CHAPTER: 1100

Inmate Health Services

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1103 – Inmate Mental Health Care, Treatment and Programs

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Arizona Department of Corrections Rehabilitation and Reentry

Department Order Manual

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PURPOSE

This Department Order (DO) establishes standards and procedures for mental health care services designed to meet the treatment needs of inmates in need of mental health care, for voluntary or involuntary mental health treatment.

References to healthcare professionals (i.e., Healthcare Services and Mental Health Services) are referring to the Contracted Healthcare Provider (CHP) or their subcontractors unless otherwise stated.

APPLICABILITY

This DO applies to all Department and Contractor staff directly or indirectly involved in the supervision or treatment of inmates receiving mental health services. Mental Health Watches shall be in accordance with DO #807, Inmate Suicide Prevention, Mental Health Watches, and Progressive Mental Health Restraints.

PROCEDURES

1.0 INFORMED CONSENT AND REFUSAL OF MENTAL HEALTH CARE

1.1 Informed Consent for Mental Health Care

1.1.1 All inmates shall be provided the opportunity to read, ask questions, and sign the Mental Health Treatment Consent, Form 1103-18, or electronic equivalent, when they arrive to Reception prior to the Initial Mental Health Assessment.

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

1.1.2.1 Limits of confidentiality within the Department, specific to:

1.1.2.1.1 Threats of harm to self or others;

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

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

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

1.1.2.1.5 Discussion of a supervisory or treatment planning nature among inmates' healthcare staff; and

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

1.1.2.1.7 Advantages/benefits and disadvantages/risks of proposed treatment.

1.1.2.1.8 Alternatives to proposed treatment.

1.2 Informed Refusal for Mental Health Care

1.2.1 Inmates may refuse and cancel any appointment that was created by their Health Need Requests (HNR), Form 1101-10ES, for limited mental health attention on the Nurses' line (such as mild symptoms that have improved since submitting the Health Need Request). If they later change their mind, they may seek and be provided treatment again.

1.2.1.1 All cancellations of inmate-initiated visits shall be made directly to a Qualified Mental Health Professional (QMHP) with a master's level degree or higher; psychology associate, psychiatric physician's assistant, psychiatric nurse practitioner, psychologist or psychiatrist by telephone, video, or face-to-face.

1.2.1.2 If an inmate will not voluntarily displace themselves to participate in the direct communication with the mental health staff required here, health care staff shall displace to the inmate's location.

1.2.1.3 An inmate must complete the Refusal to Submit to Treatment, Form 1101-4ES, when cancelling or refusing an inmate-initiated visit.

1.2.1.4 Mental health staff shall document their efforts to explain the consequences of this refusal including the potential delay in rescheduling the appointment.

1.2.1.5 After verbal presentation of the Mental Health Treatment Consent, Form 1103-18, and signatures completed, proceed to see the inmate unless they are refusing to be seen.

1.2.1.6 If the inmate changes their mind, they may seek and be provided treatment.

1.2.2 An inmate may refuse and cancel any on-site or off-site provider initiated mental health visit.

1.2.2.1 All refusals of provider-initiated on-site mental health visits shall be made by telephone, video, or face-to-face with a mental health care professional with a master's level degree or higher; psychology associate, psychiatric physician's assistant, psychiatric nurse practitioner, psychologist or psychiatrist within three calendar days after the appointment.

1.2.2.1.1 Refusal documents shall be scanned into the Electronic Health Record (EHR) within 48 hours.

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

1.2.2.3 If an inmate will not voluntarily displace themselves to participate in the direct communication with the mental health staff required here, mental health staff shall go to the inmate's location.

1.2.2.4 An inmate must complete the Refusal to Submit to Treatment, Form 1101-4ES, when cancelling or refusing a provider-initiated visit.

1.2.2.5 Mental health staff shall document their efforts to explain the consequences of this refusal, including the potential delay in rescheduling the appointment.

1.3 Documentation – The inmate must document their refusal by properly completing and signing the Refusal to Submit to Treatment, Form 1101-4ES, and submitting it to the CHP.

1.3.1 The placement of the inmate's signature on the paper Refusal to Submit to Treatment form or electronically, must be witnessed by one mental health staff member.

1.3.1.1 If the inmate refuses to sign the Refusal to Submit to Treatment, Form 1101-4ES, the inmate's refusal must be witnessed by one mental health staff member and one Correctional Officer Series staff member.

1.3.1.2 The mental health staff shall document their efforts to explain the consequences of this refusal including the potential delay in rescheduling the appointment.

1.4 If an inmate refuses to accept treatment or sign a Mental Health Treatment Consent, Form 1103-18, or electronic equivalent, mental health staff shall:

1.4.1 In language the inmate can understand, explain the consequences of their refusal to accept the proposed procedure/treatment.

1.4.2 Document exactly what was told to the inmate regarding the refusal of the procedure/treatment on the Refusal to Submit to Treatment, Form 1101-4ES, or electronic equivalent.

1.4.3 Request the inmate to sign and date the completed Refusal to Submit to Treatment form before two witnesses:

1.4.3.1 Have the witnesses sign the completed form.

1.4.3.2 File/place the completed form in the Refusals Section of the inmate's Medical Record. The completed form shall be scanned in to the EHR in the Electronic Documents/Images section and labeled as a Refusal/Consent.

1.5 If the inmate changes their mind, they may seek and be provided treatment again.

2.0 MENTAL HEALTH SCREENING AND EVALUATION FOR MENTAL HEALTH NEEDS – Within one business day of an inmate's admission to the Department, a psychologist or psychology associate shall meet with, screen and evaluate the inmate and complete the Initial Mental Health Assessment, Form 1103-27, in accordance with the Mental Health Technical Manual.

2.1 The assessment shall occur in a confidential therapeutically appropriate setting unless there is a clinical or legitimate and substantial safety and security concern that is documented, and shall include the requirements outlined in the Mental Health Technical Manual.

3.0 OUTPATIENT MENTAL HEALTH TREATMENT (MH-3) – STABLIZATION OF THE MENTALLY ILL AND THE PREVENTION OF PSYCHIATRIC DETERIORATION IN THE CORRECTIONAL SETTING - Inmates receiving outpatient treatment shall be assigned one of the five sub-codes in accordance with the below criteria and the Mental Health Technical Manual. The inmate's sub-code may change during any encounter as their condition warrants.

3.1 Sub-Code A – Inmates in acute distress who may require substantial intervention in order to remain stable (i.e., actively psychotic, delusional, current or frequent suicidal ideation, or currently under a Psychotropic Medication Review Board (PMRB)).

3.1.1 All inmates classified as Seriously Mentally Ill (SMI) shall be classified as MH-3A while receiving outpatient services.

3.1.2 Any inmate under a PMRB shall be classified by the treating provider as MH-3A while receiving outpatient services (MH-4 or MH-5 if admitted to a Residential/Inpatient Program).

3.1.2.1 These inmates shall be seen by a QMHP a minimum of every 30 calendar days. All inmates on medications shall be seen by a Psychiatrist/Psychiatric Nurse Practitioner (P/PNP) a minimum of every 90 calendar days.

3.1.2.1.1 Any inmate under a current PMRB shall be seen by the treating provider a minimum of every 30 calendar days.

3.1.2.2 An inmate cannot be decreased from MH-3A to MH-2, but shall be lowered to a MH-3D or MH-3E for at least six months in accordance with the Mental Health Technical Manual.

3.2 Sub-Code B – Inmates who may need regular interventions, but are generally stable and participate in psychiatric and psychological services. Example: An inmate with a major depressive or other affective disorder who benefits from routine contact with psychiatry and psychology staff.

3.2.1 These inmates shall be seen by a QMHP a minimum of every 60 calendar days. Additionally, they shall be seen by a P/PNP a minimum of every 90 calendar days.

3.2.1.1 If an inmate is newly placed on medications, then the P/PNP shall ensure that the MH score is appropriately updated with the correct sub-code.

3.2.1.2 If an inmate is discontinued from all of their 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 QMHP assigned to the unit.

Sub-Code C – Inmates who need infrequent intervention and have adequate coping skills to manage their mental health symptoms effectively and independently through the use of psychotropic medications only. Example: An inmate with a general mood or anxiety disorder who has learned to manage their symptoms effectively through the use of medication and infrequent contact with QMHPs.

3.2.2 These inmates shall be seen by a P/PNP a minimum of every 90 calendar days. They shall by seen by a QMHP by Health Needs Request (HNR), Form 1101-10ES, or upon referral.

3.2.3 If an inmate is requesting to no longer receive contacts from a QMHP, then the QMHP shall complete a face-to-face session and complete detailed documentation substantiating the change in services to be provided.

3.2.4 If an inmate is discontinued from all of their 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 QMHP assigned to the unit and schedule a psychologist chart review.

3.3 Sub-Code D – Inmates who have been recently taken off of psychotropic medications require follow-up for a minimum of six months to ensure stability over time.

3.3.1 The inmate shall be seen by a P/PNP within 30 calendar days of the discontinuation of the psychotropic medications. Additionally, the inmate shall be seen by a QMHP a minimum of every 90 calendar days after the medications were discontinued.

3.3.2 If the inmate demonstrates sufficient stability after six months, then the MH score may be changed to MH-3E or MH-2 as clinically indicated.

3.4 Sub-Code E – Inmates who have recently arrived to the Department, and who are generally stable but may benefit from regular contacts with a QMHP. Inmates who are only participating in outpatient group psychotherapy should also be designated as MH-3E.

3.4.1 These inmates shall be seen by a QMHP a minimum of every 90 calendar days.

3.5 Any MH-3 inmate placed in Detention or Maximum Custody shall be seen by a QMHP a minimum of every 30 calendar days regardless of their current sub-code.

3.6 Any inmate who engages in self-harm gestures/attempts shall be classified MH-3 until stability is demonstrated and then they can be changed to MH-2 as clinically indicated.

3.7 Any inmate in the Department may receive elective mental health care services or preventative mental health care by submitting a Health Needs Request (HNR), Form 1101-10ES.

4.0 MENTAL HEALTH TRANSITION PROGRAM – The Mental Health Transition Program is designed to assist inmates in successfully reintegrating into a general population unit from Mental Health Watch, Residential Treatment or Inpatient Treatment. The program allows inmates continued mental health observation in a group environment, while maintaining enhanced monitoring by Correctional Officer Series staff.

4.1 Inmate Selection

4.1.1 An Interdisciplinary Selection Team (IST), consisting of a QMHP, Correctional Officer Series staff member, and Correctional Officer III/Correctional Officer IV, shall convene once weekly, or as needed, to evaluate potential candidates for admission to this transitional program.

4.1.2 The IST shall decide the inmate suitability based upon inmate behavior, disciplinary history, programming history, mental health history, mental health needs and their present issue for participation in the Mental Health Transition Program.

4.1.3 Contract Beds personnel requesting inmate reviews shall notify the Mental Health Transition Program Deputy Warden, who will convene a review within the next business day. The requesting unit will be immediately advised of the results.

4.2 Mental Health Transition Program Intake

4.2.1 Selected inmates who are not on watch may be admitted to the Mental Health Transition Program Unit if selected.

4.2.2 The transfer of inmates who are selected from a contracted facility will be coordinated through Central Office Classification.

4.3 Mental Health Transition Program Orientation

4.3.1 Mental health staff shall conduct an orientation for the newly arrived inmate within 24 hours of their arrival.

4.3.2 Mental health staff shall explain:

4.3.2.1 Description of the program.

4.3.2.2 Expectations of the inmate's participation.

4.3.2.3 Goals of the program.

4.3.3 The Mental Health Transition Program orientation shall specify unit expectations based on the current unit brochure.

4.4 Mental Health Transition Program

4.4.1 Frequency of QMHP Contact

4.4.1.1 Inmates accepted into the Mental Health Transition Program shall have contact with mental health staff a minimum of two times each week.

4.4.1.2 Any unit staff member may refer inmates to mental health staff for an assessment.

4.4.2 Group Psycho Educational sessions shall be conducted two times each week by mental health staff.

4.4.3 Recreational Therapy sessions shall be conducted two times each week.

4.4.4 Program Reviews shall be conducted weekly with a projected completion date of 21 calendar days. The Program Review Team consisting of Mental Health Staff, Mental Health Transition Program Deputy Warden or their designee, Correctional Officer III and a Correctional Officer Series staff member shall discuss the following items:

4.4.4.1 Individual inmate evaluation based upon:

4.4.4.1.1 Inmate participation.

4.4.4.1.2 Personal conduct/behavior.

4.4.4.1.3 Personal hygiene.

4.4.4.1.4 Inmate self-evaluation.

4.4.4.2 The Program Review Team may award incentives to participants for successful progress within the program. The incentives include:

4.4.4.2.1 Earn incentives based on current Phase Level.

4.4.4.2.2 Additional recreation sessions.

4.4.4.2.3 Integrated Housing Program incentives.

4.5 Program Progress Review - Weekly, the Program Review Team shall assess each inmate individually and recommend one of the following courses of action:

4.5.1 Continue in program – The inmate is participating in the program and meeting expectations, but is not ready to transition to a general population setting. The Program Review Team will reevaluate the inmate in a week.

4.5.1.1 If the inmate has exceeded 21 calendar days they will remain in the program as needed until the Program Review Team decides otherwise.

4.5.2 Removal from the program - Prior to the projected 21 calendar days the inmate may be removed from the program due to not participating in the program or demonstrating behavior/conduct incompatible with a group setting. The inmate will be evaluated by mental health and housed accordingly.

4.5.2.1 If the inmate is placed on a Mental Health Watch, once removed from watch, the IST will reevaluate the inmate for placement back into the Mental Health Transition Program. If the inmate is denied the Mental Health Transition Program, the inmate will be moved to a location congruent with their classification and identified mental health needs.

4.5.3 Transition out of the program to the general population occurs when the Program Review Team agrees the inmate has demonstrated sufficient progress within the program and is ready to transition to general population. Inmate is given a self-evaluation and agrees to house in general population.

4.5.3.1 The inmate shall be transferred to general/specialty population appropriate to the inmate's mental health needs.

5.0 RESIDENTIAL TREATMENT (MH-4) – In accordance with the Mental Health Technical Manual, the Department operates Residential Treatment Units (RTUs) for inmates with impairment in behavioral functioning associated with serious mental illness and/or impairment in cognitive functioning. The severity of the impairment does not require inpatient level care, but the inmate demonstrates a historical and current inability to function adequately in the general population. Mental health programming at the RTUs shall include, but not be limited to, individual counseling and group therapy.

5.1 Staffing Requirements – Custody staff will be selected by an interview panel including at a minimum the:

5.1.1 Mental Health Lead

5.1.2 Deputy Warden

5.2 All Custody Officers shall receive additional mental health training within 90 calendar days of assuming the position and a minimum of one additional mental health training.

5.2.1 Training shall include the following:

5.2.1.1 Trauma-informed care in a correctional setting

5.2.1.2 3-Day Mental Health Training

5.2.1.3 Crisis Intervention Training

5.3 Referrals

5.3.1 Each Mental Health Lead shall:

5.3.1.1 Ensure referrals to the RTU are limited to inmates who have demonstrated behavior associated with a mental disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), a syndrome associated with an organic brain dysfunction, or a developmental disability.

5.3.1.2 Ensure a QMHP conducts a mental health examination of each inmate prior to referral to the RTU.

5.3.1.3 Submit to the CHP Regional Mental Health Director a completed Residential Treatment Unit (RTU) Referral, Form 1103-9, or electronic equivalent.

5.3.2 The CHP Regional Mental Health Director and Mental Health Leads shall:

5.3.2.1 Review all Residential Treatment Unit (RTU) Referral forms.

5.3.2.2 Coordinate all activities related to scheduling evaluations at the RTU.

5.3.2.3 Arrange for inmates to be evaluated by the RTU’s Mental Health Admission/Discharge Board.

5.3.3 Each Mental Health Lead shall ensure the inmate's mental health examination results and Medical Record are provided to the CHP Regional Mental Health Director prior to their evaluation of the inmate.

5.4 Evaluation of Referred Inmates – The CHP Regional Mental Health Director and Mental Health Lead shall:

5.4.1 Weekly:

5.4.1.1 Review all available information, including the inmate's Medical Record to determine if the inmate meets the admission criteria outlined in this section.

5.4.1.2 Assess the factors outlined in this section, and determine if the inmate would compromise the safe and secure operation of the RTU.

5.4.2 Review the Residential Treatment Unit (RTU) Referral, Form 1103-9.

5.4.3 Complete a Mental Health Non-Clinical Contact Note, Form 1103-5, or electronic equivalent, which shall include their recommendation to approve or deny the inmate's admission to the RTU.

5.4.4 Send email notification to the involved Deputy Wardens with the recommendation to approve or deny admission to the RTU.

5.5 Admission Criteria

5.5.1 The following criteria may indicate the need for placement in a RTU:

5.5.1.1 The inmate exhibits an acute onset or significant decompensation of a serious mental health condition.

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

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

5.5.1.2.2 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.

5.5.1.3 Limited functional ability as a result of a mental disorder, developmental disability, organic brain dysfunction, or personality disorder.

5.5.2 The CHP Regional Mental Health Director, Mental Health Leads, and Deputy Wardens of Operations or designee may deny an inmate's admission to the RTU if the inmate would compromise the safe and secure operation of the RTU.

5.6 Admissions shall be conducted in accordance with Mental Health Technical Manual.

5.6.1 The CHP Regional Mental Health Director and Mental Health Leads shall weekly:

5.6.1.1 Review the Residential Treatment Unit (RTU) Referral, Form 1103-9, and either approve or disapprove the admission.

5.6.1.2 Submit the recommendation via email for admission to the RTU to the Deputy Warden of the facility where the RTU is located.

5.6.1.3 Provide the Calculation, Records and Population Management Administrator or designee with a written list of inmates approved for admission.

5.6.2 The Calculation, Records and Population Management Administrator or designee shall ensure:

5.6.2.1 A current list of inmates evaluated and approved for admission to the RTU is maintained.

5.6.2.2 Inmates are transferred to the RTU as bed space becomes available.

5.7 Residential Services

5.7.1 Inmates shall be seen by a:

5.7.1.1 QMHP as determined by their treatment plan.

5.7.1.2 P/PNP a minimum of every 14 calendar days.

5.7.1.3 Full treatment team at least every three months, including, the primary therapist, psychologist, P/PNP, and any other staff necessary. Inmates shall be included in the meeting unless there is a clinical or legitimate and substantial safety and security concern documented in the custody and health record.

5.7.2 Inmates shall also be provided structured program activities on a weekly basis by Healthcare Services and Operations staff assigned to the program.

5.8 Discharge

5.8.1 In accordance with the Mental Health Technical Manual, the CHP Regional Mental Health Director and Mental Health Leads shall initiate the discharge process when an inmate has met one of the following discharge criteria:

5.8.1.1 Inmate has reached maximum treatment benefit and/or has completed all program elements, and is able to function in a general institutional environment.

5.8.1.2 Inmate has exhibited behavior unrelated to mental illness, which threatens the safe and secure operation of the unit/area, their personal safety, or the safety of others.

5.8.2 When an inmate has met the discharge criteria outlined in the Mental Health Technical Manual:

5.8.2.1 The CHP Regional Mental Health Director and Mental Health Leads shall:

5.8.2.1.1 Submit the recommendations to the Deputy Warden for review and final approval/disapproval of the transfer.

5.8.2.1.2 Notify the Calculation, Records and Population Management Administrator or designee of any inmates approved for discharge so they can be transferred to an appropriate institution.

5.8.2.2 Based on the CHP Regional Mental Health Director and Mental Health Leads recommendations, the inmate's primary QMHP shall complete a Mental Health Non-Clinical Contact Note reflecting the inmate's progress and further treatment needs.

6.0 INPATIENT MENTAL HEALTH TREATMENT (MH-5) – Inmates who are admitted to the Inpatient Treatment Programs licensed by the Arizona Department of Health Services.

6.1 The Inpatient Treatment Units are to provide inpatient mental health programming that includes focused evaluation and intensive treatment to inmates experiencing marked impairment and dysfunction in most areas of their lives due to uncontrolled symptom of mental illness. For inmates who exhibit significant emotional or behavioral functioning deficits and would benefit from an inpatient level of mental health care. These units provide 24-hour services, including nursing and availability of QMHP, behavioral health trained Correctional Officers, and clinical programming.

6.2 Staffing Requirements - Custody staff shall be selected by an interview panel, including at minimum:

6.2.1 Mental Health Lead

6.2.2 Deputy Warden

6.3 All Custody Officers will receive additional mental health training within 90 calendar days of assuming the position and one additional mental health specific training.

6.3.1 Training shall include the following:

6.3.1.1 Trauma informed care in a correctional setting

6.3.1.2 3-Day Mental Health Training

6.3.1.3 Crisis Intervention Training

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

6.4.1 One psychiatric provider per 25 inmates

6.4.2 One primary therapist (psychologist or psychology associate) per 10 inmates

6.4.3 One Behavioral Health Tech per 30 inmates

6.5 Inmates in Inpatient Treatment Units shall be provided the following:

6.5.1 An Individualized Treatment Plan, which defines the types and frequency of contacts with mental health staff

6.5.2 Housing to meet the therapeutic needs of the inmate

6.5.3 An Individualized Transportation Plan addressing the inmate's needs upon discharge from the inpatient care unit

6.6 Referrals

6.6.1 Referrals for Inpatient Level of Care from Intake – 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.

6.6.2 Referrals for Inpatient Level of Care from Outpatient or Residential Treatment

6.6.2.1 Each Mental Health Lead shall weekly:

6.6.2.1.1 Review all available information, including the inmate's health record to determine if the inmate meets the admission criteria outlined in this section.

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

6.6.2.1.3 Review the Inpatient Treatment Unit Referral Form.

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

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

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

6.6.4 The decision to admit an inmate into the program is decided jointly by the Mental Health Director, the Mental Health Lead, and the Deputy Warden of Operations or designee.

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

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

6.6.7 When an inmate is admitted to inpatient treatment, the psychiatric practitioner shall be contacted and collaborate on the immediate care plan.

6.6.8 The inmate must be assessed by their primary therapist as soon as possible after admission, but no later than one business day after arrival. Within 90 calendar days of admission, a Mental Health Seriously Mentally Ill (SMI) Determination, Form 1103-13, shall be completed by a licensed clinician.

6.7 Evaluation of Inmates – The CHP Regional Mental Health Director and Mental Health Leads shall weekly:

6.7.1 Review all available information, including the inmate's Medical Record to determine if the inmate meets the admission criteria outlined in this section.

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

6.7.3 Review the Pre-Admission Data - Inpatient Referral, Form 1103-23.

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

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

6.8 Therapeutic interventions shall be provided in accordance with the Mental Health Technical Manual.

6.9 Admission Criteria - Inmates may be admitted to the Inpatient Treatment Unit if they have one of the following:

6.9.1 A mental disorder, as defined by the Diagnostic and Statistical Manual of Mental Disorders that is supported by medical/psychiatric history, family/social history and/or psychological testing.

6.9.2 Significantly impaired functional ability as a result of a mental disorder, developmental disability, organic brain dysfunction or personality disorder.

6.10 Admission

6.10.1 The CHP Regional Mental Health Director and Mental Health Leads shall weekly:

6.10.1.1 Review the Pre-Admission Data - Inpatient Referral, Form 1103-23, and either approve or disapprove the admission.

6.10.1.2 Submit the recommendation via email for admission to the Inpatient Treatment Unit to the Deputy Warden of the facility where the Unit is located.

6.10.1.3 Provide the Calculation, Records and Population Management Administrator or designee and Central Office with a written list of inmates approved for admission.

6.10.2 The Multi-Disciplinary Program Team (MDPT), including the Deputy Warden and the CHP Regional Mental Health Director, may deny admission to the Inpatient Treatment Unit if an inmate's admission would jeopardize the secure and orderly operation of the unit/area.

6.10.3 The Calculation, Records and Population Management Administrator or designee shall ensure:

6.10.3.1 A current list of inmates evaluated and approved for admission to the Inpatient Treatment Unit is maintained.

6.10.3.2 Inmates are transferred to the Inpatient Treatment Unit as bed space becomes available.

6.11 Discharge Criteria and Procedure

6.11.1 Discharge from inpatient treatment shall be based upon a decision utilizing the interdisciplinary treatment team process when the inmate satisfies any of the following conditions:

6.11.1.1 The inmate has reached maximum treatment benefit, and/or has completed all program elements.

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

6.11.1.2 If the inmate is transferred directly from inpatient to an outpatient setting, they shall be seen within one business day of arrival to outpatient.

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

6.11.2 The decision to discharge an inmate from an inpatient program shall be discussed among the Mental Health Director and Mental Health Leads. All potential discharges shall be discussed on the weekly teleconference call with the complex Deputy Warden of Operations.

6.11.3 The Mental Health Director or designee, shall arrange for movement to an appropriate unit through Central Office Count Movement.

6.11.4 An inmate's MH Score shall remain MH-5 until the date they are to be transferred to another unit.

7.0 MANAGEMENT OF LICENSED MENTAL HEALTH FACILITIES

7.1 The CHP, Warden, and Deputy Warden shall ensure the licensed mental health facilities are provided with security, Food Service, Maintenance and all other systems and services needed for the operation of a prison.

7.2 The Statewide Chief Executive Officer and the CHP Facility Health Administrator shall ensure the licensed mental health facilities are provided with comprehensive treatment programs, clinical services and personnel and administrative support.

7.3 The Clinical Director for the licensed mental health facilities shall:

7.3.1 Consider an inmate's custody and internal risk level and violence potential when developing the inmate's transition/release plan.

7.3.2 Incorporate or recommend appropriate safeguards, including separation of inmates more potentially violent from those less potentially violent, consistent with institutional and public safety.

7.3.3 Incorporate the Department's classification procedures, in accordance with DO #801, Inmate Classification, when planning for the discharge of inmates from the licensed mental health facility.

7.3.4 Recommend the most appropriate placement, consistent with the inmate's classification, for each discharged inmate.

7.4 Inpatient Services (MH-5)

7.4.1 The psychiatric provider shall be contacted and shall collaborate on the immediate care plan as soon as an inmate is admitted to inpatient treatment.

7.4.2 Within one business day of admission to the Inpatient Treatment Unit, the primary QMHP shall complete a comprehensive mental health evaluation.

7.4.3 Inmates shall be seen and have their treatment progress reviewed daily by their primary QMHP, unless such an encounter would be clinically contraindicated and is clearly documented in their treatment plan.

7.4.4 Inmates shall be seen a minimum of every seven calendar days by a P/PNP.

7.4.5 Inmates shall also be provided structured program activities on a daily basis by Healthcare Services and Operations staff assigned to the program.

7.4.6 Any inmate identified as actively suicidal shall be placed on Continuous Mental Health Watch and shall be seen daily (including weekends and holidays) by a licensed QMHP.

7.4.7 Upon discharge from the program, every effort shall be made to transition the inmate to a Residential Program, when clinically indicated, prior to placement in an outpatient setting. The change in score, to a score of MH-4, MH-3A, or MH-3B, shall occur at the time movement is requested. The inmate shall remain in a corridor facility for a minimum of six months.

7.5 Discharge

7.5.1 The CHP Regional Mental Health Director and Mental Health Leads shall initiate the discharge process when an inmate has met one of the following discharge criteria:

7.5.1.1 Reached maximum treatment benefit, and/or has completed all program elements.

7.5.1.2 Exhibited behavior, unrelated to mental illness, that threatens the safe and secure operation of the unit, the inmate's own personal safety, or the safety of others.

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

7.5.2 When an inmate has met the discharge criteria, outlined in 7.5.1.1 and 7.5.1.2 of this section, the CHP Regional Mental Health Director and Mental Health Leads shall:

7.5.2.1 Review the inmate's progress and present the appropriate discharge recommendations to the Calculation, Records and Population Management Administrator or designee approximately seven calendar days prior to the inmate's expected transfer date.

7.5.2.2 Submit the recommendations to the Deputy Warden and the CHP Regional Mental Health Director for review and final approval/disapproval of the transfer.

7.5.2.3 Notify the Calculation, Records and Population Management Administrator or designee of any inmate's approved for discharge so they can be transferred to an appropriate institution.

7.5.3 Based on the CHP Regional Mental Health Director and Mental Health Lead's recommendations, the inmate's primary QMHP shall complete a Mental Health Non-Clinical Contact Note, Form 1103-5, reflecting the inmate's progress and further treatment needs.

7.6 Mental Health Follow-Up After Return From Inpatient Program – All inmates released from any inpatient program shall be seen by a QMHP within seven calendar days if transferring to an outpatient setting, and within one day if transferring to Residential Treatment.

8.0 MENTAL HEALTH WATCHES

8.1 Mental Health Watch/Crisis stabilization beds shall be used for short-term (typically only a few days) management of inmates who require acute care, e.g., suicide watch.

8.2 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.

8.3 A face-to-face assessment is required when placing an inmate on any level of Mental Health Watch.

8.3.1 During normal business hours, an inmate 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.

8.3.2 The face-to-face assessment can be completed by any of the following:

8.3.2.1 A mental health clinician or provider; or

8.3.2.2 A medical/mental health registered nurse if it is after regular business hours (weekends, nights, or holidays).

8.3.3 If the assessment is not completed by a clinician or provider, then the registered nurse (medical or mental health) shall attempt to obtain verbal orders from a Mental Health Duty Officer immediately.

8.3.3.1 The inmate is to be placed on a Continuous Mental Health Watch until mental health conducts a face-to-face suicide risk assessment with the inmate.

8.3.3.2 For inmates 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.

8.3.4 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.

8.4 The inmate shall be assessed by a psychiatric practitioner as soon after admission as possible, but no longer than one 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.

8.5 For any inmate placed on Mental Health Watch for bizarre behavior, in order to ensure there is not an underlying medical cause for the inmate's presentation, a registered nurse shall triage the inmate immediately, either by seeing the inmate, or talking to the inmate directly over the phone and then discuss the inmate with a medical practitioner (i.e., physician, nurse practitioner, or physician assistant) in a clinically appropriate timeframe, not to exceed four hours.

8.6 Inmates in a crisis stabilization bed/watch beds shall be evaluated at least daily in person by their primary therapist (or another psych associate if they have not yet been assigned a primary therapist or have transferred from another yard). Treatment providers shall document their intervention efforts, including but not limited to:

8.6.1 Assessing mental status

8.6.2 Behavioral observations

8.6.3 Documenting inmate ability to independently care for activities of daily living; type(s) of treatment provided

8.6.4 Response to interventions (including medication efficacy and compliance)

8.6.5 Anticipated length of stay

8.6.6 Criteria for placement

8.7 Continuous Mental Health Watch

8.7.1 Licensed QMHPs or psychiatric providers shall order a Continuous Mental Health Watch when an inmate has demonstrated signs or symptoms of significant mental disorder, and is acting in a manner indicating high or imminent suicide risk or risk to others.

8.7.2 This watch is for an inmate whose mental status has deteriorated and who is 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 calendar day.

8.8 15-Minute Mental Health Watch

8.8.1 Licensed QMHPs or psychiatric providers shall order a 15-Minute Mental Health Watch when an inmate has demonstrated signs or symptoms of significant mental disorder and is acting in a manner indicating moderate or lower suicide risk and/or risk to others.

8.8.1.1 Any verbal or written communication indicating suicidal ideation (without a specific plan) by the inmate shall, at a minimum, necessitate a 15-Minute Mental Health Watch.

8.9 An in-depth suicide risk assessment shall be completed with all inmates before discontinuation of any Mental Health Watch.

8.9.1 A face-to-face assessment is required when placing an inmate on any level of Mental Health Watch. The assessment can be completed by any of the following:

8.9.1.1 A licensed QMHP or psychiatric provider

8.9.1.2 A registered nurse (medical or mental health) if it is after regular business hours (weekends, nights, or holidays)

8.9.2 If the assessment is not completed by a QMHP or psychiatric provider, then the registered nurse (medical or mental health) shall obtain verbal orders from a mental health duty officer immediately.

8.9.2.1 If a mental health duty officer cannot be contacted, then the inmate shall be placed on a Continuous Mental Health Watch until a QMHP has a face-to-face visit with the inmate.

8.9.2.2 The assessment shall be documented in the inmate's Medical Record.

8.10 Only licensed QMHPs shall increase or reduce the level of observation and/or discontinue a watch.

8.11 All daily watch contacts shall be conducted in a confidential setting by a licensed QMHP, unless it is clinically contraindicated or there is a legitimate, significant safety concern that is documented in the inmate's custody record and health record.

8.12 If at any time an inmate's behavior deteriorates or suicidal ideation or gestures increases, the level of watch shall be increased according to the Mental Health Technical Manual.

8.13 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.

8.13.1 When the licensed QMHP makes a change to the level of watch, the Clinical note, completed watch order, and the new watch order shall be scanned in and attached to the documented contact.

8.14 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.

8.14.1 Inmates 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.

8.14.1.1 The primary therapist shall document this review in the inmate's EHR.

8.15 Mental Health Follow-up After Discharge from Watch

8.15.1 Post watch follow-up for inmates being discharged from any level of Mental Health Watch shall be conducted by a licensed QMHP or psychiatric provider between 24 and 72 hours after watch discontinuation. An additional watch follow-up appointment shall occur between 7-10 calendar days after watch discontinuation, and a final follow-up appointment shall occur between 21-24 calendar days after watch discontinuation.

8.15.2 The QMHP 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.

8.15.2.1 If the inmate engaged in any suicidal gestures or actions, then the score shall be at least a MH-3. If the inmate only verbalized suicidal ideation, then the QMHP shall decide if the score needs to be raised. If the QMHP decides that the score can remain a MH-2 (MH-1 is not allowed once the inmate goes on watch), then a detailed Subjective, Objective, Assessment, Plan, Education (SOAPE) Note shall be written indicating the reasons the score remained a MH-2.

8.16 In accordance with the Mental Health Technical Manual, a QMHP shall conduct an in-person, in-depth suicide risk assessment, and shall be completed with all inmates prior to removing them from a Mental Health Watch.

9.0 CONTINUITY OF CARE FOR SERIOUSLY MENTALLY ILL INMATES

9.1 Determination and management of SMI Inmates

9.1.1 An inmate shall be designated as SMI if according to a licensed mental health clinician or provider they possess:

9.1.1.1 A qualifying mental health diagnosis as indicated on the Mental Health Seriously Mentally Ill (SMI) Determination, Form 1103-13; and

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

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

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

9.1.3 Any inmate who is under a PMRB order shall be designated as SMI and seen by a psychiatric provider a minimum of every 30 calendar days.

9.2 Inmates with Intellectual Disabilities

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

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

9.2.2 The inmate shall be designated as a MH-3A or above and provided, at a minimum, the same level of services as those designated SMI in addition to other clinically indicated services.

9.3 Services for those Designated as SMI

9.3.1 Inmates designated as SMI shall not be housed in Maximum Custody or Detention, or otherwise be kept in a cell for more than 22 hours each day.

9.3.2 The minimum mental health service delivery level for any SMI inmate is determined by their mental health score and clinical need, and will be designated as MH-3A, MH-4, or MH-5.

9.3.3 Inmates designated as SMI shall be exempt from medical, dental, and mental health charges related to health needs request driven contacts.

9.3.4 Inmates may request to be evaluated to determine if they meet the criteria for being designated as SMI. They shall receive additional SMI screenings as clinically indicated.

9.4 SMI Identification – The SMI designation shall be clearly documented in the Medical Record on the Mental Health Seriously Mentally Ill (SMI) Determination, Form 1103-13.

9.5 Removal of SMI Designation - An inmate may be determined to no longer meet the criteria for an SMI designation.

9.5.1 The Mental Health Lead shall confirm that the inmate 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 inmate, the treating psychologist and psychiatric provider, has occurred.

9.5.1.1 The treatment team shall document on the Clinical Summary and Recommendations, Form 1103-69, the justification that the criteria is no longer met.

9.5.2 An inmate 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.

9.6 Mental Health Release Programs

9.6.1 No less than 90 calendar days prior to the inmate's release, mental health staff shall initiate the coordination of all transition/release plans for any special release programs, to include Legislative release programs, Grants, or Department mandated programs, in accordance with the Mental Health Technical Manual.

9.6.2 Mental Health Discharge Planners shall ensure the following:

9.6.2.1 Release planning shall be completed and documented more than seven calendar days, but less than six months, prior to the inmate's earliest release date.

9.6.2.2 All inmates 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:

9.6.2.2.1 A problem list

9.6.2.2.2 A list of active medications

9.6.2.2.3 The inmate's current symptoms and functional impairments

9.6.2.2.4 A summary of relevant care provided during incarceration

9.6.2.2.5 Any necessary follow-up care

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

9.6.2.2.7 The name and contact information of the primary therapist

9.6.2.2.8 The inmate's current treatment plan

9.6.2.2.9 An aftercare plan that reflects progress in treatment

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

9.6.3.1 This package shall be scanned into the inmate's EHR.

9.6.3.2 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.

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

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

9.6.4.2 Inmates 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 inmate.

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

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

9.6.4.3.1 The Release Planner shall document the inmate's AHCCCS number in the EHR for all eligible inmates.

9.6.4.4 The Release Planner shall work with the assigned Correctional Officer III to identify housing options. (If the inmate is homeless, inmate shall be provided resources for housing.)

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

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

9.6.4.6 Medication shall be provided for a sufficient length of time to allow the inmate to obtain and attend an appointment with a community practitioner qualified to order a new supply. Inmates shall be released with no less than a 30-day supply of medication.

9.6.4.6.1 If the psychiatric provider determines that it is unsafe to release the inmate 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.).

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

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

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

9.6.6 Court Ordered Evaluations Upon Release

9.6.6.1 If it is determined that an inmate needs to be evaluated for inpatient treatment upon release from prison, the inmate shall be petitioned for a Court Ordered Evaluation.

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

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

9.6.6.2.1.1 No inmate shall be released directly from being on a Mental Health Watch to the community without coordination with community mental health services.

9.6.6.3 If an inmate refuses release planning, ask the inmate to sign the Refusal to Submit to Treatment, Form 1101-4ES.

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

9.7 Use of Restraints – The use of restraints shall be in accordance with DO #807, Inmate Suicide Prevention, Mental Health Watches, and Progressive Mental Health Restraints and DO #1101, Inmate Access to Health Care.

9.7.1 Progressive Mental Health Restraints

9.7.1.1 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 inmates. They shall not be used for punishment.

9.7.1.2 Restraints shall only be applied for the minimum amount of time necessary to accomplish the stated need (e.g., inmate and staff safety, requisite transports, etc.).

9.7.1.3 The use of restraints shall only be authorized and reviewed in a progressive fashion by a psychologist or P/PNP.

9.7.1.3.1 Restraints shall not be used for more than four hours at a time.

9.7.1.3.2 Every effort shall be made to minimize the length of time in restraints.

9.7.1.3.3 Renewal of restraints beyond four hours shall be approved by the Facility Medical Director or designee, and must be renewed at intervals no longer than four hours.

9.7.1.3.3.1 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 inmates' medical records.

9.7.1.3.3.2 Renewals occurring after hours shall be done in collaboration with the Facility Medical Director/designee, a psychiatric practitioner, or a psychologist.

9.7.1.3.3.3 If restraints past four hours are required, the psychologist shall staff with the Mental Health Director.

9.7.1.3.3.4 If restraints continue to be needed beyond a 24 hour interval, then a transfer to a licensed mental health facility shall be considered and staffed with the Mental Health Director.

9.7.1.4 An inmate may only be placed in four-point restraints after a face-to-face evaluation by a psychiatric provider or psychologist.

9.7.1.4.1 If methods of restraint have been inadequate to prevent serious acts of self-harm, the Mental Health Director or designee, shall consult with a P/PNP regarding emergency psychotropic medication.

9.7.2 Therapeutic restraints shall be used.

9.7.3 Inmates 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 inmate's Medical Records.

9.7.4 Inmates 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.

9.8 Suicide Prevention and Intervention – Suicide prevention and intervention shall be in accordance with DO #807, Inmate Suicide Prevention, Mental Health Watches, and Progressive Mental Health Restraints.

9.8.1 The suicide prevention plan shall be approved by the CHP Regional Mental Health Director and reviewed by the Warden to ensure the Warden understands the plan that is to be implemented. The plan includes staff and inmate critical-incident debriefing and covers the management of suicidal incidents, suicide watch, and completed suicides. It ensures a review of suicidal incidents including self-injurious behavior, suicide watch, and completed suicides by administration, security, and healthcare services.

9.8.2 All staff with responsibility for inmate supervision shall be trained on an annual basis in the implementation of this program. Mental health staff shall be involved in the development of the plan and the training, which shall include but not be limited to:

9.8.2.1 Identifying the warning signs and symptoms of impending suicidal behavior

9.8.2.2 Understanding the demographic and cultural parameters of suicidal behavior, including incidence and variations in precipitating factors

9.8.2.3 Responding to suicidal and depressed inmates

9.8.2.4 Communication between correctional and healthcare personnel

9.8.2.5 Referral procedures

9.8.2.6 Housing observation and suicide watch level procedures

9.8.2.7 Follow-up monitoring of inmates who make a suicide attempt

9.8.2.8 Population specific factors, identifying high risk situations and actions that may require heightened awareness

9.8.3 In the event of an inmate's death by suspected suicide, a psychological autopsy shall be completed by a psychologist who is capable as determined by the CHP Regional Mental Health Director in conducting a psychological autopsy. This is a retrospective reconstruction of the individual's life with an emphasis on the risk factors that may have contributed to the inmate's death. (In accordance with DO #1105, Inmate Mortality Review.)

9.8.4 In the event of a suicide attempt, a Suicide Attempt Review shall be conducted in accordance with the Mental Health Technical Manual.

10.0 STAFF REPRESENTATION – ARIZONA BOARD OF EXECUTIVE CLEMENCY HEARING

10.1 The appropriate CHP Regional Mental Health Director or designee shall arrange for an interview of a SMI inmate by a QMHP upon notification by the Arizona Board of Executive Clemency (ABOEC) of a pending ABOEC Hearing and within 10 workdays prior to the inmate's ABOEC Hearing date to:

10.1.1 Advise the inmate of the date and time of the ABOEC Hearing.

10.1.2 Explain the Department's requirement for continuity of care for SMI offenders and how it may apply to the inmate.

10.1.3 Ask the inmate whether they would like staff representation at the ABOEC Hearing to report on their progress or lack of progress in the Department's Mental Health Treatment Program.

10.1.4 If the inmate accepts staff representation, advise the inmate to identify who they would like to be represented by.

10.1.5 If the inmate does not agree to accept staff representation at the ABOEC Hearing, determine if they misunderstood the question that was asked or if their mental health condition made it doubtful the inmate understood.

10.1.6 If the inmate misunderstood the question, clarify the Department's requirement for continuity of care for offenders who are SMI and how it may apply to them, and ask them again whether they would like staff representation at the ABOEC Hearing.

10.1.7 Advise the ABOEC, as authorized by the inmate, if the inmate knowingly refused the representation or was not able to make an informed decision due to a mental impairment.

10.1.8 Ask the inmate to sign the Waiver of Confidentiality – ABOEC Mental Health, Form 1103-55, if the inmate agrees to staff representation at the ABOEC Hearing, and forward the original page of the form for filing in the inmate's Medical Record.

10.1.9 Attend the ABOEC Hearing if the inmate agrees to staff representation and signs the Waiver of Confidentiality – ABOEC Mental Health form.

11.0 REFERRAL/HOSPITALIZATION OF INMATES WITH SERIOUS MENTAL HEALTH SYMPTOMS PENDING RELEASE

11.1 Security and other staff, as appropriate, shall notify a QMHP when an inmate displays behavior or makes verbal statements suggesting the inmate might require or benefit from mental health care services.

11.2 Upon notification, the QMHP shall arrange for an evaluation of the inmate.

11.2.1 If QMHP evaluating the inmate determines the inmate may have a serious mental illness and psychiatric hospitalization may be in order, they shall request a further evaluation by a psychiatric provider. If no psychiatric provider is available, the evaluation shall be by a medical provider in consultation with a QMHP.

11.3 Upon determining the need for psychiatric hospitalization of the inmate, the medical or psychiatric provider shall further determine if the inmate is willing to be hospitalized voluntarily.

11.3.1 If the inmate is willing to be hospitalized voluntarily and indicates so by signing the Conditions to Admission, Form 1103-53, or electronic equivalent, the medical or psychiatric provider shall proceed as outlined in 11.6 of this section.

11.3.2 If the inmate is not willing to be hospitalized voluntarily, the medical or psychiatric provider shall proceed as outlined in 11.7 of this section.

11.4 Upon determining the need for a course of mental health treatment other than psychiatric hospitalization, the medical or psychiatric provider shall proceed accordingly in concert with other members of the mental health team and document the proposed course of action in the inmate's Medical Record.

11.5 Community Supervision Offenders with Mental Health Symptoms

11.5.1 Community Supervision offenders (offenders) who exhibit symptoms of a mental health diagnosis shall be referred by their assigned Community Corrections Officer to a medical or psychiatric provider, hospital or mental health facility for a psychiatric evaluation.

11.5.2 If an offender refuses the referral, the assigned Community Corrections Officer shall meet with the offender to identify and assist in removing barriers to engage in the recommended mental health evaluation.

11.5.2.1 If the offender continues to refuse the referral, the assigned Community Corrections Officer shall meet with the Community Corrections Supervisor, the offender and any identified supports for the offender to develop a plan to address the mental health concerns.

11.5.2.2 If the above attempts have been unsuccessful, the Community Corrections Officer, in collaboration with the Community Corrections Supervisor, may request a warrant for the revocation of parole or Administrative Release be issued by the Assistant Director for Education, Programming and Community Reentry. If the request is approved, the warrant shall be issued.

11.5.3 If the medical or psychiatric provider determines the offender needs inpatient psychiatric treatment, the offenders may be voluntarily admitted or involuntarily committed.

11.5.4 The assigned Community Corrections Officer shall notify the ABOEC of the action taken.

11.6 Voluntary Admissions – Any inmate committed to a Department prison or Community Corrections Center may be voluntarily admitted to the appropriate mental health facility, upon referral by a medical or psychiatric provider. The medical or psychiatric provider shall:

11.6.1 Determine the inmate's need for treatment and request the inmate sign a Conditions to Admission, Form 1103-53, or electronic equivalent.

11.6.2 Contact the appropriate mental health facility admitting psychiatric provider and provide a briefing of the case.

11.6.3 Contact the admissions officer of the appropriate mental health facility to arrange for the transfer/admission of the inmate/offender.

11.6.4 Forward, in the case of all male and female inmates being transferred to an Inpatient Treatment Unit within the Department, the inmate's Medical Record to the Treatment Unit Admitting Officer.

11.6.4.1 The Medical Record shall include a written summary documenting the inmate's condition and behavior and a copy of the completed Conditions of Admission.

11.6.5 Forward, in the case of minor inmates being considered for transfer to the Arizona State Hospital, a written summary documenting the inmate's condition and behavior and a copy of the completed Conditions of Admission to the treatment unit's Admitting Officer, upon first securing authorization from the Chief Medical Officer of the Arizona State Hospital as a result of a committing court order.

11.7 Involuntary Hospitalization (Involuntary Non-Emergency Admissions)

11.7.1 When an inmate is found to have a mental disorder, but is not a current danger to themselves or others, by a medical or psychiatric provider, and is unwilling to commit themselves voluntarily to a mental health facility, the following procedure shall be followed:

11.7.1.1 A medical or psychiatric provider shall examine the inmate/offender and submit an Application for Involuntary Treatment A.R.S. §31-226, Form 1103-20, to the Director or designee, describing the inmate's condition, including a recommendation for the involuntary hospitalization of the inmate.

11.7.1.2 Upon receipt of the Application for Involuntary Treatment A.R.S. §31-226 form, the Director or designee, shall review the Application for Involuntary Treatment A.R.S. §31-226 form and, if approved, send a copy to the Department's Attorney General Liaison for filing with the appropriate court, and notify the petitioning psychiatric provider of the approval.

11.7.2 At least 10 calendar days prior to the court Hearing on the Application for Involuntary Treatment, the Office of the Attorney General shall provide the inmate the following:

11.7.2.1 A copy of the Application for Involuntary Treatment A.R.S. §31-226 form

11.7.2.2 A written notice of the hearing

11.7.2.3 A copy of the inmate's rights at the hearing

11.7.3 When the court orders the inmate be committed involuntarily, security staff assigned to transport the inmate to court shall obtain a copy of the court order from the court and transport the inmate and a copy of the court order to the hospital or the mental health facility designated by the court.

11.7.4 When the court does not order the inmate committed involuntarily, security staff assigned to transport the inmate shall return the inmate to the sending facility and notify the CHP Facility Health Administrator of the inmate's return, who shall notify the appropriate QMHP to assure continuity of care.

11.8 Involuntary Emergency Transfer to a Mental Health Facility

11.8.1 When an inmate is found by a medical or psychiatric provider to have a mental disorder, pose a current danger to them self or others, and is unwilling to commit voluntarily to a mental health facility, the medical or psychiatric provider shall:

11.8.1.1 Contact the appropriate mental health facility admitting psychiatric provider and provide a briefing of the case.

11.8.1.2 Contact the Admissions Officer of the appropriate mental health facility to arrange for the emergency transfer/admission of the inmate/offender.

11.8.1.3 Ensure, when an inmate is transferred to a mental health facility, the inmate's Medical Record and Institutional File, including all relevant documentation, is sent to the receiving facility with the inmate.

11.8.1.4 Forward, in the case of minor inmates, a written summary documenting the inmate's condition and behavior to the Arizona State Hospital's Treatment Unit Admitting Officer.

11.8.1.4.1 The minor inmate's Medical Record shall be retained at the sending facility.

11.8.1.5 Notify the appropriate CHP Regional Mental Health Director an emergency transfer has occurred.

11.8.1.6 Be available to the Department's Attorney General Liaison, as necessary, to testify in court as to their findings.

11.8.2 The receiving/admitting psychiatric provider shall:

11.8.2.1 Examine and admit the inmate on an emergency or voluntary basis.

11.8.2.2 Complete, if the inmate is not willing to be admitted on a voluntary basis and continues to appear mentally disordered and dangerous to self or others, an Application for Involuntary Treatment A.R.S. §31-226, Form 1103-20, and provide it forthwith to the Department's Attorney General Liaison for filing with the appropriate court.

11.8.2.2.1 The Application for Involuntary Treatment A.R.S. §31-226 form shall be completed within 48 hours of admission (excluding weekends and holidays).

11.8.2.3 Notify the appropriate CHP Regional Mental Health Director an emergency admission has occurred, and provide a copy of the Application for Involuntary Treatment A.R.S. §31-226 form.

11.8.3 The Clinical Director of the admitting facility shall:

11.8.3.1 Provide the court and the appropriate CHP Regional Mental Health Director or designee, as long as the court order for involuntary hospitalization is in effect, with quarterly reports detailing the inmate’s mental health status and proposed plan of treatment for the next 90 calendar days.

11.8.3.2 Notify the State Attorney General and the appropriate CHP Regional Mental Health Director when the inmate's involuntary hospitalization is terminated by discharge from the hospital.

11.9 Release or Commitment of SMI Inmates

11.9.1 The CHP Discharge Planner shall collaborate with the Correctional Officer III to ensure the following requirements are met for all inmates being released who are designated MH-4, MH-5, or SMI:

11.9.1.1 An aftercare plan is developed to reflect the inmate's current symptoms and functional impairments, progress in treatment, and treatment plan.

11.9.1.2 An evaluation for SMI designation and placement in the community is facilitated.

11.9.1.3 Follow-up care with the appropriate community provider is arranged where possible.

11.9.2 Prior to the expiration of sentence, if the inmate is determined to pose a threat to their self or others by reason of a mental disorder, an involuntary commitment shall be sought in accordance with Civil Commitment Procedures.

12.0 PRESCRIBING PSYCHOTROPIC MEDICATIONS – Psychotropic medications shall be prescribed accordance with the Mental Health Technical Manual.

12.1 The psychiatric provider shall:

12.1.1 Complete the Informed Consent for Psychotropic Medications, Form 1103-12, or electronic equivalent, and allow the inmate to sign it.

12.1.1.1 The Informed Consent for Psychotropic Medications form shall be used at any facility where psychotropic medication is administered for treatment of mental disorders.

12.1.1.2 In the event the inmate refuses to sign the Informed Consent for Psychotropic Medication form, the attending staff shall write "refused to sign" on the inmate signature line.

12.1.2 Document, on the Physician's Progress Notes in the inmate's Medical Record, the reason for prescribing psychotropic medication for an inmate with a mental disorder and whether or not the inmate consented to the treatment and signed the Informed Consent for Psychotropic Medication form.

12.1.3 Prepare a prescription to dispense psychotropic medication.

12.1.4 Ensure, in conjunction with Pharmacy and Nursing staff, the inmate receives the psychotropic medication within a medically appropriate time frame, as determined by the psychiatric provider.

12.2 When voluntarily administering psychotropic medication, QHCPs or pharmacy staff responsible for administering the psychotropic medication and documenting compliance with the psychiatric provider's prescription for psychotropic medication shall:

12.2.1 Only dispense psychotropic medication that has been ordered in a current prescription by a psychiatric provider and are so labeled.

12.2.2 Copy each medication order, exactly as written onto the Medication Administration Record, Form 1102-2, or electronic equivalent.

12.2.3 Complete a laboratory requisition form provided by the CHP, if indicated.

12.2.4 Document on the Medication Administration Record, Form 1102-2, all psychotropic medication that is administered.

12.2.5 Inform the psychiatric provider and the pharmacist of any adverse reactions to the psychotropic medication, and document the information on the Medication Administration Record form.

12.2.6 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, as prescribed, to inmates.

12.2.7 Administer psychotropic medication to inmates as determined by reviewing the prescription, by one of the following methods:

12.2.7.1 By Keep on Person (KOP) Medication

12.2.7.2 By Direct Observation Therapy (DOT)

12.2.7.2.1 QHCPs may place an inmate on DOT if they suspects the inmate may abuse the medication, but may not take an inmate off DOT without written orders from the psychiatric provider.

12.3 A psychiatrist may order psychotropic medication for and administer it involuntarily to an inmate with a mental disorder if, after evaluating the severity of the inmate's symptoms and the likely effects of the particular drug to be used, the psychiatrist determines:

12.3.1 An emergency exists.

12.3.2 Alternative methods of restraint are inadequate.

12.3.3 Forced medication is required, as a last resort, to address the emergency.

12.4 An inmate may be medicated involuntarily with psychotropic medication, for a maximum of six months, if the following conditions have been met:

12.4.1 The inmate suffers from a diagnosed mental health disorder.

12.4.2 The treating psychiatric provider has determined, due to a mental disorder, the inmate is either severely impaired or the inmate's conduct presents a likelihood of serious harm.

12.4.3 The psychiatric provider has concluded there is a substantial likelihood that psychotropic medication will ameliorate the inmate's condition and has prescribed them in the medical interest of the inmate as an integral part of the Mental Health Treatment Plan.

12.4.4 The inmate has been offered and has refused the opportunity to voluntarily participate in the Mental Health Treatment Plan, including the medication component.

12.4.5 The PMRB has reviewed the matter and determined:

12.4.5.1 The inmate suffers from a mental health disorder.

12.4.5.2 The inmate is severely impaired or their conduct presents a likelihood of serious harm.

12.4.5.3 The proposed medication is in the inmate's medical interest.

12.5 Refusal of Treatment with Psychotropic Medication (Non-Emergency Situations)

12.5.1 The treating psychiatric provider shall give the inmate at least 24 hours, written notice of their intent to convene an Involuntary Medication Hearing (Notification of Intent to Request Approval to Involuntarily Administer Psychotropic Medication, Form 1103-15) before the PMRB, during which time the inmate may not be involuntarily medicated in the absence of an emergency situation as defined in the Glossary of Terms.

12.5.1.1 The notification is to include the treating psychiatric provider's tentative diagnosis of the inmate, the factual basis for the diagnosis, and a statement as to why the psychiatric provider believes medication is necessary and in the inmate's medical interest.

12.5.2 Upon receipt of the copy of the psychiatric provider's notice to the inmate, the Mental Health Lead shall:

12.5.2.1 Schedule a meeting of the PMRB to be held no earlier than 24 hours and no later than 72 hours after the inmate receives the psychiatric provider's notification.

12.5.2.2 Notify the inmate and the Correctional Officer III using Psychotropic Medication Review Board Notification of Hearing and Inmate’s Rights, Form 1103-1, or electronic equivalent.

12.5.2.3 Notify the treating psychiatric provider of the Involuntary Medication Hearing date and time.

12.5.3 At the Involuntary Medication Hearing the inmate has the right:

12.5.3.1 To attend or refuse to attend.

12.5.3.2 At the discretion of the PMRB panel, to present evidence, and to cross-examine staff witnesses.

12.5.3.3 To the assistance and presence of a lay advisor in the form of their Correctional Officer III or the unit Correctional Officer IV.

12.5.4 A summary of the PMRB findings and a list of the attendees shall be prepared by the PMRB Chair or designee, using the Findings of Psychotropic Medication Review Board (PMRB), Form 1103-2, or electronic equivalent, at the conclusion of the hearing, and copies distributed to:

12.5.4.1 The inmate and the inmate's Correctional Officer III, within eight hours of the conclusion of the Involuntary Medication Hearing.

12.5.4.2 The CHP Facility Health Administrator, the treating psychiatric provider, the Warden, the Statewide Chief Executive Officer for Health Services or designee, and the inmate's Medical Record.

12.5.5 If the PMRB determines by a majority vote the inmate suffers from a mental disorder and is severely impaired or poses a likelihood of serious harm to self, others, or property, the inmate may be medicated against their will, provided the PMRB psychiatrist is in the majority.

12.5.5.1 The order authorized by the PMRB to medicate an inmate against their will may include needed laboratory tests to ensure safe administration of the medication regiment.

12.5.5.2 The laboratory tests shall be a component of the PMRB process and can be conducted against the inmate's will, if necessary.

12.5.6 The inmate has the right to appeal the PMRB's decision by notifying the CHP Regional Mental Health Director, via an Inmate Letter, Form 916-1, within 24 hours of receipt of the PMRB's decision.

12.5.6.1 The CHP Regional Mental Health Director or designee shall decide the appeal and notify the inmate through the CHP Facility Health Administrator of the decision via email within 24 hours of receipt (excluding weekends and holidays). Within four hours of receipt of the CHP Regional Mental Health Director's decision (excluding weekends and holidays), the Mental Health Lead or designee shall provide copies of the decision to the inmate, the inmate's Correctional Officer III, the treating psychiatric provider, and the PMRB Chair.

12.5.6.2 During the appeal period, in the absence of an emergency as defined in the Glossary of Terms, the inmate shall not be involuntarily medicated.

12.5.6.3 In the event the appeal is upheld, the inmate shall not be involuntarily medicated in the absence of an emergency as defined in the Glossary of Terms or in a court order.

12.5.7 The treating psychiatric provider may request a new Involuntary Medication Hearing no sooner than 14 workdays after the appeal is upheld.

12.5.8 If the PMRB approves the involuntary administration of psychotropic medication of an inmate and there is no upheld appeal, the inmate's treatment team shall review the inmate's case within three months and approve or disapprove by the criteria outlined in this DO and the Mental Health Technical Manual, the continuance of involuntary medication for an additional three months.

12.5.8.1 The treatment team's decision is final and shall not be subject to appeal.

12.5.9 At the end of the 180 day involuntary medication period, the PMRB order for involuntary treatment shall expire.

12.5.9.1 Using the criteria outlined in this DO and the Mental Health Technical Manual, the treating psychiatric provider may again seek authorization to involuntary medicate the inmate with psychotropic medication.

12.5.10 At any time the inmate becomes compliant with his medication and agrees to voluntarily take it, the treating psychiatric provider shall so note in the inmate's Medical Record, though the PMRB's Involuntary Medication Order shall remain in effect unless rescinded by the PMRB or it expires.

12.5.11 Whenever the PMRB meets to review an inmate's case, the Mental Health Lead or designee shall provide the PMRB with a copy of all mental health records, laboratory results received, and any Health Need Requests (HNRs) received from the inmate, since the last PMRB hearing.

12.6 Nothing in this Medication Order shall relieve the treating psychiatric provider from responsibility for adhering to Department written instructions.

12.7 The psychiatric provider may also prescribe psychotropic medication and administer it involuntarily to inmates who are involuntarily-committed inmates at the Alhambra Reception and Treatment Center if one of the following apply:

12.7.1 The conditions in 12.3 of this section exist.

12.7.2 In a non-emergency, a review and consent is obtained from a committee composed of medical and psychiatric providers/licensed psychologists.

12.8 Medication shall not be discontinued or allowed to expire without a face-to-face interview with the psychiatric provider or QMHP in consultation with the psychiatric provider.

12.8.1 Discontinuation of medication at the inmate's request shall be done in a face-to-face interview with the psychiatric provider or QMHP in consultation with the psychiatric provider, and both the interview and the refusal shall be documented in the Mental Health section of the inmate's Medical Record.

12.8.2 Non-compliance with medication regimen by an inmate shall be followed by a face-to-face interview with a QMHP, in consultation with the psychiatric provider, prior to the psychiatric provider authorizing discontinuation of the medication.

12.8.2.1 Non-compliance shall be documented in the Mental Health section of the inmate's Medical Record.

12.9 Staff discovering any unauthorized psychotropic medication in an inmate's possession shall consider the medication to be illegal contraband.

12.9.1 An inmate who possesses such medication may be charged with drug abuse in accordance with DO #803, Inmate Disciplinary Procedure.

12.9.2 A person who provides psychotropic medication to an inmate that was not ordered in a current prescription by a psychiatric provider may be charged with introduction of contraband.

12.9.3 Staff discovering unauthorized medication in an inmate's possession shall seize the contraband and process the matter in accordance with DO #909, Inmate Property.

13.0 SERVICES FOR INTELLECTUALLY DISABLED INMATES

13.1 Any inmate giving indications of intellectual disability shall be referred to the assigned QMHP for evaluation. Referrals may be made by any Department staff person.

13.2 Indicators may include but are not limited to the following:

13.2.1 Inability to comprehend verbal instructions

13.2.2 Inability to comprehend written instructions

13.2.3 Age-inappropriate behavior

13.2.4 Atypical physical characteristics

13.2.5 Inappropriate emotional responses

13.3 When indicated, a clinical psychologist or designee shall test and/or evaluate the inmate to determine the inmate's intellectual and adaptive function level.

13.4 If it is determined the inmate has an intellectual disability, the QMHP shall develop a Mental Health Treatment Plan and make recommendations to the Deputy Warden regarding the inmate's:

13.4.1 Classification.

13.4.2 Placement.

13.4.3 Work assignments.

13.4.4 Educational training.

13.4.5 Vocational training.

13.4.6 Other services or treatment that may be needed.

13.5 The Warden, Deputy Warden or Administrator shall ensure inmates who have been determined to have an intellectual disability receive the services and treatment the mental health team has recommended.

13.6 Inmates with intellectual disabilities shall be reevaluated annually by the mental health team to determine if a change of placement, assignment or treatment is necessary.

13.7 Psychological evaluations shall be retained in the inmate's Medical Record in accordance with the Mental Health Technical Manual.

14.0 MENTAL HEALTH PROGRAM – PERFORMANCE IMPROVEMENT – A system of documented internal review exists and is implemented by the CHP Regional Mental Health Director to monitor and improve mental health care/delivery of services. This monitoring is incorporated into the internal review developed for healthcare and includes:

14.1 Participating in a multi-disciplinary quality improvement committee, which includes a QMHP as a member.

14.2 Collecting, trending, and analyzing of data combined with planning, intervening and reassessing services.

14.3 Evaluating defined data, which will result in more effective access to care, improved quality of care, and better utilization of resources.

14.4 Reviewing all suicides or suicide attempts and other serious incidents, (e.g., use of force, assaults, restraints/involuntary medications) involving inmates identified with a serious mental illness.

14.5 Reviewing clinical care issues, implementing measurable corrective action plans to address and resolve important problems and concerns identified specific to mental health issues, and incorporating findings of internal review activities into the organization's educational and training activities.

14.6 Maintaining appropriate records of internal review activities.

14.7 Requiring a provision that records of internal review activities comply with legal requirements on confidentiality of records.

IMPLEMENTATION

The Assistant Director for Healthcare Services shall update and maintain Technical Manuals, which address, at a minimum, continuity of care of SMI inmates, admission of inmates to treatment units and assessment.

DEFINITIONS/GLOSSARY

Refer to the Glossary of Terms for the following:

- Contract Healthcare Provider (CHP) Facility Health Administrator
- Diagnostic and Statistical Manual Of Mental Disorders (DSM-5), Fifth Edition
- Direct Observed Therapy (DOT)
- Emergency
- Healthcare Staff
- Intellectually Disabled
- Involuntary Administration of Psychotropic Medication
- Involuntary Admission
- Keep On Person (KOP) Medication
- Licensed Mental Health Facility
- Likelihood Of Serious Harm
- Mental Health Duty Officer
- Mental Health Lead
- Mental Health Staff
- Mental Illness/Disorder
- Offender
- Prescription
- Psychotropic Medication
- Psychotropic Medication Review Board (PMRB)
- Qualified Mental Health Professional (QMHP)
- Release Referral Packet
- Seriously Mentally Ill (SMI)
- Statewide Chief Executive Officer for Healthcare Services
- Treatment (2)
- Voluntary Admission

ATTACHMENTS

Attachment A, Mental Health Transition Program Activities
Attachment B, Mental Health Transition Program

FORMS LIST

807-1, Mental Health Watch Order
916-1, Inmate Letter
1101-4ES, Refusal to Submit to Treatment
1101-10ES, Health Need Requests (HNR)
1102-2, Medication Administration Record
1103-1, Psychotropic Medication Review Board Notification of Hearing and Inmate's Rights
1103-2, Findings of Psychotropic Medication Review Board (PMRB)
1103-5, Mental Health Non-Clinical Contact Note
1103-9, Residential Treatment Unit (RTU) Referral
1103-12, Informed Consent for Psychotropic Medications
1103-13, Mental Health Seriously Mentally Ill (SMI) Determination
1103-15, Notification of Intent to Request Approval to Involuntarily Administer Psychotropic Medication
1103-18, Mental Health Treatment Consent
1103-20, Application for Involuntary Treatment A.R.S. §31-226
1103-23, Pre-Admission Data – Inpatient Referral
1103-27, Initial Mental Health Assessment
1103-53, Conditions to Admission
1103-55, Waiver of Confidentiality – ABOEC Mental Health
1103-69, Clinical Summary and Recommendations

OTHER RESOURCES

Mental Health Technical Manual

AUTHORITY

A.R.S. §31-226, Mental Disordered Prisoner; Procedure for Voluntary or Involuntary Hospitalization; Notice; Hearing; Transfer; Reports; Return to Incarceration or Release; Costs; Definition
A.R.S. §31-226.01, Emergency Transfer Procedures
A.R.S. §32-1401 et seq, Arizona Medical Board
A.R.S. §32-1602, Board of Nursing; Member Terms; Immunity
A.R.S. §32-1902 et seq, Board of Pharmacy
A.R.S. §32-2062 et seq, Board of Psychologist Examiners
A.R.S. §32-2501 et seq, Certification of Physician's Assistants
A.R.S. §32-3301 et seq, Professional Counselors; Certification; Requirements
A.R.S. §36-501, Definitions
A.R.S. §36-551, Definitions
A.A.C. R4-6-701 et seq, Certification of Substance Abuse Counselors
A.A.C. R4-16-101 et seq, Arizona Medical Board
A.A.C. R4-17-101 et seq, Joint Board on the Regulation of Physician Assistants
A.A.C. R4-19-101 et seq, Board of Nursing
A.A.C. R4-23-101 et seq, Board of Pharmacy
A.A.C. R4-26-101 et seq, Board of Psychologist Examiners

A.A.C. R5-1-1201 et seq, Involuntary Administration of Psychotropic Medication

ATTACHMENT A

MENTAL HEALTH TRANSITION PROGRAM ACTIVITIES

SATURDAY	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
0630 INSULIN CALL (IN HOUSE) 0700 AM MEAL 0730 MED PASS (IN HOUSE) 0730-1030 REC HU4/DAY ROOM/PHONE 1100 COUNT 1230-1400 NAIL CLIPPERS BEARD CLIPPERS 1400-1530 POD SANITATION 1545-1645 LARGE RECREATION FIELD 1600 COUNT 1700 PM MEAL	0630 INSULIN CALL (IN HOUSE) 0700 AM MEAL 0730 MED PASS (IN HOUSE) 0800-1000 REC HU4/DAY ROOM/PHONE 1045-1145 LARGE REC FIELD 1100 COUNT 1230–1400 NAIL CLIPPERS BEARD CLIPPERS 1400-1530 POD SANITATION 1600 COUNT 1700 PM MEAL	0630 INSULIN CALL (IN HOUSE) 0700 AM MEAL 0730 MED PASS (IN HOUSE) 0730-1030 REC HU4/DAY ROOM/PHONE 1100 COUNT 1200 MID MEAL 1230–1400 NAIL CLIPPERS BEARD CLIPPERS 1400-1530 POD SANITATION 1545-1645 LARGE RECREATION FIELD 1600 COUNT 1700 PM MEAL	0630 INSULIN CALL (IN HOUSE) 0700 AM MEAL 0730 MED PASS (IN HOUSE) 0800-1000 REC HU4/DAY ROOM/PHONE 1045-1145 REC LARGE REC FIELD 1100 COUNT 1200 MID MEAL 1230–1400 NAIL CLIPPERS BEARD CLIPPERS 1400-1530 POD SANITATION 1600 COUNT 1700 PM MEAL 1730-1900 REC HU4/DAY ROOM/PHONE	0630 INSULIN CALL (IN HOUSE) 0700 AM MEAL 0730 MED PASS (IN HOUSE) 1045-1145 REC (SM. REC) 1100 COUNT 1200 MID MEAL 1230–1400 NAIL CLIPPERS BEARD CLIPPERS 1400-1530 POD SANITATION 1600 COUNT 1700 PM MEAL	0630 INSULIN CALL (IN HOUSE) 0700 AM MEAL 0730 MED PASS (IN HOUSE) 0730-1030 REC HU4/DAY ROOM/PHONE 1100 COUNT 1200 MID MEAL 1230–1400 NAIL CLIPPERS BEARD CLIPPERS 1400-1530 POD SANITATION 1545-1645 LARGE RECREATION FIELD 1600 COUNT 1700 PM MEAL	0630 INSULIN CALL (IN HOUSE) 0700 AM MEAL 0730 MED PASS (IN HOUSE) 0800-1000 REC HU4/DAY ROOM/PHONE 1045-1145 REC LARGE REC FIELD 1100 COUNT 1200 MID MEAL 1230–1400 NAIL CLIPPERS BEARD CLIPPERS 1400-1530 POD SANITATION 1600 COUNT 1700 PM MEAL 1730-1900 REC HU4/DAY ROOM/PHONE

It should also be noted that inmates at any time while in their assigned living area (POD) are able to move about freely in the pod and use the showers, except during formal counts at 1100 and 1600 hours.

Games and other activities shall be available for check out and use by inmates while in their living areas. These activities are meant to promote pro-social interaction with others and provide unstructured leisure activities for the inmates.

ATTACHMENT B

MENTAL HEALTH TRANSITION PROGRAM

TIME	HU4A MONDAY, THURSDAY SATURDAY
0600 – 0700	
0730 - 1030	HU4 REC FIELD/DAY ROOM/PHONE
1045 – 1145	
1545 – 1645	LARGE REC FIELD
1700 – 1900	
	12 hours

TIME	HU4A TUESDAY, FRIDAY, SUNDAY
0600 – 0700	
0800 - 1000	HU4 REC FIELD/DAY ROOM/PHONE
1045 – 1145	LARGE REC FIELD
1545 – 1645	
1730 – 1900	HU4 REC FIELD/DAY ROOM/PHONE
	13.5 hours-total - 25.5 hours for week