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PROCEDURE NUMBER: **404.004**

PROCEDURE TITLE: **MENTAL HEALTH INPATIENT MULTIDISCIPLINARY TREATMENT AND SERVICES**

RESPONSIBLE AUTHORITY: **OFFICE OF HEALTH SERVICES**

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SUPERSEDES: **NONE**

RELEVANT DC FORMS: **DC4-529, DC4-642H-S, DC4-643A, DC4-643D, DC4-649, DC4-650, DC4-655, DC4-657, DC4-657A, DC4-661, DC4-664, DC4-664B, DC4-664C, DC4-673, DC4-706, DC4-711A, DC4-713C, DC4-717A, DC4-761, DC4-797H, DC6-229, DC6-1008, DC6-2087, AND NI1-071**

ACA/CAC STANDARDS: **4-4373, 4-4374, 4-4403, 4-4404, 4-4405, AND 4-4413**

STATE/FEDERAL STATUTES: **SECTIONS 945.40-945.49, AND 20.315, F.S.**

FLORIDA ADMINISTRATIVE CODE: **RULES 33-404 AND 33-601.800(8), F.A.C.**

PURPOSE: To ensure the integrity of inpatient mental health units as safe and secure therapeutic environments, provide guidelines that support recovery and discharge readiness planning, and describe the levels of care that comprise the inpatient mental health delivery system.

DEFINITIONS:

(1) **Attending Clinician**, where used herein, refers to a clinician credentialed to admit and discharge patients from a level of inpatient mental health care in accordance with "Credentialing and Peer Review Program," Health Services Bulletin (HSB) 15.09.05.

(2) **Behavioral Health Clinician**, where used herein, refers to a Psychologist or Behavioral Health Specialist.

(3) **Behavioral Management Progress System**, where used herein, refers to a structured system of performance-based behavioral incentives and consequences used to facilitate adaptive functioning, promote constructive goal-oriented behavior, develop coping skills, and provide opportunities to demonstrate self-care, self-control, appropriate interpersonal interactions, compliance with rules, and cooperation with the treatment regimen.

(4) **Behavioral Safety Assessment**, where used herein, refers to a component of the self-injury reduction plan, which provides the estimation of a behavior's severity and frequency over time; identification of the conditions under which a problem behavior is likely to intensify; and identification of the conditions under which the problem behavior is unlikely to emerge.

(5) **Clinical Encounter**, where used herein, refers to a scheduled or spontaneous meeting for evaluation, case management or treatment with a patient by a Psychologist, Psychiatric Clinician, or Behavioral Health Specialist.

(6) **Clinical Group Therapy**, where used herein, refers to 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 the patients' thoughts, feelings, experiences, and skills.

(7) **Corrections Mental Health Treatment Facility**, where used herein, refers to a mental health inpatient unit that provides ongoing involuntary mental health treatment in accordance with section 945.40-49, F.S.

(8) **Crisis Stabilization Care**, where used herein, refers to a mental health inpatient treatment unit that includes intensive management, observation, and treatment intervention while seeking rapid stabilization of acute symptoms and conditions.

(9) **Functional Assessment**, where used herein, refers to a component of the self-injury reduction plan that describes the circumstances, precipitating factors, and consequences of a problem behavior in order to ascertain its purpose and function.

(10) **Incidental Note**, where used herein, refers to a method of documenting information of relevance to health care delivery, which was obtained outside of a clinical encounter, in a simple narrative style.

(11) **Individual Psychotherapy**, where used herein, refers to a collaborative treatment based on the therapeutic relationship between the patient and Mental Health Clinician, including, but not limited to, cognitive behavioral, dialectical behavioral, psychodynamic, and interpersonal modalities.

(12) **Individualized Services Plan (ISP)**, where used herein, refers to a dynamic, written description of mental health problems, goals, and services that is developed and implemented by a multidisciplinary services team and the patient.

(13) **Infirmary Mental Health Care (IMH)**, where used herein, refers to the first and least restrictive level of inpatient mental health care that consists of brief admission to the institutional infirmary for patients residing in the general prison community.

(14) **Inpatient Unit**, where used herein, refers to a crisis stabilization unit (CSU), transitional care unit (TCU), or corrections mental health treatment facility (CMHTF).

(15) **Isolation Management Room (IMR)**, where used herein, refers to a room in the infirmary area or inpatient mental health unit that has been certified by the Regional Mental Health Director in accordance with "Suicide and Self-Injury Prevention," Procedure 404.001.

(16) **Medical Care**, where used herein, refers to medical treatment (e.g. sutures, removal of a foreign object, treatment at a medical facility) which, if not provided, would place the health of a patient in serious jeopardy.

(17) **Mental Health Clinician**, where used herein, refers to a Psychologist, Psychiatrist, Psychiatric Advanced Registered Nurse Practitioner (ARNP), or Behavioral Health Specialist.

(18) **Mental Health Observation Status (MHOS)**, where used herein, refers to a clinical status ordered by the attending Clinician for patients admitted to outpatient infirmary mental health care that provides for safe housing and close monitoring of patients who present with acute symptoms of mental impairment.

(19) **Multidisciplinary Services Team (MDST)**, where used herein, refers to 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 patients in accordance with their identified mental health needs, and which collaboratively develops, implements, reviews, and revises an "Individualized Service Plan," DC4-643A, as needed.

(20) **Psychiatric Clinician**, where used herein, refers to a Psychiatrist or Psychiatric Advanced Practice Registered Nurse.

(21) **Psychoeducational Group Intervention**, where used herein, refers to 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. This may include workbook and/or homework activity. Examples include medication education, stress/anger management, social skills, activities of daily living, etc.

(22) **Registered Nurse Specialist**, where used herein, refers to a registered nurse with at least one year of experience as a Mental Health Nurse.

(23) **Secure Treatment Seating (STS)**, where used herein, refers to a chair or desk designed to secure potentially violent patients during the provision of Structured Out-of-Cell Treatment and Services (SOCTS) and specified unstructured out-of-cell time. STS provides patients with safeguarded freedom of movement while maintaining patient and staff safety.

(24) **Self-Harm Observation Status (SHOS)**, where used herein, refers to a clinical status ordered by the attending Clinician that provides for safe housing and close monitoring of patients who are determined to be suicidal or at risk for serious self-injurious behavior, by mental health staff, or in the absence of mental health staff, by medical staff.

(25) **Self-Injury Profiling System (SIPS)**, where used herein, refers to a profiling system to identify risk factors associated with serial acts of serious self-injurious behaviors and provide trend analyses of pertinent factors.

(26) **Self-Injury Reduction Plan (SIRP)**, where used herein, refers to a set of planned and proactive interventions that reinforce positive or desired behaviors and minimize inadvertent reinforcement of self-injurious behavior.

(27) **Serious Self-Injurious Behavior**, where used herein, refers to a deliberate self-harm behavior that has, or could have, caused serious bodily harm as assessed by mental health staff, or in the absence of mental health staff, by medical staff, as evidenced by the need for medical care.

(28) **S-Grade**, where used herein, refers to a mental health classification of patients as defined in "Assignment of Health Classification Grades to Inmates," HSB 15.03.13.

(29) **SOAP**, where used herein, refers to an acronym for a style of health record documentation for clinical encounters. The SOAP note is divided into four sections

(a) Subjective: reason for the encounter;

(b) Objective: relevant history from the record, what health care staff observes about the patient, and observations of the patient by others as reported to health care staff;

(c) Assessment: what health staff determines to be the clinical significance of subjective and objective information (e.g., a clinical judgment is made as to whether a health problem or need exists, nature and severity of the problem, and the diagnosis if indicated); and

(d) Plan: actions taken or to be taken by health staff to address the identified problem or need.

(30) **<u>Structured Out-of-Cell Treatment and Services (SOCTS)</u>**, where used herein, refers to a weekly scheduled individualized treatment services, psychoeducational groups, and therapeutic activities in an inpatient unit to ameliorate disabling symptoms of a diagnosed mental illness and improve behavioral functioning as identified in the individualized service plan.

(31) **<u>Therapeutic Activities</u>**, where used herein, refers to an individual or group therapeutic services provided by staff or volunteers designed to improve resiliency in behavioral functioning and self-directed recovery. Examples include substance abuse, education and vocational training, horticulture, yoga, chess club.

(32) **<u>Therapeutic Community</u>**, where used herein, refers to a large group forum where patients and clinical staff share issues, identify concerns, and develop problem solving skills.

(33) **<u>Transitional Care Unit (TCU)</u>**, where used herein, refers to a mental health inpatient treatment unit that includes intermediate level care for patients transitioning from a more intensive level of inpatient care (CSU or CMHTF) back to an outpatient setting, and long term care for patients with chronic and severe mental illness.

(34) **<u>Unstructured Out-of-Cell Time</u>**, where used herein, refers to out-of-cell activities monitored by security staff without involvement of mental health staff, including, but not limited to, outdoor recreation, dayroom, visitation, telephone calls, and showers.

<u>SPECIFIC PROCEDURES</u>:

(1) **<u>ADMISSION TO THE MENTAL HEALTH INPATIENT UNITS</u>:**

(a) Placement in an inpatient mental health unit requires the presence of a mental illness, as referenced in chapter 33-404.103, with associated impairment in psychological, cognitive, or behavioral functioning that renders the inmate unable to adequately function in a less restrictive setting.

(b) Referral to an inpatient level of mental health care is appropriate when a multidisciplinary services team (MDST) has determined:

1. a mental disorder continues to significantly compromise an inmate's ability to adjust to the demands of prison life to the extent that the inmate's needs for mental health care exceed what can be provided at an outpatient level of mental health care; or
2. the inmate has failed, and is likely to continue to fail, to respond adequately to mental health infirmary level care in accordance with "Infirmary Services," HSB 15.03.26, and "Suicide and Self-Injury Prevention," Procedure 404.001; or
3. the inmate's judgment is so affected by a mental illness that s/he lacks the capacity to make a well-reasoned, willful, and knowing decision concerning her/his mental health treatment will be referred for transfer to a CMHTF.

(c) Referral to an inpatient level of mental health care requires:

1. approval for transfer in accordance with "Mental Health Transfers," Procedure 404.003;

2. documentation that less restrictive interventions have been and will likely continue to be inadequate to afford the degree of protection and care necessary and;
3. referring institution's Chief Health Officer or designee has confirmed in the transfer request and documented via an incidental note in the health record, that the inmate is medically cleared for transport and how identified impairment/disability needs are to be addressed in accordance with "Medical Transfers," Procedure 401.016.

(d) Upon approval for transfer, the Mental Health Clinician making the referral will complete whichever of the following forms is appropriate to the referral:
1. "Summary of Outpatient Mental Health Care," DC4-661, if the referral is to TCU level mental health care from general population, that is, the inmate is not housed on MHOS at the time of the referral; or
2. "Transfer Summary for Inpatient Mental Health Care," DC4-657A, if the inmate is housed on Self-Harm Observation Status (SHOS) or Mental Health Observation Status (MHOS) at the time of the referral to CSU.

(e) Subsequent to arrival at the institution, and prior to admission to an inpatient unit, the inmate may be placed in a holding cell for a period not to exceed two hours. If the inmate was transferred on SHOS, or is placed on SHOS after arrival, observations will be documented at least every 15 minutes on the "Observation Checklist," DC4-650.

(f) Patients may be admitted only by order of the attending Clinician. Upon admission, nursing staff will:
1. inform the patient of the reason(s) for admission;
2. provide verbal orientation to the unit;
3. provide written orientation materials unless the patient is on SHOS, and there is clear clinical justification documented by the attending Clinician for prohibiting such material; and
4. except for CMHTF admissions, attempt to obtain the patient's informed consent on the "Consent to Inpatient Mental Health Care," DC4-649.

(g) A nursing assessment will be completed within four hours of admission and documented on the "Inpatient Mental Health Admission Nursing Evaluation," DC4-673. Along with the written documentation required by the Nursing Manual, this nursing assessment will be recorded in OBIS using the MHNAS encounter code, in conjunction with the identifying action code (CSU, TCU, or CMHTF) related to the specific unit.

(h) Within 24 hours of an admission (or the first business day following weekends/holidays), the attending Clinician will complete an admission note that will include:
1. chief complaint;
2. relevant mental health history;
3. mental status exam;
4. diagnoses; and
5. plan/orders.

NOTE: No admission note is necessary if a psychiatric evaluation is completed within 24 hours of admission.

(i) Within three business days of admission to an inpatient unit:
1. The attending clinician will update the S-grade corresponding with level of care on the "Health Services Profile," DC4-706;
2. Clerical or other support staff will update the OBIS HS06 screen;
3. A physical examination will be completed and documented on the "Inpatient History/Physical," DC4-713C;
4. The assigned Behavioral Health Specialist will meet with the patient to explain the behavioral management progress system and conduct a service planning interview with documentation on the "Inpatient Mental Health Screening Evaluation," DC4-642J;
5. Completion of a typed or neatly printed (cursive handwriting is not permitted) psychiatric evaluation on the "Psychiatric Evaluation," DC4-655, for admission from a lower level of care, or psychiatric follow-up on the "Inpatient Psychiatric Follow-up," DC4-642H, for admissions from the same or higher level of care; and
6. For CMHTF, a petition for involuntary treatment will be initiated.

(j) Emergent referrals for admission to a CSU during non-business hours and admission to a CMHTF have additional and distinctive requirements:
1. Emergent referrals for admissions to a CSU during non-business hours will be made in accordance with section (13) (a-j) of "Mental Health Transfers," Procedure 404.003.
2. Court-ordered transfers for admission to a CMHTF will be in strict accordance with "Placement of Inmate in a Mental Health Treatment Facility," section 945.43, F.S. and as delineated in "Mental Health Transfers," Procedure 404.003.
3. Emergency transfers to a CMHTF will be in accordance with "Emergency Placement of Inmate in a Mental Health Treatment Facility," section 945.44, F.S. and as delineated in "Mental Health Transfers," Procedure 404.003.
4. Admission to a CMHTF can only be made from a CSU. A patient in a CSU whose judgment is so affected by a mental illness that s/he lacks the capacity to make a well-reasoned, willful, and knowing decision concerning her/his mental health treatment will be referred for transfer to a CMHTF.

(2) **GENERAL GUIDELINES FOR THE DELIVERY OF MENTAL HEALTH INPATIENT MULTIDISCIPLINARY TREATMENT AND SERVICES:**

(a) All mental health inpatient treatment and services will be provided in accordance with chapter 33-404, F.A.C.

(b) Mental health service planning and documentation will be in accordance with "Planning and Implementation of Individualized Mental Health Services," HSB 15.05.11, which requires that treatment and services decisions will be based on consensus of members of the multidisciplinary services team (MDST).

(c) Medical screening, care, and nursing interventions will be provided in accordance with "Medical and Dental Care for Mentally Disordered Inmates," HSB 15.05.20.

(d) Nursing staff responsibilities, including the admission process, will be accomplished in accordance with the Nursing Manual.

(e) Use of psychotropic medications for patients in the mental health inpatient units will be in accordance with "Psychotropic Medication Use Standards and Informed Consent," HSB 15.05.19, and its Appendix: *Testing Standards for Psychotropic Medication Usage*. Labs ordered, drawn and processed will be documented on the 'Laboratory Log," DC4-797H.

(f) Identification, intervention, treatment, and management of patients at risk of serious self-injurious behavior will be accomplished in accordance with "Suicide and Self-Injury Prevention," Procedure 404.001; "Isolation Management Rooms and Observation Cells," Procedure 404.002; and "Planning and Implementation of Individualized Mental Health Services," HSB 15.05.11.

(g) The use of psychiatric restraint in inpatient mental health units will be in accordance with "Psychiatric Restraint," HSB 15.05.10.

(h) Risk assessments will be documented in accordance with Rule 33-404.102 F.A.C., and Rule 33-404.112 F.A.C.

(i) Discipline of mentally disordered patients in an inpatient level of care, as defined in Rule 33-404.103, F.A.C, will be in accordance with Rule 33-404.108, F.A.C., and "Mental Health Staff on Disciplinary Teams," HSB 15.05.13.

(j) Evaluation and treatment of inmates meeting criteria for a diagnosis of gender dysphoria and management of transgender patients in the inpatient units will be in accordance with "Identification and Management of Transgender Inmates and Inmates Diagnosed with Gender Dysphoria," Procedure 403.012, at designated institutions.

(k) As clinically indicated, psychological testing will be used to assist in clarifying diagnostic and treatment planning issues. The reporting of psychological testing results will be documented in the inpatient record. Raw test data and testing protocols will be retained only in the "Psychological Record Jacket," DC4-761, which is stored in accordance with the requirements outlined in "Health Records," HSB 15.12.03.

(l) Rounds will be conducted on the inpatient units to ensure the well-being and general patient functioning of each patient. The Psychiatric Clinician or Psychologist will conduct daily rounds during business days to personally observe each patient. The Psychologist will conduct one of the required rounds each week in the CSU, biweekly in the CMHTF, and monthly in the TCU. Documentation of rounds will be via the "Mental Health Inpatient Unit Rounds Documentation Log," DC4-717A.

(m) When a patient is discharged from an inpatient mental health unit, the MDST will consider and act in accordance with "Health Care Clearance/Holds," HSB 15.02.02.

(n) Patients on an inpatient unit who are within six months of end of sentence (EOS), will receive mental health re-entry services in accordance with "Mental Health Re-Entry Aftercare Planning Services," HSB 15.05.21. For patients, whose needs may be best met with post-release placement in a nursing home or assisted living setting, re-entry and

aftercare services will comply also with "Prerelease Planning for Continuity of Health Care," HSB 15.03.29.

(3) **MULTIDISCIPLINARY OPERATIONAL DIRECTIVES:**

(a) The minimum membership of the MDST will be a Behavioral Health Specialist, Psychologist, Psychiatric Clinician, Registered Nurse Specialist, Behavioral Health Technician, Corrections Officer, and Classification officer.

(b) All mental health staff assigned to the inpatient unit will be under the supervisory authority of the Psychological Services Director, who will report directly to the Regional Mental Health Director.

(c) The Supervising Nurse for a mental health inpatient unit will be, at a minimum, a Registered Nurse with a bachelor's degree in nursing and with inpatient psychiatric nursing experience.

(d) Patients transferred to a mental health inpatient unit may refuse treatment, but may not refuse admission.

(e) The Attending Clinician for all inpatient units must be either a Psychologist or Psychiatric Clinician. For purposes of admission and discharge to the CMHTF, the Attending Clinician must be a Psychiatrist.

(f) Patients assigned to an inpatient mental health unit will be housed within the designated area unless medical needs require housing in an infirmary or hospital.

(g) Pending completion of the initial assessment by the risk assessment team, patients admitted to the inpatient units will retain the same level of out-of-cell security restraints they had in the setting from which they were transferred.

(h) Security will not be present in the room during clinical encounters with mental health clinical staff unless requested by the Clinician. In addition to the clinical documentation for the encounter, the request will be documented in the inpatient record via an incidental note explaining the reason for the request by the Clinician.

(i) A Psychiatric ARNP can provide clinical services in accordance with her/his credentialed privileges on mental health inpatient units.

(j) In the absence of a Psychologist or Psychiatrist during non-business hours in an inpatient unit:

1. The shift supervisor, after consulting with on duty health care staff, may authorize the temporary restriction on any property being used to create an immediate threat to the security of the unit that prevents security staff from accomplishing required functions in the unit;
2. The shift supervisor will ensure that any property restrictions are limited to those items necessary to neutralize the threat;

3. Health care staff will document the consultation via an incidental note in the inpatient record and security staff will document on the "Daily Record of Special Housing," DC6-229; and
4. The shift supervisor will complete a referral to mental health staff on the "Staff Request/Referral," DC4-529, to ensure review by the MDST for further disposition on the next business day.

(k) After the initial risk assessment by the risk assessment team, any modifications to housing, program participation, and/or clinical activities will be determined by the MDST with documentation on the "MDST Meeting Docket," DC4-642M.

(l) At inpatient units where a regional mental health ombudsman is assigned, they will:
1. be under the supervisory authority of the Central Office Mental Health Ombudsman;
2. coordinate closely with the warden or his/her designee to proactively identify concerns pertinent to access to necessary mental health treatment in the inpatient units and facilitate resolution of identified issues;
3. ensure patients have access to health and comfort items in accordance with "Inmate Health and Comfort Items-Issuance," NI1-071, in chapter 33-602.101;
4. review SOCTS requirements and observe MDST meetings;
5. conduct weekly well-being checks, which will be documented on the "Well-Being Check Incidental Note," DC4-642R, on a randomized sample of the inpatient population;
6. as clinically necessary, make referrals and order emergent transfers to higher level of care; and
7. in addition to the Central Office Mental Health Ombudsman, receive notification of incident reports of allegations of staff abuse or neglect on the mental health inpatient units.

(m) The Institutional ADA Coordinator will be notified of all admissions of ADA impaired and/or disabled patients, as well as when any new ADA impairment and/or disability has been diagnosed. All impairments and/or disabilities that qualify for consideration under the Americans with Disabilities Act shall be handled in accordance with "ADA Provisions for Inmates," chapter 33-210.201, F.A.C., and "Americans with Disabilities Act Provisions for Inmates," Procedure 604.101. Upon discharge, the Institutional ADA Coordinator will be notified to assist with appropriate housing.

(n) The Institutional Health Services Administrator, or her/his designee, will monitor the inpatient records weekly to ensure they are organized, complete, up to date, and include all the documentation necessary to support the provision of treatment and care to patients in accordance with "Health Records," HSB 15.12.03.

(o) All mental health appointments, encounters, laboratory information, and community care information are required data entry on the appropriate OBIS-HS screens in accordance with "Offender-Based Information Systems-Health Services (OBIS-HS)," HSB 15.06.04. All data entry must be kept up to date and performed on a daily basis.

(p) Unstructured out-of-cell time will be supervised by security and include activities such as showers, telephone access, visitation, dayroom, recreation, and work assignments. Religious activities and canteen may also be counted if conducted out of the cell. A minimum of five of the ten required hours of unstructured out-of-cell time per week will consist of outdoor exercise.

(q) If a patient refuses to come out of her/his cell for all SOCTS for more than one week, efforts will be made to bring the patient out of her/his cell to conduct a well-being and mental status exam. These efforts and the result of the well-being and mental status exam will be documented on the "Well-being and Mental Status Exam," DC4-642S, in the patient's mental health record.

(4) **<u>THE MULTIDISCIPLINARY SERVICES TEAM AND TREATMENT PLANNING</u>:**

(a) Whereas all members of the MDST collaborate to ensure patient access to necessary treatment and services, the Mental Health Clinician members have sole responsibility for the diagnostic disposition of patients admitted to the inpatient units. Any change in diagnosis by an individual Mental Health Clinician will be documented as provisional. A consensus of the clinical members of the MDST is required for a ratification of the diagnosis documented on the ISP.

(b) The MDST will conduct routine meetings for initial approval and subsequent reviews of the ISP in accordance with the timeframes specified in "Planning and Implementation of Individualized Mental Health Services," HSB 15.05.11. A medical provider will attend the initial MDST meeting and coordinate medical care with the patient's mental health treatment, in accordance with "Medical and Dental Care for Mentally Disordered Inmates," HSB 15.05.20.

1. For all inpatient units, the initial ISP will be completed within seven calendar days of admission;
2. CSU: review patients every 14 calendar days;
3. CMHTF: review every 30 calendar days; and
4. TCU: review every 60 calendar days.

(c) Routine meetings of the MDST will ensure:

1. the ISP reflects the patient's current treatment needs, as well as changes in her/his progress toward treatment goals;
2. the ISP is reviewed in its entirety with the patient, allowing for the opportunity to read and review before signing;
3. the patient is provided a copy of the ISP, unless the attending Clinician documents the specific clinical justification for withholding it;
4. includes Problem #308 *Discharge Planning and Readiness Skills*; and
5. includes Problem #*310 Self-Directed Recovery Skills*.

(d) Spontaneous MDST meetings will be to consider any necessary changes to a patient's ISP when a patient's mental/behavioral functioning significantly changes. Examples necessitating a spontaneous MDST meeting include, but are not limited to:

1. receipt of a disciplinary report;

2. placement on SHOS;
3. refusal of treatment for more than five calendar days;
4. refusal to maintain hygiene for more than seven calendar days;
5. incidents indicating significant deterioration in mental or behavioral functioning;
6. assaultive behavior;
7. consideration prior to transfer to a different level of care;
8. refusal of 50% of SOCTS over a thirty-day calendar period; and
9. if a patient refuses to come out of her/his cell for all SOCTS for more than seven calendar days.

(e) Spontaneous MDST meetings will occur as soon as possible, but no later than three business days, after the occurrence of a precipitating event. Any changes made to the ISP during a spontaneous MDST will reset the interval for the routine MDST meeting for ISP reviews. If the ISP is amended by a spontaneous MDST meeting, the new time intervals for MDST meetings shall be noted on the amended ISP.

(f) Routine and spontaneous MDST meetings will be documented on DC4-642M. It is imperative that the time allocated for each MDST meeting is sufficient to ensure adequate discussion of issues and concerns germane to the patient's psychological and behavioral functioning, allow for participation by the patient and input from all members of the MDST, and completion of the requisite documentation.

(g) The Psychologist will serve as the MDST chair in order to:
1. lead and ensure the meetings are conducted in accordance with the required time frames;
2. ensure all members of the MDST provide input during MDST meetings and is documented during the meeting on DC4-642M;
3. patients are encouraged to attend the MDST meetings in order to allow them to participate in the development and coordination of a collaborative plan of care; and
4. if a patient refuses to attend, the reason for the refusal and efforts to encourage her/him are documented on DC4-642M and on the "Refusal of Health Care Services," DC4-711A, by a Behavioral Health Clinician.

(h) All members of a patient's MDST are required to attend each MDST meeting regarding that patient. Exceptions include emergent circumstances, such as emergency treatment orders and temporary situations, such as when a member of the MDST is unavailable due to illness or vacation. In such cases, a representative of the same service provider's discipline may attend the MDST meeting, but must document her/his temporary status on the DC4-642M. It is also the responsibility of any attending MDST member to consult with and obtain information pertinent to the patient from all service providers in her/his discipline prior to the MDST meeting.

(5) **<u>STRUCTURED OUT OF CELL TREATMENT AND SERVICES REQUIREMENTS</u>:**

(a) Patients in CSU, TCU, and CMHTF will be offered a minimum of ten hours per week of structured out-of-cell treatment and services (SOCTS) and ten hours per week of unstructured out-of-cell time except for patients on SHOS, whose care and management of imminent risk for suicide or serious self-injury will be provided in accordance with section

(9)(b)3. Each level of care will offer a range of the structured treatment and therapeutic services that are individualized and targeted to the assessed mental health needs of each patient.

1. Structured treatment includes the following clinical encounters:
   a. Psychologist consultation;
   b. Psychiatric clinician consultation;
   c. clinical group therapy;
   d. individual psychotherapy; and
   e. case management.
2. Refusal of a clinical encounter will be documented on DC4-711A. The Case Manager or other Mental Health Clinician member of the MDST will counsel with the patient within 24 hours of the refusal. The patient will be encouraged to participate in future clinical encounters. The counsel and encouragement will be documented via an incidental note in the inpatient record.
3. Structured therapeutic services include:
   a. therapeutic community;
   b. psychoeducational groups; and
   c. therapeutic activities.

NOTE: Except for medication education groups, refusal of a therapeutic service will be documented on DC4-711A by a Behavioral Health Technician or Behavioral Specialist along with an incidental note explaining the reason for the refusal and the efforts taken to encourage participation.

(b) SOCTS will be prescribed for the patient by a consensus of the MDST and integrated into the ISP with the following requirements:
1. all SOCTS are linked to identified problems and treatment goals documented on the patient's ISP;
2. at least two, but no more than four hours of SOCTS are offered on weekends;
3. patient participation will be documented on the "Mental Health Structured Out-of-Cell Treatment and Services Attendance Record," DC4-664, on the same day the service is provided;
4. a Behavioral Health Specialist will review and sign the DC4-664 on a weekly basis; and
5. clinical encounters cannot be rendered concurrently with another Mental Health Clinician (e.g., a Psychiatric encounter cannot be rendered at the same time a case management encounter is conducted).

(c) The clinical encounters for psychiatric consultation by a Psychiatric Clinician will be provided based upon the particular level of care. Each encounter requires documentation on either DC4-655 or DC4-642H. Psychiatric evaluations will comprise a minimum of 60 minutes for the individualized assessment and psychiatric follow-ups will comprise a minimum of 15 minutes for the clinical encounter. Requirements for a psychiatric consultation to assess the mental status, psychotropic medication management, and progress of patients for each level of care are:
1. CSU: at least three occasions within the first seven calendar days of admission and at least every seven calendar days thereafter;

2. TCU: at least once within the first seven calendar days and at least every 30 calendar days thereafter; and
3. CMHTF: at least three occasions within the first seven calendar days on and at least every 14 calendar days thereafter.

(d) The clinical encounters for individual psychotherapy, clinical group therapy, and case management by a Behavioral Health Clinician will be targeted to address the identified problems and treatment goals documented on the patient's ISP. Required clinical encounters for each level of care are:
1. CSU: clinical group therapy, individual psychotherapy, and case management at least every seven calendar days;
2. TCU: clinical group therapy at least every seven calendar days and individual psychotherapy and case management at least every 30 calendar days; and
3. CMHTF: clinical group therapy at least every seven calendar days and individual psychotherapy and case management at least every 14 calendar days.

NOTE: For clinical encounters in all levels of care, if Problem #142 *Resistance to Treatment* is documented on the ISP for refusal of scheduled clinical encounters case management will be provided weekly by a Behavioral Health Specialist.

(e) Documentation requirements for clinical encounters by the behavioral health clinician are:
1. individual psychotherapy will be documented on the "Inpatient Individual Psychotherapy Note," DC4-642P, and comprise a minimum of 30 minutes of one-on-one clinical intervention;
2. clinical group therapy will consist of a minimum of 60-minute sessions, not exceed ten patients, and will be documented on the "Inpatient Unit Clinical Group Therapy Note," DC4-642I; and
3. case management will comprise a minimum of 30 minutes and will be documented on the "Inpatient Unit Mental Health Case Management," DC4-642L.

(f) Therapeutic community will be provided one hour weekly by a Behavioral Clinician. Patient participation in therapeutic community will be documented on the DC4-664.

(g) Psychoeducational groups, which are more didactic and focus on skills acquisition, will be offered as a group therapeutic intervention by a Behavioral Health Technician or Registered Nurse Specialist. Guidelines are as follows:
1. groups will not exceed 15 participants;
2. consist of a minimum of 60-minute sessions;
3. Readiness for Discharge psychoeducational groups will be limited to a 60-minute session offered once weekly; and
4. patient participation will be documented on the "Inpatient Psychoeducational Group Incidental Note," DC4-642N.

(h) Medication education, which is a psychoeducational group, will be provided by a Registered Nurse Specialist for patients exhibiting a pattern of non-compliance with medication. A pattern of noncompliance is defined as at least three consecutive medication refusals or at least five medication refusals in a month. The Behavior Specialist will document the pattern of non-

compliance on the "Inpatient Mental Health Weekly Summary Note," DC4-642K, and apprise the MDST. The MDST will revise the ISP and add Problem #142 *Resistance to Treatment*, and the patient will be offered enrollment in a medication education group. Refusals will be documented by mental health nursing staff on the DC4-711A along with an incidental note explaining the reason for the refusal and the efforts taken to encourage participation. For patients assigned to a medication education group, these groups will be limited to a 60-minute session offered once weekly.

(i) Therapeutic activities will be provided by Behavioral Health Technicians to patients for improving resiliency and promoting self-directed recovery through involvement in purposeful, constructive activities. Whether provided individually or in groups, therapeutic activities will consist of a minimum of 60-minute sessions. Up to five hours of therapeutic activities may be used toward fulfilling the weekly required SOCTS hours if:
1. the therapeutic activity is provided by, or in conjunction with, a Behavioral Health Technician;
2. therapeutic community, Readiness for Discharge group, and all other required clinical encounters for the week have been offered; and
3. the therapeutic activity is structured and not intermingled with unstructured recreational time.

NOTE: Patient participation in therapeutic activities will be documented on the DC4-664. Refusals will be documented by the Behavioral Health Technician on the DC4-711A, along with an incidental note explaining the reason for the refusal and the efforts taken to encourage participation.

(j) For weeks in which individual and group clinical services, in conjunction with the therapeutic community and Readiness for Discharge group, do not total five hours, psychoeducational and clinical groups will be offered for the purposes of meeting the required ten hours of SOCTS.

(k) A weekly review by the Behavioral Health Specialist that is serving as the patient's case manager will document each patient's treatment compliance and progress toward ISP goals on the DC4-642K. The review will include whether changes or modifications in structured therapeutic services are needed for consideration at the next MDST meeting

(l) A monthly schedule of SOCTS in each inpatient unit will:
1. be completed by the Psychological Services Director;
2. be reviewed, revised as necessary, and approved jointly by the Regional Mental Health Ombudsman and Assistant Warden-Inpatient; and
3. be authorized by the Warden for posting.

NOTE: All monthly schedules will accommodate the required hours for both SOCTS and unstructured out-of-cell time for all patients in the inpatient unit. Revisions requiring an ongoing change in scheduled treatment, services, activities, or structured out-of-cell time must be approved jointly by the Regional Mental Health Ombudsman and the Mental Health Assistant Warden.

(6) **<u>RISK ASSESSMENT OF PATIENTS IN THE INPATIENT UNITS</u>:**

(a) In accordance with Rule 33-404.112 F.A.C., a violence risk assessment will be completed for all patients residing in an inpatient unit. Requirements for the risk assessment are:
1. the risk assessment will be completed by a team comprising a Psychologist, Classification Officer, and Major or Lieutenant, who will serve as the team leader;
2. decisions on the use of security restraints will be individualized and made on a case-by-case basis;
3. a risk assessment will be completed within three working days of admission to CSU;
4. within seven working days of admission to TCU or CMHTF; and
5. shall occur at least every 90 calendar days thereafter.

(b) At any time between the required intervals, the Psychologist, with the consent of the MDST, may request the risk assessment team to review and determine the necessity for the security restraints, or the level of security restraints, any time s/he is outside of her/his cell. The MDST's request will be documented by the Psychologist in the patient's inpatient record.

(c) Psychologists will be responsible for the completion of risk assessments utilizing a validated violence risk assessment instrument, which includes a clinical interview and record review to complete "Risk Assessment for Inpatient Treatment," DC6-2087, in accordance with Rule 33-404.112. The validated violence risk assessment may be completed in conjunction with a Behavioral Health Specialist and other interdisciplinary staff, but the clinical interview component of the risk assessment and the DC6-2087 must be completed by a Psychologist. The Psychologist will document the results of the validated violence risk assessment on the "Psychological Violence Risk Assessment," DC4-642Q.

(d) The Psychologist will provide information to the other members of the risk assessment team of whether the recommended restraints are contraindicated by the inmate's current psychological/behavioral functioning. If the Psychologist determines there is a contraindication, but security and/or classification team members determine the security restraints must be applied, the Warden and Florida Department of Corrections' Director of Mental Health Services or her/his designee will collaborate to make a final determination. Under no circumstances shall the Psychologist decide whether an inmate shall be subjected to security restraints.

(e) If correctional restraints are used, the type of restraints, including the use of secure treatment seating (STS), will be individualized. STS may be used for a patient for no more than two consecutive hours.

(7) **<u>DISCIPLINE OF PATIENTS IN THE INPATIENT UNITS</u>:**

(a) In accordance with Rule 33-404.108 F.A.C., prior to the issuance of a disciplinary report for an incident of maladaptive behavior, the security shift supervisor will discuss the incident and circumstances with the supervising Psychologist or Psychological Services Director to determine whether the disciplinary report will be issued. This consultation, the purpose of which is to determine if, due to the mental status of the patient, the rule infraction may be addressed using the behavioral management progress system (BMPS) in conjunction with

therapeutic interventions rather than through the disciplinary report process, will be documented in the inpatient record via an incidental note by the Psychologist and the incident will be reviewed by the MDST by the next business day.

(b) For patients who receive a disciplinary report, the Psychologist or, in her/his absence, the Psychiatrist will schedule a minimum of 30 minutes to review a of copy of the statement of facts, conduct a review of the inpatient record, and complete a clinical interview using a SOAP note in order to provide the required input to the disciplinary team. A copy of the completed "Disciplinary Team Mental Health Consultation," DC6-1008, will be filed in the inpatient record. The disciplinary team shall incorporate this input into their final decision.

(c) For a patient found guilty of a disciplinary report, the disciplinary team will refer their findings to the MDST. The MDST will review the disciplinary team's findings and, as necessary, revise the ISP to address the behavior and consider modification of privileges within the BMPS.

(d) After hours, disciplinary reports may be written, but not issued prior to consultation with the supervising Psychologist or Psychological Services Director.

(8) **ASSESSMENT AND TREATMENT FOR SERIOUS SELF-INJURY:**

(a) Mental Health Clinicians will provide appropriate assessment for the causes of serious self-injurious behaviors. The assessment will include the identification of the antecedents, precipitating factors, and consequences of the incident of self-injurious behavior. The MDST will develop and incorporate appropriate treatment interventions for serious self-injurious behaviors. Based on the patient's assessed needs, clinical interventions include, but are not limited to:

1. individual psychotherapy using cognitive behavioral or dialectical behavioral therapy;
2. psychotropic medication management;
3. behavioral interventions;
4. clinical group therapy; and
5. psychoeducational group and therapeutic activities.

(b) Patients who are at imminent risk for serious self-injurious behavior will be managed in accordance with "Suicide and Self-Injury Prevention," Procedure 404.001. The MDST will meet within three business days of a patient's placement on SHOS to update the ISP.

(c) Following discharge from SHOS, if the patient engaged in an incident of serious self-injury or suicide attempt, the patient will be provided individual psychotherapy using cognitive behavioral or dialectical behavioral therapy at least weekly. Each therapy session will include discussion of the antecedent, precipitating factors, and consequences of the self-injurious behavior.

(d) In collaboration with other members of the MDST and the patient, a Psychologist will be assigned to develop, implement and modify treatment interventions pertinent to self-injurious behavior. In accordance with "Planning and Implementation of Individualized Mental Health Services," HSB15.05.11, Problem #101 *Abusive to Self* will be documented on

the ISP. If suicidal intent is present, Problem #152 *Suicidal Behavior* will be documented. The minimum of weekly treatment with individual psychotherapy will continue as long as Problem #101 *Abusive to Self* or #152 *Suicidal Behavior* is documented as an active problem on the ISP.

(e) When a patient engages in serial (two or more in three months) serious self-injurious behaviors, the Psychologist will develop a "Self-Injury Reduction Plan (SIRP)," DC4-643D, which will be implemented by the MDST. Included in the SIRP will be a functional assessment and behavioral safety assessment of the specific behavioral problems. The SIRP will include:

1. Completion of a functional assessment, which will include:
    a. a chronology of the problem behaviors, their antecedents and their consequences;
    b. conditions under which the problem behaviors are less likely; and
    c. a detailed description of the circumstances, precipitating factors, and consequences of the problem behavior in order to ascertain its purpose and function.
2. Completion of a behavioral safety assessment, which will include:
    a. estimating the behavior's severity and frequency over time;
    b. identifying the conditions under which the problem behavior is likely to intensify;
    c. identifying the conditions under which the problem behavior is unlikely to emerge;
    d. identification of a set of replacement behaviors and treatment goals that are measurable, realistic, and protect the patient from engaging in the self-injurious behaviors;
    e. identification of the patient's strengths that can be used to support treatment progress;
    f. identification of any skill deficits or special needs that need to be addressed to support patient progress with the SIRP;
    g. development of a plan of interventions to address skill deficits, including use of in-cell or psycho-educational group programming that is already available;
    h. identification of communication strategies that are most likely to be well received and effective with the patient. This includes staff behavior and tone of communication when responding to crises; and
    i. identification of a sequence of structured incentives that can be used to reinforce desired behavioral change to include:
        i. the frequency and duration to be used in providing these incentives;
        ii. the behavioral objectives that will be achieved to earn incentives, including the pace at which the patient can "earn" incentives; and
        iii. an individualized incentive schedule requiring input from the patient to ensure that the incentives hold value and meaning for the patient.

(f) If clinically indicated and implemented by the MDST, the SIRP will be documented on DC4-643D and referenced on the ISP as an intervention in accordance with "Planning and Implementation of Mental Health Services, HSB 15.05.11. An isolated suicide attempt in the context of serious mental illness or repeated self-injurious behaviors that are driven by delusional beliefs or cognitive impairment are not appropriate indications for implementation of a SIRP.

(g) Structured incentives, treatment interventions, and progress toward goals identified in the SIRP to reinforce desired behavioral change will be reviewed and, if clinically indicated, modified by the MDST during routinely scheduled ISP reviews or during a spontaneous MDST meeting resulting from an event involving self-injury behavior or ideation. This update/review will be documented on the DC4-643D.

(h) The FDC Chief of Mental Health Services or her/his designee may provide the MDST with information pertinent to the behavioral safety and functional assessments using a self-injury profiling system (SIPS).

(i) Patients with an active SIRP will not be discharged from the inpatient setting.

(j) A SIRP may be discontinued when Problem #101 *Abusive to Self* or #152 *Suicidal Behavior* is discontinued as an active problem on the ISP.

(9) **THE BEHAVIORAL MANAGEMENT PROGRESS SYSTEM:**

(a) The behavioral management progress system (BMPS), which is a structured, behavioral level system consisting of performance-based behavioral incentives and consequences, will be incorporated into the mental health operational and delivery system in all inpatient units. Each level is associated with access to a set of privileges and activities that are delineated on the "Behavioral Management Progress System (BMPS)," DC4-664B, with the intent of:
1. improving behavioral functioning;
2. promoting constructive goal-oriented behavior;
3. improving resiliency, social identity, and self-directed recovery; and
4. providing a behavioral management structure which incentivizes pro-social behaviors and discourages the occurrence of aggressive, disruptive, or other maladaptive behaviors.

(b) Guidelines for implementing the BMPS:
1. Assignment of a patient to a level in the BMPS will be based on behavioral functioning in accordance with the judgment of the MDST and does not have to be sequential;
2. The MDST will provide clear justification for its decision in level assignments on the DC4-642M, in the inpatient record:
    a. Level 1 will be automatically assigned upon admission to an inpatient unit from a lower level of care, upon discharge from SHOS in the inpatient unit, or if a patient decompensates and the MDST determines necessity for intensive evaluation and needs assessment. The needs assessment, evaluation and review of the patient's mental and behavioral functioning will occur within seven business days. Level 1 assignments that exceed seven business days will be reviewed with clinical justification provided by the MDST on a daily basis;
    b. Level 2 assignments will be reviewed with clinical justification provided by the MDST on a weekly basis;
    c. Level 3 assignments will be reviewed with clinical justification provided by the MDST at least every two weeks;
    d. Level 4 assignments will be reviewed with clinical justification provided by the MDST at least monthly.

3. Placement on SHOS results in removal from the BMPS levels, with access to property and activities in compliance with the provisions of Rule 33-404.102, F.A.C., and "Suicide and Self-Injury Prevention," Procedure 404.001.
4. All individualized modifications of levels within the BMPS will be documented via an incidental note or on the DC4-642M, in the inpatient record and include the rationale and clinical justification.
5. MDST meetings involving a BMPS level review resulting in an increase or no change in level can be documented on the "Behavioral Management Progress System Incidental Note," DC4-644c, and do not require the presence of the patient. During this meeting, an MDST member will be assigned to notify the patient of his/her level status and document this notification in the record via an incidental note by the next working day.

(c) Modifications to the BMPS:
1. The Psychological Services Director or Psychologist is authorized to temporarily modify privileges, property, and participation in specific activities or treatment modalities on singular occasions. The decision to enhance or restrict privileges must be documented via an incidental note and discussed at the next MDST meeting.
2. Ongoing access to privileges, property, or participation in specific activities or treatment modalities may be modified within an assigned level based on a consensus of the MDST. These enhancements or restrictions must be clinically justified and documented on the DC4-642M or DC4-664C, in the inpatient record.
3. All ongoing modifications to the BMPS will be reviewed and clinically justified weekly by the MDST and documented on the DC4-642M or DC4-664C.
4. Modifications to the BMPS will not affect the minimum required SOCTS.
5. Any MDST decision which limits a patient's access to participation in scheduled clinical encounters will be reviewed and documented daily by the Psychologist via an incidental note in the inpatient record.

(10) **MENTAL HEALTH INPATIENT UNIT TRANSFERS AND DISCHARGES:**

(a) Request for transfer to another inpatient mental health unit or a different level of inpatient mental health care, or the decision to discharge from inpatient status, will be by consensus of the MDST. The Regional Mental Health Ombudsman, however, may order emergent transfers to higher level of care without prior consensus by the MDST, as referenced in section (3)(l). The clinical justification for the transfer or discharge and consideration of any potential adjustment issues related to the transfer will be documented in the inpatient record via an incidental note.

(b) Transfers to and from an inpatient unit will be conducted in accordance with "Mental Health Transfers," Procedure 404.003. Transfers from one inpatient mental health unit to another, regardless of level of care involved, require completion of DC4-657A, at the time of transfer. When a patient is discharged from an inpatient unit to general population, "Discharge Summary for Inpatient Mental Health Care," DC4-657, will be completed and will include an outpatient aftercare plan. A copy of the discharge or transfer summary will be placed in the outpatient health record at the time of discharge or transfer. The inpatient record will be packaged separately, clearly marked, and forwarded with the health record.

(c) Criteria for Transfer or Discharge from a CSU:
  1. transfer from CSU to CMHTF: The patient's judgment is so affected by a mental illness impairment that s/he lacks the capacity to make a well-reasoned, willful, and knowing decision concerning her/his, mental health treatment and requires a treatment regimen that is not available in the CSU.
  2. transfer from CSU to TCU: Patient's symptomatology matches the general characteristics of TCU.

(d) Discharge from CSU to Outpatient:
  1. the attending Clinician, representing the MDST consensus, will consult with the Institutional Psychological Services Director to determine if discharge from the CSU to an outpatient level of care is clinically appropriate. The attending Clinician will document the consultation as an incidental note in the inpatient record;
  2. at least seven calendar days will have elapsed since the end of the last episode of psychiatric seclusion, psychiatric restraints, or self-harm observation status;
  3. An outpatient aftercare plan has been completed prior to discharge documented on the DC4-657;
  4. a CSU patient will be discharged with an S grade of 3, unless the MDST has documented sufficient clinical justification for an exception in the inpatient record. However, without exception, patients with a current diagnosis of psychotic disorder, bipolar disorder, or major depressive disorder will be discharged with an S grade of 3;
  5. patients in the CSU will not be discharged to a confinement or close management setting before they have been stepped down to a TCU; and
  6. at the time of discharge, the attending Clinician will update the S-grade on DC4-706, and clerical or other support staff will update the OBIS HS06 screen accordingly.

(e) Criteria for Transfer or Discharge from a TCU:
  1. transfer from TCU to CSU: A patient who requires a higher level of care will be referred to CSU by the MDST in a timely manner, with clinical rationale clearly documented in the inpatient record.
  2. discharge from TCU to Outpatient:
     a. The MDST has met and documented its clinical justification that the patient's mental status and level of functioning will enable satisfactory adjustment to the specific outpatient setting to which the patient will be discharged.
     b. A patient transferred from CMHTF will be treated at TCU level of care for at least 30 calendar days prior to being discharged to an outpatient level of mental health care.
     c. An outpatient aftercare plan has been completed prior to discharge and documented on the DC4-657;
     d. At least seven calendar days have lapsed since the end of the last episode of psychiatric seclusion, psychiatric restraints, or self-harm observation status.
     e. A TCU patient will be discharged with an S grade of 3, unless the MDST has documented sufficient clinical justification for an exception in the inpatient record. Without exception, patients with a current diagnosis of psychotic disorder, bipolar disorder, or major depressive disorder will be discharged with a mental health grade of S-3.

f. At the time of discharge, the attending clinician will update the S-grade on the DC4-706 and clerical or other support staff will update the OBIS HS06 screen accordingly.

(f) Discharge from CMHTF: A patient discharged from CMHTF will be referred to a TCU; transport from CMHTF to a TCU will be direct.

(11) **REGIONAL CONSULTATION AND REVIEW REQUIREMENTS:**

(a) Patients with resistance to treatment (Problem #142) documented on their ISP will be reviewed by the Regional Mental Health Director quarterly for TCU and every 30 calendar days for CSU. The Regional Consultations will be documented by the supervising Inpatient Psychologist with an incidental note in the inpatient record. If additional consultation is clinically indicated, then the Regional Mental Health Director will continue to consult through her/his chain of command for further deliberation.

(b) A patient who has been in the CSU for more than 60 calendar days, or in the TCU for more than one year will be reviewed by the Regional Mental Health Director with documentation via an incidental note by the supervising Inpatient Psychologist. This consultation, and accompanying documentation, will be reported to the Director of Mental Health. The Director of Mental Health will forward a report summarizing the clinical justification for each patient's length of stay to the FDC Chief of Mental Health Services and Central Office Mental Health Ombudsman for review.

(c) Any patient that refuses to come out of her/his cell for all SOCTS for more than 14 calendar days, will be reviewed by the Regional Mental Health Director and documented by the supervising Inpatient Psychologist with an incidental note in the inpatient record. This consultation, and accompanying documentation, will be reported to the Director of Mental Health. The Director of Mental Health will forward a mental health summary and action plan for each patient to the FDC Chief of Mental Health Services and Central Office Mental Health Ombudsman for review.

(12) **TRAINING REQUIREMENTS FOR STAFF ASSIGNED TO INPATIENT UNITS:**

(a) Clinical and security staff will receive annual training on the identification and assessment of suicide risk, suicide prevention, SHOS procedures and required supervision of patients on SHOS, to include policies regarding attending clinicians' orders for required supervision, and checks for patients on SHOS, including ordering continuous observation, as warranted.

(b) Clinical and security staff will receive annual training on the prevention, management, and treatment of patients at risk to engage in self-injurious behavior.

(c) Clinical and medical records staff will receive annual training regarding the elements of an organized and complete medical record, to include timely completion of medical records.

(d) Mental health clinical staff will receive annual training on the development, implementation, and revision of ISPs.

(e) All staff working in the inpatient unit will receive annual training regarding the purpose, required attendees and substance of an appropriate multidisciplinary services team meeting, to include a discussion about both routine meetings and those events that trigger the need for a meeting.

(f) Psychologists, Psychiatrists and security staff will receive annual training on the proper procedure, documentation, and considerations in determinations regarding whether to discipline a patient on the mental health units.

(g) Clinical and security staff will receive annual training on how to conduct individualized assessments for the use of restraints, the application of restraints on the inpatient mental health units, and the use of emergency treatment orders.

(h) Security staff will receive crisis intervention training and at least eight hours of specialized training annually pertinent to the inpatient mental health units.

(i) Prescribing staff will receive training initially and periodically on both the OBIS and laboratory record systems.

(j) Security staff will receive training in motivational interviewing.

(13) **RELEVANT POLICIES AND PROCEDURES:**

(a) “Health Care Clearance/Holds,” HSB 15.02.02;

(b) “Assignment of Health Classification Grades to Inmates,” HSB 15.03.13;

(c) “Infirmary Services,” HSB 15.03.26;

(d) “Prerelease Planning for Continuity of Health Care,” HSB 15.03.29;

(e) “Psychiatric Restraint,” HSB 15.05.10;

(f) “Planning and Implementation of Individualized Mental Health Services,” HSB 15.05.11;

(g) “Mental Health Staff on Disciplinary Teams,” HSB 15.05.13;

(h) “Psychotropic Medication Use Standards and Informed Consent,” HSB 15.05.19;

(i) “Medical and Dental Care for Mentally Disordered Inmates,” HSB 15.05.20;

(j) “Mental Health Re-Entry Aftercare Planning Services,” HSB 15.05.21;

(k) “Offender-Based Information Systems – Health Services (OBIS-HS),” HSB 15.06.04;

(l) “Credentialing and Peer Review Program,” HSB 15.09.05

(m) "Health Records," HSB 15.12.03;

(n) "Inmate Health and Comfort Items – Issuance," NI1-071;

(o) "Medical Transfers," Procedure 401.016;

(p) "Identification and Management of Transgender and Inmates Diagnosed with Gender Dysphoria," Procedure 403.012;

(q) "Suicide and Self-Injury Prevention," Procedure Manual 404.001;

(r) "Isolation Management Rooms and Observation Cells," Procedure 404.002;

(s) "Mental Health Transfers," Procedure 404.003;

(t) "Americans with Disabilities Act Provisions for Inmates," Procedure 604.101.

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Chief of Staff