date: 2/15/2024 Supersedes: 12/24/2019

Chapter 2, Section 2.0 Mental Health Limits of Confidentiality (Consents and Refusals)

PURPOSE: To ensure that every patient who participates in mental health treatment understands the limits of confidentiality, alternatives, advantages, disadvantages, and potential risks and benefits to the treatment for which he/she is providing consent.

RESPONSIBILITY: The mental health staff assigned to a reception unit shall ensure that a Mental Health Consent Form is read and signed by the patient. The mental health clinicians are also responsible for explaining the limits of confidentiality and the effect(s) it may have on the patient's mental health care for all patients on his/her caseload.

1.0 Procedure

1.1 All patients shall be provided the opportunity to read and sign the Mental Health Consent Form when they arrive to Reception prior to the Initial Mental Health Assessment.

1.1.1 Should the patient be unwilling or unable to sign the Mental Health Consent Form, then the Mental Health Lead shall meet with the patient to discuss any concerns and/or issues related to consent.

1.2 All patients participating in ongoing mental health treatment (classified as an MH-3 or above), shall be advised by the clinician assigned to that unit of the following:

1.2.1 Limits of confidentiality within ADCRR, specific to:

1.2.1.1 Threats of harm to self or others;

1.2.1.2 Threats to the safe, secure, and orderly function of the institution (e.g., escape, disturbances, drug trafficking);

1.2.1.3 Information related to abuse, neglect, or molestation of a minor, vulnerable or developmentally disabled adult, or elder adult;

1.2.1.4 Legal proceedings that requires that records be opened/released pursuant to state statute or a court order;

1.2.1.5 Discussion of a supervisory or treatment planning nature among patient health services staff; and

1.2.1.6 Information related to an unsolved capital offense (e.g., unsolved murder).

1.2.2 Alternatives to proposed treatment.

1.3 If the proposed treatment is medication, the P/PNP shall have the patients sign the appropriate Psychiatric Medication Informed Consent Form.

1.3.1 When a patient is admitted to an inpatient facility, a new consent form shall be signed by the patient for each medication that he/she is currently prescribed. A consent form shall be signed for any new medication prescribed to him/her while admitted to the inpatient facility.

1.4 The treatment clinician/provider and witnesses (as required) shall sign the form at the time of the patient's consent.

2.0 If a patient refuses to sign a Mental Health Consent Form, the content of the form shall be read and explained to the patient (with another staff member as a witness) to ensure that the patient's questions have been answered.

2.1 On the patient signature line, write "refused to sign."

2.2 The mental health professional shall sign the form and include their position, printed name or name stamp, and the date.

2.3 The witness shall also sign the form and include their position, printed name or name stamp, and the date.

2.4 After verbal presentation of the Consent Form, and signatures completed, proceed to see the patient unless he/she is refusing to be seen.

3.0 Refusal of mental health appointments. A patient has the right to refuse to be seen for their mental health appointment.

3.1 The mental health staff P/PNP shall ensure a description of the service being refused is documented.

3.2 The mental health staff P/PNP shall document evidence that the patient has been informed of any adverse mental health consequences that may occur because of the refusal.

4.0 Any request made by the patient to refuse mental health/psychiatric services must be made in person by the patient coming to or being escorted to the health unit to sign the refusal.

5.0 If a patient will not voluntarily displace him/herself to participate in the direct communication with healthcare staff required here, healthcare staff shall go to the patient's location.

6.0 Documentation of Refusal: The patient must document their refusal by properly completing and signing the Refusal to Submit to Treatment, Form 1101-4, or electronic equivalent and submitting it to the mental health P/PNP staff.

6.1 The patient's signature on the form or electronic signature must be witnessed and signed by one mental health P/PNP staff member.

6.2 The Refusal to Submit to Treatment, Form 1101-4, shall be scanned into the patients' health record, if not completed electronically within two (2) business days.

7.0 If a patient refuses to sign a Refusal to Submit to Treatment, Form 1101-4, CHP mental health P/PNP staff shall, in front of a witness:

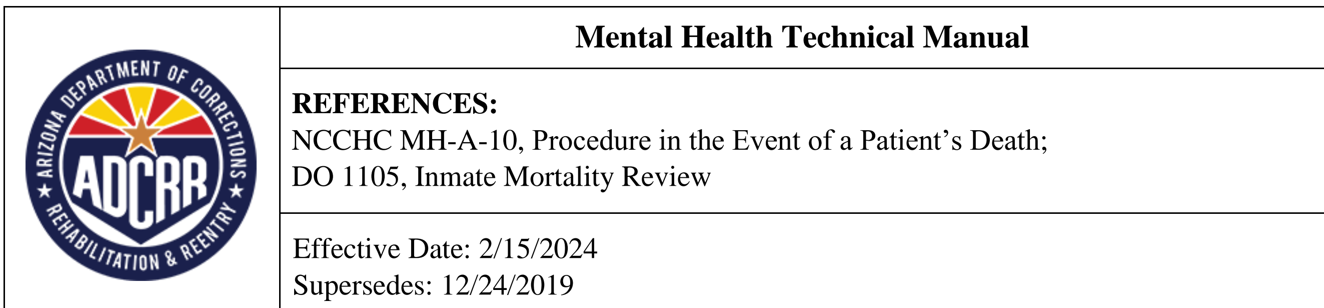
7.1 Explain the consequences of the patient's refusal to accept the proposed procedure/treatment, in a language the patient can understand.

7.2 Document exactly what was told to the patient regarding the refusal of the procedure/treatment on the Refusal to Submit to Treatment Form.

7.3 Have the Refusal to Submit to Treatment signed by the two witnesses.

7.3.1 The mental health P/PNP staff will sign the form with one witness who may be a member of security staff if necessary.

8.0 If the patient changes their mind, they may seek and be provided treatment.



	Mental Health Technical Manual
	REFERENCES: NCCHC MH-A-10, Procedure in the Event of a Patient's Death; DO 1105, Inmate Mortality Review
	Effective Date: 2/15/2024 Supersedes: 12/24/2019

Chapter 2, Section 3.0 Suicide Attempt or Completed Suicide Review

PURPOSE: A psychological autopsy or suicide attempt review shall be completed to provide a retrospective review of a patient's life with an emphasis on factors which may have contributed to the patient attempting suicide or causing his/her own death.

RESPONSIBILITY: It is the responsibility of the MHD to assign a psychologist who is not materially/clinically involved with the case to complete a psychological autopsy or suicide attempt review on all patients who make a suicide attempt or complete suicide regardless of their mental health score.

1.0 Purpose

1.1 To provide a clearer understanding of the patient's state of mind prior to death or suicide attempt.

1.2 To provide a written account of collateral information received from the patient, staff first responders, other patients who were friends with the deceased, and the patient's family members.

1.3 To provide insights and specific recommendations regarding how best to address the clinical needs of future patients.

1.4 To identify any deficiencies in institutional policies, procedures, or practices.

2.0 Procedure

2.1 Suicide Attempt or Completed Suicide Review Committee – Upon notification of a patient's suicide or suicide attempt, a self-harm incident where the individual had the intent to end their life, the Mental Health Lead has fourteen (14) days to convene the committee.

2.1.1 The Suicide Attempt or Completed Suicide Review Committee shall:

2.1.1.1 Consist of the FHA, Unit Deputy Warden, MHD, Director of Psychiatry, and any additional staff that the Mental Health Lead deems pertinent.

2.1.1.2 Review the patient's medical/mental health record, including Medical Examiner's Report and toxicology reports if available.

2.1.1.3 Review any source of data (e.g., Information Reports, investigation reports, Department documents, etc.) relevant to the incident.

2.1.1.4 Make recommendations concerning policy or procedural changes, as necessary, to the Mental Health Lead for consideration and inclusion in the Joint Mortality Review Committee (JMRC).

2.2 The psychologist assigned to complete the psychological autopsy or suicide attempt review, shall compose an integrated report in a format defined by ADCRR.

2.3 The Mental Health Lead shall submit the psychological autopsy or suicide attempt review to the MHD and the HSD within twenty-one (21) days of the patient's suicide or suicide attempt.

2.3.1 Any additions or corrections recommended by the MHD and/or HSD shall be completed within the next four (4) days.

2.4 A root cause analysis, based on prioritization of all errors identified, shall be conducted if clinically appropriate and an effective and sustainable plan shall be created and implemented within thirty (30) days of the death or suicide attempt.

2.4.1 A sustainable plan is one, which outlives staff memory from a single training after the review or staff turnover.

2.4.2 The remedial plan shall be monitored for effectiveness and appropriate and timely modifications will be made to the plan based on the monitoring.

2.4.3 For each suicide, the plan in this section shall be crafted and implemented whether or not the medical examiner's report is available. If the medical examiner's report was unavailable, the plan shall be revisited and modified, if necessary, within one (1) month of receipt of the report.

2.5 The MHD and HSD's Mental Health Director shall meet with the ADCRR investigator assigned to the case to discuss any relevant information that either party has received.

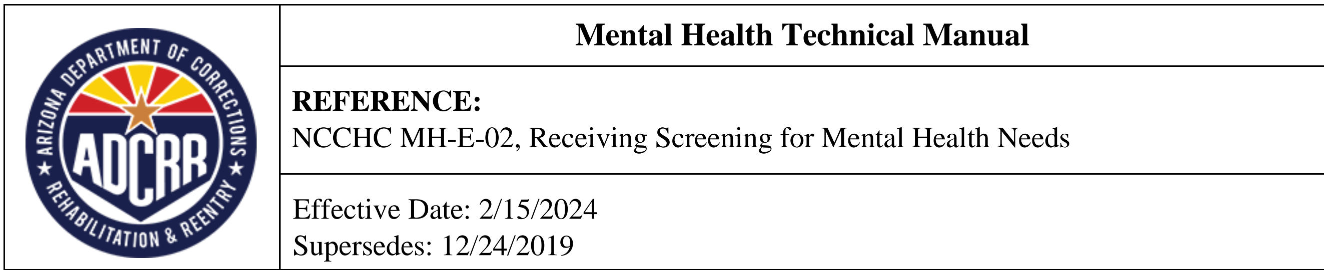
3.0 The psychological autopsy shall be kept in draft form until the Medical Examiner's (ME) report is received (to include toxicology results).

3.1 Within ten (10) days of receiving the ME report, the psychological autopsy shall be finalized with any necessary addendums incorporating the information from the ME report.

3.2 A monthly administrative review will take place, including ADCRR custody leadership, mental health director or designee, and medical director or designee.

3.2.1 This multidisciplinary meeting will review all completed suicides and suicide attempts and determine if training, education, or policy changes are necessary.

3.2.1.1 An active log of all identified errors and problems will be maintained.



	Mental Health Technical Manual
	REFERENCE: NCCHC MH-E-02, Receiving Screening for Mental Health Needs
	Effective Date: 2/15/2024 Supersedes: 12/24/2019

Chapter 3, Section 1.0 Initial Comprehensive Mental Health Evaluation

PURPOSE: To ensure that all patients, upon their arrival in ADCRR, have an initial comprehensive mental health evaluation completed. This evaluation shall be used to assist in decisions regarding classification, placement, and need level for further mental health services and/or programming.

RESPONSIBILITY: Mental health staff assigned to a reception center as well as mental health clinicians assigned to units where patients are received directly from the community, county facility, or federal facility, is responsible for completing a comprehensive evaluation to determine individual mental health needs.

1.0 Procedure

1.1 Within one (1) business day of a patient's arrival to ADCRR, a licensed mental health clinician shall assess the patient and complete an initial comprehensive mental health evaluation.

1.2 The evaluation shall occur in a confidential therapeutically appropriate setting unless there is a clinical or legitimate and substantial safety concern.

1.3 The evaluation shall identify and document sufficient relevant information including but not limited to:

1.3.1 The presence and severity of mental health symptoms

1.3.2 Current level of functioning

1.3.3 History of hospitalization/treatment, response to treatment

1.3.4 History of suicide attempts; assess suicide risk

1.3.5 Behavioral observations of staff

1.3.6 Psychotropic medication

1.3.7 Preliminary designation of level of care

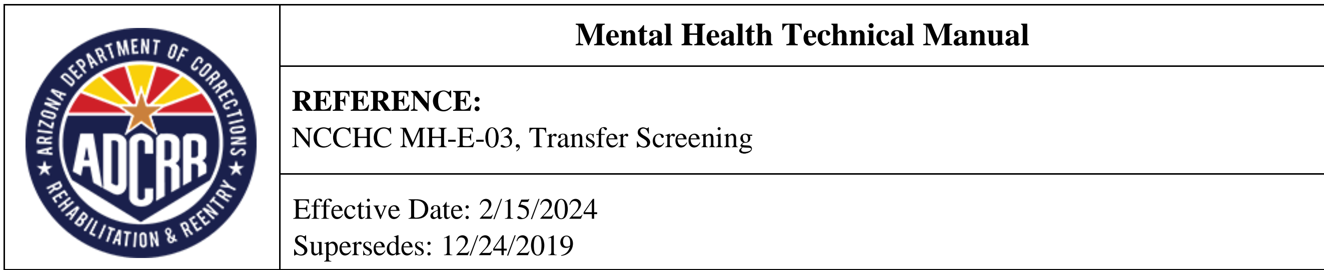
1.4 The completed evaluation shall be located in the patient's Medical Record.

1.5 The licensed mental health clinician shall document the appropriate mental health score in the medical record.

1.5.1 For facilities still utilizing paper records, the licensed mental health clinician shall enter the mental health score directly into ACIS.

1.6 If the patient is not able to engage in the initial comprehensive mental health evaluation (e.g., intoxicated, floridly psychotic, etc.), basic information shall be gathered to determine the need for a mental health watch and shall be documented in the mental health record.

1.6.1 The initial comprehensive mental health evaluation shall be completed when the patient is able to meaningfully engage in the assessment process.



	Mental Health Technical Manual
	REFERENCE: NCCHC MH-E-03, Transfer Screening
	Effective Date: 2/15/2024 Supersedes: 12/24/2019

Chapter 3, Section 2.0 Transferred Patients

PURPOSE: To ensure that each patient's medical record is reviewed by qualified health care professionals upon arrival to the complex. This information shall be used to alert mental health staff about any significant issues for each new patient.

RESPONSIBILITY: Assigned mental health/medical personnel completing the medical record reviews are responsible for ensuring the continuity of mental health services and making referrals for further services when indicated.

1.0 Procedure

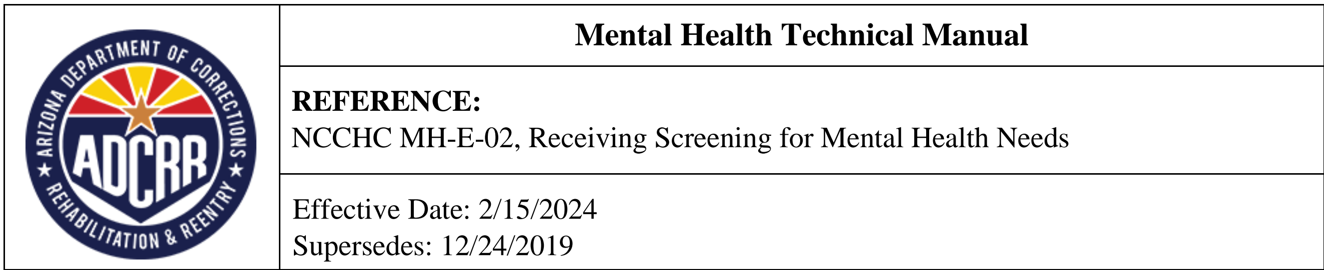
1.1 An initial medical record review shall be completed by medical/mental health staff within twelve (12) hours of a patient's arrival to the complex.

1.1.1 In the event that the review was completed by medical staff, the information resulting from the record review shall be made available to the mental health clinician on the patient's receiving unit within one (1) business day.

1.2 The psychologist assigned to the unit shall also complete a daily medical record review of all incoming patients. The psychologist shall ensure that the patient's mental health score is accurate and all patients with a mental health score of MH-3 or above have appropriate mental health follow-up appointments scheduled.

1.2.1 If there is insufficient information in the Health Record to make this determination, the psychologist shall assess the patient face-to-face and ensure the patient has an appropriate mental health score with appropriate mental health follow-up appointments scheduled.

1.2.2 The assigned psychologist shall document the following in the Health Record: Review of medical records, any referrals to mental health programming, pending appointments, outstanding HNR requests, medication expiration dates, and most recent mental health contact dates.



Chapter 3, Section 3.0 Mental Health Contacts for Patients After Reception

PURPOSE: To provide standardization of timeframes for the initial clinical contact after a patient is received by the Arizona Department of Corrections, Rehabilitation and Reentry.

RESPONSIBILITY: It is a shared responsibility between the mental health team at the reception centers and the mental health team at the receiving facilities.

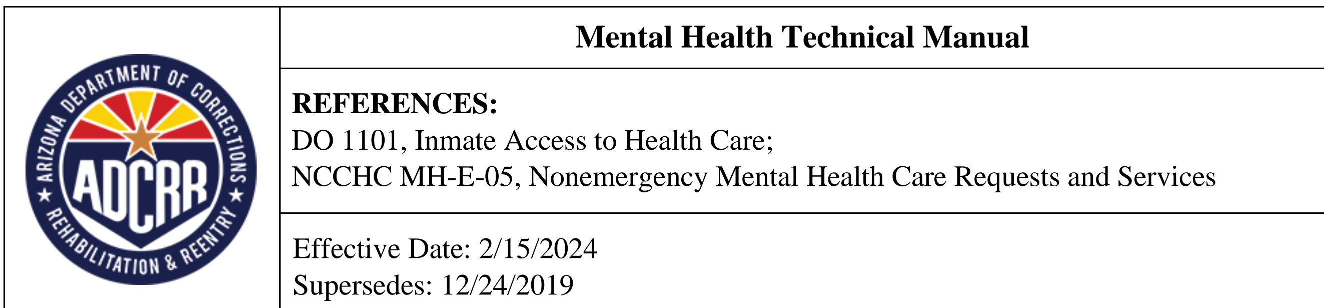
1.0 Procedure

1.1 After the comprehensive mental health evaluation is completed at Reception, all patients on the mental health caseload shall be tracked by the mental health team at each reception center.

1.1.1 The Reception mental health clinician shall schedule follow-up appointments for the patient to see a mental health clinician and P/PNP if clinically necessary, based on the comprehensive mental health evaluation and assigned mental health score.

1.1.2 It is the responsibility of the receiving facilities to monitor daily all patients who are arriving to their unit.

1.2 Patients shall then be seen by the mental health clinicians and psychiatric providers based on their current mental health score.



	Mental Health Technical Manual
	REFERENCES: DO 1101, Inmate Access to Health Care; NCCHC MH-E-05, Nonemergency Mental Health Care Requests and Services
	Effective Date: 2/15/2024 Supersedes: 12/24/2019

Chapter 3, Section 4.0 Triage for Health Needs Requests

PURPOSE: To provide direction regarding the assessment and immediacy of mental health issues submitted via Health Needs Requests (HNRs).

RESPONSIBILITY: The Primary Therapist or Designee triaging HNRs is responsible for making necessary referrals and follow-up appointments as clinically indicated.

1.0 The assigned Primary Therapist or Designee (psychology associate or psychologist) shall triage and address all mental health and psychiatry HNRs within twenty-four (24) hours of submission.

1.1 "Triage" means determining whether the request requires immediate attention and resolution or whether the request can safely be deferred until the primary therapist can address it.

1.2 "Address" means evaluating the request, determining the clinical need, and if an action is required (e.g., face-to-face visit, inmate letter, therapeutic materials sent), planning that action to occur in a clinically appropriate timeframe.

1.3 The Primary Therapist or Designee shall mark "Triaged & Addressed" on the HNR to indicate that it has been triaged and addressed.

2.0 Patients who are not yet on the mental health caseload but request mental health treatment shall submit requests to be seen through the procedures for seeking medical care, set forth in the Medical and Dental Services Technical Manual Section P-E-07.01.

2.1 Patients who present with urgent or emergent mental health concerns shall be addressed in accordance with Chapter 5, Section 1.0 of this manual.

Chapter 3, Section 5.0 Outpatient Mental Health Services

PURPOSE: To provide a standardized system of patient mental health need identification that is consistent with both established standards of mental health care and the mental health needs of incarcerated individuals.

RESPONSIBILITY: It is the responsibility of the patient's primary therapist and provider(s) to ensure that all patients are provided services in accordance with the minimum level of service delivery outlined below.

All mental health encounters with all patients shall occur in a confidential, therapeutically appropriate setting unless there is a legitimate and substantial safety and security concern that is documented.

1.0 **MENTAL HEALTH 1 (MH-1)** – Patients who have no history of mental health issues or receiving mental health treatment.

1.1 These individuals shall not be regularly monitored by mental health staff, but may request mental health services in accordance with the HNR protocols.

1.2 The mental health score may be increased when clinically indicated based upon the treating clinician's assessment of the individual's current functioning.

2.0 **MENTAL HEALTH 2 (MH-2)** – Patients who have received mental health treatment in the past but do not currently have any mental health needs, and have demonstrated behavioral and psychological stability for at least six (6) months.

2.1 These individuals shall not be regularly monitored by mental health staff, but may request mental health services in accordance with the HNR protocols.

2.2 The mental health score may be increased when clinically indicated based upon the treating clinician's assessment of the individual's current functioning.

2.3 Individuals with a reported suicide attempt shall be classified as MH-2 or greater.

3.0 **MENTAL HEALTH 3 (MH-3)** – Patients who have current mental health needs requiring outpatient treatment.

3.1 Each patient requiring outpatient mental health treatment shall be assigned a primary therapist (PT) who serves as the single point of contact and coordinates the provision of care for that patient.

3.1.1 When an assigned primary therapist is unavailable, another psych associate or psychologist acts on his or her behalf.

3.1.2 A new PT shall be assigned when a patient's living unit changes and the current PT does not cover that unit, e.g., when the patient's yard or MH Level of Care changes.

3.2 Patients receiving outpatient treatment shall be assigned one of the five (5) subcodes in accordance with the below criteria. The patient's subcode may change during any encounter as their condition warrants:

3.2.1 Subcode A: Patients with serious mental health symptoms that impact their ability to function in an outpatient setting. These patients require substantial therapeutic intervention in order to remain stable in an outpatient environment (i.e., psychotic symptoms, delusional thought content, frequent suicidal ideation, or currently under a Psychotropic Medication Review Board (PMRB)) order for involuntary medication.

3.2.1.1 All patients classified as Seriously Mentally Ill (SMI) shall be classified as MH-3A while receiving outpatient services (or MH-4/MH-5 if admitted to a residential/inpatient program).

3.2.1.1.1 Any patient under a PMRB shall be classified by the treating provider as MH-3A while receiving outpatient services (or MH-4/MH-5 if admitted to a residential/inpatient program).

3.2.1.2 These patients shall be offered an out of cell, confidential contact with a mental health clinician a minimum of every thirty (30) days.

3.2.1.2.1 All patients on psychotropic medications shall be seen by a P/PNP as often as clinically required but no less often than every ninety (90) days.

3.2.1.2.2 Any patient under a current PMRB shall be seen by the treating provider a minimum of every thirty (30) days.

3.2.1.3 A patient cannot be decreased from MH-3A to MH-2, but may be lowered to a MH-3B, MH-3C, MH-3D or MH-3E.

3.2.1.3.1 A patient must be stable for at least six (6) months prior to having their score decreased from a MH-3A.

3.2.1.4 When changing a patient's mental health score from a MH-3A, the clinician shall clearly document the rationale for the change in mental health level of care and the patient's anticipated treatment needs.

3.2.1.4.1 The clinician shall schedule a psychologist chart review.

3.3 All mental health patients designated as (MH-3A) shall have a comprehensive mental health evaluation (mental health assessment) by their assigned primary therapist:

3.3.1 Within seven (7) calendar days of designation as MH-3A

3.3.2 At least once per year

3.3.3 Whenever clinically indicated to reflect a change in service delivery (i.e., change in mental health score)

3.4 All patients designated as (MH-3A) shall have a new treatment plan developed within thirty (30) days of being designated as MH-3A.

3.4.1 MH-3A treatment plans shall be updated minimally every six (6) months, or more often as clinically indicated.

3.4.1.1 The primary therapist shall conduct a treatment plan meeting with the patient, unless there is a clinical or legitimate and substantial safety and security concern documented.

3.4.1.2 The psychologist or psychiatric practitioner shall be present for complex cases and in all other cases shall provide input to the PT prior to the treatment plan meeting.

3.4.1.3 The patient's treatment plan shall be reviewed and updated to determine:

3.4.1.3.1 Adherence to treatment

3.4.1.3.2 Efficacy of interventions

3.4.1.3.3 Evaluation of the level of care needs

3.4.1.3.4 Diagnostic impressions

3.4.1.3.5 Progress to date in treatment

3.4.1.3.6 Steps taken toward moving to a less restrictive environment, if applicable

3.4.1.4 The treatment plan shall include a date for next review based on the content of the plan and mental health score.

3.5 Patients designated as MH-3B, MH-3C, MH-3D, MH-3E shall have the following:

3.5.1 A comprehensive mental health evaluation by their assigned primary therapist:

3.5.1.1 Within seven (7) calendar days of designation as MH-3B, MH-3C, MH-3D, or MH-3E

3.5.1.2 At least once per year

3.5.1.3 Whenever clinically indicated to reflect a change in service delivery (i.e., change in mental health score)

3.5.2 A treatment plan developed within thirty (30) days of being designated as MH-3B, MH-3C, MH-3D, and MH-3E.

3.5.2.1 Treatment plans shall be updated every three hundred and sixty-five (365) days, or more often as clinically indicated.

3.5.2.1.1 The primary therapist shall conduct a treatment plan meeting with the patient, unless there is a clinical or legitimate and substantial safety and security concern documented. The psychologist or psychiatric practitioner shall also be present for complex cases and in all other cases shall provide input to the PT prior to the treatment plan meeting.

3.5.2.1.2 The patient's treatment plan shall be reviewed and updated to determine:

3.5.2.1.2.1 Adherence to treatment

3.5.2.1.2.2 Efficacy of interventions

3.5.2.1.2.3 Evaluation of the level of care needs

3.5.2.1.2.4 Diagnostic impressions

3.5.2.1.2.5 Progress to date in treatment

3.5.2.1.2.6 Steps taken toward moving to a less restrictive environment, if applicable.

3.5.2.1.3 The treatment plan shall include a date for next review based on the content of the plan and mental health score.

3.5.3 Subcode B: Patients with mental health symptoms that moderately impact their ability to function. These patients are generally stable in an outpatient setting with psychiatric and psychological services. Example: A patient with a major depressive or other affective disorder who benefits from routine contact with psychiatry and psychology staff.

3.5.3.1 Each newly designated MH-3B patient shall receive a comprehensive mental health evaluation by their assigned primary therapist within seven (7) calendar days of designation.

3.5.3.2 These patients shall be seen by a mental health clinician a minimum of every sixty (60) days.

3.5.3.3 All patients on psychotropic medications shall be seen by a P/PNP as often as clinically required but no less often than every ninety (90) days.

3.5.3.3.1 If a patient is newly placed on medications, then the P/PNP shall ensure that the MH score is appropriately updated with the correct subcode.

3.5.3.4 If a patient is discontinued from all of their psychotropic medications, then the P/PNP shall change the mental health score to MH-3D on the date of discontinuation, and shall communicate this change to the mental health clinician assigned to the unit.

3.5.3.4.1 The P/PNP shall schedule a psychologist chart review.

3.5.3.4.2 The P/PNP shall schedule a follow-up psychiatry appointment within thirty (30) days of medication discontinuation.

3.5.3.5 When changing a patient’s mental health score from a MH-3B, the clinician shall clearly document the rationale for the change in mental health level of care and the patient’s anticipated treatment needs.

3.5.3.5.1 The clinician shall schedule a psychologist chart review.

3.5.4 Subcode C: Patients with mental health symptoms that minimally impact their ability to function and require only psychotropic medication in order to remain stable in an outpatient environment. Example: A patient with a general mood or anxiety disorder who has learned to manage their symptoms effectively through the use of medication and infrequent contact with mental health clinicians.

3.5.4.1 Each newly designated MH-3C patient shall receive a face-to-face visit with their assigned primary therapist within seven (7) calendar days of designation.

3.5.4.1.1 This subcode shall not be used upon a patient's arrival to ADCRR.

3.5.4.1.2 Patients may be designated as a MH-3C if they are requesting to no longer receive counseling services from a mental health clinician and have demonstrated stability for a minimum of six (6) months.

3.5.4.1.3 The mental health clinician shall complete a face-to-face session and complete detailed documentation substantiating the change in services to be provided.

3.5.4.1.3.1 The psychiatric provider may not change a patient to a MH-3C.

3.5.4.2 All patients on psychotropic medications shall be seen by a P/PNP as often as clinically required but no less often than every ninety (90) days.

3.5.4.3 Patients shall by seen by a mental health clinician by HNR or upon referral.

3.5.4.4 If a patient is discontinued from all of their psychotropic medications, then the P/PNP shall change the mental health score to MH-3D on the date of discontinuation, and shall communicate this change to the mental health clinician assigned to the unit.

3.5.4.4.1 The P/PNP shall schedule a psychologist chart review.

3.5.4.4.2 The P/PNP shall schedule a follow-up psychiatry appointments within thirty (30) and ninety (90) days of medication discontinuation.

3.5.4.5 When changing a patient's mental health score from a MH-3C, the clinician shall clearly document the rationale for the change in mental health level of care and the patient's anticipated treatment needs.

3.5.4.5.1 The clinician shall schedule a psychologist chart review.

3.5.5 Subcode D: Patients (other than those designated as SMI) who have been recently taken off of psychotropic medications require follow-up for a minimum of six (6) months to ensure stability over time before lowering their score.

3.5.5.1 Each newly designated MH-3D patient shall receive a comprehensive mental health evaluation by their assigned primary therapist within seven (7) calendar days of designation.

3.5.5.2 Patients who have their psychotropic medication discontinued while housed in ADCRR shall be seen by a P/PNP within thirty (30) and ninety (90) days of the discontinuation of the psychotropic medications.

3.5.5.3 Patients will be seen by a mental health clinician a minimum of every ninety (90) days after the medications were discontinued.

3.5.5.4 All patients with verified psychotropic medication discontinued within the six (6) months prior to their arrival at ADCRR shall be designated as a Subcode D.

3.5.5.4.1 The patient shall be seen by a P/PNP within thirty (30) days of arrival to ADCRR.

3.5.5.4.2 The patient will be seen by a mental health clinician a minimum of every ninety (90) days after their arrival to ADCRR.

3.5.5.5 If the patient demonstrates sufficient stability after six (6) months of classification as MH-3D, then the MH score may be changed to MH-3E or MH-2 as clinically indicated.

3.5.5.6 When changing a patient's mental health score from a MH-3D, the clinician shall clearly document the rationale for the change in mental health level of care and the patient's anticipated treatment needs.

3.5.5.6.1 The clinician shall schedule a psychologist chart review.

3.5.6 Subcode E: Patients who are generally stable, with minimal mental health symptoms, which may benefit from regular counseling services. These patients do not require psychiatric intervention in order to remain stable in an outpatient setting. Patient's prescribed psychotropic medication shall not be classified as MH-3E.

3.5.6.1 Each newly designated MH-3E patient shall receive a comprehensive mental health evaluation by their assigned primary therapist within seven (7) calendar days of designation.

3.5.6.2 These patients shall be seen by a mental health clinician in accordance with their treatment plan.

3.5.7 Patients designated as MH-3E can be lowered to a MH-2 when clinically appropriate.

3.5.8 When changing a patient's mental health score from a MH-3E, the clinician shall clearly document the rationale for the change in mental health level of care and the patient's anticipated treatment needs.

3.5.8.1 The clinician shall schedule a psychologist chart review.

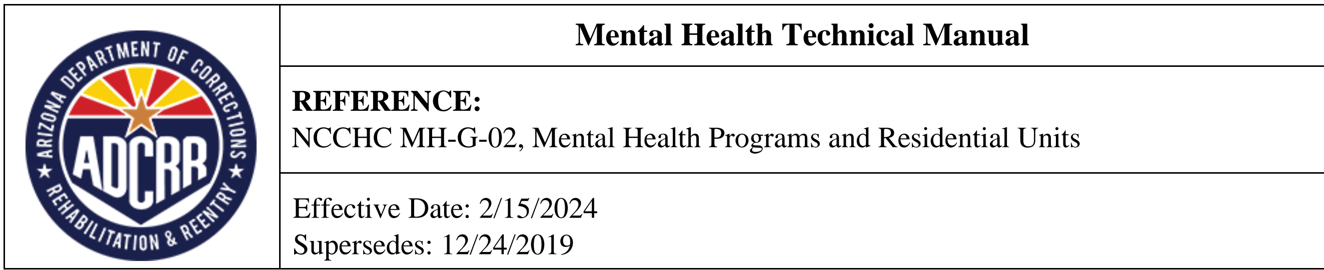
3.6 Any MH-3 patient placed in detention or maximum custody shall be offered an out of cell, confidential contact with a mental health clinician a minimum of every thirty (30) days, regardless of their current subcode.

3.6.1 MH-3A SMI patients shall not be placed in detention, maximum custody, restrictive housing or enhanced housing.

3.7 Any patient who is placed on mental health watch shall be classified as a MH-3 or above until stability is demonstrated and then they can be changed to MH-2 as clinically indicated.

4.0 Discharge from Mental Health Caseload

4.1 A psychologist shall review the records of each patient who is added to, or discharged from, the mental health caseload. The psychologist shall provide appropriate documentation of this review in the patient's health record.



Chapter 3, Section 6.0 Residential Treatment Unit and Mental Health Mediation and Transition Housing Unit

PURPOSE: To provide uniform guidelines for all Residential Treatment Units (RTU) throughout ADCRR. Residential mental health programming includes focused evaluation and treatment of mental health conditions that are limiting an incarcerated individual's ability to adjust and adequately function in a general population environment.

RESPONSIBILITY: The Mental Health Lead shall be responsible for the provision of mental health programming per the below-outlined protocol.

All mental health encounters with all patients shall occur in a confidential, therapeutically appropriate setting unless there is a legitimate and substantial safety and security concern that is documented.

1.0 Staffing Requirements:

1.1 Custody staff will be selected by an interview panel including at a minimum: Mental Health Lead and Deputy Warden.

1.2 All Custody Officers will receive additional mental health training within ninety (90) days of assuming the position and a minimum of two times a year thereafter.

1.2.1 Training will include the following:

1.2.1.1 Trauma-informed care in a correctional setting

1.2.1.2 Signs and symptoms of mental illness

1.2.1.3 Working with incarcerated individuals with mental illness

1.2.1.4 Suicide risk detection, prevention, and response

1.2.1.5 Behavior management plan, rationale, development and implementation

1.2.1.6 De-escalation techniques and use of force response

1.3 The following clinical staffing ratios shall be utilized in the Residential Treatment Unit:

1.3.1 One Psychiatric Provider per fifty (50) patients

1.3.2 One Primary Therapist (psychologist or psychology associate) per thirty (30) patients

1.3.3 One Behavioral Health Tech per fifty (50) patients

2.0 Admission Criteria

2.1 All incarcerated individuals of all statuses and custody levels are eligible for placement in the Residential Treatment Unit if it is clinically indicated.

2.2 The following criteria may indicate the need for placement in a Residential Treatment Unit (RTU):

2.2.1 The patient exhibits an acute onset or significant decompensation of a serious mental health condition.

2.2.2 The patient has a demonstrated inability to function in an outpatient setting due to a serious mental health condition.

2.2.2.1 As evidenced by an inability to participate in work, education, religious services, self-help programming, recreational activities, etc. as a consequence of a serious mental health condition; or

2.2.2.2 The presence of dysfunctional or disruptive social interactions including withdrawal, bizarre or disruptive behavior, inability to follow staff direction, etc., as a consequence of a serious mental health condition.

2.3 Admission Procedures

2.3.1 Patients designated as SMI who request protective custody, refuse to house, receive a disciplinary infraction, or are otherwise unable to house in general population, will be admitted to the Mental Health Mediation and Transition Housing Unit (MHMTU) for assessment, treatment and stabilization.

2.3.1.1 These individuals shall be evaluated as soon as possible after transfer to the MHMTU, but no later than twenty-four (24) hours.

2.3.2 Other patients requiring Residential Treatment shall be admitted following the process outlined below.

2.3.2.1 The Primary Therapist for the patient shall complete a Residential Treatment Unit (RTU) Referral, Form 1103-9, or equivalent electronic form.

2.3.2.2 The Contract Mental Health Director (psychologist) and Mental Health Leads shall:

2.3.2.2.1 Review all Residential Treatment Unit Referral forms.

2.3.2.2.2 Coordinate all activities related to scheduling evaluations at the Residential Treatment Units.

2.3.2.2.3 Arrange for the patient's EHR to be reviewed by the Mental Health Admissions Committee.

2.3.2.3 Evaluation of Referred Patients – The Contract Mental Health Director and Mental Health Leads shall weekly:

2.3.2.3.1 Review all available information, including the patient's Health Record to determine if the patient meets the admission criteria outlined in this section.

2.3.2.3.2 Assess the factors outlined in this section, and determine if the incarcerated individual would compromise the safe and secure operation of the Residential Treatment Unit.

2.3.2.3.3 Review the Residential Treatment Unit Referral Form.

2.3.2.3.4 Complete a Mental Health Non-Clinical Contact Note, Form 1103-5, or equivalent electronic form, which shall include their recommendation to approve or deny the incarcerated individual's admission to the Residential Treatment Unit.

2.3.2.3.5 Send email notification to the involved Deputy Wardens with the recommendation to approve or deny admission to the Residential Treatment Unit.

2.3.3 All potential admissions shall be discussed on the weekly teleconference call with the complex Deputy Warden or Deputy Warden of Operations.

2.3.4 The decision to admit a patient into the program is decided jointly by the Mental Health Director, the Mental Health Lead and the Deputy Warden of Operations or Designee.

2.4 The decision to admit or deny admission to the Residential Treatment Unit, shall be documented in the patient's health record in a Non-Clinical Contact Note, Form 1103-5, or equivalent electronic form.

2.5 Placement into the program is not voluntary, but the patient's participation in the services offered is voluntary, unless the patient is under PMRB and required to take clinically indicated psychotropic medication.

2.6 The psychiatric practitioner is contacted and collaborates on the immediate care plan as soon as an incarcerated individual is admitted to residential treatment.

2.7 The patient must be assessed by their primary therapist as soon as possible after admission, but no later than one (1) business day after arrival.

2.8 Within ninety (90) days of admission, a SMI Determination Form shall be completed by a licensed clinician.

3.0 Therapeutic Interventions

3.1 All patients in residential level of care (i.e., MH-4) shall have a comprehensive mental health evaluation by their primary therapist:

3.1.1 Whenever there is a significant change in the course of treatment, e.g., new type of treatment including medication, significant decompensation;

3.1.2 At least annually, documenting the patient's need for residential level of care.

3.2 Each participant shall be afforded clinical contact with his or her primary therapist either individually or in group psychotherapy as indicated in their treatment plan.

3.3 A psychiatric provider shall evaluate each patient in residential treatment a minimum of every fourteen (14) days.

3.3.1 Patients under an active PMRB order in the residential treatment unit shall be evaluated by a psychiatric provider a minimum of every seven (7) days.

3.4 MH-4 patients shall not be placed in detention, maximum custody, restrictive housing or enhanced housing.

3.5 Each participant in residential therapy shall be offered no less than ten (10) hours per week of scheduled, structured therapeutic activities such as:

3.5.1 Group psychotherapy and group psycho-educational groups

3.5.1.1 Group therapy may only be provided by a licensed mental health clinician.

3.5.1.2 Psycho-education groups may be provided by an LPN or BHT with appropriate supervision and training by an independently licensed psychology associate or psychologist.

3.5.2 Individual therapy

3.5.2.1 Individual therapy is provided by licensed psychology associates or psychologists.

3.5.3 Recreational and occupational therapy

3.5.3.1 Occupational or recreational therapy is counted as a structured activity only if an appropriate clinician: LPN, BHT, or Recreational Therapist.

3.5.4 Work and education

3.5.4.1 Paid work opportunities and education are facilitated through institutional programming. If the treatment team indicates that work and education are beneficial to the patient's overall mental health and well-being, these activities may count for up to four (4) hours of structured activity time per week.

3.6 Each patient in residential treatment shall be offered a minimum of two (2) hours per day, seven (7) days per week of recreation.

3.7 Additional out-of-cell time will be made available for structured or unstructured activity up to two (2) hours per day for patients that have demonstrated stability, engagement, and safe peer-to-peer interactions.

3.8 Each patient will have an interdisciplinary treatment team meeting a minimum of every ninety (90) days.

3.9 The following individuals shall be included in the treatment team meeting:

3.9.1 Patient shall be included in the meeting unless there is a clinical or legitimate and substantial safety and security concern documented in the custody record.

3.9.2 Primary Therapist (PT)

3.9.3 Psychologist

3.9.4 Psychiatric Provider

3.9.5 Mental Health Officer familiar with patient's case

3.9.6 Other staff as clinically indicated

3.10 The interdisciplinary treatment team meeting shall address the following at minimum:

3.10.1 Current symptoms

3.10.2 Diagnostic impressions

3.10.3 Progress to date in treatment

3.10.4 Functional Impairment

3.10.5 History of treatment interventions utilized

3.10.6 Patient's history of adherence to treatment

3.10.7 History of treatment efficacy

3.10.8 Potential obstacles to wellness

3.10.9 Steps taken toward moving to a less restrictive environment

3.10.10 Evaluation of their level of care needs

3.10.11 Goals for treatment

3.10.11.1 Type and frequency of therapeutic interventions (i.e., identifying triggers, cognitive restructuring, imagery training, communication training, mindfulness, problem solving skills training) to be utilized to reach treatment goals.

3.10.11.2 Type and frequency of treatment activities (i.e., individual therapy, group therapy) patient will engage in to reach treatment goals.

3.10.11.3 Stage-level incentives as determined to be clinically appropriate for the patient.

3.10.12 Criteria for discharge

3.10.13 The rationale for continued placement or discharge from Residential Treatment.

4.0 RTU Discharge Criteria and Procedure

4.1 Discharge from RTU will be based upon a decision utilizing the interdisciplinary treatment team process when the patient satisfies any of the following conditions:

4.1.1 The patient has reached maximum treatment benefit, and/or has completed all program elements, and can function adequately in a general population setting.

4.1.2 The patient has decompensated and requires a referral to the inpatient treatment program.

4.1.3 The patient has reached their parole/discharge date and will have an aftercare plan developed for transition into the community.

4.1.4 The patient has exhibited behaviors unrelated to mental illness that threaten the safe and secure operation of the unit, the patient's own safety, or the safety of others.

4.1.4.1 Such behaviors shall be documented in accordance with DO 105, Information Reporting.

4.2 The decision to discharge a patient from a residential program shall be discussed among the MHD and Mental Health Leads. All potential discharges shall be discussed on the weekly teleconference call with the complex DWOPs.

4.2.1 The MHD, or designee, shall arrange for movement to an appropriate yard through Central Office Count Movement.

4.3 A psychologist shall document the review, discussion, and decision regarding transfer to a new level of care and/or location.

4.4 A mental health discharge summary shall be completed and placed in the patient's EHR including:

4.4.1 The patient's reason for admission to RTU

4.4.2 The treatment team's intervention efforts and the patient's response to interventions

4.4.3 The rationale for the change in mental health level of care

4.4.4 Anticipated treatment needs

4.5 Following the decision to discharge a patient from the Residential Treatment Unit, the Primary Therapist shall schedule a psychologist chart review.

4.6 The Primary Therapist (psychologist or psychology associate) at the receiving unit shall meet with the arriving patient within the following parameters:

4.6.1 If the patient is transferred to an outpatient setting the new PT shall meet with the patient within seven (7) calendar days of arrival.

4.6.2 If the patient is transferred to an inpatient setting, the new PT shall meet with the patient within one (1) business day of arrival.

5.0 MHMTU Discharge Criteria and Procedure

5.1 Discharge from the MHMTU shall occur when the following conditions are met:

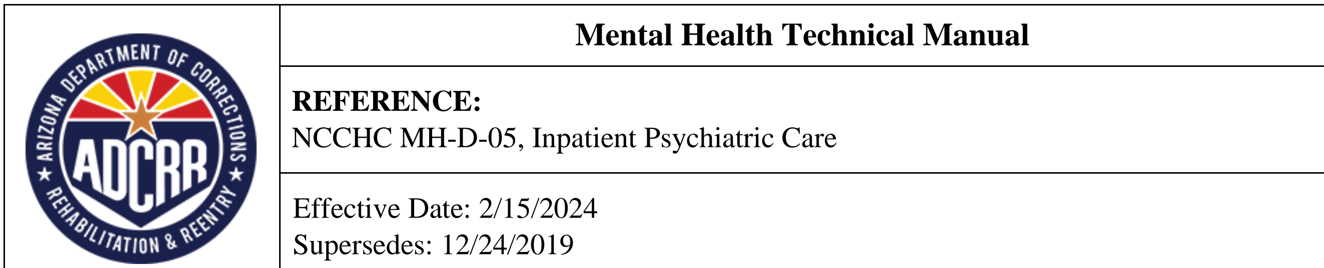
5.1.1 When the issue that led to the patient's placement in the MHMTU (e.g. 805, discipline) has been resolved; AND

5.1.2 The Mental Health Team completes a Level of Care Assessment to determine the patient's ongoing care needs.

5.2 Transition to Appropriate Housing from the MHMTU

5.2.1 Once the conditions in 5.1 are met, the patient will transition to appropriate housing.

5.2.2 If the Mental Health Team assesses that a higher level of care is clinically indicated, the patient will remain in MHMTU until they can be transferred to a Residential or Inpatient program based on clinical need.



	Mental Health Technical Manual
	REFERENCE: NCCHC MH-D-05, Inpatient Psychiatric Care
	Effective Date: 2/15/2024 Supersedes: 12/24/2019

Chapter 3, Section 7.0 Inpatient Treatment Unit

PURPOSE: To provide inpatient mental health programming that includes focused evaluation and intensive treatment to individuals experiencing marked impairment and dysfunction in most areas of their life due to uncontrolled symptoms of mental illness.

RESPONSIBILITY: The Mental Health Lead shall be responsible for the provision of mental health programming in accordance with the below outlined protocol.

All mental health encounters with all patients shall occur in a confidential, therapeutically appropriate setting unless there is a legitimate and substantial safety and security concern that is documented.

1.0 Staffing Requirements:

1.1 Custody staff will be selected by an interview panel including at minimum: Mental Health Lead and Deputy Warden.

1.2 All Custody Officers will receive additional mental health training within ninety (90) days of assuming the position and a minimum of two (2) times a year thereafter.

1.2.1 Training will include the following:

1.2.1.1 Trauma informed care in a correctional setting

1.2.1.2 Signs and symptoms of mental illness

1.2.1.3 Working with incarcerated individuals with mental illness

1.2.1.4 Suicide risk detection, prevention and response

1.2.1.5 Behavior management plan, rationale, development and implementation

1.2.1.6 De-escalation techniques and use of force response

1.3 The following clinical staffing ratios shall be utilized in the Inpatient Treatment Unit:

1.3.1 One Psychiatric Provider per twenty-five (25) patients

1.3.2 One Primary Therapist (psychologist or psychology associate) per ten (10) patients

1.3.3 One Behavioral Health Tech per thirty (30) patients

2.0 Admission Criteria

2.1 All incarcerated individuals of all statuses and custody levels are eligible for placement in the Inpatient Treatment Unit if it is clinically indicated.

2.2 The following criteria may indicate the need for placement in an Inpatient Treatment Unit (ITU):

2.2.1 The patient exhibits an acute onset or significant decompensation of a serious mental health condition that is causing marked impairment in daily living activities, communication, and social interaction.

2.2.2 Dangerousness to Others as a consequence of a serious mental illness/Dangerousness to Self.

2.2.3 Grave disability/persistently and acutely disabled.

2.3 All individuals assessed to need Inpatient Level of Care at Intake shall be placed on watch until they can be transferred to the Inpatient Treatment Unit.

3.0 Admission Procedure

3.1 The primary therapist for the patient shall complete an Inpatient Treatment Unit (RTU) Referral Form, or equivalent electronic form.

3.2 The Contract Mental Health Director (psychologist) and Mental Health Leads shall:

3.2.1 Review all Inpatient Treatment Unit Referral forms.

3.2.2 Coordinate all activities related to scheduling evaluations at the Inpatient Treatment Units.

3.2.3 Arrange for the patient's EHR to be reviewed by the Mental Health Admissions Committee.

3.3 Evaluation of Referred Patients – The Contract Mental Health Director and Mental Health Leads shall weekly:

3.3.1.1 Review all available information, including the patient's Health Record to determine if the patient meets the admission criteria outlined in this section.

3.3.1.2 Assess the factors outlined in this section, and determine if the incarcerated individual would compromise the safe and secure operation of the Inpatient Treatment Unit.

3.3.1.3 Review the Inpatient Treatment Unit Referral Form.

3.3.1.4 Complete a Mental Health Non-Clinical Contact Note, Form 1103-5, or equivalent electronic form, which shall include their recommendation to approve or deny the patient's admission to the Inpatient Treatment Unit.

3.3.1.5 Send email notification to the involved Deputy Wardens with the recommendation to approve or deny admission to the Inpatient Treatment Unit.

3.4 All potential admissions shall be discussed on the weekly teleconference call with the complex Deputy Warden or Deputy Warden of Operations.

3.5 The decision to admit a patient into the program is decided jointly by the Mental Health Director, the Mental Health Lead and the Deputy Warden of Operations or Designee.

3.6 The decision to admit or deny admission to the Inpatient Treatment Unit, shall be documented in the patient's health record in a Non-Clinical Contact Note, Form 1103-5, or equivalent electronic form.

3.7 Placement into the program is not voluntary, but the patient's participation in the services offered is voluntary, unless the patient is under PMRB and required to take clinically indicated psychotropic medication.

3.8 The psychiatric practitioner is contacted and collaborates on the immediate care plan as soon as an incarcerated individual is admitted to inpatient treatment.

3.9 The patient must be assessed by their primary therapist as soon as possible after admission, but no later than one (1) business day after arrival. Within ninety (90) days of admission, a SMI Determination Form shall be completed by a licensed clinician.

4.0 Therapeutic Interventions

4.1 All mental health encounters with all patients shall occur in a confidential, therapeutically appropriate setting unless there is a clinical or legitimate and substantial safety and security concern that is documented.

4.2 All patients in inpatient level of care (i.e., MH-5) shall have a comprehensive mental health evaluation conducted by their PT if already on the mental health caseload (otherwise by the mental health provider assigned to the inpatient unit):

4.2.1 At least annually a comprehensive mental health evaluation reflecting rationale for inpatient placement including but not limited to;

4.2.1.1 Current symptoms and functional impairment

4.2.1.2 Timing and pattern of decompensation

4.2.1.3 Interventions attempted

4.2.1.4 Diagnostic impressions (including potential substance-related impacts)

4.2.1.5 Progress in treatment to date

4.2.1.6 Goals for treatment in the inpatient setting

4.2.1.7 Anticipated length of stay

4.2.1.8 Criteria for discharge

4.3 Each participant shall have daily clinical contact with their primary therapist either individually or in group psychotherapy; individual clinical contact shall be provided at least every other day.

4.4 A psychiatric provider shall conduct a clinical encounter with each patient in inpatient treatment as often as indicated, but no less than every seven (7) days.

4.5 Each patient will have an interdisciplinary treatment team meeting a minimum of once a week.

4.5.1 Each patient shall have their treatment progress reviewed daily.

4.6 The following individuals shall be included in the treatment team meeting.

4.6.1 Patient, unless there is a clinical or legitimate substantial safety and security concern documented

4.6.2 Primary Therapist (PT)

4.6.3 Psychiatric Provider

4.6.4 Psychologist

4.6.5 Nursing

4.6.6 Behavioral Health Technician

4.6.7 Providers from patient’s previously assigned unit whenever possible

4.6.8 Custody Officer familiar with the patient

4.6.9 Other staff as clinically indicated

4.7 The interdisciplinary treatment team meeting shall address the following at minimum:

4.7.1 Current symptoms

4.7.2 Functional Impairment

4.7.3 Timing and pattern of decompensation

4.7.4 Anticipated length of stay

4.7.5 History and current treatment interventions

4.7.6 Patient’s history of adherence to treatment

4.7.7 History of treatment efficacy

4.7.8 Potential obstacles to wellness

4.7.9 Goals for treatment

4.7.9.1 Type and frequency of therapeutic interventions (i.e., identifying triggers, cognitive restructuring, imagery training, communication training, mindfulness, problem solving skills training) to be utilized to reach treatment goals

4.7.9.2 Type and frequency of treatment activities (i.e., individual therapy, group therapy) patient will engage in to reach treatment goals

4.7.9.3 Stage level incentives as determined to be clinically appropriate for the patient

4.7.10 Diagnostic impressions

4.7.11 Criteria for discharge

4.7.12 Rationale for continued placement or discharge from inpatient treatment

4.8 Each participant in inpatient therapy shall be offered no less than fourteen (14) hours per week of scheduled, structured therapeutic activities such as:

4.8.1 Group psychotherapy and group psycho-educational groups.

4.8.1.1 Group therapy may only be provided by a licensed mental health clinician.

4.8.1.2 Psycho-education groups may be provided by a LPN or BHT with appropriate supervision and training by an independently licensed psychology associate or psychologist.

4.8.2 Individual therapy

4.8.2.1 Individual therapy is provided by licensed psychology associates or psychologists.

4.8.3 Recreational and occupational therapy

4.8.3.1 Occupational or recreational therapy is counted as a structured activity only if an appropriate clinician: LPN, BHT or Recreational Therapist.

4.8.4 Work and education

4.8.4.1 Paid work and education are facilitated through institutional programming. If the treatment team indicates that work and education are beneficial to the patient's overall mental health and wellbeing, these activities may count for up to four (4) hours of structured activity time per week.

4.9 Each patient in inpatient treatment shall be offered a minimum of two (2) hours per day, seven (7) days per week of recreation.

4.10 MH-5 patients shall not be placed in detention, maximum custody, restrictive housing or enhanced housing.

5.0 Discharge Criteria and Procedure

5.1 Discharge from inpatient treatment will be based upon a decision utilizing the interdisciplinary treatment team process when the inmate-patient satisfies any of the following conditions:

5.1.1 The patient has reached maximum treatment benefit, and/or has completed all program elements.

5.1.1.1 Every effort shall be made to transition patients being discharged from the inpatient program to a residential mental health program prior to placement in an outpatient setting.

5.1.1.2 If the patient is transferred directly from inpatient to an outpatient setting, they shall be seen within one (1) business day of arrival to outpatient.

5.1.2 The patient has reached their parole/discharge date and will have an aftercare plan developed for transition into the community.

5.2 The decision to discharge a patient from an inpatient program shall be discussed among the MHD and Mental Health Leads. All potential discharges shall be discussed on the weekly teleconference call with the complex DWOPs.

5.2.1 The MHD, or designee, shall arrange for movement to an appropriate yard through Central Office Count Movement.

5.3 A psychologist shall document the review, discussion, and decision regarding transfer to a new level of care and/or location.

5.4 A mental health discharge summary shall be completed and placed in the patient's EHR including:

5.4.1 The patient's reason for admission to ITU

5.4.2 The treatment team's intervention efforts and the patient's response to interventions

5.4.3 The rationale for the change in mental health level of care

5.4.4 Anticipated treatment needs

5.5 Following the decision to discharge a patient from the Inpatient Treatment Unit, the Primary Therapist shall schedule a psychologist chart review.

5.6 The Primary Therapist (psychologist or psychology associate) at the receiving unit shall meet with the arriving patient within the following parameters:

5.6.1 If the patient is transferred to an outpatient or residential treatment setting, the new PT shall meet with the patient within one (1) business day of arrival.

Chapter 3, Section 8.0 Determination and Management of Seriously Mentally Ill (SMI) Patients

PURPOSE: To provide a standardized system of identifying patients who need to be designated as Seriously Mentally Ill (SMI) while incarcerated in ADCRR.

RESPONSIBILITY: It is the responsibility of each licensed mental health clinician or provider to administer the SMI Determination Form (#1103-13) when clinically indicated in accordance with this policy.

1.0 Definition

1.1 A patient shall be designated as SMI if:

1.1.1 According to a licensed mental health clinician or provider they possess:

1.1.1.1 A qualifying mental health diagnosis as indicated on the SMI Determination Form; and

1.1.1.2 A severe functional impairment directly relating to their mental illness.

1.1.2 Any patient determined to be SMI in the community (SMI-C) shall also be designated as SMI in ADCRR. The SMI-C designation shall be automatically uploaded into ACIS from the Arizona Health Care Cost Containment Services (AHCCCS) on a daily basis.

1.1.2.1 The clinician shall ensure that the patient's SMI designation is correctly documented in both ACIS and the EHR.

1.1.3 Any patient who is under a PMRB order shall be designated as SMI and seen by a psychiatric provider a minimum of every thirty (30) days.

1.2 Patients with Intellectual Disabilities

1.2.1 If a patient is determined to have an intellectual disability, the clinician shall enter the appropriate diagnosis and set the corresponding flag in the EHR.

1.2.1.1 Any patient previously determined as qualifying for Division of Developmental Disabilities (DDD) services, or otherwise determined to have a developmental disability as defined in A.R.S. § 36-551 shall have the appropriate diagnosis set and the corresponding flag set in the EHR.

1.2.2 The patient shall be designated as a MH-3A or above and provided the same level of services as those designated SMI.

2.0 Services for those Designated as SMI

2.1 Patients designated as Seriously Mentally Ill (SMI) shall not be housed in maximum custody, detention, or close management, or otherwise kept in a cell for more than twenty-two (22) hours each day.

2.2 The minimum mental health service delivery level for any SMI patient is determined by their mental health score, and they shall always be designated as MH-3A, MH-4, or MH-5.

2.3 Patients designated as SMI shall be exempt from medical, dental, and mental health charges related to HNR driven contacts.

2.4 A patient can request to be evaluated to determine if he/she meets the criteria for being designated as SMI. They shall receive additional SMI screenings as clinically indicated.

3.0 SMI Identification

3.1 The SMI designation shall be clearly documented in the medical record on the SMI Determination Form.

4.0 Removal of SMI Designation

4.1 A patient may be determined to no longer meet the criteria for an SMI designation.

4.1.1 The Mental Health Lead shall confirm that the patient is not currently designated as SMI in the community prior to any changes made to this designation. The change in SMI status shall only be made after a treatment team staffing, including the patient, the treating psychologist and psychiatric provider, has occurred. The treatment team shall document (Form #1103-69) the justification that the criteria is no longer met.

4.1.2 A patient may request a decertification of their SMI status with the community. The paperwork will be completed by a licensed clinician and submitted to the Regional Release Planning Manager if clinically indicated.

Chapter 3, Section 9.0 Mental Health Treatment Plans

PURPOSE: To ensure that each patient classified as MH-3, MH-4, or MH-5 has an individualized treatment plan based on an assessment of their clinical needs.

RESPONSIBILITY: The Mental Health Lead at each complex has oversight responsibility in ensuring that patients who meet the aforementioned criteria have a complete and current treatment plan in their medical record.

1.0 Procedure

1.1 Patients with a Mental Health score of MH-3 or above shall have a current treatment plan.

1.2 The primary therapist (PT) responsible for the patient's mental health care shall complete and update the treatment plan routinely, based on the patient's mental health score as described below.

1.2.1 The mental health treatment plan shall be individualized, contain measurable goals and interventions, and be specific to issues addressed in the Subjective, Objective, and Education sections of the progress notes. It shall also contain all current diagnoses.

1.3 At each contact, the P/PNP shall review the current treatment plan and document their review in the S.O.A.P.E note.

1.4 When a patient's score is lowered to a MH-2, the mental health treatment plan shall indicate that the patient's treatment goals have been met and the patient no longer requires mental health treatment.

1.4.1 For an electronic medical record, the mental health clinician shall open an addendum to the treatment plan, date, and write, "Patient is now MH-2 as all identified treatment goals have been met."

2.0 Outpatient Treatment Plans (MH-3)

2.1 The primary therapist shall conduct a treatment plan meeting with the patient. The psychologist or psychiatric practitioner shall also be present for complex cases and in all other cases shall provide input to the PT prior to the treatment plan meeting.

2.2 The patient's treatment plan shall be reviewed and updated to determine:

2.2.1 Adherence to treatment

2.2.2 Efficacy of interventions

2.2.3 Evaluation of the level of care needs

2.2.4 Diagnostic impressions

2.2.5 Progress to date in treatment

2.2.6 Steps taken toward moving to a less restrictive environment, if applicable.

2.3 The treatment plan shall include a date for next review based on the content of the plan.

2.4 A new treatment plan shall be developed within thirty (30) days of being placed on the mental health caseload.

2.4.1 MH-3A treatment plans shall be updated minimally every six (6) months, or more often as clinically indicated.

2.4.2 MH-3B, 3C, 3D, and 3E treatment plans shall be updated minimally every twelve (12) months, or more often as clinically indicated.

3.0 Residential Treatment Plans (MH-4)

3.1 The full treatment team meeting as outlined in Chapter 3, Section 6, shall occur and a new treatment plan shall be developed for all patients upon admission to the residential mental health program.

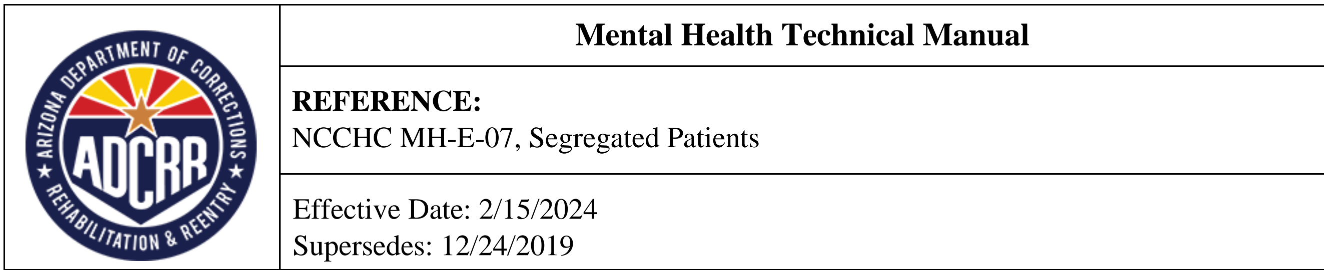
3.1.1 This treatment plan shall be updated minimally every ninety (90) days, or more often as clinically indicated.

4.0 Inpatient Treatment Plans (MH-5)

4.1 The full treatment team meeting as outlined in Chapter 3, Section 7, shall occur and a new treatment plan shall be developed for all patients upon admission to the inpatient mental health program.

4.1.1 This treatment plan shall be updated minimally every ninety (90) days, or more often as clinically indicated.

4.1.2 In the event that a patient is not admitted to the inpatient or residential program, the mental health clinician assigned to that area shall ensure that the Treatment Plan is updated with the patient's current level of functioning and any services that shall be provided.



	Mental Health Technical Manual
	REFERENCE: NCCHC MH-E-07, Segregated Patients
	Effective Date: 2/15/2024 Supersedes: 12/24/2019

Chapter 3, Section 10.0 Mental Health Service Delivery in Restrictive Housing

PURPOSE: To outline protocols for the management and mental health services provision to patients in restrictive housing (all patients subjected to confinement in a cell for twenty-two (22) or more hours each day).

RESPONSIBILITY: Mental health clinicians assigned to a unit with patients in restrictive housing are responsible for the mental health care of such patients in accordance with the procedures identified in this section.

1.0 Maximum Custody Arrivals

1.1 All patients who have been newly assigned to a maximum custody unit shall be evaluated by a mental health clinician within one (1) business day of their arrival; the patient shall be offered an out of cell, confidential contact.

1.1.1 This initial evaluation is for the purpose of determining if the patient needs to be placed in a residential mental health program or an inpatient mental health program.

1.2 Any patient displaying significant mental health issues that will substantially affect their ability to maintain stability in their current location shall be immediately reported to security, and the patient shall be placed on a watch if necessary.

2.0 Restrictive Status Housing Program (RSHP)

2.1 All patients placed in the RSHP shall be evaluated by a mental health clinician within one (1) business day of placement (even if they originated from a maximum custody unit).

2.2 All patients with a MH score of MH-3 shall be offered an out of cell, confidential contact by a mental health clinician a minimum of every thirty (30) days while in RSHP.

3.0 General Mental Health Contacts

3.1 All patients classified as MH-3 shall be offered an out of cell, confidential mental health contact (group or individual) a minimum of once every thirty (30) days while in restrictive housing, or more often as determined by the patient's primary therapist.

4.0 Segregation Rounds

4.1 All patients (regardless of mental health score) housed in restrictive housing, max custody, or detention shall receive segregation rounds a minimum of three (3) times a week by mental health or medical staff (not to include LPNs, CNA's, MH-clerks).

4.2 All patients designated as MH-3 and above housed in restrictive housing, max custody, or detention shall receive segregation rounds at least weekly by mental health staff (not to include LPNs, CNA's, MH-clerks).

4.3 Segregation Rounds should include at a minimum:

4.3.1 Face-to-face contact including:

4.3.1.1 MH staff introduction

4.3.1.2 Patient acknowledgement of staff presence

4.3.1.3 Check-in with the patient regarding his or her well-being

4.3.1.4 Review of the process for accessing mental health services

4.3.2 Observation of cell cleanliness/odors

4.3.3 Observation of personal hygiene

4.3.4 Observation of affect and behavior

4.3.5 Observation of patient activity or lack thereof

4.3.6 Report any negative changes in behavior or appearance to mental health team immediately

4.3.7 Forward any requests for healthcare services to appropriate discipline

Chapter 3, Section 11.0 Mental Health Service Delivery for Minors

PURPOSE: To outline protocols for the provision of mental health services to minor patients (younger than eighteen (18) years of age) sentenced to the custody of ADCRR.

RESPONSIBILITY: The Primary Therapist assigned to the Minor Reception areas is responsible for the mental health care of such patients in accordance with the procedures identified in this section.

1.0 Procedure

1.1 No patient under the age of eighteen (18) shall be placed into maximum custody, detention, or close management, or otherwise kept in a cell for more than twenty-two (22) hours each day.

1.2 Within one (1) business days of a minor's arrival to ADCRR, psychologist shall conduct a comprehensive mental health evaluation in an out of cell, confidential setting.

1.3 The comprehensive mental health evaluation shall include a Mental Status Exam.

1.3.1 The findings from the evaluation shall be documented immediately in the patient's medical record and shared with the education department as appropriate.

1.3.2 When appropriate, the psychologist shall refer minor patients to the P/PNP for assessment.

1.4 A psychologist shall determine if additional testing is needed in the following areas:

1.4.1 Psychopathology

1.4.2 Personality functioning

1.4.3 Neuropsychological functioning

1.4.4 Intellectual functioning

1.5 The results of psychological testing shall be documented in the medical record and shared with the education department as appropriate.

1.5.1 Psychological assessment reports shall include, at a minimum, identifying data, reason for referral, mental health history, current findings, and recommendations.

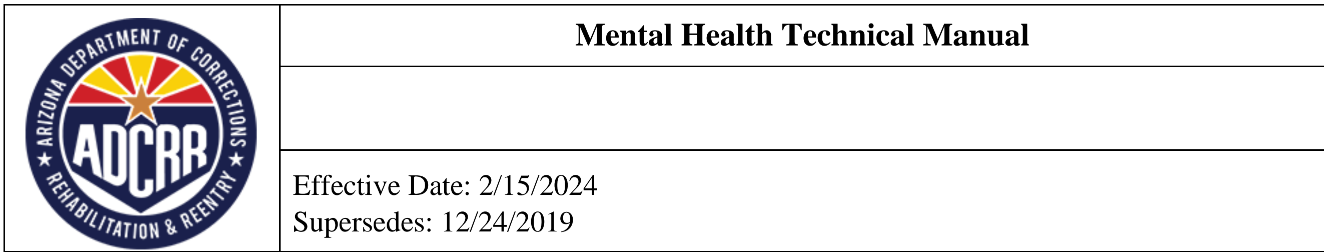
1.5.2 Reports of psychological testing shall be documented either in S.O.A.P.E format or in the form of a psychological assessment report.

1.5.3 Reports of any psychological testing shall be signed or counter-signed by a licensed psychologist.

1.6 All minor patients classified as MH-3 shall be offered an out of cell, confidential contact a minimum of every thirty (30) days by a psychologist who serves as their primary therapist, regardless of their current subcode.

1.7 Minor patients on psychotropic medications shall be offered an out of cell, confidential contact a minimum of every thirty (30) days with their psychiatric provider.

1.7.1 Minor patients on newly prescribed medication shall be seen within seven (7) days of the new prescription, within fourteen (14) days of the new prescription, and every thirty (30) days thereafter.



Chapter 3, Section 12.0 Mental Health Service Delivery for Transgender, Intersex, and Gender Non-Conforming Individuals

PURPOSE: To establish policy and procedures for the identification, assessment, monitoring, and management of patients who present or identify as transgender, intersex, or meet DSM-5-TR criteria for Gender Dysphoria.

RESPONSIBILITY: The Mental Health Lead is responsible for the delivery of mental health services to the transgender, intersex, and gender non-conforming population at his/her complex.

1.0 Definitions

1.1 Gender – socially constructed roles, behaviors, activities, and attributes that a given society typically or historically assigns to men and women.

1.2 Gender Dysphoria (GD) – psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity.

1.3 Gender Identity – refers to a person's internal, deeply felt sense of being male, female, or something else. A person's self-identified gender, versus their anatomical gender at birth.

1.4 Gender Nonconforming – a person's behavior and appearance that does not conform to the social expectations for one's gender.

1.5 Intersex – a condition in which a person is born with external genitalia, internal reproductive organs, chromosome patterns, or an endocrine system that does not fit typical definitions of male or female.

1.6 Transgender – a person who identifies with or expresses a gender identity that differs from the one which corresponds to their assigned gender at birth.

1.7 Transgender Committee – a multi-disciplinary team outlined in DO 810 that reviews and determines appropriate housing assignments, recommends safety plans, and provides operational support for patients who identify as transgender or intersex.

1.8 Transition – ongoing process of physical and psychological adaptation to the characteristics of an alternate gender.

2.0 Procedure

2.1 Assessments, reviews, and management of patients who identify as transgender, intersex, or gender non-conforming shall be done on a case-by-case basis, in a respectful manner and confidential setting, and in consideration of individual circumstances, including but not limited to current physical sexual characteristics, gender identification, physical presentation, behavior, and programming needs.

2.2 Identification – the identification can occur at the Reception Center or at any time during their incarceration. Information may be provided by the patient, a county jail, or other relevant collateral sources.

2.2.1 These patients shall be referred to the Mental Health Lead for evaluation and referral to medical for hormone replacement therapy (HRT) as clinically indicated.

2.3 Assessment – the mental health clinician shall conduct a clinical interview in order to assess and determine identification of transgender and gender dysphoria that are present and may require intervention.

2.3.1 Any identified housing concerns shall be relayed to the Transgender Committee as identified in DO 801.

2.3.2 GD is based on an individual's self-report. Therefore, the history or subjective component of the evaluation serves as the primary source for identifying a person as having GD. The clinical interview shall include assessment of the following:

2.3.2.1 A history of gender identity issues (age of onset of feeling like other identified gender, passing as other sex via clothing, body changes, or other physical distortions, family/community reactions and impacts, name changes via legal methods such as driver's license or birth certificate modifications).

2.3.2.1.1 Confirm symptoms to meet DSM-5-TR criteria for gender dysphoria.

2.3.2.2 A history of any mental health symptoms, to include an assessment for co-occurring mental health disorders that may complicate treatment or confound diagnosis of GD such as factitious disorder, personality disorder, delusion disorder, psychosis, etc.

2.3.2.3 Background information on GD counseling or HRT.

2.3.2.4 Trauma history.

2.3.3 The findings from the clinical interview and assessment shall be documented in the patient's medical record.

2.3.4 The mental health clinician shall provide a referral to psychiatry when the patient presents with co-occurring psychiatric disorders that may complicate treatment or confound a diagnosis of GD.

2.4 Housing – facility and housing assignments shall be made, by custody, on a case-by case basis, considering the patient's health and safety as well as potential programming, management and security concerns. A patient's own views regarding safety shall be given careful consideration.

2.4.1 The Transgender/Intersex Committee shall interview any patient who identifies as transgender or intersex, and convene a meeting within seven (7) calendar days of the patient's arrival to provide input to custody to assist in determining appropriate housing conducive to the patient's needs.

2.5 Treatment – mental health and psychiatric staff shall provide ongoing services as clinically indicated and provide appropriate referral documentation for outside consultation services (e.g., Endocrinology).

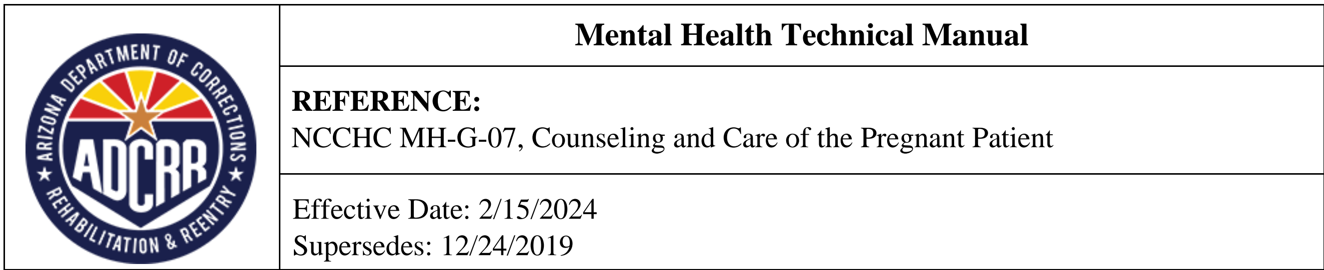
2.5.1 Patients diagnosed with GD shall have access to clinically appropriate treatment options to include:

2.5.1.1 Psychological treatment that addresses ambivalence and/or dysphoria regarding gender.

2.5.1.2 Appropriate psychiatric care.

2.5.2 Medical providers shall provide assessments, monitoring, and primary care for patients who are receiving HRT.

2.5.2.1 Healthcare staff shall request that the mental health team complete an assessment described above when a patient requests HRT.



Chapter 3, Section 13.0 Mental Health Follow-up Peripartum

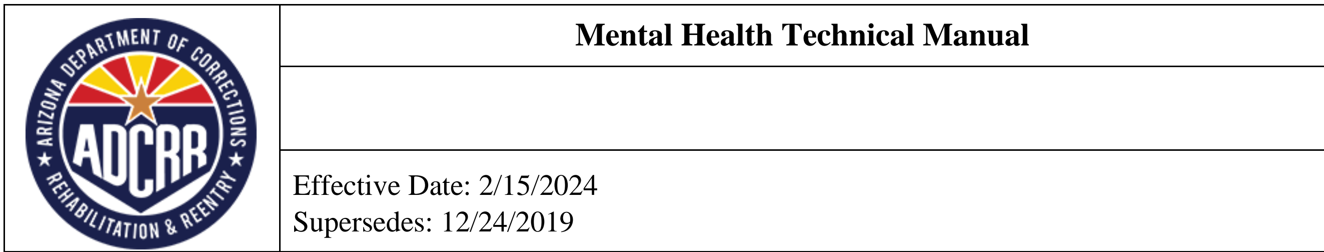
PURPOSE: To provide direction regarding mental health service delivery for female patients during peripartum (before and after delivery).

RESPONSIBILITY: It is the responsibility of the medical staff assigned to each unit to communicate with mental health staff regarding a patient in a peripartum stage.

1.0 The licensed mental health clinician assigned to the unit shall offer an out of cell, confidential contact with each female patient within two (2) days of their return from the hospital after delivering a baby or after experiencing a miscarriage, stillbirth or pregnancy termination.

 1.1 If it is determined that the patient is suffering from depression, then the clinician shall schedule routine contact with the patient until the depression is resolved. This may include changing the MH score to a MH-3 or above.

2.0 Medical may also refer a pregnant patient if prepartum depression is suspected.



Chapter 3, Section 14.0 Mental Health Evaluation of Interstate Compact

PURPOSE: To provide direction for requests to complete psychological evaluations on patients who are being considered for an interstate compact transfer.

RESPONSIBILITY: The Mental Health Lead shall ensure that all requests for psychological evaluation relating to Interstate Compacts are completed.

1.0 Upon request from the Interstate Compact Coordinator, the Mental Health Lead will assign a psychologist to complete the required psychological evaluation as specified under the proposed interstate compact agreement.

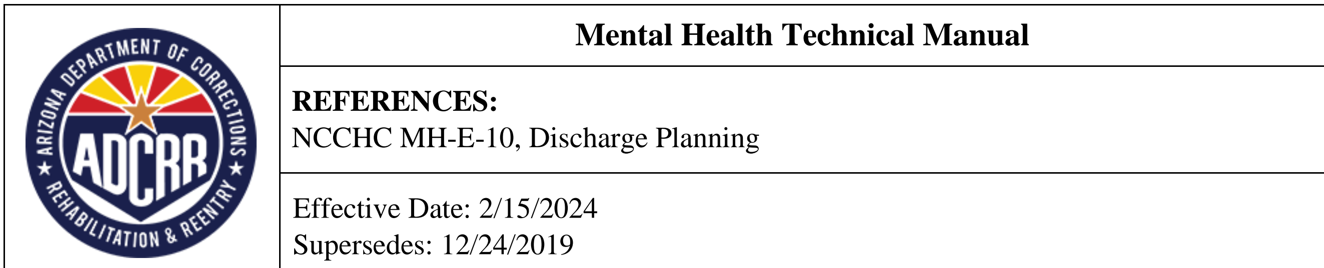
2.0 Prior to the completion of any evaluation and/or testing the psychologist shall ask the patient to read and sign the Consent for Release of Medical Information for Facilitation of Interstate Corrections Compact Transfer (Form #1101-40).

3.0 Once completed, the psychologist shall:

3.1 Send the originals of the Consent Form as well as the final psychological evaluation to the Interstate Compact Coordinator though the internal mail system.

3.2 Ensure copies of all submitted materials related to the Interstate Compact have been scanned into the patient’s medical record (placed in the legal section in a paper record).

3.3 Forward copies of all submitted materials related to the Interstate Compact to Central Office records to be filed in the patient’s institutional master file.



	Mental Health Technical Manual
	REFERENCES: NCCHC MH-E-10, Discharge Planning
	Effective Date: 2/15/2024 Supersedes: 12/24/2019

Chapter 3, Section 15.0 Release Planning

PURPOSE: To ensure that all patients have adequate planning to address their mental health needs in the community after release from prison.

RESPONSIBILITY: The designated Release Planners, working in conjunction with mental health staff on each unit, are responsible for coordinating plans for patient contact with community mental health agencies.

1.0 Release planning shall be completed and documented more than seven (7) days, but less than six (6) months, prior to patient's earliest release date.

2.0 All patients designated as MH-3 or above who have identified treatment providers in the community, and consent to the release of information, shall have the following information provided to their treatment providers prior to release:

2.1 A problem list

2.2 A list of active medications

2.3 The patient's current symptoms and functional impairments

2.4 A summary of relevant care provided during incarceration

2.5 Any necessary follow-up care

2.6 One or more points of contact if a community provider requires further information

2.7 The name and contact information of the primary therapist

2.8 The patient's current treatment plan

2.9 An aftercare plan that reflects progress in treatment

2.10 The above information shall be collected/printed and saved as a Continuity of Care Package.

2.10.1 This package shall be scanned into the patient's EHR.

2.10.2 Documentation shall be made in the EHR indicating when the package was provided, via what means it was provided and to whom it was provided.

3.0 SMI patients and those classified as MH-3A, MH-4 or MH-5 shall receive the following additional release planning services:

3.1 Release Planner shall develop and document an aftercare plan that reflects the patient's current symptoms and functional impairments, progress in treatment, and treatment plan.

3.2 Patients shall be referred to the appropriate Regional Behavioral Health Authority (RBHA) for follow-up care and Mental Health staff shall facilitate evaluation for SMI designation and placement in the community, as clinically indicated or when requested by the patient.

3.2.1 If a patient is currently open with a RBHA, an appointment shall be made to establish contact and resume services as soon as possible after release.

3.3 An AHCCCS application shall be submitted, if no longer active in the system.

3.3.1 The release planner shall document the patient's AHCCCS number in the EHR for all eligible patients.

3.4 Release Planner shall work with the assigned COIII to identify housing options. (If the patient is homeless, patient shall be provided resources for housing.)

3.5 Patients shall be given a Community Resource Packet which identifies the address and phone numbers of mental health agencies specific to the community where the patient plans to reside.

3.5.1 The Community Resource Packet shall be reviewed and updated no less than quarterly.

3.6 Medication shall be provided for a sufficient length of time to allow the patient to obtain and attend an appointment with a community practitioner qualified to order a new supply. Patients shall be released with no less than a thirty (30) day supply.

3.6.1 If the psychiatric provider determines that it is unsafe to release the patient with a supply of their medication due to it being an injectable antipsychotic, then the psychiatric provider shall document this and any efforts taken to ensure continuity of care back to the community (i.e., switching medication to pill form, moving the date of injection to be completed just before release, etc.).

4.0 Release planning for all MH-3E, MH-3D, MH-3C and MH-3B patients shall include the following:

4.1 These patients shall be given a Community Resource Packet, which identifies the address and phone numbers of mental health agencies specific to the community where the patient plans to reside.

4.2 If a non-SMI patient requests an SMI evaluation, a referral to the appropriate RBHA shall be completed.

5.0 Court Ordered Evaluations (COE) Upon Release

5.1 If it is determined that a patient needs to be evaluated for inpatient treatment upon release from prison, the patient shall be petitioned for a COE.

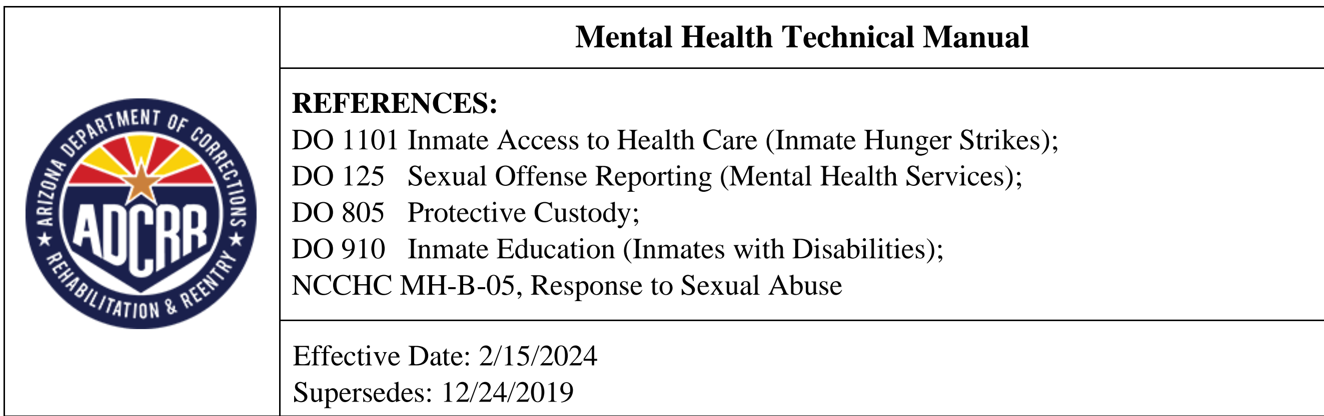
5.2 The patient shall be transported to the Inpatient Treatment Unit at least two (2) weeks before the release date for the clinical team to fully evaluate the patient's needs and to be able to file the appropriate paperwork.

5.2.1 In the event that there is insufficient time prior to the patient's release, the Regional Release Planning Manager and MHD, or designee, shall assist the Mental Health Lead at the Complex where the patient currently resides in determining the appropriate release plan available.

5.2.1.1 No patient shall be released directly from being on a mental health watch to the community without coordination with community mental health services.

5.2.2 If a patient refuses release planning, ask the patient to sign the Refusal to Submit to Treatment, Form 1101-4.

5.2.2.1 Patient shall be given a Community Resource Packet, which identifies the address and phone numbers of mental health agencies specific to the community where the patient plans to reside.



	Mental Health Technical Manual
	REFERENCES: DO 1101 Inmate Access to Health Care (Inmate Hunger Strikes); DO 125 Sexual Offense Reporting (Mental Health Services); DO 805 Protective Custody; DO 910 Inmate Education (Inmates with Disabilities); NCCHC MH-B-05, Response to Sexual Abuse
	Effective Date: 2/15/2024 Supersedes: 12/24/2019

Chapter 3, Section 16.0 Additional Delivery of Services

PURPOSE: To provide reference to policy and procedures relating to additional delivery of services by mental health clinicians and providers.

RESPONSIBILITY: It is the responsibility of the mental health clinicians and providers to familiarize themselves with the policies related to the interdisciplinary services discussed in this section.

1.0 Hunger Strike

1.1 A psychiatrist or psychologist shall complete a mental health assessment as to the patient's capacity to make decisions about his/her health care. There will also be an interdisciplinary clinical staffing panel to determine any potential issues and attempt to resolve them in accordance with MDSTM chapter P-F-01.04 Hunger Strike and Clinical Support.

2.0 PREA

2.1 Upon notification of an alleged sexual assault, sexual abuse or sexual harassment, a mental health clinician or psychiatric provider shall evaluate each patient to determine if crisis intervention or ongoing treatment is necessary. If it is after business hours, the Mental Health Duty Officer shall be contacted.

2.2 A mental health clinician shall speak directly and confidentially to all patients allegedly involved in the PREA event and complete the following:

2.2.1 Assess for danger to self or others

2.2.1.1 Place on mental health watch if individual is a danger to themselves or others.

2.2.2 Assess risk for victimization

2.2.2.1 Make appropriate recommendations to custody if individual is at risk for victimization.

2.2.3 Offer follow-up mental health services and schedule accordingly

3.0 Patients Requesting Protective Custody

3.1 No patient designated as SMI or under the age of eighteen (18) shall be placed into maximum custody, detention, or close management, or otherwise kept in a cell for more than twenty-two (22) hours each day.

3.2 Once a patient is formally placed in the Protective Custody review process, a mental health clinician shall be immediately notified by security staff.

3.3 The mental health clinician shall evaluate/interview every patient (regardless of MH score) no later than one (1) business day after notification, to determine risk of self-harm.

3.4 These patients shall be seen face-to-face in a confidential setting by their primary therapist every thirty (30) days or less during this process.

3.5 All patients designated as MH-3 and above formally placed in the Protective Custody Review Process shall receive segregation rounds at least weekly by mental health staff (not to include LPNs, CNA's, MH-clerks).

3.6 Segregation Rounds should include at a minimum:

3.6.1 Face-to-face contact including:

3.6.1.1 MH staff introduction

3.6.1.2 Patient acknowledgement of staff presence

3.6.1.3 Check-in with the patient regarding his or her well-being

3.6.1.4 Review of the process for accessing mental health services

3.6.2 Observation of cell cleanliness/odors

3.6.3 Observation of personal hygiene

3.6.4 Observation of affect and behavior

3.6.5 Observation of patient activity or lack thereof

3.6.6 Report any negative changes in behavior or appearance to mental health team immediately

3.6.7 Forward any requests for healthcare services to appropriate discipline

3.7 When a patient is denied Protective Custody or approved for alternate placement, a mental health clinician shall be immediately notified and evaluate the patient no later than one (1) business day after notification.

4.0 Work/Education Exemptions

4.1 Mental health clinicians shall not provide routine exemptions from patient work or mandatory education, but they may provide necessary information after a release of information has been completed by the patient.

4.1.1 Requests from a patient for exemptions from mandatory education shall be referred to the education department.

4.1.1.1 In the event that a request is sent to the health services staff from the education department, then the staff shall provide any necessary medical/mental health information to the education department.

4.1.1.2 The decision to exempt a patient from education is at the discretion of the education department but shall take into consideration the information provided by the healthcare staff.

4.1.2 Requests for any modification of work duty shall be done through the appropriate CO III and the Mental Health Lead.

Chapter 4, Section 1.0 Continuation of Psychotropic Medications for Reception Patients

PURPOSE: To provide direction regarding continuity of psychotropic medications for new ADCRR admissions.

RESPONSIBILITY: It is the responsibility of the P/PNP to continue psychotropic medications for patients new to ADCRR custody in accordance with the protocols of this section.

1.0 Medications can be prescribed for continuity of care for new ADCRR arrivals who have not been assessed by a P/PNP under the following circumstances:

1.1 Healthcare staff shall verify active psychotropic medication prescription(s) through one of the following:

1.1.1 Receipt of a continuity of care form from the referring facility

1.1.2 Documentation from a pharmacy

1.1.3 Current, properly labeled prescription bottles

1.1.4 Current and/or previous medical records

1.2 Once psychotropic medications are verified, a RN shall contact a P/PNP to obtain medication orders.

1.2.1 If medications cannot be verified the RN shall immediately contact a P/PNP for instructions.

1.3 For patients admitted to ADCRR on a psychotropic medication(s) which is not on ADCRR's formulary:

1.3.1 The medication shall be continued if, based on the patient's history, there is a significant risk of worsening of the condition if a different medication is prescribed.

1.3.2 If no such risk exists, the medication shall be continued long enough to allow a safe transition to a different medication or medications.

1.4 Formulary and non-formulary (excluding controlled substances), can be continued for up to thirty (30) days without a non-formulary request.

1.4.1 If an electronic medical record is not utilized at the facility, then Healthcare staff shall attach a copy of the means of verification to the prescription sent to the Vendor's pharmacy.

1.5 A psychiatric appointment shall be scheduled within thirty (30) days of the medication order.

2.0 For all patients who arrived to a state prison facility with active prescriptions for psychotropic medications who are assessed by a P/PNP upon arrival:

2.1 Healthcare staff shall verify active psychotropic medication prescriptions through one of the following:

2.1.1 Receipt of a continuity of care form from the referring facility

2.1.2 Documentation from a pharmacy

2.1.3 Current, properly labeled prescription bottles

2.1.4 Current and/or previous medical records

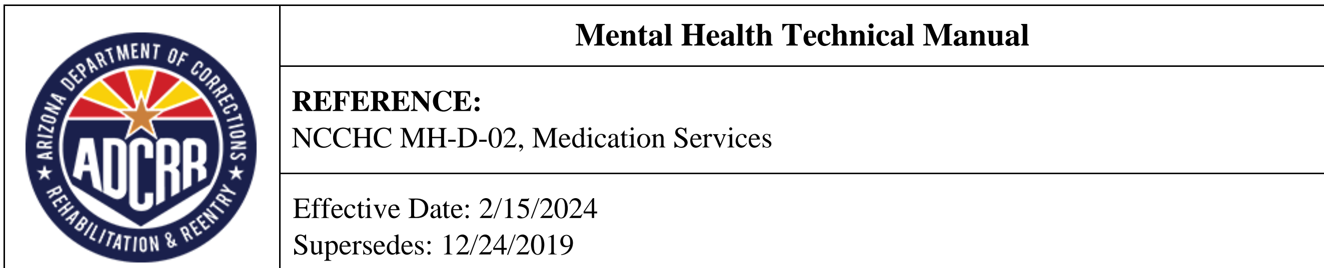
2.2 Formulary and non-formulary psychiatric prescriptions (excluding controlled substance), can be continued for up to ninety (90) days.

2.2.1 If an electronic medical record is not utilized at the facility, then Healthcare staff shall attach a copy of the means of verification to the prescription sent to the Vendor's pharmacy.

2.2.2 Non-formulary prescriptions can be continued on patients who are seen, without a non-formulary request.

2.2.2.1 Non-formulary prescriptions with duration in excess of ninety (90) days shall require completion of a non-formulary request form.

2.3 Starting a new non-formulary medication shall require completion of a non-formulary request form.



	Mental Health Technical Manual
	REFERENCE: NCCHC MH-D-02, Medication Services
	Effective Date: 2/15/2024 Supersedes: 12/24/2019

Chapter 4, Section 2.0 Psychotropic Medication Protocol

PURPOSE: To provide direction regarding monitoring, assessing, and prescribing psychotropic medications by authorized medical personnel.

RESPONSIBILITY: It is the responsibility of all authorized medical personnel to act in accordance with this policy.

1.0 The ADCRR formulary for psychotropic medications will be no broader than the formulary used by AHCCCS.

2.0 Prior to ordering psychotropic medications, all patients shall be assessed to determine pharmacologic treatment appropriateness. Laboratory tests, psychiatric diagnosis, clinical benefits and risks, drug-drug interactions, comorbid illness, age, pregnancy, and prior medication trials are examples of clinical elements use to determine pharmacologic treatment appropriateness.

2.1 Psychiatric diagnosis shall be determined by one or more of the following:

2.1.1 Full psychiatric evaluation

2.1.2 Psychiatric progress note

2.1.3 Psychological testing

2.1.4 Review of prior ADCRR medical records

2.1.5 Review of community mental health records

3.0 If psychotropic medications are prescribed, the psychiatric/medical provider shall routinely assess and monitor treatment efficacy, adverse reactions, drug interactions, resulting medical sequelae, patient safety, and laboratory studies.

4.0 Certain psychotropic medication classes (Stimulants, Antidepressants, Antipsychotics, Mood Stabilizers, Antianxiety agents) may require specific laboratory tests, routine laboratory tests, monitoring, and physical assessments.

4.1 All prescribing psychiatric/medical providers shall follow such guidelines as indicated by pharmaceutical manufacturer(s), FDA, and/or clinical standards.

4.2 The following list of laboratory tests and physical assessments shall be used, as clinically indicated, when monitoring psychotropic medications (not an inclusive list). The frequency of monitoring/use is established by clinical standards, FDA, and/or pharmaceutical manufacturer(s).

4.2.1 Abnormal Involuntary Movement Scale (AIMS)

4.2.1.1 Completed when increasing dose of antipsychotic medication.

4.2.1.2 Completed at a minimum of every six (6) months.

4.2.2 ECG/EKG

4.2.3 Lithium level

4.2.4 Depakote level

4.2.5 Liver function tests

4.2.6 Vital signs

4.2.7 Thyroid Function tests

4.2.8 Complete Metabolic Panel

4.2.9 Complete Blood Cell count with or with Differential

4.2.10 Lipid studies

4.2.11 Blood glucose, HbA1c

5.0 The P/PNP shall use a psychiatric progress note or full psychiatric evaluation note to document the following clinical information:

5.1 S.O.A.P.E

5.2 DSM 5-TR Diagnosis

5.3 Clinical rationale for psychopharmacologic treatment

5.4 Medication education

5.5 Medication consent

5.6 Plan for monitoring as recommended by FDA

5.7 Review of laboratory results, if clinically indicated

5.8 Review of echocardiogram results, if clinically indicated

5.9 Review of medication administration record(s), if clinically indicated

5.10 Review of medical illness; active, chronic, and/or past

6.0 The P/PNP shall prescribe medication utilizing the EHR (or paper chart where utilized), or provide a RN with a telephone order for the planned prescriptions.

6.1 Ensure, in conjunction with pharmacy and nursing staff, that the prescription is accurate, complies with duration guidelines, complies with dispensing guidelines, complies with non-formulary protocols, and patient receives the psychotropic medication within a medically appropriate period.

7.0 When administering psychotropic medication to a voluntary patient, the nurse responsible for administering the medications and documenting patient's compliance shall:

7.1 Only administer active psychotropic medication(s); expired or discontinued medication shall not be administered.

7.2 Document on the MAR all psychotropic medication administered

7.3 Document on the MAR all psychotropic medications refused.

7.4 Inform the P/PNP of psychotropic medication adverse reactions, and document the information on a progress note.

7.5 If an electronic medical record is not being utilized at the facility, then the nurse must also:

7.5.1 Transcribe each medication order onto the MAR.

7.5.2 Bracket, after transcribing the orders, all orders in RED and write "noted," followed by the date, time, the healthcare staff's name and title.

7.6 Keep all psychotropic medication in containers bearing the Pharmacist's original label and store it in a securely locked medicine cabinet where the institution's prescription medications are stored and dispensed.

8.0 Medication Administration

8.1 Psychotropic medication(s) shall be administered by one of the following routes, as ordered by the P/PNP:

8.1.1 Oral

8.1.1.1 Pill, tablet, wafer, liquid

8.1.1.2 Crush and float

8.1.1.3 Sublingual and buccal

8.1.2 Injection

8.1.3 Rectal

8.1.4 Nasal

8.1.5 Optic

8.1.6 Ocular

8.1.7 Transdermal

8.1.8 Cutaneous

8.2 Psychotropic medication(s) shall be administered under one of the following styles/ observations as ordered by the P/PNP:

8.2.1 Directly Observed Therapy (DOT)

8.2.1.1 Prescribed medications for DOT administration shall be administered as ordered.

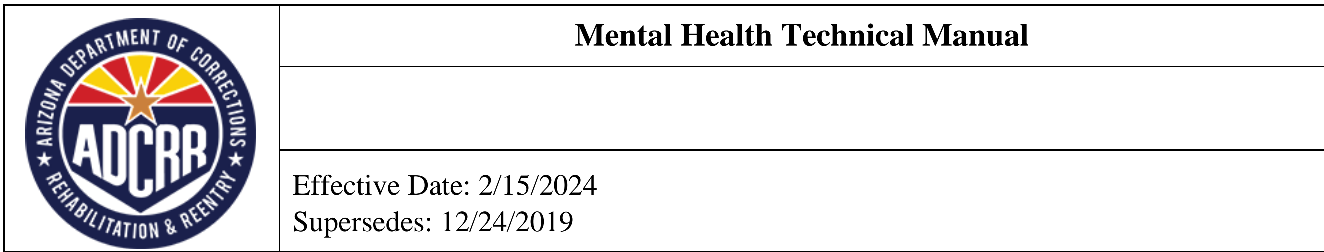
8.2.1.1.1 There shall be documentation if there is a valid reason for non-administration and shall include the identity of the administrator.

8.2.1.2 DOT can only be discontinued with written orders from the P/PNP.

8.2.1.3 All medications dispensed to a patient on a mental health watch shall be DOT.

8.2.1.4 Any health care prescriber may place a patient on DOT if he or she suspects that the patient may not take the medication as prescribed.

8.2.2 Keep-On-Person (KOP)



	Mental Health Technical Manual
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Chapter 4, Section 3.0 Psychotropic Prescription Duration

PURPOSE: To outline the processes and timelines under which a prescription for psychotropic medications can be authorized.

RESPONSIBILITY: The P/PNP is responsible for acting in compliance with the prescription writing processes outlined in this section.

1.0 Psychotropic medication prescriptions shall not exceed duration of more than six (6) months.

2.0 For patients on multiple medications:

2.1 When a P/PNP makes prescription adjustments or prescribes new medication(s), the expiration date shall match the expiration date of current psychotropic medications.

3.0 Release prescription(s) shall be provided for a sufficient length of time to allow the patient to obtain and attend an appointment with a community practitioner qualified to order a new supply. Patients shall be released with no less than a thirty (30) day supply.

Chapter 4, Section 4.0 Registered Nurse Interim Follow-up

PURPOSE: To outline the procedures under which a P/PNP may order a RN to assess a patient's health.

RESPONSIBILITY: The RN is responsible to conduct the ordered assessment in accordance with the protocols outlined in this section.

1.0 The P/PNP may order a formal patient follow-up by the RN.

2.0 The RN shall complete patient assessments within the ordered time frame designated by the P/PNP. If clinically indicated, the RN may also assess patients without a P/PNP order. The encounter may include assessment of one or more of the following:

- 2.1 Vitals
- 2.2 Current symptoms
- 2.3 Medication efficacy
- 2.4 Presence or absence of adverse reactions
- 2.5 Risk assessment (danger to self or others, ability to function in current environment)
- 2.6 Chronic medical illness
- 2.7 Acute medical illness
- 2.8 Medication refusal(s)
- 2.9 Appointment refusal(s)
- 2.10 Heat intolerance/insensitivity
- 2.11 Patient education

3.0 Once the RN assessment is complete, he/she shall determine if the clinical findings need to be staffed with the treating P/PNP or medical provider. Examples of clinical findings requiring P/PNP staffing include:

3.1 Acute psychiatric symptoms

3.2 Acute safety concerns

3.3 Increase of patient risk for harm to self and others

3.4 Adverse reactions

3.5 Medication diversion

3.6 Heat intolerance/insensitivity secondary to psychotropic medications

3.7 Acute medical illness

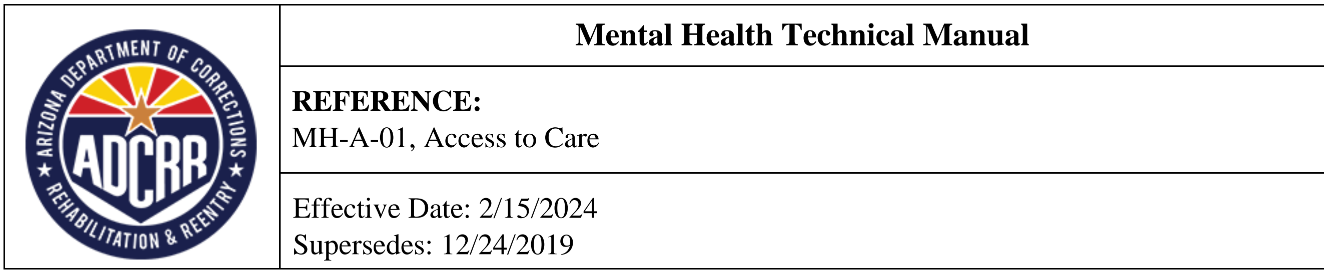
3.8 Abnormal vitals or laboratory results

4.0 If the treating P/PNP is not available and clinical findings are urgent, the RN shall staff the patient's case with an alternate P/PNP, medical provider, Urgent Response P/PNP, or Regional Psychiatric Director.

5.0 The RN shall document the patient encounter and P/PNP staffing in the medical record. The documented encounter shall be sent to the appropriate P/PNP, medical provider, Urgent Response P/PNP, or Regional Psychiatric Director for review.

6.0 If the RN does not identify acute or urgent clinical concerns, and no medical intervention is required, the patient shall follow-up with the P/PNP as previously ordered. The RN may provide additional interim follow-up with the patient prior to the patient's next contact with the P/PNP.

7.0 If clinically indicated, the RN shall schedule the patient with a P/PNP within five (5) days of the RN encounter.



	Mental Health Technical Manual
	REFERENCE: MH-A-01, Access to Care
	Effective Date: 2/15/2024 Supersedes: 12/24/2019

Chapter 4, Section 5.0 Protocols for Referral of Patients for Psychiatric Services

PURPOSE: To provide a standardized protocol for P/PNP referrals.

RESPONSIBILITY: It is the responsibility of the healthcare staff to operate in accordance with the protocol outlined in this section.

1.0 All referrals for psychiatric care shall be triaged and addressed by the patient's primary therapist within twenty-four (24) hours of receipt.

2.0 Upon receipt of a psychiatric referral with urgent concerns, the patient shall be seen by a P/PNP the same day.

3.0 Upon receipt of a psychiatric referral with non-urgent concerns, the patient shall be seen by a P/PNP within five (5) business days.

3.1 Requests for the adjustment of medication administration time (AM to PM, noon, or PM to AM) do not require a psychiatry assessment.

3.1.1 If a written HNR request to change medication administration time, the P/PNP shall review prescribed medication(s), provide patient education regarding medication administration times and change the administration time if clinically appropriate.

3.1.1.1 If treating P/PNP is not available, an alternative P/PNP or the Regional Psychiatric Director should be contacted.

Chapter 4, Section 6.0 Procedures for Voluntary Use of Psychotropic Medications

PURPOSE: To provide guidance to a P/PNP for prescribing psychotropic medications to voluntary patients as clinically indicated for the treatment of a psychiatric illness and/or reducing the risk of harm as the result of a psychiatric illness.

RESPONSIBILITY: The P/PNP is responsible for prescribing medications in accordance with departmental policy and protocols.

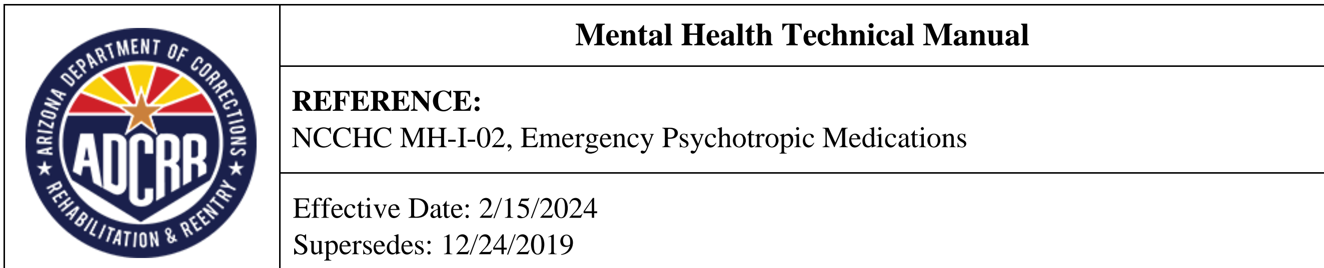
1.0 When prescribing psychotropic medication(s) to a voluntary patient, the P/PNP shall:

1.1 Determine if a psychiatric illness is present, psychopharmacologic treatment is indicated, benefits of treatment outweigh associated risks, and if prescription medication is appropriate at the time of the patient encounter.

1.2 Complete an Informed Consent for Psychotropic Medication (Form #1103-12).

1.2.1 If the patient declines to sign the consent form, healthcare staff shall write, "Refused to sign" on the patient signature line.

1.2.2 If an approved medication specific consent form for the proposed medication is available, it should be utilized in place of Form #1103-12.



	Mental Health Technical Manual
	REFERENCE: NCCHC MH-I-02, Emergency Psychotropic Medications
	Effective Date: 2/15/2024 Supersedes: 12/24/2019

Chapter 4, Section 7.0 Procedures for Involuntary Use of Psychotropic Medications

PURPOSE: To provide guidance to P/PNP (or other providers when necessary) for involuntary or emergency administration of psychotropic medications to incarcerated individuals when clinically indicated as a means of treating a psychiatric illness or urgently reducing harm, dangerousness, or severe violence towards self or others.

RESPONSIBILITY: The P/PNP is responsible for determining if a psychiatric illness is present, urgent psychopharmacologic intervention is indicated, benefits of treatment outweigh associated risks, prescription medication is appropriate at the time of the patient encounter and if involuntary administration is necessary to reduce harm, violence, and further severe decompensation secondary to a psychiatric illness.

1.0 Involuntary Administration of Psychotropic Medications – Emergent

1.1 A P/PNP (or another attending Physician/Nurse Practitioner/Physician Assistant if P/PNP is unavailable) may order involuntary administration of emergency psychotropic medication if the P/PNP (or attending Physician, NP, PA) clinically reviews or directly assesses patient and determines:

1.1.1 Presence of serious imminent danger to one's self, others, and/or violence as a result of a psychiatric illness.

1.1.1.1 Danger to self – behavior that, as a result of a psychiatric illness, constitutes a danger of inflicting serious physical harm on oneself, including attempted suicide or the serious threat thereof, if the threat is such that, when considered in the light of its context and in light of the individual's previous acts, it is substantially supportive of an expectation that the threat will be carried out.

1.1.1.2 Danger to others – the judgement of a person who has a psychiatric illness is so impaired that the person is unable to understand the person's need for treatment and as a result of the person's psychiatric illness the person's continued behavior can reasonably be expected, on the basis of competent medical opinion, to result in serious physical harm of another person.

1.1.2 Benefit(s) of involuntary administration of psychotropic medication(s) outweigh the associated risk(s) of pharmacological intervention.

1.1.3 At the time of emergency, the patient does not exhibit the capacity to manage the psychiatric emergency.

1.1.4 Alternative methods of confinement or restraint are inadequate.

1.1.5 Involuntary administration of psychotropic medication is clinically indicated, as a last resort, to immediately reduce serious imminent danger.

2.0 Involuntary Administration of Psychotropic Medications – Non-Emergent

2.1 Involuntary administration of psychotropic medication during a non-emergent situation requires the following:

2.1.1 Psychotropic Medication Review Board (PMRB) – an internal board consisting of a non-treating psychiatrist, a non-treating psychologist and a non-treating psychology associate.

2.1.1.1 Board chair shall be the non-treating psychiatrist.

2.1.1.2 The treating psychiatric provider shall present the case.

2.1.1.3 The patient has the right to the assistance and presence of a lay advisor in the form of the patient's correctional officer.

2.1.1.4 The committee shall determine, by a majority vote, if the criteria listed in 2.2 have been met.

2.1.1.4.1 The non-treating psychiatrist must be in the majority.

2.1.1.5 If all criteria for involuntary administration of psychotropic medication are present, the board shall decide whether or not to approve the request for involuntary treatment(s).

2.2 Clinical criteria for PMRB hearing:

2.2.1 The patient suffers from a DSM 5-TR psychiatric illness.

2.2.2 The patent does not exhibit the capacity to make mental health decisions.

2.2.3 The patient has a grave disability and/or is persistently or acutely disabled secondary to a psychiatric illness and is unable to provide for his/her own basic physical needs.

2.2.4 The patient is severely impaired and/or the patient's symptoms/behaviors present a likelihood of serious harm to self or others, secondary to a psychiatric illness.

2.2.4.1 Severely impaired – a significant deterioration in cognitive functioning, physical health, reality testing, or volitional control over actions.

2.2.4.2 Serious harm to self or others – action or lack of action resulting in bodily harm or risk to health or safety.

2.2.5 There is a substantial likelihood that psychotropic medication will ameliorate the patient's condition.

2.2.6 The prescribed psychotropic medications will likely reduce suffering, risk, and improve clinical outcomes.

2.2.7 The patient has been offered pharmacological psychiatric treatment(s) and has refused the opportunity to voluntarily participate in the pharmacological treatment plan.

2.3 Procedural Timelines

2.3.1 Notification of Intent – A mental health staff member shall provide the patient at least twenty-four (24) hours written notice (excluding weekends and holidays) of the intent to convene an involuntary medication hearing before a PMRB, during which time the patient may not be involuntarily medicated (unless in an emergency situation).

2.3.1.1 The Notification of Intent to Request Approval for Involuntary Medication (Form #1103-15P) shall include the treating P/PNP's tentative psychiatric diagnosis, factual basis for the diagnosis, examples of impairment, examples of danger to self and/or others, examples of patient treatment refusal, pertinent medical illness associated with psychiatric decompensation, clinical evidence that supports the use of psychotropic medication, and a statement as to why the involuntary administration of medication is necessary.

2.3.1.2 The form shall be distributed as follows: White copy to Legal/Administrative section of patient medical record, Canary copy to Mental Health Lead, and Pink copy to patient.

2.3.2 Scheduled PMRB – The Mental Health Lead, or designee, shall schedule a PMRB meeting between twenty-four (24) hours and seventy-two (72) hours (excluding weekends and holidays) of the patient's receipt of the Notification of Intent to Request Approval for Involuntary Medication Form.

2.3.2.1 The patient shall be notified of the PMRB hearing using the Psychotropic Medication Review Board Notification of Hearing and Patient's Rights (Form #1103-1P) which shall include the date and time of the hearing.

2.3.2.1.1 The patient has the right to attend or refuse to attend the hearing. If after encouragement the patient refuses to attend the hearing it shall be documented on the Finding of the Psychotropic Medication Review Board (Form #1103-2P).

2.3.2.1.2 At the discretion of the PMRB panel, the patient may present evidence and cross-examine witnesses.

2.3.2.2 The Mental Health Lead, or designee, shall distribute the form to the patient's Correctional Officer III (COIII), the treating P/PNP, and the PMRB members of the hearing.

2.3.2.3 The form shall be distributed as follows: White copy – Legal/Administrative section of patient medical record, Green copy - treating P/PNP, Canary copy - Deputy Warden or Associate Deputy Warden, Pink copy - patient's COIII, and Goldenrod copy – patient.

2.3.3 Notification of Results – The patient shall be informed of the Board results within eight (8) hours via receipt of the Finding of the Psychotropic Medication Review Board (Form #1103-2P).

2.3.4 Appeal of PMRB Decision – The patient may appeal the Board's decision to the MHD (or designee) by notification via a patient letter, within twenty-four (24) hours (excluding weekends and holidays) of receipt of the PMRB's decision.

2.3.4.1 The patient letter shall be electronically sent to the MHD, or designee, along with copies of relevant P/PNP documentation and the Findings of Psychotropic Medication Review Board Form.

2.3.4.2 The MHD, or designee, shall decide the outcome of the appeal and notify the Mental Health Lead, or designee, of the decision, via electronic transmission, within twenty-four (24) hours of receipt (excluding weekends and holidays).

2.3.4.3 Within four (4) hours of receipt of the MHD's decision, the Mental Health Lead, or designee, shall provide copies of the decision to the patient, the patient's COIII, the treating P/PNP, and the PMRB chair.

2.3.4.4 During the appeal period, in the absence of an emergency as defined in this Section, the patient shall not be involuntarily medicated.

2.3.4.5 In the event that the appeal is upheld, the patient shall not be involuntarily medicated unless there is an emergency as defined in this Section, or by a Court order.

2.3.5 New Hearing After Appeal Upheld – The treating P/PNP may request a new involuntary medication hearing no sooner than fourteen (14) working days after the appeal is upheld.

2.3.6 PMRB Approval for Involuntary administration of psychotropic medications: In the absence of an emergency, a patient may receive involuntary administration of psychotropic medication, for a maximum of one hundred and eighty (180) days.

3.0 Follow-up contacts after PMRB

3.1 If the PMRB approves involuntary administration of psychotropic medication, and there is no upheld appeal, the patient’s current treatment team shall review the patient's case within ninety (90) days and approve or disapprove, by use of the criteria cited in this Order, the continuance of involuntary medication for an additional ninety (90) days.

3.1.1 The treatment team’s decision is final and not subject to appeal.

3.2 The laboratory tests shall be a component of the PMRB process and can be conducted against the patient’s will if necessary.

3.2.1 If laboratory tests or medication administration must be conducted against the patient’s will and require a planned use of force, clinical intervention shall be provided by mental health in accordance with DO 804.

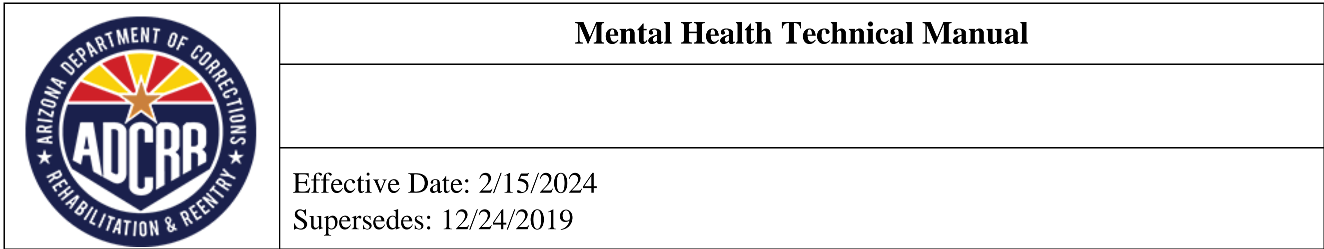
3.3 At any time that the patient becomes compliant with his medication(s) and agrees to voluntary administration, the treating P/PNP shall so note in the patient's medical record, though the PMRB order shall remain in effect unless rescinded by the PMRB or it expires.

3.3.1 The P/PNP shall meet with the patient a minimum of every thirty (30) days while there is an active PMRB order.

3.4 At the end of the one hundred and eighty (180) day involuntary medication period, the PMRB order for involuntary medication shall expire.

3.4.1 The treating P/PNP may, pursuant to the criteria above, again seek authorization to involuntarily medicate the patient with psychotropic medication.

4.0 Medications administered involuntarily shall be documented in the same way as medication administered voluntarily. The injections shall be clearly documented on the MAR, including location of injection.



Chapter 4, Section 8.0 Protocols for Psychiatric Services at Non-Corridor Complexes

PURPOSE: To provide guidance regarding the processes for provision of psychiatric services to patients housed at non-corridor complexes.

RESPONSIBILITY: The Mental Health Lead at the non-corridor facility is responsible for coordinating the psychiatric services and/or requesting the transfer of patients to an appropriate corridor facility as clinically indicated.

1.0 Patients with assigned Mental Health scores of MH-3C and MH-3E, who otherwise meet the custody classification requirements, may be housed at non-corridor facilities.

2.0 Telemedicine appointments may be scheduled where appropriate, following Telemedicine Technical Manual procedures.

3.0 MH-1, MH-2, MH-3E identified by mental health staff as needing a psychiatric evaluation or psychiatric care shall be scheduled for the next P/PNP's appointment line.

4.0 Each non-corridor facility shall have a corridor facility with which they are affiliated for purposes of psychiatric coverage.

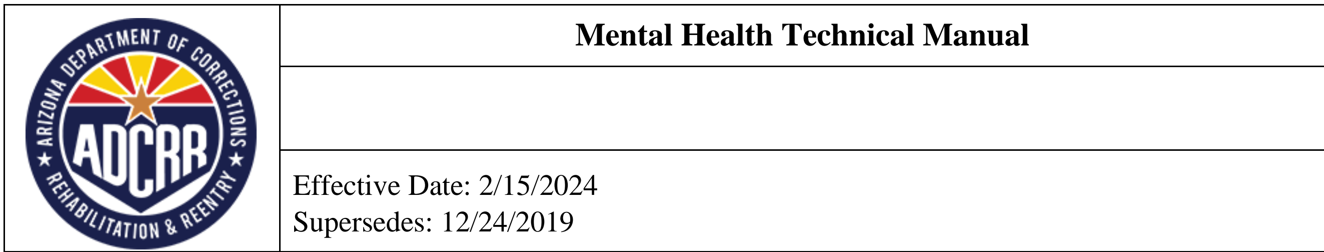
5.0 Procedure for patients being placed on watch.

5.1 Patients being placed on watch shall be assessed by psychiatric practitioner as soon after placement but not longer than one (1) business day.

5.2 Patients being placed on watch who require an increase to level MH-3B or above shall be transported to the appropriate facility by security staff from the sending unit.

5.3 The affiliated corridor complex shall provide emergency support services to the designated non-corridor complex.

5.4 Affiliations for outlying facilities shall be designated by the Vendor's Administration in consultation with the MHD, or designee.



Chapter 4, Section 9.0 Discontinuation of Psychotropic Medication

PURPOSE: To provide direction regarding the protocols and personnel involved in the timely initiation and assessment of patients who are refusing psychotropic medications or whose psychotropic medications have been discontinued.

RESPONSIBILITY: It is the responsibility of the P/PNP assigned to each complex to ensure the appropriate treatment and subsequent follow-up of any abrupt, unexpected, or planned discontinuation of psychotropic medication.

1.0 Clinical events, at the discretion of the P/PNP, that may lead to the discontinuation of psychotropic medications, after face-to-face visit include:

1.1 Intolerable adverse reactions;

1.2 Pregnancy;

1.3 Laboratory studies;

1.4 Drug-to-drug interactions;

1.5 Medication diversion;

1.6 Onset of complicating medical comorbidity;

1.7 Iatrogenic mental status change;

1.8 Substance intoxication / abuse / dependence;

1.9 Patient request (via communication with health staff verbally or by written HNR);

1.10 The absence of, or clinically inappropriate low, serum blood levels of prescribed psychotropic medications;

1.11 Refusal of three consecutive medication administrations; or

1.12 Refusal of two (2) P/PNP appointments.

2.0 Procedure

2.1 Emergent situations may warrant immediate discontinuance of medications such as urinary retention, acute change in mental status, suspicions of Neuroleptic Malignant Syndrome, suspicions of Serotonin Syndrome, or critical labs.

2.1.1 The patient shall be seen immediately by either a medical/psychiatric provider or an RN.

2.1.1.1 If the patient is assessed by an RN, the RN shall contact a P/PNP and staff the case. The RN shall note all verbal orders and document the clinical occurrence in the medical record.

2.1.2 Discontinuing medications following a face-to-face interaction, nurse triage, provider staffing, or critical / emergent event, shall prompt the responsible P/PNP to document reasons for the immediate discontinuation, treatment plan to address emergent situation, and the formal plan for follow-up.

2.1.3 When psychotropic medications are stopped abruptly secondary to an emergent situation, follow-up care by a P/PNP shall occur within three (3) business days.

2.2 For all planned medication discontinuations, the patient shall be seen by a P/PNP for an evaluation, and the reasons for the discontinuation shall be clearly documented in the medical record.

2.2.1 For patients who are no longer on any psychotropic medications, they shall be seen again by a P/PNP no more than thirty (30) days after the discontinuation of the medications.

2.2.2 For patients who are still on at least one psychotropic medication, the P/PNP shall document a formal plan for follow-up related to the discontinued medication(s).

2.3 If patient refuses to attend their psychiatric appointment, then the P/PNP shall document in the medical record a formal plan for follow-up to include a required contact by a psychiatric RN or a mental health clinician.

2.3.1 If clinically indicated, the P/PNP may write an order for continuance of medication up to a thirty (30) day period and set a new return to clinic appointment within thirty (30) days.

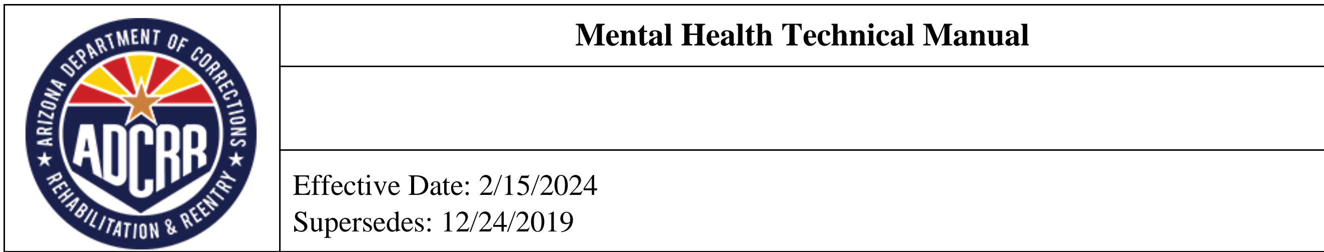
2.3.2 If clinically indicated, P/PNP may discontinue medications immediately and schedule return to clinic appointment within thirty (30) days.

3.0 It is the responsibility of the P/PNP to notify the mental health team that a patient is no longer prescribed psychotropic medications.

3.1 The provider shall schedule a psychologist review appointment.

3.2 The P/PNP is also required to change the mental health score to a MH-3D (unless the patient is SMI or in a Residential/Inpatient Treatment Program).

4.0 Upon the discovery of any unplanned discontinuation of psychotropic medication, the patient shall be seen immediately by a mental health clinician or an RN to determine if the patient needs to be placed on watch or referred to psychiatry for a same day visit.



	Mental Health Technical Manual
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Chapter 4, Section 10.0 Management of Photosensitivity Reactions to Medications

PURPOSE: To provide direction regarding the management of medication-induced photosensitivity.

RESPONSIBILITY: It is the responsibility of the P/PNP, medical provider, and/or RN, to assess all suspected medication-induced sunburns and duly act in accordance with the protocols outlined in this section.

1.0 All suspected cases of medication-induced sunburn, shall be verified by direct clinical examination by medical staff. Health record documentation shall support an unequivocal diagnosis of significant sunburn (to include erythema at a minimum), via progress note and/or physical assessment.

2.0 If the P/PNP, or medical provider, determines that the rash is consistent with medication-induced photosensitivity, the P/PNP shall meet with the patient and discuss management options.

2.1 These options include, but are not limited to:

2.1.1 Switch psychotropic medications

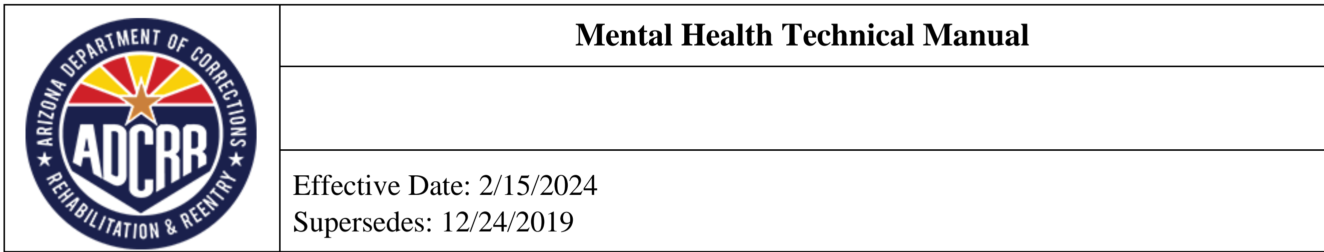
2.1.2 Avoid excessive skin exposure to sunlight

2.1.3 Sun protection to include sunscreen and/or protective clothing provided free of charge to the patient

2.1.4 Psychiatric prescriber initiating a Special Needs Order (SNO) that limits any work assignments in the sun/heat

2.1.5 Psychiatric prescriber initiating SNO for ice

3.0 For cases in which the P/PNP and patient agree that switching psychotropic medications is not desirable, the patient shall be counseled as to proper use of sunscreen. The P/PNP shall order sunscreen for the patient (minimum SPF 30).



Chapter 4, Section 11.0 Management of Heat Intolerance Reactions to Medications

PURPOSE: To provide direction regarding the management of heat intolerance and psychotropic medications.

RESPONSIBILITY: It is the responsibility of the P/PNP, and/or RN, to assess heat intolerance in combination with psychotropic medications and duly act in accordance with the protocols outlined in this section.

1.0 The Mental Health Lead will consult with Complex Administration to identify patients who may need additional monitoring and services during periods of extreme heat.

2.0 All cases of suspected Heat Intolerance shall be verified by direct clinical examination by medical staff.

3.0 Medical staff shall document in the medical record their clinical examination, pertinent laboratory findings, and the unequivocal diagnosis of hyperthermia (body temperature above 99.5 degrees Fahrenheit), heat stroke, heat exhaustion, or orthostatic hypotension (drop of 20mm Hg or greater on rising).

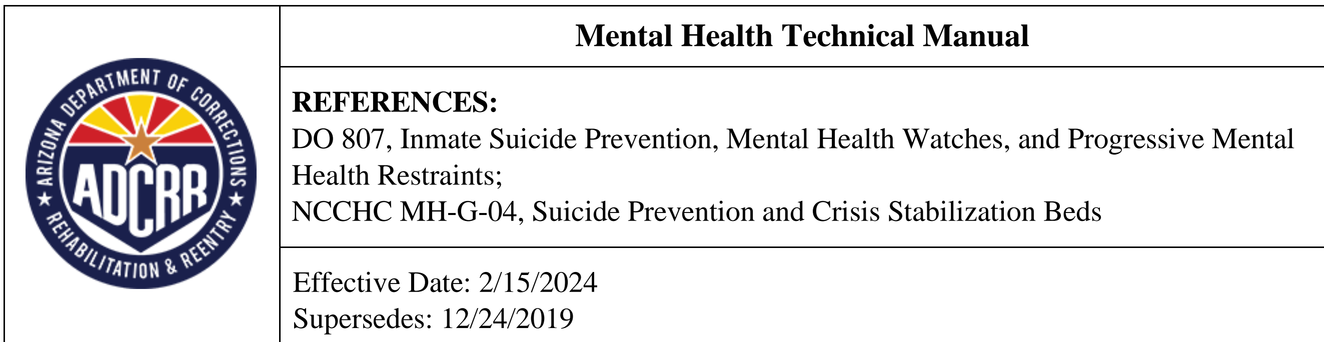
4.0 If the patient is prescribed psychotropic medication by the P/PNP, medical staff shall refer the patient for additional psychiatric management.

  4.1 The P/PNP assessment shall occur within five (5) days of the referral.

5.0 If the P/PNP determines that the psychotropic medication is contributing to heat intolerance, the P/PNP shall meet with the patient and discuss treatment alternatives.

6.0 For cases in which the P/PNP and patient agree that alternative treatment options are not appropriate, the P/PNP shall consult with the medical provider regarding a duty status, including issuing special clothing, to minimize heat exposure.

7.0 If all reasonably available steps have been taken to prevent heat injury or illness and the symptoms continue, the patient shall be transferred to a housing area where there is adequate cooling to maintain the health of the patient.



	Mental Health Technical Manual
	REFERENCES: DO 807, Inmate Suicide Prevention, Mental Health Watches, and Progressive Mental Health Restraints; NCCHC MH-G-04, Suicide Prevention and Crisis Stabilization Beds
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Chapter 5, Section 1.0 Mental Health Watch Protocol

PURPOSE: To provide direction regarding mental health watches for patients displaying suicidal ideation, suicidal gestures, homicidal ideation, and/or bizarre behavior.

RESPONSIBILITY: It is the responsibility of all mental health clinicians and providers to assign the appropriate level of mental health watch/crisis stabilization bed to patients in crisis.

1.0 Mental health watch/Crisis stabilization beds shall be used for short term (typically only a few days) management of patients who require acute care, e.g., suicide watch.

2.0 All individuals assessed to need Inpatient Level of Care at Intake shall be placed on watch until they can be transferred to the Inpatient Treatment Unit.

3.0 A face-to-face assessment is required when placing a patient on any level of mental health watch.

3.1 During normal business hours, a patient who presents as a suicide risk shall have a formal in-person suicide risk assessment completed by a licensed psych associate, psychologist, or psychiatric practitioner to determine the acute suicidal risk and the level of protection that is needed.

3.2 The face-to-face assessment can be completed by any of the following:

3.2.1 A mental health clinician or provider; or

3.2.2 A medical/mental health RN if it is after regular business hours (weekends, nights, or holidays).

3.3 If the assessment is not completed by a clinician or provider, then the RN (medical or mental health) shall attempt to obtain verbal orders from a Mental Health Duty Officer immediately.

3.3.1 The patient is to be placed on a Continuous Mental Health Watch until mental health conducts a face-to-face suicide risk assessment with the patient.

3.3.1.1 For patients placed on watch for suicidal concerns, a suicide risk assessment shall be completed upon admission that identifies risk and protective factors and items/privileges they are allowed (based on treatment needs) while on mental health watch.

3.3.1.2 Upon a face-to-face assessment being completed by a Mental health clinician or P/PNP, watch orders can be changed to the clinically appropriate level.

4.0 The patient shall be assessed by a psychiatric practitioner as soon after admission as possible, but no longer than one (1) business day, in order to ensure there is not a medication issue or a question of medication appropriateness that contributed to suicidal ideation. The assessment is to be documented in the medical record.

5.0 For any patient placed on mental health watch for bizarre behavior, in order to ensure there is not an underlying medical cause for the patient's presentation, an RN shall triage the patient immediately, either by seeing the prisoner, or talking to the prisoner directly over the phone and then discuss the patient with a medical practitioner (i.e., physician, nurse practitioner, or physician assistant) in a clinically appropriate timeframe, not to exceed four (4) hours.

6.0 Patients in a crisis stabilization bed/watch beds shall be evaluated at least daily in person by their PT (or another psych associate if they have not yet been assigned a PT or have transferred from another yard). Treatment providers shall document their intervention efforts, including but not limited to:

6.1 Assessing mental status; behavioral observations; documenting patient ability to independently care for activities of daily living; type(s) of treatment provided; response to interventions (including medication efficacy and compliance); anticipated length of stay; and criteria for discharge.

7.0 Continuous Mental Health Watch:

7.1 Mental health clinicians or providers shall order a Continuous Watch when a patient has demonstrated signs or symptoms of significant mental disorder or is acting in a manner indicating imminent suicide risk or risk to others.

7.1.1 This watch is for patients whose mental status has deteriorated and are considered acutely suicidal (actively engaging in self-injurious behavior and/or threatening suicide with a specific plan). Any gesture or attempt to self-harm shall necessitate a continuous watch for a minimum of one (1) calendar day.

8.0 15 Minute Mental Health Watch:

8.1 Mental health clinicians or providers shall order a 15-Minute Watch when a patient has demonstrated signs or symptoms of significant mental disorder and is acting in a manner indicating high suicide risk and/or risk to harming others.

8.1.1 Any verbal or written communication indicating suicidal ideation (without a specific plan) by the patient shall at a minimum, necessitate a 15-Minute Watch.

9.0 Any deviation from the items required on the Mental Health Watch Order Form (807-1) shall only be approved by the MHD.

10.0 Only licensed mental health clinicians shall increase or reduce the level of observation and/or discontinue a watch.

10.1 All daily watch contacts shall be conducted in person, by a licensed mental health clinician or psychiatric provider in a confidential setting.

10.2 A clinical note shall be entered whenever the level of suicide watch is changed.

11.0 Monday through Friday, daily huddles composed of the primary therapist, mental health lead or designee, psychologist and psychiatric provider, shall be conducted to review all individuals on mental health watch.

11.1 Patients projected to remain on watch over the weekend or holiday shall be discussed during the daily huddle the day prior to the weekend or holiday.

11.2 The primary therapist shall document this review in the patient's EHR.

12.0 Continued treatment in a crisis stabilization bed/watch bed requires review and approval by a psychologist initially at seven (7) days and every three (3) days thereafter. Starting at ten (10) days following placement in a Crisis Stabilization bed/watch pod bed, the psychologist and/or psychiatric prescriber shall document the justification for their continued assignment to the Crisis Stabilization/watch bed rather than a Residential or Inpatient bed.

13.0 If at any time, a patient's behavior deteriorates or suicidal ideation or gestures increase, the level of watch shall be increased according to the policy outlined above.

14.0 For Complexes utilizing an electronic medical record, the Mental Health Watch Order Form (807-1) shall be scanned in by, and attached to the encounter of the staff member writing the watch order.

14.1 When the licensed mental health clinician makes a change to the level of watch, the canceled watch order and the new watch order shall be scanned in and attached to the documented contact within forty-eight (48) hours.

15.0 “Safety contracts” (verbal or written forms signed by patients, agreeing not to hurt themselves) shall not be used.

16.0 Transferring a patient in crisis to a different yard or complex can be clinically disruptive. When possible and safe, attempts shall be made to provide stabilization at the complex at which the patient has been housed unless there is documented clinical justification for transfer based on the low likelihood of stabilization and/or clinical danger if the patient is maintained at the complex.

17.0 An in-person, in-depth suicide risk assessment shall be completed with all patients prior to removing them from a mental health watch which documents:

17.1 The change/reduction in suicidal risk.

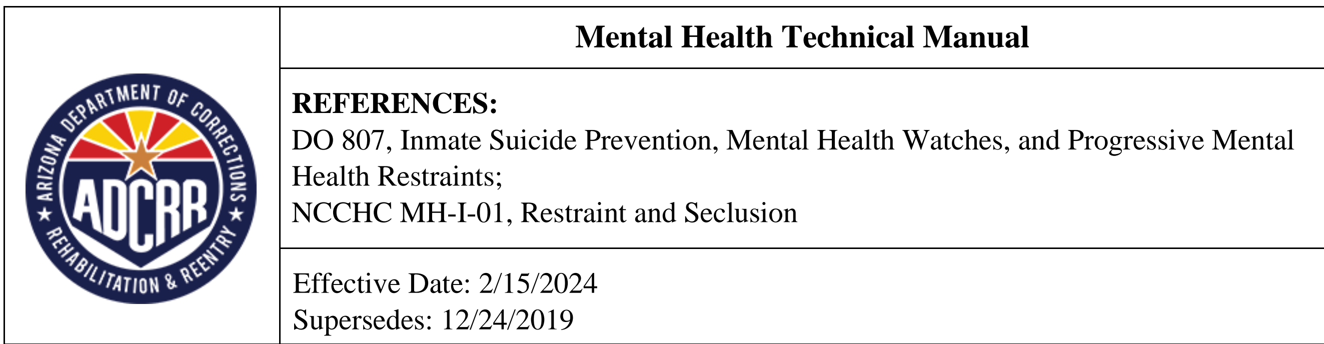
17.2 The patient’s identified protective factors.

17.3 Plans for follow-up treatment, including the timeline for follow-up in accordance with Chapter 5, Section 5.0.

17.4 All decisions to discharge patients from mental health watch shall be made by a treatment team composed of the primary therapist, psychologist and psychiatric provider.

15.4.1 The psychologist shall document this decision in a quick note in the patient’s EHR.

17.5 Aftercare including a safety plan developed in collaboration between the patient and treatment providers.



REFERENCES:
DO 807, Inmate Suicide Prevention, Mental Health Watches, and Progressive Mental Health Restraints;
NCCHC MH-I-01, Restraint and Seclusion

Effective Date: 2/15/2024
Supersedes: 12/24/2019

Chapter 5, Section 2.0 Progressive Mental Health Restraints

PURPOSE: To provide direction regarding the use of progressive mental health restraints.

RESPONSIBILITY: It is the responsibility of the healthcare staff to operate in accordance with the protocol outlined in this section.

1.0 Progressive Mental Health Restraints

1.1 Restraints shall be used only to prevent harm to one's self and/or others and to ensure the safety of the staff and other patients. They shall not be used for punishment.

1.2 Restraints shall only be applied for the minimum amount of time necessary to accomplish the stated need (e.g., patient and staff safety, requisite transports, etc.).

1.3 The use of restraints shall only be authorized and reviewed in a progressive fashion by a psychologist or P/PNP.

1.3.1 Restraints shall not be used for more than four (4) hours at a time.

1.3.2 Every effort shall be made to minimize the length of time in restraints.

1.3.3 Renewal of restraints beyond four (4) hours shall be approved by the Facility Medical Director/designee and must be renewed at intervals no longer than four (4) hours.

1.3.3.1 If the Medical Director/designee are not available, a licensed mental health provider may approve continued use. The justification for continued use shall be documented in the patients' medical records.

1.3.3.2 Renewals occurring after hours shall be done in collaboration with the Facility Medical Director/designee, a psychiatric practitioner, or a psychologist.

1.3.3.3 If restraints past four (4) hours are required, the psychologist shall staff with the MHD.

1.3.3.4 If restraints continue to be needed beyond a twenty-four (24) hour interval, then a transfer to a licensed mental health facility shall be considered and staffed with the MHD.

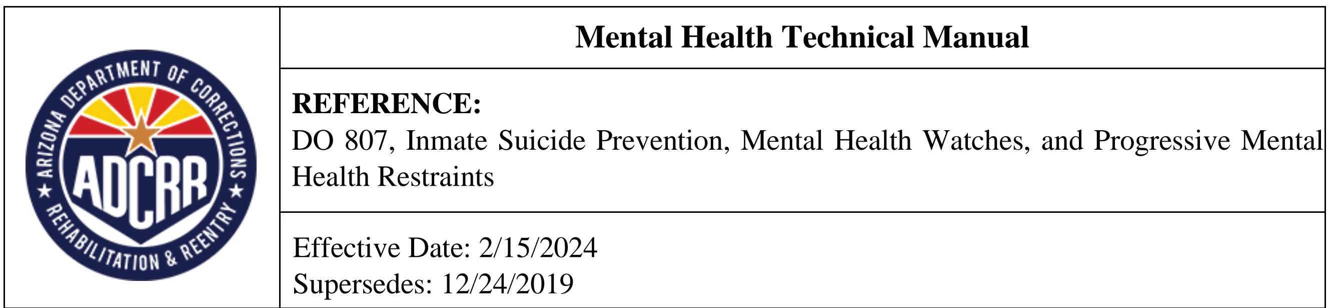
1.3.4 A patient may only be placed in four-point restraints after a face-to-face evaluation by a psychiatric provider or psychologist.

1.3.5 If methods of restraint have been inadequate to prevent serious acts of self-harm, the MHD, or designee, shall consult with a P/PNP regarding emergency psychotropic medication.

2.0 Soft restraints shall be used whenever possible.

3.0 Patients shall be restrained only in settings that allow nurses sufficient access to perform wellness checks and provide necessary medical care. Nurses shall ensure that the restraints do not impair any essential health needs, such as breathing or circulation to the extremities. These checks shall be documented in the patient's medical records.

4.0 Patients in restraints shall be under direct observation at all times. If an observer notes any ill effects of the restraints, every effort shall be made to remedy the ill effects and a psychiatric or medical practitioner shall be notified immediately.



	Mental Health Technical Manual
	REFERENCE: DO 807, Inmate Suicide Prevention, Mental Health Watches, and Progressive Mental Health Restraints
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Chapter 5, Section 3.0 Double Bunking (Cohorting) Patients on Watch

PURPOSE: To provide guidelines regarding the safety review, appropriateness, and mutual decision-making process between security and mental health staff regarding double-bunking patients while on mental health watches.

RESPONSIBILITY: It is the responsibility of the security shift commander and the assigned psychologist or psychiatric provider to assign double-bunked watches according to the criteria outlined below.

1.0 Upon recommendation from a psychologist or psychiatric practitioner that housing a patient on suicide watch in the same room with another/other patient(s) on suicide watch would be clinically as safe as or safer than housing each patient in isolation, patients shall be double celled or cohorted according to the following criteria:

1.1 Patients on watch may only be double-bunked (cohorted) after a review of pertinent patient data by security staff and a review of the mental health record by a psychologist or psychiatric provider.

1.2 Security and the assigned psychologist or psychiatric provider to the unit shall consult one another regarding a decision to double-bunk patients on watch.

1.2.1 If consensus between security and the assigned mental health staff cannot be reached, then the patient shall not be double-bunked.

1.3 Patients shall only be double-bunked if each patient is within one custody level of the potential cellmate. Patients must also be on the same level of watch (i.e., a 15-minute watch with another 15-minute watch) and have the same allowable property while on watch.

2.0 The decision to double-bunk (cohort) patients, and any conditions or changes shall be documented in each patient's medical record by the responding psychologist or psychiatric provider at the time of the event.

3.0 In the event the issue of double bunking two patients on watch arises during non-business hours, under no circumstances shall the On-Call Mental Health Duty Officer be contacted to address this situation. This decision shall be completed during normal business hours.

Chapter 5, Section 4.0 Medication Distribution during Watch and Post Watch

PURPOSE: To provide direction regarding the management of psychotropic and medical medications with regards to patients who are placed on watch and those who have been discontinued from watch.

RESPONSIBILITY: The P/PNP and medical provider are responsible for managing prescribed medications for mental health watch admissions and discharges. The appropriate clinical specialty shall order psychiatric and/or medical medications as indicated in the treatment plan, medication administration record, and/or by the clinical assessment.

1.0 Patients who are placed on any level of mental health watch shall have all medications dispensed as DOT, unless they meet the criteria outlined below in 1.1, 1.2, and 1.3.

1.1 Patients on watch with diabetes who are at significant risk of hypoglycemia shall be provided a source of glucose KOP. Exceptions may be made for prisoners living in a unit with 24-hour nursing and access to an emergency call button.

1.2 Patients on watch who are prescribed rapid-delivery nitroglycerin for cardiac disease shall be provided the medication KOP. Exceptions may be made for prisoners living in a unit with 24-hour nursing and access to an emergency call button.

1.3 Patients on watch with asthma who are at significant risk of serious respiratory impairment if they do not use their rescue inhaler immediately, shall be provided a rescue inhaler KOP. Exceptions may be made for prisoners living in a unit with 24-hour nursing and access to an emergency call button. Exceptions may also be made for prisoners where custody staff can document a significant and serious penological need to prohibit a particular patient from having such an inhaler. In such case, the medication must be kept in the vicinity of the patient's location and provided to the patient by custody staff immediately upon patient request.

1.4 Once the mental health watch paper work is complete, the psychologist, psychology associate, and/or psychiatric provider shall inform a psychiatric RN or receiving RN at the unit where the patient will be for the mental health watch.

1.5 The psychiatric RN or receiving RN at the mental health watch unit shall review the health records and identify if KOP medications are prescribed.

1.6 If KOP medications are prescribed, the psychiatric RN or receiving RN at the mental health watch site, shall contact the appropriate clinical specialty/provider for DOT medication orders.

1.6.1 The RN can accept telephone orders from the provider; or

1.6.2 The responsible provider can change the KOP order to DOT in the health record.

1.7 Patients placed upon watch shall not have access to KOP medications.

2.0 Prior to the mental health watch discontinuation, the mental health clinician conducting the daily watch contacts shall notify an RN of the pending watch discontinuation.

2.1 Prior to discontinuation, the RN shall review the MAR for accuracy, DOT status, and prescription dispense duration for all prescribed medications.

2.2 Patients discharged from mental health watch who were placed on watch because of a potential overdose, shall have all prescriptions designated as DOT status and a minimum dispense duration of thirty (30) days.

3.0 After mental health watch discontinuation due to a potential overdose, patients shall continue to receive their medications DOT for the following minimum dispense duration:

3.1 For a minimum of thirty (30) days if there is no suicidal gesture or attempt.

3.2 For a minimum of twelve (12) months if a suicidal gesture or attempt was involved.

3.3 If the patient is placed on watch subsequent to an intentional overdose of prescription or OTC medications, then the patient shall remain on DOT status indefinitely.

4.0 After the minimum time period has elapsed, the P/PNP may discuss with the patient KOP and DOT psychiatric medication status. In addition, the P/PNP may collaborate with the responsible medical provider regarding KOP and DOT status of medical medications.

Chapter 5, Section 5.0 Mental Health Follow-up after Discharge from Watch

PURPOSE: To provide direction regarding mental health service delivery and post watch follow-up for patients being discharged from a mental health watch.

RESPONSIBILITY: It is the responsibility of the licensed mental health clinician discontinuing any watch, to notify appropriate security staff and the mental health team at the Complex. It is the responsibility of the Mental Health Lead, or designee, to notify the mental health clinicians on a daily basis of the dates of watch discharges and the patients' current locations.

1.0 Post watch follow-up for patients being discharged from any level of mental health watch shall be conducted by a mental health clinician, psychiatric provider, or between one (1) day and three (3) days after watch discontinuation. An additional watch follow-up appointment shall occur between seven (7) and ten (10) days after watch discontinuation, and a final follow-up appointment shall occur between twenty-one (21) and twenty-four (24) days after watch discontinuation.

2.0 The mental health staff performing the first watch follow-up check shall verify the appropriateness of the Mental Health Score, and make any necessary changes in the medical record (and in ACIS if one of the private prison facilities).

2.1 If the patient engaged in any suicidal gestures or actions, then the score shall be at least a MH-3. If the patient only verbalized suicidal ideation, then the clinician shall decide if the score needs to be raised. If the clinician decides that the score can remain a MH-2 (MH-1 is not allowed once the patient goes on watch), then a detailed S.O.A.P.E note shall be written indicating the reasons the score remained a MH-2.