I. PURPOSE:

The purpose of this health services bulletin is to delineate the scope, goals, and guidelines for the delivery of outpatient mental health services.

II. POLICY:

The department provides a comprehensive range of outpatient mental health services including evaluation, counseling, case management, and psychiatric care. Inmates requiring a higher level of care than can be provided on an outpatient basis will be referred to the clinically appropriate inpatient mental health level of care.

III. DEFINITIONS:

A. **Clinical Group Psychotherapy**: a cognitive behavioral or psychodynamic process by which a group of individuals is led by a psychologist or behavioral health specialist to guide interpersonal and intrapersonal growth through an examination of patients' thoughts, feelings, experiences and skills.

B. **Multidisciplinary Services Team (MDST)**: a group of staff representing different professions, and/or disciplines, which has the responsibility for ensuring access to necessary assessment, treatment, continuity of care and services to inmates in accordance with their identified mental health needs, and which collaboratively develops, implements, reviews, and revises an "Individualized Service Plan," form DC4-643A, as needed.

C. **Psychoeducational Group Intervention**: a didactic form of group therapeutic services designed to teach patients about their disorder and help them learn how to manage the related symptoms, behaviors and consequences. May include workbook and/or homework activity. Examples include medication management, stress/anger management, social skills, activities of daily living, etc.

D. **Residential Continuum of Care (RCC)**: specialized residential mental health units that work together, in conjunction with the inpatient system, to provide augmented outpatient mental health treatment and habilitation services in a protective environment for inmates with serious psychological impairment associated with a historical inability to successfully adjust to daily living. In general, RCC units include Cognitive Treatment Units (CTU), Diversion Treatment Units (DTU) and/or Secure Treatment Units (STU).

E. **S-II Institution**: an institution within the department which is authorized to receive and house inmates who are classified as 1 or 2, on category S (mental

health) of the health profile. Mental health staff at S-II institutions is comprised of non-prescribing mental health clinicians (e.g., psychologists, doctoral and master's level counselors) who provide such services as evaluation, crisis intervention, counseling and case management.

F. **S-III Institution**: an institution within the department which is authorized to receive and house inmates who are classified as 1, 2, or 3 on category S (mental health) of the health profile. Both non-prescribing mental health clinicians and psychiatry staff are allocated to these institutions.

G. **S-grade:** Mental Health Grade - An inmate who:

1. **S-1** = Demonstrates no significant impairment in the ability to adjust within an institutional environment and does not exhibit symptoms of a mental disorder (which includes intellectual disability). Although inmates classified as S-1 do not require ongoing mental health treatment, they have access to routine mental health services.

2. **S-2** = Exhibits impairment associated with a diagnosed mental disorder. The impairment is not so severe as to prevent satisfactory adjustment in general inmate housing with the assistance of mental health case management, psychological services, and counseling. This mental health grade also applies to an inmate who, as determined by psychiatry staff, is sufficiently stable on select psychotropic medications for medication management by a non-psychiatric physician or APRN in consultation with a psychologist.

3. **S-3** = Shows impairment in adaptive functioning due to a diagnosed mental disorder. The impairment is not so severe as to prevent satisfactory adjustment in general inmate housing with the assistance of mental health case management, psychological services, counseling, and psychiatric consultation for psychotropic medication. S-3 is also assigned routinely to an inmate who is determined to need psychotropic medication, even if the inmate may be exercising the right to refuse such medication.

4. **S-4** = Is assigned to a transitional care unit (TCU), which is an inpatient level of mental health care. The mental health classification S-4 can only be assigned or changed at a TCU.

5. **S-5** = Is assigned to a crisis stabilization unit (CSU), which is an inpatient level of mental health care. This classification can only be assigned or changed at a CSU.

6. **S-6** = Is admitted to a Mental Health Treatment Facility (MHTF), which is the highest and most intensive level of inpatient mental health care. Admission to an MHTF requires judicial commitment.

7. **S-9** = Is in the reception process and is scheduled to be evaluated by psychiatry staff.

IV. TARGET POPULATION AND GOALS FOR OUTPATIENT CARE:

A. **Mental Health** staff will offer assessment, consultation, and treatment services to inmates in order to facilitate an inmate's ability to adequately function in a prison environment. Mental health care will be provided in the context of a collaborative therapeutic relationship with the inmate.

B. **Crisis intervention** services are offered to inmates who may be experiencing acute distress and/or acute symptoms of mental illness to prevent suicide and self-injury (in accordance with Procedure 404.001, *Suicide and Self-Injury Prevention*) and/or to provide relief from symptoms of mental illness and prevent further decompensation.

C. **Assessment and Consultation** services are provided in response to referrals by staff, inmate requests and/or situational factors (such as an inmate being segregated from the general inmate population). In providing these services, mental health staff assess an inmate's mental health needs and provide guidance or recommendations regarding treatment needs and/or precautions.

D. **Ongoing mental health care** will be provided on an outpatient basis to alleviate symptoms of mental illness that result in impairment of an inmate's ability to adapt and function in the prison environment. An *Individualized Service Plan* (ISP; form DC4-643A) must be developed in accordance with HSB 15.05.11, *Planning and Implementation of Individualized Mental Health Services*, for those inmates participating in ongoing mental health care.

V. GENERAL GUIDELINES:

A. Any inmate may receive an interview with mental health staff by staff or self-referral. Routine self-referrals are accomplished via completion of the DC6-236 *Inmate Request*. Mental health staff will respond within ten (10) calendar days of

receiving the completed DC6-236 with the follow-up encounter occurring within fourteen (14) calendar days, if needed. Any Inmate Request deemed clinically urgent or emergent in nature will be seen on the same day as it is received. For routine staff referrals, mental health staff will respond within seven (7) calendar days of receiving the completed DC4-529 *Staff Request/Referral* and shall schedule clinical appointments as clinically indicated. Inmate-declared emergencies and emergent staff referrals will be responded to as promptly as feasible but must be responded to by health services staff within one (1) hour of notification. At institutions where twenty-four (24) hour health care coverage is not available security staff will coordinate with available health care staff at the nearest institution to ensure response to emergent referrals in accordance with Procedure 404.001.

B. Chaplaincy requested consultations related to inmate marriages will be managed in accordance with HSB 503.002, *Chaplaincy Services.* These requests should be processed as a staff referral, with the clinical interview conducted by the psychologist documented on the DC4-642B *Mental Health Screening Evaluation* and a copy of the DC5-318 *Mental Health Consultation Response* placed in the mental health section of the inmate's medical record.

C. Mental health evaluations must only be performed by qualified mental health professionals who are privileged to perform psychiatric or psychological evaluations in accordance with HSB 15.09.05, *Credentialing and Peer Review Program.*

D. Inmates without a diagnosed mental disorder are not suitable or appropriate for ongoing outpatient mental health care.

E. Inmates receiving outpatient care (S-2 and S-3 mental health grades) who engage in masturbation or displaying of their genitalia in the presence of staff will receive appropriate mental health intervention. The identified behavior (for example, Problem #130 Masturbates Publicly) will be documented on their Individualized Service Plan and mental health staff will provide outpatient services necessary to assist the inmate patient in gaining control of the maladaptive behavior and facilitate satisfactory adaptive functioning. However, this does not preempt the disciplinary process in Rules 33-601.301-601.314, F.A.C. Disciplinary reports will be written for all occurrences of the conduct described in Rule 33-601.314, Rules of Prohibited Conduct and Penalties for Infractions, 1-6 ("Lewd or lascivious exhibition . . . .").

F. Inmates referred for placement to the TCU level of care will be evaluated at least weekly by a mental health clinician to ensure they are functioning adequately while awaiting transfer to an inpatient unit. Inmates requiring more frequent evaluation and counseling will be seen in accordance with their assessed mental health needs.

G. Augmented outpatient services are provided in the Residential Continuum of Care units consistent with Procedure 404.005, *Residential Continuum of Care Units.* Criteria for admission, treatment, and discharge to the units of the RCCU are referenced in Procedure 404.005.

H. Discipline of inmates with diagnosed mental disorders in any outpatient level of care will be subject to provisions of Rules 33-404.108 and 33-601.301-314, F.A.C.

I. Inmates receiving ongoing mental health care that are currently enrolled in a substance use program will be asked to sign a DC4-711B *Consent and Authorization for Use and Disclosure, Inspection, and Release of Confidential Information,* to allow substance use staff and mental health staff to coordinate services.

VI. SCREENING AND ORIENTATION OF NEWLY ARRIVING INMATES:

All inmates received at a permanent institution shall receive an initial screening by nursing staff in accordance with Procedure 401.014 Hea*lth Services Intake and Reception Process* that is documented on form DC4-760A, *Health Information Transfer/Arrival Summary*. During this screening, nursing staff shall provide instructions for accessing health care services, including mental health services. Nursing staff shall immediately refer to mental health staff any inmate they believe is showing active symptoms of psychosis (e.g., active hallucinations, delusions, etc.), a manic episode (unexplained agitation, pressured speech, etc.), or risk of self-injury/suicide, and must take necessary precautions to provide for the inmate's safety in accordance with Procedure 404.001 *Suicide and Self- Injury Prevention*.

A. In addition to the initial screening by nursing staff, all inmates will be oriented to mental health services within eight (8) calendar days of arrival. This orientation to mental health services shall be provided in-person by a mental health clinician and will include both verbal and written descriptions of services available, as well as how to access those services. The written description shall be available in English and Spanish. Mental health orientation shall be documented in OBIS.

B. The limits of confidentiality shall be explained and consent to evaluation or counseling shall be obtained by completing *Consent to Mental Health Evaluation or Treatment*, form DC4-663, before the initiation of screening or treatment, unless emergency care is necessary to prevent injury to the inmate or others.

C. An inmate may revoke consent for a specific treatment or mental health treatment in general by signing a *Refusal of Health Care Services* form, DC4-711A. Refusals shall be documented in accordance with Rule 33-401.105, F.A.C. "Refusal of Health Care Services".

D. Medical staff shall ensure continuity of psychotropic medications and psychiatric care for newly arriving S-3 inmates in accordance with HSB 15.05.19 *Psychotropic Medication Use Standards and Informed Consent*. Medical staff shall ensure continuity of pharmacotherapy for any newly arriving S-3 inmate. A newly arriving inmate who is classified as S-3 shall be continued on any current psychotropic medication and will be assessed by a psychiatric provider prior to the expiration of the current psychotropic prescription.

E. Each newly arriving S-2 and S-3 inmate shall be interviewed by a mental health provider (master or doctoral level clinician) within fourteen (14) calendar days and the treatment plan will be reviewed in accordance with the requirements of HSB 15.05.11 to ensure continuity of mental health care. This initial interview must be documented using the DC4-642B, *Mental Health Screening Evaluation*.

F. All S-1 inmates who did not receive an intake mental health reception screening shall be interviewed by a mental health provider (master or doctoral level clinician) within fourteen (14) calendar days of arrival at their first permanent institution to assess mental status and confirm the S-grade. The interview shall be documented on the DC4-642B.

G. Inmates assigned to Death Row shall receive their initial screening, to include reception level testing and interview by a mental health clinician, at their assigned location: FSP for men and Lowell CI for women. All reception timelines outlined in HSB 15.05.17 *Intake Mental Health Screening at Reception Centers* are applicable to these required services.

VII. ONGOING SERVICE DELIVERY:

A. Case manager assignments shall be made and documented in accordance with HSB 15.05.11.

B. Mental health services will be provided in the context of a collaborative therapeutic relationship with the inmate.

C. Individual and/or group psychotherapy will be offered no less than once every sixty (60) days for all inmates on the mental health case load.

D. Inmates receiving outpatient mental health level of care that have a current diagnosis of a psychotic disorder, or any disorder with psychotic features, must be maintained at a mental health grade of S-3. Case management services will be offered to these inmates at least once every thirty (30) days.

E. If an S-2 or S-3 inmate refuses to participate in a treatment as prescribed on his/her ISP, but does not rescind his/her consent to treatment recorded on DC4-663, *Consent to Mental Health Evaluation or Treatment*, case management services will be continued in order to monitor the inmate's behavioral functioning as long as ongoing mental health services are deemed to be needed.

F. After being placed in the Mental Health section of the outpatient record, all documentation of encounters – including refusals – will be documented on the DC4-701, *Chronological Record of Health Care*. This may take the form of an entry using a stamp reading "Seen in Mental Health" or "Inmate Refused Mental Health Service" and must include the date, time, stamp and signature of the service provider.

G. Case management will occur at least every sixty (60) days for S-2 and S-3 inmates and shall consist of at least the following:

1. Review of *Medication and Treatment Record (MAR)*, form DC4-701A, to evaluate and document psychotropic medication compliance as applicable.

2. Review of all other treatment and therapeutic activities as specified in the ISP to determine compliance and progress.

3. Review of collateral information (e.g., confinement placements, staff referrals, etc.) to assist in the assessment of the inmate's adaptive functioning. In addition to documented collateral information, the case manager may obtain further information through direct staff contacts.

4. Brief encounter to assess relevant mental status and institutional adjustment.

5. Documentation on form *Outpatient Mental Health Case Management*, DC4-642D.

H. If the inmate refuses the case management interview, such refusal will not obviate the need for the case manager to continue to monitor functioning through call-

outs, review of the DC4-701A, collateral information, and assessment of observable elements of the inmate's mental status.

I. Each permanent institution will offer group interventions, as clinically indicated, that are designed to meet the needs of inmates who are eligible for ongoing outpatient services. Clinical group psychotherapy shall be conducted only by an appropriately credentialed qualified mental health clinician and shall be designed based on the problems, objectives and goals identified on the patient's ISP. These process groups should not exceed 8-10 participants in the group. Group psychotherapy notes shall be individualized for each patient on the DC4-642U, *Clinical Group Therapy Note.*

J. In addition to clinical group psychotherapy, psychoeducational groups, which are more didactic and focus on skills acquisition, may be offered as a group therapeutic intervention. Psychoeducational groups target the development of coping skills, problem-solving strategies, interpersonal skills, stress/anger management, and improving frustration tolerance, impulse control, and resiliency. These groups can be provided by Behavioral Health Technicians or qualified mental health professionals. Documentation of a psychoeducational group shall be accomplished via monthly completion of a DC4-642V, *Outpatient Psychoeducational Group Incidental Note.*

K. If medication management, which is a psychoeducational group, is offered, it must be provided by nursing staff with concurrence of the Psychiatrist or Psychiatric APRN. Medication management ranges from teaching the patient the rationale for and effects of psychotropic medications, to assisting him/her in the process of medication reduction or discontinuation for health reasons.

L. All inmates who are returned to an outpatient setting from a TCU or a CSU shall receive outpatient mental health services at the S grade assigned upon discharge from inpatient care for at least 120 days before the inmate is eligible to be considered for a downgrade in her/his S grade.

M. Some inmates will exercise the right to refuse medication that the physician considers necessary. If the psychiatry staff determines the inmate requires psychotropic medication in order to maintain her/his adaptive functioning in an outpatient setting, the inmate must be maintained as S-3 and be provided psychiatric follow-up and case management until the inmate consents to psychotropic medication or until psychiatry staff determines the inmate no longer requires psychotropic medication in order to maintain her/his adaptive functioning in an outpatient setting. Psychiatric follow-up for such cases shall occur at least

every ninety (90) days. Case management shall occur at least every sixty (60) days (except every thirty (30) days for inmates diagnosed with psychotic features), with the psychologist referring the inmate to the psychiatry staff as the need arises. When the psychiatry staff determines that psychotropic medication is no longer indicated, the inmate's S grade shall be lowered from S-3 to S-2 and the inmate will be removed from the psychiatric caseload. Mental health staff shall provide case management for at least 120 days before the inmate is eligible to be considered for a downgrade to S-1.

N. Inmates who meet the criteria for intellectual disability (i.e., IQ <70 and impaired adaptive behavior [Adaptive Behavior Checklist <35]) should have the "SY-D" designation under Category I of the health profile and must be maintained as an S-2 or above for the duration of their incarceration. Those inmates with the "SY-Y" designation who do not meet the criteria for intellectual disability may be downgraded from S-2 if they demonstrate good adjustment for twelve (12) months and have no significant behavioral issues (e.g. no more than two (2) placements in disciplinary confinement). This downgrade should be reversed should the inmate begin demonstrating issues with adjustment as evidenced by placement in disciplinary confinement. A downgrade of an "SY-Y" designated inmate due to good adjustment does not allow for the removal of the designation in accordance with HSB 15.05.17 *Intake Mental Health Screening at Reception Centers.*

IV. DOCUMENTATION:

A. All progress notes concerning outpatient mental health care, including incidental and SOAP notes, shall be made in the mental health section of the health record on the pertinent form of the DC4-642 series. All documentation must be legible, completed in its entirety, signed, dated, and stamped by the clinician.

B. Each individual clinical encounter must be documented in SOAP format in the mental health section of the health record on a DC4-642 series form on the date of the encounter.

C Psychiatric documentation on the DC4-655, *Psychiatric Evaluation*, or DC4-642A, *Outpatient Psychiatric Follow-up*, must be typed or neatly printed (cursive handwriting is not permitted).

D. Group psychotherapy contacts shall be documented with an incidental note on DC4-642U, *Clinical Group Therapy Note,* at least monthly and upon group enrollment and termination. The monthly group psychotherapy note shall include

the proportion of scheduled sessions attended, the inmate's relative level of participation, and the inmate's observed progress toward treatment goals as referenced by ISP problem number.

E. The following guidelines apply to the writing of SOAP notes:

1. **Subjective:** This section should include the reason for the clinical encounter and a brief summary of the inmate's concerns.

2. **Objective:** This section should include what the clinician observes information from staff members, pertinent data from review of the clinical record, and other sources of information. This includes but is not limited to inmate behavior, reported and observable symptoms, relevant history, environmental factors and medication information.

   Included in this section is information pertaining to lab tests and reports and documentation of any side effects of medications.

   Clinical contacts intended to assess the inmate's current level of functioning (e.g., case management and treatment planning interviews, psychological evaluations, mental health emergency assessments, psychiatric evaluations, etc.) shall include a mental status evaluation (MSE). The MSE should address all elements of the inmate's mental status that are relevant to the clinical areas of concern. At minimum, the MSE will address the following areas:

   a. **Appearance**: Note relevant areas (e.g., hygiene, abnormalities in gait or other movements, clothing, condition of cell if observed, any apparent injury).

   b. **Behavior**: Note relevant areas (e.g., cooperative vs. uncooperative, noteworthy movements, threats, compliance, hyper- or hypoactive).

   c. **Orientation**: Awareness of person, time, place, and situation. Given that many inmates do not have to organize their activities based on a calendar date, do not consider it to be a sign of impairment if the inmate cannot identify the exact date.

   d. **Perception**: Is the inmate reporting any hallucinations (e.g., auditory, visual, tactile, olfactory, or gustatory)? If hallucinations are reported, elaborate. What is the content? Are any command hallucinations present? Does the inmate find the hallucinations to be distressing? Does the inmate understand that these are

perceptual disturbances and not actual stimuli causing the perceptions? When was the onset of hallucinations? When was the last time hallucinations were experienced?

e. **Thinking**: Are there indications of delusions (e.g., persecution, grandiosity, verifiably false beliefs, etc.) or cognitive disturbance (memory, attention, concentration, intellectual functioning, etc.)? Note content of delusions and how delusions and/or cognitive disturbances are impacting the inmate's adaptive functioning.

f. **Memory**: Are the inmate's memory functions (immediate, short-term, remote) grossly intact?

g. **Speech**: Is the inmate's speech pressured vs. normal rate, clear vs. slurred, is there a poverty of speech, etc.?

h. **Vegetative functions** (e.g., appetite/meals eaten per day; number of hours of sleep per night; energy level)

i. **Mood**: What is the mood ("sad", "depressed", "angry", "fine", "happy", etc.) that the inmate reports that he/she experiences the majority of the time?

j. **Affect**: What is the emotional tone (sad, depressed, angry, euthymic, happy, labile, broad, blunted, etc.) that the clinician observes during the clinical contact? Is the observed affect congruent with the reported mood?

k. **Suicide/homicide ideation**: Does the inmate report any current thoughts about suicide, self-injury or harming others? If yes, does he/she intend or feel compelled to carry-out such acts? Does the inmate have a plan and/or the means to carry-out such acts? Does the inmate express hope and/or an orientation toward the future?

l. **Insight**: If the inmate exhibits marked symptoms of, or is diagnosed with, a mental and/or behavioral disorder, is he/she aware of having the problem and of its impact on adaptive functioning including interactions with others?

Insight should be noted as:

- "N/A" (no significant mental health problem to be considered)
- "Good" (acknowledges problem and potential impact)

- "Poor" (inmate denies the problem and/or is unaware of its impact). If "poor" is indicated, elaborate.

m. **Judgment**: To what extent does the inmate make rational decisions and take action appropriate to the circumstances? Assessment of judgment must be tailored to the problems faced by the inmate (e.g., "What should you do if you have the urge to hurt yourself?") and should reflect knowledge of the inmate's actual behavior. Judgment should be noted as "good", "fair", or "poor", with brief clinical justification if assessed as "poor".

3. **Assessment**: This section should include the clinician's judgment of the inmate's clinical condition based on the available subjective and objective data. This may include a provisional or final diagnosis, a comparison of current status with previous status (if known) an assessment of the inmate's response to treatment (e.g., improvement of target symptoms), and/or identification of current risks to the inmate, others or institutional security. The inmate's ability to adaptively function in the prison environment is the primary consideration in the assessment section.

4. **Plan**: What the clinician did to resolve the problem, if it was resolved during the session, and/or what the clinician will do to help resolve the problems/needs or issues. If future actions are indicated, a subsequent note in the clinical record must address the status of the planned action (e.g., "consulted with Dr. A. Jones, routine psychiatry consult scheduled."). Physicians shall note a listing of medications prescribed linked to their respective target symptoms, lab tests requested, and referrals made to other providers.

F. Documentation of relevant information from sources other than a clinical encounter shall be in the form of an incidental note on the DC4-642 or on the applicable note within the DC4-642 series.

G. Each mental health clinician shall have access to the applicable version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) in accordance with HSB 15.06.06 *Required Reference Materials/Manuals for Health Services Units*. Per this HSB, a current edition of the Physician's Desk Reference (PDR) shall be available in the mental health unit at each S-3 facility. In addition, mental health clinicians shall have access to the pertinent sections of the applicable version of the International Classification of Disease (ICD) as needed.

H. When ongoing outpatient care (e.g., case management, counseling, psychiatric care) is discontinued altogether because it is no longer clinically indicated, a *Summary of Outpatient Mental Health Care,* DC4-661 must be prepared and filed in the health record within seven (7) business days.

X. RELEVANT FORMS AND DOCUMENTS:

A. DC4-529, *Staff Request/Referral*
B. DC4-642, *Chronological Record of Outpatient Mental Health Care*
C. DC4-642A, *Psychiatric Follow-up*
D. DC4-642B, *Mental Health Screening Evaluation*
E. DC4-642D, *Outpatient Mental Health Case Management*
F. DC4-642U, *Clinical Group Therapy Note*
G. DC4-642V, *Outpatient Psychoeducational Group Incidental Note*
H. DC4-643A, *Individualized Service Plan*
I. DC4-655, *Psychiatric Evaluation*
J. DC4-661, *Summary of Outpatient Mental Health Care*
K. DC4-663, *Consent to Mental Health Evaluation or Treatment*
L. DC4-664, *Mental Health Attendance Record*
M. DC4-701, *Chronological Record of Health Care*
N. DC4-701A, *Medication and Treatment Record (MAR)*
O. DC4-711A, *Refusal of Health Care Services*
P. DC4-711B, 711B *Consent and Authorization for Use and Disclosure, Inspection, and Release of Confidential Information*
Q. DC4-760A, *Health Information Transfer/Arrival Summary*
R. DC6-236, *Inmate Request*
S. Procedure 401.014, *Health Services Intake and Reception Process*
T. Procedure 403.003, *Mental Health Transfers*
U. Procedure 404.001, *Suicide and Self-Injury Prevention*
V. Procedure 404.005, *Residential Continuum of Care Units*
W. HSB 15.05.11, *Planning and Implementation of Individualized Mental Health Services*
X. HSB 15.05.19, *Psychotropic Medication Use Standards and Informed Consent*
Y. HSB 15.06.06, *Required Reference Materials/Manuals for Health Service Units*
Z. HSB 15.09.05, *Credentialing and Peer Review Program*
AA. Rule 33-401.105 F.A.C.
BB. Rule 33-404.108 F.A.C.
CC. Rules 33-601.301 through 601.314, F.A.C

Director of Health Services | Date

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