

	State of Indiana Indiana Department of Correction	Effective Date 4/1/2022	Page 1 of 25	Number 4.03A
HEALTH CARE SERVICES DIRECTIVE Manual of Policies and Procedures				

Title ADULT MENTAL HEALTH SERVICES
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Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101	National Correctional Behavioral Health Standards

I. PURPOSE:

Incarcerated adults with mental health needs shall have access to comprehensive mental health services. This Health Care Services Directive (HCSD) provides an overview of the delivery of mental health services in adult facilities.

II. DEFINITIONS:

For the purposes of this Health Care Services Directive, the following definitions are presented:

- A. APPRAISAL: An act of assessing or evaluating someone or something.
- B. ADDICTION RECOVERY SERVICES (ARS): The entire continuum of services and programming offered at IDOC facilities for the treatment of problematic substance use.
- C. CAPACITY EVALUATION: The assessment of one's ability to utilize information about an illness and proposed treatment options to make a choice that is congruent with one's own values and preferences.
- D. CASE PLAN CREDIT TIME (CPCT): CPCT is an earned credit time cut structure that is driven by the needs indicated in the IRAS and incentivized through the individual case plan to provide each individual the opportunity to earn the maximum credit time as allowed by law.

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- E. CO-OCCURRING DISORDERS: A condition in which an IDP has at least one diagnosable mental illness along with one or more substance use disorders.
- F. GRAVELY DISABLED: A condition in which a patient, as a result of a mental illness, is unable to independently and successfully perform activities of daily living.
- G. INDIVIDUAL TREATMENT PLAN (ITP): A series of written statements specifying a course of mental health services for a patient and the roles and responsibilities of staff in carrying out the course of mental health services.
- H. IPAS SETTLEMENT: A settlement between the Department and the Indiana Protection and Advocacy Services Commission (IPAS) that states incarcerated individuals who are classified as Seriously Mentally Ill may not be housed for more than thirty (30) consecutive days in restrictive status housing, other than under the rare exceptions as detailed in HCSD 2.21A, "Evaluation of Incarcerated Individuals in Restrictive Status Housing."
- I. MENTAL HEALTHCARE PROFESSIONAL (QMHP): A person with professional training, experience, and demonstrated competence in the treatment of mental illness. QMHPs include physicians, psychiatrists, psychologists, social workers, mental health counselors, mental health nurse practitioners, mental health-trained nurses, or other qualified persons as designated by the Executive Director of Behavioral Health Services.
- J. MENTAL HEALTH SERVICES: The use of a variety of psychosocial and pharmacological therapies, provided individually or in groups, including biological, psychological, and social interventions to alleviate symptoms, eliminate maladaptive behavior, attain appropriate functioning and prevent relapse.
- K. MENTAL HEALTH UNIT: A housing unit dedicated to the provision of mental health services to incarcerated individuals who are unable to function in a standard prison environment as a result of a mental illness.
- L. MENTAL ILLNESS: A psychiatric disorder that substantially disturbs an individual's thinking, feeling, or behavior, and impairs the individual's ability to function.
- M. MULTIDISCIPLINARY TEAM (MDT): A treatment team comprised of individuals from different disciplines that contribute a broad range of perspectives and treatment modalities in the management of patients' needs.

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- N. PSYCHIATRIC PRESCRIBER: A physician or nurse practitioner authorized to prescribe medications for the treatment of mental illness.

III. GUIDELINES:

- A. Mental Health Services within the Department shall include screening for mental illness, evaluating mental illness, and treating patients with mental illness.
- B. Each facility must have a sufficient number of QMHPs to complete the above. QMHPs are expected to provide these services as well as prepare for discharge planning by communicating these needs to the Transitional Healthcare Division for continuity of care into the community. .
- C. QMHPs are also expected to assist in training all staff in Suicide Prevention and Intervention for new employee and annual in-service training, the treatment component of the Certified Treatment Specialist training for all staff who work in mental health units and participate in the training for Suicide Watch Companions and mentors.
- D. Each facility shall have identified a lead QMHP who functions as the coordinator for the mental health services provided within the facility. The lead QMHP shall collaborate with the Health Services Administrator, Warden, and other facility staff to ensure the facility's mental health services are properly managed and available. At facilities without a psychologist, the contracted vendor's Regional Director of Behavioral Health or designee, shall identify a psychologist and psychiatrist from another facility who shall provide leadership and direction as necessary.
- E. Mental Health Intake Appraisals, and diagnostic testing shall be carried out by QMHPs as appropriate to their professional scope, competency, and training. Such functions may include interviews and behavioral observations as well as administering, scoring, and interpreting instruments for assessment, diagnosis, and treatment planning.
- F. All treatment interventions by QMHPs must inform patients, in writing, of the limits of confidentiality at the initiation of mental health treatment.
- H. Regardless of housing assignment, patients must have access to mental health services necessary to screen for, evaluate, and treat mental illness. Mental health services must be provided in a manner which affords the patient confidentiality and provides physical protection for the staff.

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- I. All incarcerated individuals shall be screened for mental illness and suicide risk by a mental health trained nurse or QMHP at Intake, within twenty-four (24) hours of admission to a restrictive status housing unit (HCSD 2.21A, "Evaluation of Incarcerated Individuals in Restrictive Status Housing"), or upon transfer to a new facility (HCSD 2.07A, "Inter-Facility Transfers,") and annually (HCSDA 2.08, "Annual Health Screen").

All incarcerated individuals shall be assessed for mental health needs by a mental health provider at Intake, within seventy-two (72) hours of admission to a restrictive status housing unit, and within one (1) business day of admission to a mental health unit.

- J. Mental health services shall be provided to all incarcerated individuals who need mental health treatment in accordance with an ITP. Psychiatric services shall be provided, when necessary, in accordance with the ITP.
- K. Mental health staff shall identify treatment goals to be documented on the Clinical Review Form for clients who are participating in the Case Plan Credit Time process and who have been identified as needing mental health treatment. Annual reviews documenting the client's progress in mental health treatment shall be completed on the Clinical Review Form annually during the client's regularly scheduled 90-day or 180-day mental health appointment. A copy of the Clinical Review Form with feedback on goal progress shall be shared upon request with the client's Unit Team staff to be considered in the client's Case Plan Credit Time review.
- L. Diagnosis of mental illness must be coded using the most current standard of care outlined in the Diagnostic and Statistical Manual of Mental Disorders. Current diagnoses must be listed on the "Problems," or "Diagnosis" tab within the electronic medical record (EMR). In addition, the "Treatment Plan" template must be kept current, with problems entered as "new" and noted as "resolved" when appropriate.
- L. Each facility shall maintain an accurate roster of patients with mental health needs. Patients with identified mental health needs shall be seen at a minimum of one (1) time each ninety (90) day period by a QMHP to monitor their mental health needs, and progress toward goals identified on their treatment plan. Patients who have been prescribed psychotropic may be seen, no less than every one hundred eighty (180) days by a prescriber only, per the ITP.

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- M. A patients with a serious suicide attempt or self-injurious behavior shall be identified as a “D” Behavioral Health code and shall remain in treatment for a minimum of one year post incident to ensure appropriate treatment and monitoring. Additionally, patients who present to the Department upon Intake with a serious suicide attempt history prior to their incarceration will be monitored as a “D” Behavioral code for one year to ensure stability of mental health needs, appropriate adjustment to incarceration, and provide education to patients of behavioral health services available during their incarceration. Following the year, in both cases, the treating clinician can determine the client’s risk for continued suicidal ideation and behavior and identify which Behavioral Health code most accurately represents the patients continued behavioral health needs.
- N. Incarcerated individuals found guilty but mentally ill in accordance with IC 35-36-2 shall be screened, evaluated, and treated in the same manner as all other patients.
- O. The management and treatment of substance use is the responsibility of the Director of Addiction Recovery Services and the Health Services vendor’s Regional Director of Addiction Recovery Services. Incarcerated individuals are screened at Intake for the presence of substance use (acute intoxication, withdrawal, and history) including alcohol and other drugs. When substance use is recognized as a need by anyone within Behavioral Health Services or Custody, the incarcerated individual shall be referred for addiction recovery services in accordance with current ARS procedures and referral guidelines. QMHPs and ARS staff shall work collaboratively to address the needs of patients with co-occurring disorders.
- P. The management of intoxication and withdrawal is the responsibility of Health Services personnel who address physical needs. However, psychiatric consultation and services may be needed and, when necessary, they shall be provided in collaboration with the physical health primary care provider. A referral shall be made to Addictions Recovery Services in every instance of intoxication and a referral to mental health as clinically indicated by Health Services staff personally treating the patient.
- Q. The management and treatment of incarcerated individuals who are convicted of sexual offenses and required to participate in programming as a result is the responsibility of the Sex Offender Monitoring and Management (SOMM) Program staff. If there are co-occurring disorders present, QMHPs and ARS staff shall work in collaboration with the staff from the SOMM Program to provide appropriate treatment.

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R. In order to prevent dual relationships, professional conflicts of interest, adversarial relationships with other governmental entities, and/or other ethical/professional dilemmas, QMHP's shall not provide the following services:

- Competency evaluations requested by the judiciary or other third parties;
- Pre-sentence psychological evaluations regardless of the referral source;
- Employee assistance assessment or counseling; or,
- Special assessments (e.g., prediction of violence, recidivism, or other future behavior) requested by an entity outside the Department.

IV. CONTINUUM OF CARE:

Clinical mental health services including intake services, routine interventions, crisis management and special needs services shall be available to all patients. Mental health services shall be provided in the least restrictive setting in which the patient's mental illness may be managed. When specialized mental health services are required, the patient shall be transferred to a mental health unit which is most suitable for the patient's treatment needs. Acute stabilization services (e.g., emergency psychotropic medication) shall be provided, when necessary, prior to any transfer to a mental health unit as appropriate.

Intake services are available at all facilities that accept transfers from outside the Department. These services include mental health screening, Intake appraisal, and evaluation to determine mental health needs and plan for treatment in accordance with HCSD 2.02A, "Reception Screening."

Routine services are available at general population facilities and, to a limited extent, at work release centers. These interventions include screening, evaluation, treatment planning, individual and group therapies, psychoeducation, and discharge planning. Routine psychiatric interventions include evaluation, medication management, and the use of involuntary medications in accordance with Health Care Services Directive 4.05 "Involuntary Psychotropic Medication Administration – Non Emergent."

Crisis management services are available at general population facilities, work release centers, and mental health units twenty-four (24) hours per day. These services include evaluation and stabilization to ensure safety. Psychiatric crisis management includes evaluation, stabilization, and the use of emergency involuntary psychotropic medications in accordance with HCSD 4.04A, "Emergency Involuntary Psychotropic Medication."

Specialized mental health services are available at mental health units located at the New Castle Correctional Facility, Wabash Valley Correctional Facility, and Pendleton Correctional Facility for male patients and the Indiana Women's Prison for female patients.

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Services provided include all of the above, as well as increased individual and group therapy, behavioral modification, and psychoeducation services in a highly structured environment. . Discharge planning for patients receiving intensive mental health services shall involve a comprehensive multidisciplinary treatment team approach.

V. CLINICAL SERVICES:

A. Intake Services

Staff working at Intake units processing new intersystem arrivals and parole violators shall obtain information from the transporting officer regarding the incarcerated individual's conduct and demeanor during transport. Incarcerated individuals who are lethargic or difficult to arouse or acting strangely or in a bizarre manner shall be seen immediately by the nursing staff.

1. Nursing Screening

All incarcerated individuals shall be screened by a mental health-trained nurse as soon as possible after arrival. When emergency mental health needs are identified, the patient shall be immediately evaluated by a QMHP. If a QMHP is not on site, the nurse shall contact the appropriate QMHP for direction. For patients who are potentially suicidal, the patient must be placed under direct visual observation until an evaluation by, or consultation with, a QMHP has been completed.

2. Mental Health Intake Appraisal

Within fourteen (14) days of an incarcerated individual's arrival to an Intake facility (inter-system transfer), or as a parole violator (intra-system transfer), a QMHP must perform a Mental Health Intake Appraisal.

The comprehensive Mental Health Intake Appraisal shall include use of a structured interview that addresses and documents the following areas:

- Current mental status, symptoms, and condition including orientation to person, place and time, and response to incarceration;
- Review of available historical records of inpatient and outpatient psychiatric treatment and treatment with psychotropic medications;
- History of or current suicidal potential and person-specific circumstances that increase suicide potential;
- Past psychiatric hospitalization and outpatient treatment including

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psychotherapy, psychoeducational groups, and classes or support groups and treatment with psychotropic medication;

- Assessment of Drug and alcohol use, history, and treatment;
- Educational history including special education placement;
- History of sex offenses or sexual abuse-victimization and predatory behavior;
- Assessment of violence potential and person-specific circumstances that increase violence potential;
- History of traumatic life events and losses;
- History of violent behavior directed towards others or property
- History of victimization;
- History of prior suicide attempts or self-injurious behavior;
- History of cerebral trauma or seizures;
- Emotional response to incarceration;
- Estimation of overall intellectual abilities
- Need for referral for further mental health evaluation and treatment, as indicated;
- Development and implementation of a treatment plan, including recommendations concerning housing and job assignment and program participation; and,
- Use of additional assessment tools, as indicated.

B. Mental Health Transfer Screen

Patients transferring from one Department facility to another Department facility with a behavioral health code of “B” or higher shall be evaluated by a QMHP to include the following information within fourteen (14) days of arrival:

- Mental Status Examination
- Suicide Risk Assessment
- Review of current Behavioral Health code, diagnosis, Treatment Plan, and Clinical Review Form when applicable for accuracy. These shall be developed or updated as needed.
- Consent for Treatment and Limits of Confidentiality
- Referral to Psychiatry, if indicated
- Referral to Addiction Recovery Services, if indicated

C. Routine Services

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Routine services are available at general population facilities and to a limited extent work release centers.

1. Consent and Confidentiality

QMHPs are responsible for obtaining patient's informed consent prior to providing treatment by completing State Form 48429, "Consent for Treatment and Limits of Confidentiality," located in the EMR document library, prior to undertaking any therapeutic intervention other than crisis management.

2. Requests and Referrals for Service

All patients, regardless of Behavioral Health code, may access mental health services by submitting State Form 45913, "Request for Health Care Services (HCRF)" and seen in accordance with the provisions of HCSD 2.01A, "Access to Care." Nursing staff shall collect HCRFs daily and screen for needs requiring emergent or urgent attention. Patients requiring crisis stabilization services or who have an urgent or emergent mental health concern shall be identified and seen immediately by a QMHP. If Behavioral Health staff are not on-site nursing staff shall contact a QMHP for direction.

For routine Behavioral Health needs, nursing shall properly triage. As HCRFs often contain incomplete information, it may be necessary to conduct a face-to-face interview before establishing a priority for subsequent individual or group treatment. This Behavioral Health screening shall be completed within seven (7) calendar days of receipt of State Form 45913 unless there is a documented justification otherwise.

In some situations, patients may repeatedly request to be seen for unnecessary services. As long as there is not a new concern or a change in circumstances the QMHP may document that the appropriate assessment or review has already been completed, there is no need for another assessment or treatment, and notify the patient of that decision by responding on State Form 45913. Care must be taken to ensure new problems are assessed when reported.

All staff referrals shall be seen by mental health within 7 days as outlined in HCSD 2.01A, "Access to Care."

3. Treatment Planning

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Individual Treatment Plans (ITP) are formal written plans that identify serious mental health conditions referenced from the list of diagnoses in the EMR and include treatment modalities and interventions to be used to address the problem(s).

ITPs must be unique and specific to the patient and include the problem being addressed, a list of goals and objectives specific to the problems, and a description of the specific interventions to be provided. The treatment plan shall include the staff responsible for the interventions to be provided and the frequency or interval of follow up encounters.

Patients receiving mental health services must be seen in accordance with the time frames established in the ITP. Mental Health staff responsible for implementing the treatment plan must chart the patient's progress at each treatment plan review.

Treatment plans must be reviewed and revised at a minimum in accordance with the following time schedule:

- General population units, every six (6) months;
- Specialized mental health units, every three (3) months;
- Restrictive status housing units, every six (6) months.

ITP goals will also be used in the Case Plan Credit Time (CPCT) process for patients who have opted in prior to January 1, 2022 or entered the Department on or after January 1, 2022. Goals shall be documented on the Clinical Review Form when a patient is participating in the CPCT process. A copy of the Clinical Review Form with identified goals shall be uploaded in the EMR. Annually during the patient's regularly scheduled 90- or 180-day contact, mental health staff shall complete a review of the established Clinical Review Form, documenting progress the patient has made toward goals. A copy of the completed Clinical Review Form shall be provided to the patient's Unit Team staff upon request. A new Clinical Review Form with newly identified or continued goals shall be completed at Intake at each review unless mental health services are no longer required.

5. Mental Health Therapies

QMHP's shall provide individual and / or group therapies as appropriate to the mental health needs of the patient and in accordance with the patient's ITP.

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6. Psychoeducation

QMHP's and bachelor's degree-level staff shall provide psychoeducational groups to the patient as appropriate to the mental health needs of the patient and in accordance with their ITP.

7. PREA Follow-Up

If at any time during incarceration the patient indicates they have experienced prior sexual victimization or perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, mental health staff shall be notified. Mental Health staff shall ensure the patient has been offered services previously for this victimization and/or perpetration or is offered mental health services in line with other referrals and seen within seven (7) days.

8. Psychiatric Evaluation and Treatment

Psychotropic medications are to be used for the management of symptoms of a mental illness when such medication is the accepted treatment.

A patient who has been referred for routine psychiatric evaluation shall be seen within seven (7) days of the referral. At a minimum, the psychiatric evaluation shall include:

- The patient's current complaint or reason for the evaluation;
- A notation regarding the symptoms the patient is experiencing including comments regarding severity, associated features and precipitating and aggravating factors if indicated;
- A review of the patient's past physical and mental health history;
- An inquiry into the patient's alcohol and substance use;
- Outcome of a mental status exam; and,
- A functional assessment.

The patient who requires psychotropic medication shall complete an informed consent for treatment with psychotropic medication form. The medical provider's specialized consent forms may be used upon approval of the Chief Medical Officer (CMO), or Executive Director of Behavioral Health. No psychotropic medication shall be provided if the patient declines to sign the consent unless the patient is considered gravely disabled or dangerous and the involuntary psychotropic medication process has been initiated in

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accordance with the provisions of HCSD 4.04A, “Emergency Involuntary Psychotropic Medication,” or HCSD 4.05A, “Involuntary Psychotropic Medication Administration – Non-Emergent.”

Psychotropic medications should be prescribed judiciously for the management of distinct target symptoms and treatment goals and initiated with the patient’s consent, only after reviewing the potential risks, benefits, side effects, and alternatives with the patient. The use of psychotropic medication should be voluntary unless a psychiatric emergency exists or the patient is receiving treatment under involuntary psychotropic medication guidelines. Psychotropic medications should never be prescribed solely for disciplinary reasons.

Once medication therapy has been initiated, the patient must be seen by a prescriber and reassessed within thirty (30) days, even if the patient is noncompliant with the treatment plan or refuses other mental health services. Any patient who is prescribed a psychotropic medication shall be seen at a minimum of one time each one hundred eighty (180) day period by a prescriber to monitor their mental health needs and response to psychiatric intervention. The patient must be monitored for desired and adverse effects of psychotropic medication including extrapyramidal symptoms (EPS). Patients prescribed neuroleptic drugs must be screened for movement disorders using the Abnormal Involuntary Movement Scale (AIMS). AIMS testing shall be done:

- Before the first dose is administered
- Every six (6) months following initiation unless more frequent testing is indicated
- If AIMS testing is positive, the patient shall be monitored every three (3) months
- If medication is stopped due to positive AIMS testing, the patient shall be monitored as clinically indicated for symptoms that persist.

Patients receiving second generation / atypical antipsychotics (e.g., risperidone, ziprasidone, olanzapine, etc.) must have a body weight, blood pressure, fasting blood glucose and lipid panel obtained at baseline and follow current American Psychiatric Association (APA) guidelines regarding metabolic monitoring parameters for atypical antipsychotic medications. Prescribers may defer the orders for these tests if the patient is followed in Chronic Care Clinic for diabetes or heart disease and the parameters are already being measured and monitored by the provider.

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Serum drug levels (e.g. Lithium) should be obtained within the time frames established in national standards.

Patients housed in mental health units, but are not prescribed psychotropic medication, must be seen by a prescriber at least every one hundred eighty days (180) days.

Patients requesting psychiatric evaluation are first screened by the QMHP to determine mental health symptoms, clinical significance, and appropriateness of referral to psychiatry. In the event the QMHP does not believe a referral is appropriate and the patient continues to request psychotropics while engaging in services, the QMHP shall consult with psychiatry at minimum and document such consultation and plan of care.

10. Prescribing Guidelines

Prescribers are expected to adhere to the current evidence-based treatment guidelines of psychiatric disorders.

11. Capacity Evaluations

Psychiatry staff shall conduct Capacity Evaluations for patients being considered for advanced directives in accordance with HCSD 2.13A, "Advanced Directives."

12. Discontinuation of Mental Health Services

It is appropriate for a QMHP to discontinue mental health services when:

- The goals and objectives of treatment have been met and the QMHP determines mental health services are no longer required;
- The patient is released from the Department;
- The patient has repeatedly refused to comply with the interventions recommended on the ITP and the QMHP has determined the patient is not at substantial risk of harm. A refusal form should be completed in accordance with the guidelines of HCSD 2.12A, "Consents and Refusals." However, if a patient who is at risk of harm to themselves or others, refuses to comply with the recommended interventions, the

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patient must be assessed for potential placement in an appropriate mental health unit or involuntary psychotropic medication

- When psychiatric medication is discontinued, either by the patient upon request or by the psychiatric prescriber due to change in clinical condition or nonadherence to the drug regimen, the patient should be seen for follow up by the psychiatric prescriber within thirty (30) days to determine if there is any further clinical action necessary. No further follow-up is required unless clinically indicated.
- Noncompliance with treatment may be taken into consideration in evaluating the patient's progress for the purpose of the CPCT review. Noncompliance should not be considered a lack of progress on the Clinical Review Form if the patient is not capable of engaging meaningfully in treatment, or if it is determined the patient is not in need of mental health treatment by a clinical provider.

D. Crisis Management Services

Every facility must have access to both a prescribing and non-prescribing QMHP to manage crisis situations. Crisis situations shall be managed at each facility as appropriate to ensure safety of incarcerated individuals, staff, and facilities. A mental health risk assessment shall be completed as soon as the incarcerated individual in crisis has been identified. Depending upon the severity of crisis due to mental illness, substance use, or dangerous behavior, increased intervention or crisis supervision may be required. Mental health clinicians should consider the risk of harm to self, others, or the facility when implementing special accommodations, from least to most restrictive.

- Patients displaying symptoms of psychosis, acutely altered mental status, adjusting to medication, exhibiting poor coping skills, or experiencing deterioration in functioning, physical health, or cognition, and who are not at risk of harm to self or others but would benefit from temporary removal from the general population may be relocated to a designated area of a housing unit which is quieter or in close proximity to an officer station on Safety Precautions. The patient must be seen at least once every business day by a QMHP until they are able to return to their assigned housing. A referral to physical health may be initiated by the evaluating QMHP prior to release from safety precautions to rule out clinical reasons for the change. The QMHP must determine and communicate to the Custody staff the type of clothing, personal property,

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bedding, and meals (e.g., no packing/no utensils if necessary) a patient may have while on safety precautions. .

- Narcan shall be used as a life-saving measure in situations of suspected or known overdose as outlined in HCSD 3.07A, “Intoxication and Withdrawal.” When substance use or overdose is suspected or known, the patient shall be tested to determine the type of substance used. Patients with a suspected or known overdose or intoxication shall be referred to Addiction Recovery Services as well as Mental Health as clinically necessary.
- Facility staff must intervene immediately whenever a patient attempts suicide or inflicts self-harm. Patients must be managed in accordance with the applicable Health Care Services Directive or Directives:
 - 4.06A, “Suicide Prevention and Self Injury”;
 - 4.04A, “Emergency Involuntary Psychotropic Medication”; and
 - 4.02A, “Therapeutic Restraint.”

E. Specialized Mental Health Services

A continuum of mental health services is offered in most facilities. In some cases, patients may require placement in specialized mental health treatment units for stabilization and treatment. Facilities shall identify and attempt less restrictive means of addressing the patients’ needs prior to referring to the mental health units for admission. This includes collaborating with the facility Multidisciplinary Treatment Teams, and attempting all reasonable interventions including psychotherapy, psychiatric referral, and psychotropic medications including involuntary medication, if appropriate.

1. Referral and Clinical Staffing Process

Patients who have been identified as needing a higher level of services can be identified by mental health teams at any facility. Once less restrictive interventions have been attempted unsuccessfully or with incomplete success, a referral to a mental health unit is appropriate. In the case that the transfer need is emergently, the site Lead QMHP shall contact either the Health Services vendor’s Regional Director of Mental Health or designee to staff emergency admissions to one of the three adult male mental health units and/or the Special Needs Unit (SNU) at Indiana Women’s Prison for women. Following a Serious Suicide Attempt or Serious Self Injury, the Director of Mental Health and the Health Services vendor’s Regional

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Director of Mental Health should be notified at the earliest possible time if admitting the patient to a mental health unit upon release from an outside hospitalization is preferable to returning them to their former facility.

In most Mental Health unit transfer cases, the facility's Lead QMHP, or designee from each adult male facility, including mental health units, shall participate in the Mental Health Movement Call. During this call, all patients being considered for admission to, or discharge from, a mental health unit shall be discussed. At this time, determination shall be made as to whether admission to a mental health unit is appropriate or if an alternative treatment plan shall be explored first. Determination of the appropriate mental health unit placement shall also be made at this time.

All female patients requiring mental health unit placement shall be housed at the Indiana Women's Prison Special Needs Unit (SNU). Due to the single mental health unit and the lower frequency of transfer needs, Mental Health Movement Calls for adult women may occur on an as needed, rather than weekly, basis.

New Castle Psychiatric (NCP)

- Further stabilization of acute psychotic symptoms
- Recent serious suicide attempts
- Recent serious, frequent, or extreme self-injurious behavior, including substance use
- Assessment and clarification
- High security risk patients requiring mental health unit placement

Pendleton INSIGHT (Intent on Shaping Individual Growth with Holistic Treatment) Treatment Unit (IRT)

- Additional need for either transitional treatment and/or structured environment
- Patients meeting criteria for Serious Mental Illness and currently housed in Restrictive Status Housing, who are security appropriate for an open milieu treatment environment
- Patients who require a transitional level of care and do not require placement at a facility with an infirmary for medical needs
- Patients who have co-occurring disorder behavioral health needs

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Wabash Valley Correctional Facility Special Needs Unit (SNU)

- Additional need for either transitional treatment and/or structured environment
- Patients for whom placement in a double cell is an appropriate and anticipated component to transition back into a general population setting
- Patients meeting criteria for Serious Mental Illness and currently housed in Restrictive Status Housing who are security appropriate for an open milieu treatment environment
- Patients who require a transitional level of care and require placement at a facility with an infirmary for medical needs
- Patients who are diagnosed with cognitive disorders who require some prompting or support to complete ADLs

Indiana Women's Prison Special Needs Unit (IWP SNU)

- Further stabilization of acute psychotic symptoms
- Recent serious suicide attempts
- Recent serious, frequent, or extreme self-injurious behavior, including substance use
- Assessment and clarification
- Additional need for transitional treatment and/or structured environment
- Patients meeting criteria for Serious Mental Illness and who would be placed in Restrictive Status Housing who are appropriate for an open milieu treatment environment

2. Mental Health Admission Transfer Process

Once a determination has been made as to the appropriate mental health unit placement, an authorization from the Health Services vendor's Regional Director of Mental Health or designee is sent to the Department's Director of Mental Health and Program Director for Behavioral Health Services. , Once final approval has been received from the Department's Director of Mental Health or designee, an email is sent to the Health Services and Mental Health staff of the sending and receiving facilities, as well as the Central Office Classification and Operational Support division. The QMHP shall then provide the facility Classification Supervisor a copy of the patient's updated Behavioral Health code. The QMHP shall complete the

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Electronic Medical Record (EMR) Transfer Summary template including the narrative Mental Health Treatment Summary.

3. Mental Health Unit Intake Process

A licensed nurse shall review SF 45998, “Record of Point of Entry” and complete the Intake screening template in the EMR to include the Suicide Risk Assessment. This template shall be completed within twelve hours of arrival. Patients admitted to a specialized mental health unit must be seen by a QMHP within one business day in order to assess for acute needs.

A Comprehensive Mental Health Appraisal shall be completed within seven (7) days of arrival to a mental health unit. Patients who are placed at NCP or IWP SNU must be seen within seven (7) days of arrival by a prescriber. Patients who are placed at IRT or SNU must be seen within fourteen (14) days of arrival by a prescriber. Newly admitted patients shall have an ITP established or revised by all appropriate QMHPs.

4. Mental Health Unit (MHU) Treatment and Documentation

Each patient in a MHU shall be seen at a minimum of once a month for individual therapy. If the patient refuses to attend an individual therapy session, they must be seen by a mental health QHMP on the day of the refusal. If a patient is determined to be inappropriate for individual therapy due to a mental health reason, the patient must be visited daily by a QMHP to assess for appropriateness to participate in individual sessions. If the patient is determined to be inappropriate for individual sessions for a safety or security reason, the patient must be seen daily by a QMHP only after they have been on that status for seven (7) days. Documentation should be entered as an EMR progress note.

Patients who are on psychotropic medications shall be seen at least every ninety (90) days by a prescriber. Patients on involuntary medications must be seen at least every thirty (30) days by a prescriber. Patients who are not on psychotropic medications shall be seen within thirty (30) days of arrival and then at a minimum of every one hundred eighty (180) days, or in accordance with the patient’s ITP. All interactions should be documented as EMR medication management notes.

Each patient must be offered the opportunity to participate in ten (10) hours of out-of-cell therapeutic programming per week unless the patient is

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determined to be inappropriate for mental health or safety or security reasons. If a patient refuses to attend a group session, they must be seen by mental health staff on the day of the refusal to encourage continued participation in treatment. If a patient is determined to be inappropriate for group sessions due to a mental health reason, the patient must be visited daily by a QMHP to assess for appropriateness to participate in group sessions. If a patient is determined to be inappropriate for group sessions due to a safety or security reason, the patient must be seen daily by a QMHP. Patients who are inappropriate for either mental health or safety and security reasons should be permitted to participate in group sessions as soon as they are stable or safe enough to attend. Weekly group notes should be entered in EMR and on weekly Out-Of-Cell Summary Reports. If less than ten hours of out-of-cell therapeutic programming was offered, appropriate documentation shall be made reflecting the reasons this did not occur.

Each patient's ITP must be reviewed at a minimum of every ninety (90) days or in accordance with the patient's ITP or the facility directive. ITP shall additionally be reviewed upon diagnosis or when a significant change in clinical status occurs; when a course of planned treatment is completed; and when the patient will be discharged from the MHU. ITPs reviews shall be documented in the EMR Treatment Plan Review Template.

5. Mental Health Unit Discharge/Transfer Process

A patient shall be discharged from a mental health unit when their mental health needs no longer are appropriate for placement in the unit. The reasons this may occur include, but are not limited to:

1. The clinical and behavioral goals and objectives of treatment have been met and the assigned therapist and Multidisciplinary Treatment Team determine that the level of mental health services is no longer required;
2. The patient has failed to progress in treatment and transfer to a higher acuity unit is required due to a worsening of mental health status after treatment plan updates and reasonable attempts to treat the patient's mental health needs have been documented;
3. The patient presents safety and security risks that cannot be managed in the unit; such as either a continued pattern of disruptive or destructive behavior in the unit, or engaging in assaultive

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behavior toward staff or other program participants **and** if removal does not pose a substantial risk to the individual;

4. The patient does not wish to participate in the mental health unit programming and removal from the unit does not pose a substantial risk to the patient.
5. The patient does not participate in individual and group therapy as required and has not engaged in treatment after treatment plan updates and reasonable attempts to gain the patient's treatment compliance have been made or documented. The patient may only be discharged for these reasons if removal does not pose a substantial risk to the individual.

When a MHU's Treatment Team determines a patient is appropriate for discharge, or no longer appropriate for that level of care, a Transfer Summary is prepared and sent to the Health Services vendor's Regional Director of Mental Health. The patient is then discussed on the weekly Mental Health Movement Call. If the patient is approved for discharge, the same process used for approving admissions into mental health units will be used to process the patient's discharge. Mental health staff shall continue to see the patient until they are transferred to a different site.

If a patient is being discharged to Restrictive Status Housing from a MHU, a Restrictive Housing Review should be completed by a QMHP at the discharging site and submitted to the Executive Director of Behavioral Health and the Director of Mental Health for review. If approved, the individual may be discharged directly to Restrictive Status Housing. If the patient meets criteria for classification as Seriously Mentally Ill, a safety and security exception for placement in Restrictive Housing shall be submitted, reviewed, and approved by the Executive Director of Behavioral Health Services. If approval is not received in either of these situations, the individual shall remain in the MHU until an appropriate placement can be determined.

After the transfer is completed, the patient shall be seen within one (1) business day of arrival at the receiving facility by Mental Health staff to assess for stability after transfer and adjustment to new facility. The patient shall continue to be seen weekly for the first month and once per month from the second to the sixth months, or more frequently as indicated by the ITP. One exception is if the purpose of the mental health unit was diagnostic

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clarification and clinical documentation clearly identifies that this follow-up is not clinically indicated.

F. Restrictive Status Housing

1. Admission

In accordance with the guidelines established in Health Care Services Directive 2.21, "Evaluation of Incarcerated Individuals in Restrictive Status Housing," the Health Services staff must be informed immediately when an incarcerated individual is assigned to Restrictive Status Housing. A health record screening and review must be completed by a nurse, nurse practitioner, or physician to determine if any contraindication to Restrictive Status Housing exists.

If the health record review show that the incarcerated individual is a "D" Behavioral Health code or is within the thirty (30) day period of post-release follow up after having been removed from suicide watch precautions, the reviewer must immediately conduct the suicide risk and mental health screening and contact the facility's lead psychologist or designee. During business hours, the psychologist or designee must assess the patient to determine if any immediate action is necessary. If placement and review occurs after normal business hours, the lead psychologist or designee must assess the patient on the next business day.

Regardless of Behavioral Health code, within seventy-two hours (72) hours of placement in a restrictive status housing unit, a QMHP shall conduct an evaluation of the individual placed in restrictive housing to determine if the patient meets criteria for classification as Seriously Mentally Ill or if there are other clinical reasons why extended restrictive status housing placement is contraindicated. This evaluation shall include a review of the patient's pertinent mental health history, a thorough review of all active and provisional diagnoses, a validation of current mental health diagnoses, and a determination of the severity of both the clinical symptoms and any resulting functional impairment.

Patients may be identified as meeting Serious Mental Illness criteria as a part of either the initial restrictive status housing review process (as noted above) or as part of a subsequent identification during mental health monitoring at any time during restrictive status housing placement. When a patient receives a new Serious Mental Illness-qualifying diagnosis, the

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QMHP shall notify the Health Services vendor's Director of Mental Health or designee, the Department's Director of Mental Health, and the facility SMI point of contact by email within one (1) business day of the patient's diagnosis. This shall be discussed with the facility Restrictive Status Housing Multidisciplinary Team and determination made by the Team as to the anticipated length of stay in restrictive status housing.

If a determination is made that the patient is unlikely to return to general population in thirty (30) days, the patient is not clinically appropriate to be permitted to consent to remain in restrictive status housing, and the patient is not clinically appropriate to be considered for a safety and security exception, the QMHP should complete and submit a Transfer Summary to the Health Services vendor's Regional Director of Mental Health to be presented on the Mental Health Movement Call for potential placement in an MHU.

If mental health needs are identified by the MHP during the evaluation, the QMHP must make a determination regarding the frequency of contacts necessary for maintenance during restrictive status housing placement and modify the treatment plan accordingly. Mental health services personnel must ensure that proper services and support continue to be provided during restrictive status housing placement by escorting the patient to the appropriate location for services or by providing services in an appropriate setting on the restrictive status housing unit. If at any time the patient's treatment needs cannot be met in restrictive status housing and they are not appropriate to return to a general population setting, the QMHP should complete and submit a Transfer Summary to the Health Services vendor's Regional Director of Mental Health to be presented on the Mental Health Movement Call for potential placement in a MHU.

2. Remainder of Stay

All incarcerated individuals in restrictive status housing must be evaluated by a QMHP within thirty (30) days of placement and every thirty (30) days after in accordance with HCSD 2.21, "Evaluation of Offenders in Restrictive Status Housing," even if no mental illness is present. Mental health evaluations of patients with an identified mental health need(s) must be done in a location which affords the patient confidentiality; the evaluation may not be done at the cell front unless patient refuses an out of cell visit. Follow up evaluations shall be done in accordance with the time frames noted in the ITP which may not exceed thirty (30) days.

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Unless mental health attention is needed more frequently, each incarcerated individual in restrictive status housing shall receive a weekly visit from mental health staff to ensure that offenders have access to the behavioral health system. The presence of a mental health staff in Restrictive Housing is announced and the announcement is recorded in the unit log. The mental health authority determines the frequency of mental health professionals to Restrictive Housing units.

In accordance with a Settlement Agreement between the Indiana Protection and Advocacy Services Commission (IPAS) and the Department, QMHPs assigned to restrictive status housing areas within the Department are required to fulfill unique assessment responsibilities. The attachment to HCSD 2.21A presents a matrix for the types of mental health contacts, frequency of contacts, location of contacts, and documentation required for patients in restrictive status housing.

3. Special Confinement Unit

QMHPs shall evaluate all incarcerated individuals referred for placement in a special confinement unit. This evaluation shall consist of a mental status examination and chart review for mental health needs. Findings including presence of a mental health diagnosis and risk of decompensation in a long term restrictive status housing environment shall be communicated to classification professionals.

Incarcerated individuals placed in a special confinement unit will be reviewed and evaluated by a QMHP to determine whether they meet criteria to be classified Seriously Mentally Ill and will receive the same follow-up and treatment as is required in other restrictive status housing placements.

G. Release/Discharge Planning

Transitional Healthcare staff identify patients who potentially have special needs upon release and triage them to be staffed by a Transitional Healthcare Facilitator and the Lead QMHP at their facility. If the facility does not have an assigned facilitator, a Transitional Healthcare Specialist shall work, as needed, directly with the Lead QMHP. Once special needs are identified, post-release care coordination is triaged and release planning continues until the IDP is discharged from IDOC.as directed in HCSD 5.01, "Transitional Health Care."

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H. Parole Board Evaluation Requests

All Parole Board requests for mental health evaluation shall be routed to the Department's Director of Mental Health or designee who shall, in turn, contact the appropriate QMHP.

The QMHP shall compile the information itemized below and forward to the Parole Board within thirty (30) days of the request.

- For individuals who are currently in treatment, mental health staff shall forward:
 1. A summary description of the treatment and/or interventions provided to the patient;
 2. The patient's response to treatment and/or interventions;
 3. A current mental status summary; and,
 4. Recommendations regarding continuity of care upon release.
- For patients who have a history of receiving mental health treatment, but are not currently in treatment, Mental health staff shall review and summarize for the Parole Board available treatment records including the mental health services discharge summary as well as the timeframe when the patient last received services.
- For patients with no known history of mental illness or of mental health treatment, mental health staff shall not be expected to provide evaluations or reports. The absence of mental illness or treatment history shall be communicated to the Parole Board.

If the Parole Board indicates that additional information beyond that described above is necessary, the Parole Board will submit a formal request to the Executive Director of Behavioral Health or designee.

Under no circumstances shall a QMHP recommend for or against release.

H. Civil Commitment Upon Release

Individuals nearing the end of their commitment to the Department, who are believed to pose a danger to themselves, others, or are gravely disabled as a result of a mental illness shall be considered for Civil Commitment. Cases shall be reviewed by the Health Services vendor's Regional Director of Psychiatry,

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Regional Director of Mental Health, Executive Director of Behavioral Health, Executive Director of Transitional Healthcare, and the Legal Services Division. Alternate release plans should be developed in the event a patient is not civilly committed.

VI. APPLICABILITY:

This Health Care Services Directive is applicable to all facilities housing incarcerated adults.

Kristen Dauss, MD
Chief Medical Officer

Date