



**U.S. Department of Justice**  
Federal Bureau of Prisons

## PROGRAM STATEMENT

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# Treatment and Care of Inmates With Mental Illness

/s/

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## 1. PURPOSE AND SCOPE

This Program Statement provides policy, procedures, standards, and guidelines for the delivery of mental health services to inmates with mental illness in all Federal Bureau of Prisons (Bureau) correctional facilities.

For the purpose of this Program Statement, mental illness is defined as in the most current *Diagnostic and Statistical Manual of Mental Disorders*:

“A mental disorder is a syndrome characterized by clinical significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.”

Classification of an inmate as seriously mentally ill requires consideration of his/her diagnoses; the severity and duration of his/her symptoms; the degree of functional impairment associated with the illness; and his/her treatment history and current treatment needs. Mental illnesses not listed below may be classified as seriously mentally ill on a case-by-case basis if they result in significant functional impairment.

The following diagnoses are generally classified as serious mental illnesses:

- Schizophrenia Spectrum and Other Psychotic Disorders.

- Bipolar and Related Disorders.
- Major Depressive Disorder.

In addition, the following diagnoses are often classified as serious mental illnesses, especially if the condition is sufficiently severe, persistent, and disabling:

- Anxiety Disorders.
- Obsessive-Compulsive and Related Disorders.
- Trauma and Stressor-Related Disorders.
- Intellectual Disabilities and Autism Spectrum Disorders.
- Major Neurocognitive Disorders.
- Personality Disorders.

The primary purpose of this Program Statement is to ensure that inmates with mental illness are identified and receive treatment to assist their progress toward recovery, while reducing or eliminating the frequency and severity of symptoms and associated negative outcomes of mental illness, such as exacerbation of acute symptoms, placement in restrictive housing, need for psychiatric hospitalization, suicide attempts, and death by suicide.

The secondary purpose of this Program Statement is to address dynamic risk factors associated with recidivism in inmates with mental illness to increase pro-social and adaptive living skills and the likelihood of successful reentry to the community.

a. **Summary of Changes**

*Policy Rescinded*

P5310.13      Institution Management of Mentally Ill Inmates (3/31/95)

This reissuance incorporates the following modifications:

- Evidence-Based Practices for the treatment and care of mentally ill inmates are detailed and Priority Practices are established.
- The mental health care level system is operationalized. Mental health care level definitions are provided, which include diagnostic, impairment, and intervention-based criteria. In addition, care level-based treatment and documentation requirements are noted.
- A team approach to mental health care is established, including introduction of an institution Care Coordination and Reentry (CCARE) Team with joint Psychology Services and Health Services membership.
- Enhanced procedures for screening, evaluation, and intervention with inmates in restrictive housing settings are detailed.

- Procedures for providing mental health training for staff are outlined, including basic training for all staff as well as specialty training for interested staff.
- A mental health companion program is established to provide peer assistance and support to inmates with mental illnesses.
- Achievement awards for inmate participation in mental health programming are introduced.
- Designation, transfer, and release procedures for mentally ill inmates are updated and refined, with an emphasis on continuity of care – both across institutions and to the community.

#### **b. Program Objectives**

- To identify inmates with mental illness through screening and classification upon their entry into the Bureau and again upon their arrival at an institution to achieve an accurate diagnosis and determine the severity of mental illness and suicide risk.
- To ensure Psychology Treatment Programs and mental health interventions prescribed in treatment plans ordinarily rely on evidence-based practices for the treatment of inmates with mental illness and rehabilitation needs.
- To extend support for inmates with mental illness beyond traditional professional services through creation of specific supportive communities, specialized staff training, inmate peer support programs, care coordination teams, and institutions with specialized mental health missions.
- To enhance continuity of care through a network of accessible, interrelated interventions and communication among care providers when inmates transfer between institutions, to a Residential Reentry Center (RRC), to home confinement, or to the community.
- To reduce the proportion of inmates with mental illness in restrictive housing settings through informed disciplinary processes, initial screening procedures, enhanced treatment in these settings, and strategies for successful reintegration into the general population.
- To increase rates of successful reentry among inmates with mental illness through accurate identification of at-risk inmates, effective skill building in prison, and comprehensive release plans.

## **2. RESPONSIBILITIES**

a. **Psychology Services Branch and Health Services Division.** The Psychology Services Branch (Branch), Reentry Services Division, and Health Services Division (HSD) provide oversight and consultation regarding institution treatment and care of inmates with mental illness through remote reviews of the Psychology Data System (PDS) in the Bureau Electronic Medical Record (BEMR) and other BEMR documentation; remote reviews of inmates in restrictive housing; recommendations regarding transfers and designations of mentally ill inmates; and

direct consultation with Chief Psychologists, Psychiatrists, other Health Services staff, and Executive Staff.

The Branch is responsible for developing Annual Refresher Training lesson plans that provide staff with information about working with mentally ill inmates. They also develop and disseminate supplemental staff training materials for use by the Mental Health Treatment Coordinator during staff recalls, lunch and learn events, department head meetings, etc. The Branch also identifies and disseminates evidence-based practices, described below.

b. **Warden.** Each Warden is responsible for the appropriate management of mentally ill inmates in his/her institution. He/she must provide the Mental Health Treatment Coordinator with adequate time to educate staff about the need to detect and report any unusual inmate behaviors that might suggest mental illness. For example, this education should occur at department head meetings, staff recalls, lieutenants' meetings, and annual training.

c. **Chief Psychologist.** Each Chief Psychologist ensures the provisions of this Program Statement are implemented, including designation of a psychologist to serve as Mental Health Treatment Coordinator, and informing institution staff of the designation. The Chief Psychologist is also responsible for ensuring information about the availability of mental health services is disseminated to inmates during Admission and Orientation. Specifically, the Chief Psychologist ensures the Admission and Orientation lesson plan developed by the Psychology Services Branch is utilized to convey this information. In addition, the Chief Psychologist is responsible for ensuring basic psychological services (e.g., mental health screening, brief counseling), as detailed in the Program Statement **Psychology Services Manual**, are made available to inmates.

d. **Mental Health Treatment Coordinator.** The Mental Health Treatment Coordinator is a licensed doctoral-level psychologist who manages the treatment and care of inmates with mental illness and ensures that all provisions of this Program Statement are implemented. A licensed doctoral-level psychologist has satisfactorily completed all the requirements for a doctoral degree directly related to full professional work in psychology (i.e., a Ph.D. or Psy.D. in Clinical or Counseling Psychology), and has obtained a license to practice as a psychologist.

e. **Social Worker.** The institution Social Worker is a licensed professional who may provide individual or group counseling in support of this policy. Additionally, the institution Social Worker or Regional Social Worker may develop comprehensive release plans to ensure continuity of care for inmates with mental illness who transition to the community without the benefit of Residential Reentry or Home Confinement placement. In this capacity, Social Workers coordinate with United States Probation Officers, Courts, community mental health professionals, and families to identify appropriate placements and to address reentry needs.

f. **Psychiatrist/Psychiatric Nurse Practitioner.** Health Services organizes, conducts, and administers psychiatric services. The Psychiatrist/Psychiatric Nurse Practitioner accepts referrals through BEMR for cases believed to be in need of psychiatric medication evaluations. Regular interdisciplinary communication is maintained between the Mental Health Treatment Coordinator and Health Services staff, including contract psychiatrists, to optimize treatment efficacy.

g. **Health Services Administrator.** In facilities that use contract psychiatric services, the Health Services Administrator is responsible for contract development and oversight with input from the Mental Health Treatment Coordinator.

h. **Clinical Director.** The Clinical Director will ensure that the general medical needs of each inmate are addressed and that HSD staff rounding in the units and conducting sick call and clinics have received the necessary training to recognize signs and symptoms of mental illness.

i. **Community Treatment Services (CTS).** CTS is responsible for the establishment and oversight of community-based mental health, substance abuse, and sex offender treatment services.

j. **Residential Reentry Management Branch (RRMB).** RRMB is responsible for coordinating with the Psychology Services Branch, in particular CTS staff, to ensure mentally ill inmates releasing through Residential Reentry Centers and Home Confinement are placed appropriately.

j. **Care Coordination and Reentry (CCARE) Team.** The CCARE Team is a multidisciplinary team that uses a holistic approach to ensure that critical aspects of care for inmates with mental illness are considered and integrated. The CCARE Team is responsible for identifying potential concerns affecting inmates with mental illness in a correctional environment.

j. **All Staff.** Any staff member who observes unusual behavior in an inmate that may indicate mental illness should report these observations to the Chief Psychologist or Mental Health Treatment Coordinator.

### 3. RECOVERY-ORIENTED PROGRAM MODEL

Consistent with the recommendations of the President's New Freedom Commission on Mental Health, the Bureau has identified recovery as a guiding principle in the treatment and care of inmates with mental illness. Mental health recovery refers to the process by which people are able to live, work, learn, and participate fully in their communities. For some individuals,

recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.

According to the National Consensus Statement on Mental Health Recovery, there are ten fundamental components of recovery. The Bureau strives to integrate these components into its Psychology Treatment Programs (PTPs), mental health interventions, and treatment plans for inmates with mental illness. The components of recovery are: self-direction, individualized and person-centered care, empowerment, holistic treatment, non-linear progression, strengths-based focus, peer support, respect, responsibility, and hope.

#### 4. **EVIDENCE-BASED PRACTICES (EBPs)**

Psychology Treatment Programs, mental health interventions, and individualized treatment plans for inmates with mental illness rely on evidence-based clinical practices that have been demonstrated to reduce the symptoms of mental illness. EBPs are quickly evolving and cannot be fully listed in the present policy. Therefore, the Bureau maintains a database of EBPs on Sallyport, which is updated as indicated by professional literature. The Psychology Services Branch facilitates implementation of EBPs with materials, education, training, and consultation.

Holistic, recovery-oriented care for inmates with mental illness involves assessing their need for both mental health treatment and rehabilitation programs that reduce the risk of recidivism; services are provided in each of these areas as appropriate. EBPs are selected based on their adherence to this model. Consistent with evidence-based practice, the delivery of mental health services is prioritized for inmates classified as CARE2-MH, CARE3-MH, and CARE4-MH.

a. **Cognitive Behavioral Therapy (CBT).** The Bureau's treatment programs and mental health services are unified clinical activities organized to treat inmates' complex psychological and behavioral problems throughout the course of incarceration. The Bureau has chosen CBT as a theoretical model because of its proven effectiveness with inmate populations. This guiding model creates theoretical continuity, ensuring that learning and practice are built upon similar principles regardless of the institution, treatment provider, or treatment program in which they occur.

CBT emphasizes the learning and practice of skills associated with improved mental health and adaptive, pro-social behavior. Therefore, inmates who participate in CBT and related interventions (e.g., Dialectical Behavior Therapy [DBT]) are better able to achieve goals the Bureau has for all inmates, including responsibility, self-awareness, and independence.

b. **Group Treatment.** Group treatment has proven to be both clinically effective and an efficient use of resources in the treatment of mental illness. Group treatments have the benefit of modeling by the facilitator and other participants, building social support, and allowing the

immediate practice of new skills. A number of EBPs supported by the Bureau were designed specifically for or can be adapted to a group format. Mental health clinicians are encouraged to provide treatment using a therapeutic group format.

For the purposes of mental health care in the general population, therapeutic groups may be open or closed, are evidence-based, and ordinarily:

- Use an established Bureau protocol.
- Are facilitated by a mental health clinician (i.e., psychologist, psychiatrist, social worker, mental health treatment specialist, psychology intern).
- Meet at least every other week.
- Have a continuity in membership, no greater than 12 participants.
- Provide a therapeutic intervention (not just to “check in” with the therapist).
- Hold rapport building and mutual concern among members as a primary goal.

Following participation in therapeutic groups, it may be appropriate to place an inmate in a maintenance group. Maintenance groups have the same characteristics as therapeutic groups, except that their goal is to maintain progress on therapeutic goals and they may meet less frequently (but at least monthly).

c. **Priority Practices.** The Psychology Services Branch designates certain EBPs as Priority Practices – EBPs delivered in group format that address core needs of the inmate population. They prioritize services for inmates with the most severe forms of mental illness and give consideration to a balanced offering of groups that address mental illness and criminal thinking. They may differ across institutions, based on security level, care level, and mission. The Psychology Services Branch places information regarding Priority Practices for each type of institution on Sallyport.

Ordinarily, Psychology Services departments are actively engaged in the provision of Priority Practices as a vital function. Priority Practices are offered before other types of groups. At a minimum, Psychology Services departments offer at least one Priority Practice therapeutic group each quarter, in addition to groups offered in PTPs. For complexes, each institution is considered independently. Satellite facilities are excluded, unless a full-time clinical staff member is assigned.

d. **Skills Training.** The Bureau emphasizes the learning and practice of skills as an important component of treatment for inmates with mental illness. Treatments that emphasize developing new skills (e.g., CBT, DBT, Illness Management and Recovery, Anger Management) encourage responsibility, empowerment, and independence upon reentry.

e. **Criminal Thinking and Risk.** For most inmates with mental illness, the treatment of mental health symptoms is necessary but not sufficient to reduce the risk of recidivism. Holistic treatment considers which empirically validated dynamic risk factors associated with recidivism must be included in the treatment plan (e.g., criminal thinking errors, substance use, antisocial associates, lack of leisure and recreation activities, school or work functioning).

f. **Peer Support.** Peer support is an EBP and core component of the Mental Health Recovery Model; it functions as an adjunct to professional interventions by extending the mental health system. Inmates who underuse professional services may actively engage in peer support activities that benefit their mental health and that of their peers.

## 5. MENTAL HEALTH CARE LEVELS

Mental health care levels are used to classify inmates based on their need for mental health services. The contact frequencies described below refer to contacts where psychosocial interventions are provided.

### a. Definitions

(1) **CARE1-MH: No Significant Mental Health Care.** An individual is considered to meet CARE1-MH criteria if he/she:

- Shows no significant level of functional impairment associated with a mental illness and demonstrates no need for regular mental health interventions; and
- Has no history of serious functional impairment due to mental illness or if a history of mental illness is present, the inmate has consistently demonstrated appropriate help-seeking behavior in response to any reemergence of symptoms.

(2) **CARE2-MH: Routine Outpatient Mental Health Care or Crisis-Oriented Mental Health Care.** An individual is considered to meet CARE2-MH criteria if he/she has a mental illness requiring:

- Routine outpatient mental health care on an ongoing basis; and/or
- Brief, crisis-oriented mental health care of significant intensity; e.g., placement on suicide watch or behavioral observation status.

(3) **CARE3-MH: Enhanced Outpatient Mental Health Care or Residential Mental Health Care.** An individual is considered to meet the criteria for CARE3-MH if he/she has a mental illness requiring:

- Enhanced outpatient mental health care (i.e., weekly mental health interventions); or



- Residential mental health care (i.e., placement in a residential Psychology Treatment Program).

(4) **CARE4-MH: Inpatient Psychiatric Care.** A mentally ill inmate may meet the criteria for CARE4-MH and require acute care in a psychiatric hospital if the inmate is gravely disabled and cannot function in general population in a CARE3-MH environment.

b. **Determination of Mental Health Care Levels.** All current mental health illnesses should be diagnosed in a Diagnostic and Care Level Formulation note in PDS, including personality disorders and intellectual disabilities. The cumulative impact of the disorders on functioning is taken into account when assigning a mental health care level.

To assign a care level, staff consider the inmate's current, recent, and historical need for services. However, this is not the only indicator, as it must be balanced with the inmate's diagnosis and anticipated need for future services. For example:

- Inmates diagnosed with major mental illnesses and/or currently taking antipsychotic medications are not ordinarily classified as CARE1-MH due to their risk of relapse and the lack of resources to address such a relapse at a CARE1-MH facility.
- Inmates releasing from Medical Referral Centers (MRCs) where they received treatment for acute mental health problems are ordinarily classified as CARE3-MH, due to the resources required to assist them in adjusting to a mainline institution.

*Discrepancies in the Record.* Occasionally there are diagnostic discrepancies between providers. When this occurs, the Mental Health Treatment Coordinator or treating psychologist attempts to reconcile these differences. The Mental Health Treatment Coordinator or treating psychologist reviews the record, consults with other treatment providers (including Health Services staff), performs a clinical interview, and observes symptoms and behaviors. The Coordinator or psychologist then integrates the data, noting alternate conceptualizations; attempts to reach consensus between care providers; enters a diagnosis in the Diagnostic and Care Level Formulation note in PDS; and provides a rationale for the decision. If the discrepancy cannot be resolved at this level, the Chief Psychologist and Chief Psychiatrist, if applicable, will review the case, resolve the discrepancy, and document their findings.

A supplemental Mental Health Care Level Training Guide is available on Sallyport. The guide is also disseminated during Psychologist Familiarization Training and annual mental health training events. This guide is designed to assist psychologists in determining appropriate mental health care levels.

c. **Treatment Requirements for Mental Health Care Levels.** The required treatment detailed below is not necessarily provided exclusively by the Mental Health Treatment Coordinator; for example, another psychologist may provide this care.

(1) **Mental Health Care Level One.** Inmates classified as CARE1-MH are not required to receive any regular mental health services or to have a treatment plan. When mental health services are provided to these inmates, they are documented in PDS.

(2) **Mental Health Care Level Two.** Required services include, but are not limited to:

- A diagnosis and mental health care level for each inmate will be documented in a Diagnostic and Care Level Formulation note in PDS.
- A rationale for the diagnosis and assigned care level will also be documented in the Diagnostic and Care Level Formulation note in PDS.
- A collaborative, individualized treatment plan that describes the inmate's problems and goals, and the interventions planned to assist with goal attainment will be developed, reviewed, and updated at least every 12 months.
- Evidence-based psychosocial interventions on at least a monthly basis (if group treatment is offered, it should occur at least every other week, to provide continuity of care).

(3) **Mental Health Care Level Three.** Required services include, but are not limited to:

- A diagnosis and mental health care level for each inmate will be documented in a Diagnostic and Care Level Formulation note in PDS.
- A rationale for the diagnosis and assigned care level will also be documented in the Diagnostic and Care Level Formulation note in PDS.
- A collaborative, individualized treatment plan that describes the inmate's problems and goals, and the interventions planned to assist with goal attainment, will be developed, reviewed, and updated at least every 6 months.
- Evidence-based psychosocial interventions on at least a weekly basis are provided via enhanced outpatient care or on a scheduled basis consistent with a residential Psychology Treatment Program.

(4) **Mental Health Care Level Four.** This treatment takes place only in a Medical Referral Center. Required services include, but are not limited to:

- A diagnosis and mental health care level for each inmate will be documented in the Diagnostic and Care Level Formulation note in PDS.
- A rationale for the diagnosis and assigned care level will also be documented in the Diagnostic and Care Level Formulation note in PDS.

- A collaborative, individualized treatment plan that describes the inmate’s problems and goals, and the interventions planned to assist with goal attainment will be developed, reviewed, and updated at least every 90 days.
- Evidence-based psychosocial interventions and/or individual mental health contacts will occur on at least a weekly basis.

At CARE4-MH sites, for inmates too cognitively impaired to engage in traditional psychosocial interventions (i.e., severe neurocognitive disorders), supportive contacts from a broad variety of providers may be the most appropriate care plan. Frequency and type of care will be determined on an individual basis for these cases.

d. **Treatment Refusal.** If an inmate declines treatment consistent with his/her mental health care level, a treatment plan is developed and implemented to frequently assess the inmate’s mental status, build rapport, and encourage engagement in a treatment process. Ordinarily, the treatment plan will include a monthly attempt to engage the inmate. Rapport building strategies may include: group leisure activities; visits to the inmate’s unit or work site; and “drop-in” group for informal socialization with peers.

An inmate who refuses mental health treatment consistent with his/her mental health care level may be considered for involuntary commitment.

## 6. IDENTIFICATION AND PLACEMENT OF MENTALLY ILL INMATES

All Bureau facilities employ psychologists skilled in the screening, diagnosis, and treatment of mental disorders. Although the Bureau concentrates mental health resources at some institutions, all institutions, regardless of care level, are expected to provide services for inmates with mental illness.

Psychology Services and Health Services departments within each institution ensure every inmate with a clinically identified need for psychological treatment has access to mental health care. They ensure inmates undergo appropriate screening, assessment, and referral to identify and address their mental health, substance abuse, and other behavioral health needs. Psychology Services departments offer a variety of services and programs for inmates – psycho-educational groups, brief counseling, individual and group psychotherapy, crisis intervention, suicide prevention, and residential treatment programs. Health Services departments provide inmates with access to appropriate psychiatric medications to address identified mental health conditions.

a. **Pre-Designation Screening.** Newly designated inmates are screened by Designation and Sentence Computation Center (DSCC) staff based on information in their Pre-Sentence Report (PSR). This screening matches the inmate’s estimated need for mental health services with an institution’s resources at the time of initial designation.

b. **Initial Care Level Assignment.** Mental health screen assignments (SCRNX-MH) are part of the designation process. The assignments are generated by DSCC staff using the medical calculator and are based on review of the PSR, information received from outside sources, a review of other records, etc.

c. **Medical Staff Screening.** Medical staff provide an initial screening for physical and mental health concerns, including suicide ideation, symptoms of mental illness, and sexual victimization. They document their findings in BEMR and advise Psychology Services of any concerns.

d. **Psychology Intake Screening.** Psychology Intake Screening occurs within the timeframes specified in the Program Statement **Psychology Services Manual** and is documented in PDS. At this time the mental health screen assignment is replaced with the mental health care level assignment in SENTRY, and the mental health care level is documented in Psychology Intake Screening, along with a rationale. If the care level is CARE2-MH, CARE3-MH, or CARE4-MH, a Diagnostic and Care Level Formulation note is entered into PDS. In addition, Psychology Services staff notify Health Services staff of any relevant concerns; e.g., a recommendation for a psychiatric medication consultation.

e. **Assignment and Change of Mental Health Care Level Assignment.** Bureau psychologists, psychiatrists, and qualified mid-level practitioners (i.e., a physician assistant or nurse practitioner who is licensed in his/her field of medicine and has specialized training in mental health care) can determine a mental health care level following a review of records and a face-to-face clinical interview. Therefore, assigned mental health care levels represent clinical information about an inmate and are not changed for administrative, designation, or transfer purposes. If there is not agreement regarding an inmate's mental health care level assignment, refer to Section 5b of this policy to resolve any discrepancies.

Mental health care levels are to be entered into SENTRY by Bureau psychologists. As applicable, information provided by Bureau psychiatrists will inform decisions regarding mental health care level assignments. To assign or change a mental health care level a psychologist, psychiatrist, and qualified mid-level practitioner must:

- Review the clinical record.
- Conduct a clinical interview.
- Establish a diagnosis or indicate the absence of a diagnosis.
- Indicate and explain the type and frequency of mental health care contacts required.
- Document this information in the Diagnostic and Care Level Formulation note.

Mental health care level assignments, and changes to these assignments, are not required for inmates housed in non-Bureau facilities; i.e., private correctional institutions, Residential Reentry Centers, and other contract facilities. In addition, these assignments are not required for inmates in transit. If it becomes clear that a mental health care level assignment needs to be updated to accurately represent the inmate's needs upon return to a Bureau facility, Psychology Services Branch staff update the code and enter a note in PDS describing what is known about the situation and the inmate's mental health needs.

f. **Facilities with Pretrial Inmates.** Psychology Services staff are not required to enter mental health care level assignments for all pretrial inmates. However, they must enter assignments for the following pretrial inmates:

- Inmates who undergo a Psychology Intake Screening on the basis of their endorsements on the Psychology Services Inmate Questionnaire (PSIQ).
- Inmates who self-refer or are referred to Psychology Services due to mental health symptoms.
- Inmates who have a recently completed forensic evaluation by a Bureau psychologist or psychiatrist.
- Inmates who require a Suicide Risk Assessment.

If a pretrial inmate does have a care level assignment, it is expected that he/she will receive mental health services consistent with the frequency requirements of that care level. The creation of a treatment plan is clinically appropriate for inmates for whom a long stay is anticipated. However, due to the rapid and unpredictable turnover associated with pretrial facilities, treatment plans are not required.

If the DSCC receives a request for an initial designation and a pretrial facility has already classified a mental health care level for the inmate, the DSCC does not modify this assignment or change it back to a screen code.

## 7. **TEAM APPROACH TO CARE**

Due to their potential vulnerability in a correctional setting, inmates with mental illness may require special accommodation in areas such as housing, discipline, work, education, designations, transfers, and reentry to ensure their optimal functioning. The Bureau uses a team approach to ensure the needs of inmates with mental illness are identified and addressed.

The institution Care Coordination and Reentry (CCARE) Team is a multidisciplinary team that uses a holistic approach to ensure critical aspects of care for inmates with mental illness are considered and integrated. It is a required component at all CARE2-MH, CARE3-MH, and CARE4-MH institutions. It is not required at pretrial facilities or Federal Transfer Centers.

The CCARE Team identifies potential concerns affecting inmates with mental illness in a correctional environment, such as:

- Mental health symptoms that are unreported or unidentified by the inmate.
- Housing problems or cellmate conflicts.
- Work and/or leisure time deficits.
- Criminal thinking and behavior.
- Bullying or abuse by other inmates.
- Escalating patterns of destructive or dangerous behavior.

The CCARE Team also identifies strategies and supports to mitigate potentially negative interactions between inmates with mental illness and the correctional environment, such as:

- Positive reinforcers for behavior consistent with treatment goals.
- Social supports (cellmates, positive staff relationships, spiritual community, mental health companion program).
- Housing accommodations.
- Meaningful ways to spend time (work, supported employment, recreation, drop-in group).

The CCARE team considers how these strategies and supports might be applied to improve functioning and enhance opportunities for recovery. Meetings are ordinarily held no less than once a month and may be held in conjunction with the SHU Meeting.

Every CARE4-MH inmate is reviewed by the team at least quarterly. Every CARE3-MH inmate is reviewed by the team as needed and at least semi-annually. CARE2-MH inmates are reviewed by the team as needed and at least annually. If an inmate participates in a residential PTP, his/her case may be staffed in that setting at the discretion of the Mental Health Treatment Coordinator.

At a minimum the CCARE Team includes:

- Mental Health Treatment Coordinator (CCARE Team co-leader).
- Provider of psychiatric services (CCARE Team co-leader).
- Treating psychologist.
- Institution Social Worker (if applicable).
- Pharmacist.

In addition, the Mental Health Treatment Coordinator invites the following staff, and others as deemed appropriate, to attend CCARE Team meetings:

- Clinical Director. Clinical Directors are strongly encouraged to attend, particularly at CARE4-MH facilities.
- Supervisor of Recreation.
- Applicable unit managers.
- Correctional Services Supervisor.
- Supervisory Chaplain.

The following staff serve on the CCARE Team in special circumstances, as detailed below:

- Regional Social Workers and Community Treatment Services (CTS) staff are required to attend only when reentry needs are being discussed. They may attend via video or teleconference.
- The Disciplinary Hearing Officer (DHO) may attend if a mentally ill inmate is facing serious disciplinary action.
- Depending on the focus of the meeting, other staff may be invited, such as work supervisors or teachers.

In Psychiatric Referral Centers team composition may vary. However, the team model is used.

## 8. RESTRICTIVE HOUSING

The Bureau strives to avoid prolonged placement of inmates with serious mental illness in settings such as Special Housing Units (SHU) and the Special Management Unit (SMU). However, sometimes such placement of inmates is required due to safety and security needs. If, due to safety and/or security needs, an inmate with a serious mental illness needs to be placed in restrictive housing, he/she will continue to receive mental health care commensurate with his/her treatment needs.

a. **Services for Inmates in Restrictive Housing.** Ordinarily, all critical contacts, regardless of an inmate's mental health care level, will, to the extent possible, be conducted in a private area. These include:

- Diagnostic assessments.
- Suicide risk assessments.
- Crisis intervention contacts.
- Protective custody reviews.
- Sexual assault prevention intervention.
- Mental health treatment contacts as indicated by the treatment plan.
- Any other service that addresses potentially sensitive issues or high-risk behaviors.

Additionally, all inmates with mental illness in restrictive housing units (e.g., SHU, SMU, ADX) will receive, at a minimum, face-to-face mental health contacts consistent with the type and

frequency indicated by their care level, to the extent feasible. These contacts take place in a manner that protects an inmate's privacy to the extent that safety and security of staff are not compromised. Contacts should be consistent with the goals of the treatment plan, and are in addition to any critical contacts or contacts required by policy (e.g., SHU Review).

Exceptions to private critical contacts and mental health treatment contacts should be made in cases where the inmate is behaving in an aggressive manner or when institutional safety and security considerations are determined to require an exception. Contacts should be suspended if an inmate becomes aggressive, such that the staff member is concerned about his/her safety. The contact is reinitiated once additional security is in place or when the inmate has regained control of his/her behavior. Exceptions are not made due to logistical issues concerning moving the inmate out of his/her cell or difficulty locating a private space.

The Bureau recognizes that an inmate's mental health may deteriorate during a restrictive housing placement. Potential issues are mitigated through a variety of strategies that are applied collaboratively by staff across disciplines:

- During rounds, all staff will make themselves available for brief conversations that demonstrate concern and their availability to provide assistance.
- Except in unique circumstances, mental health clinicians will not participate as a team member in a calculated use of force situation.
- Inmates are removed from their cells for private or extended interviews with Psychology and Psychiatry Services staff as a standard procedure.
- In-cell activities (e.g., books, puzzles, games, audio/video entertainment and programming [if applicable]) will be provided by the corresponding departments.
- Close attention will be paid to the importance of out of cell, unstructured recreation time specific to inmates' needs and encouraging inmates to take advantage of out of cell activities.

If restrictive housing appears to have a negative impact on the inmate's mental health, the Mental Health Treatment Coordinator actively works with the CCARE Team to mitigate the negative impact or identify an appropriately secure alternative placement.

**b. Extended Restrictive Housing Placement Reviews.** Inmates referred for extended placement in restrictive housing (i.e., SMU, ADX) must be reviewed by Psychology Services staff to determine if mental health issues exist that preclude placement in this setting. Psychiatry Services staff may be consulted in making this determination. In addition, inmates housed in restrictive housing for an extended period of time receive an enhanced mental health review, detailed below. The Psychology Services Branch provides oversight of mentally ill inmates in restrictive housing through the procedures and reviews described below.



(1) **SMU Referral Review Procedures.** The following SMU referrals are reviewed by the Psychology Services Branch in collaboration with the Chief Psychiatrist, Health Services Division, as applicable, prior to placement:

- Inmates classified as CARE2-MH, CARE3-MH, and CARE4-MH in SENTRY.
- Inmates classified as PSY ALERT in SENTRY.
- Inmates noted to be receiving psychiatric medications.
- Any inmate for whom the institution Chief Psychologist requests a review based on mental health or cognitive limitation concerns.
- Any inmate for whom the DSCC requests a review based on mental health or cognitive limitation concerns.

In conducting this review, the Branch applies the exclusionary criteria noted below (SMU/ADX Exclusionary Criteria) to identify any inmates precluded from SMU placement.

(2) **ADX Referral Review Procedures.** A mental health evaluation is a required component of **all** referral packets for the ADX Florence Control Unit and ADX Florence General Population (per the Program Statements **Control Unit Programs** and **Inmate Security Designation and Custody Classification**, respectively).

The mental health evaluation is conducted by a licensed doctoral level psychologist. An interview of the inmate and psychological testing (the current version of the Personality Assessment Inventory) are required components. In addition, screening for intellectual disability is required (the current version of the Kaufman Brief Intelligence Test) and, if indicated, further testing (the current version of the Wechsler Adult Intelligence Scale). Before the interview, a notice of psychological evaluation must be provided. Notification forms are BP-A1055, Notice of Psychological Evaluation – ADX Control Unit, and BP-A1056, Notice of Psychological Evaluation – ADX General Population. If the inmate refuses to cooperate with the interview or psychological testing, the evaluation proceeds. This refusal is noted in the report.

The required format for the mental health evaluation report is outlined below:

### **ADX Mental Health Evaluation**

- **Identifying Data.** Identifying data includes: inmate name and register number, gender, race, ethnicity, languages spoken, date of birth and age, current sentence, and projected release date. In addition, the identifying data section indicates the date and place of the evaluation and the name of the evaluator.
- **Notice of Psychological Evaluation.** Confirms the inmate was provided with the Notice of Psychological Evaluation. If he/she refused to sign, the information is noted in this section.

- **Assessment Procedures.** Lists the assessment procedures used, including: Notice of Psychological Evaluation, clinical interview, PSR and Central File review, collateral information and observations by other staff, and psychological testing (specify tests administered; e.g., PAI, WAIS-IV, KBIT-2). *Note:* An attempt to interview the inmate and conduct psychological testing must occur in all cases. If the inmate refuses to cooperate, his/her refusal is noted in this section and in the psychological testing section.
- **Psychosocial History.** Briefly addresses the inmate’s psychosocial history, as relevant to this report, noting not only significant deficits or limitations, but also areas of specific strength. Topics that may be addressed include:
  - **Family History.** Describes family of origin; any noteworthy criminal, psychiatric, or medical history of relatives; any history of abuse or trauma in the family; and marital history if applicable.
  - **Educational History.** Briefly notes the inmate’s educational history, with emphasis on noted intellectual disabilities, cognitive impairments, and results of intelligence testing.
  - **Employment History.** Briefly describes the inmate’s employment history, including any prior military experience.
- **Medical History.** Briefly notes significant medical conditions, such as chronic illnesses or disabilities.
- **Mental Health History.** Typically contains a greater level of detail and includes the following (if applicable): historical information related to psychiatric hospitalizations, past mental health diagnoses, use of psychiatric medication, history of suicidal behavior/gestures, mental health treatment history prior to and within the Bureau, and history of mental health deterioration during confinement in a restrictive housing setting. *Note:* PSR and PDS/BEMR review are mandatory in the preparation of this section.
- **Substance Abuse History.** Briefly describes any substance abuse issues.
- **Psychosexual History.** Briefly describes any deviant sexual interests, history of sexually abusive behavior or victimization, and history of sexual crimes.
- **Criminal History.** Describes the inmate’s criminal history, including juvenile and adult crimes, escape attempts, and incident reports. Special attention is given to crimes, escape attempts, and incident reports contributing to the ADX referral. In addition, this section addresses the inmate’s view of his/her criminal activity, including the incident(s) associated with the referral. *Note:* It is not necessary to list every arrest, conviction, and incident report in this section. The evaluator may summarize information. For example, “Inmate Smith has received 37 incident reports in the past 3 years, the majority of which involve insolence and possession of intoxicants.”
- **Interview/Mental Status Examination.** Summarizes findings from the clinical interview and mental status examination. If the inmate refuses to participate in the clinical interview

and mental status examination, his/her refusal is noted in this section and all pertinent observations are recorded.

- **PAI Results.** Summarizes PAI results. If the inmate refuses to complete the PAI, his/her refusal is noted in this section.
- **Case Formulation.** Contains an analysis and synthesis of the data, which integrates psychological testing results with history, mental status, and clinical observations. Diagnostic impressions should be fully supported. If prior documentation of a mental illness exists, but is no longer valid, or if the evaluator believes it was never valid, this should be noted and supported by the evaluator. The case formulation also includes the evaluator's conclusion whether any psychological factors would preclude the inmate's placement at the ADX.
- **Diagnostic and Care Level Formulation.** Lists any diagnoses and notes the inmate's mental health care level.

The completed mental health evaluation report is entered in the PDS in the "Evaluations" section; the document is titled "ADX Referral Mental Health Evaluation." The report is entered directly into PDS; it is not entered as a Word attachment. Psychological testing data are scanned into PDS as an attachment linked to the evaluation note. Once the report is entered into PDS, an email notification is sent to the Psychology Services Branch at *BOP-RSD/Psychology SVCS~*. The inmate's name and register number are included in the subject line. The Psychology Services Branch reviews the report, psychological testing results, and the PDS records. Any concerns are discussed with the Chief Psychologist or Clinical Director at the inmate's facility. If no concerns are noted, a concurrence email is sent to the Chief Psychologist and the Warden for inclusion in the referral packet.

c. **SMU/ADX Exclusionary Criteria.** Ordinarily, seriously mentally ill inmates (classified as CARE3-MH) are diverted from SMU or ADX placement and CARE4-MH inmates are not placed in these facilities. Inmates who are identified as seriously mentally ill will not be designated to or housed at the ADX or SMUs, except as noted below. Placement of a seriously mentally ill inmate in the ADX or a SMU will only occur if extraordinary security needs are identified that cannot be managed elsewhere. In such circumstances, an individualized mental health treatment plan will be developed commensurate with the inmate's treatment needs. The decision to exclude a seriously mentally ill inmate from the ADX or a SMU is not contingent on his/her willingness to participate in a mental health treatment program. In addition, the Psychology Services Branch, in collaboration with the Chief Psychiatrist, Health Services Division, will generally recommend against SMU or ADX placement in the following instances:

- A review of documentation suggests SMU or ADX placement would interfere with the inmate's participation in necessary mental health treatment interventions.

- A review of documentation suggests the inmate's mental health disorder or cognitive limitations make it unlikely he/she could successfully progress through the phases of the SMU or ADX.
- A review of documentation suggests SMU or ADX placement is likely to exacerbate an inmate's mental health condition.

Inmates identified as in need of inpatient psychiatric care (CARE4-MH) are not referred for placement in a SMU or the ADX. The appropriate placement for these inmates is a Psychiatric Referral Center.

If a seriously mentally ill inmate is determined to be unable to function in a less restrictive setting due to special safety and security needs, he/she will continue to receive mental health services commensurate with his treatment needs while in restrictive housing.

d. **Extended Restrictive Housing Reviews.** Inmates in restrictive housing placements for an extended period will receive regular mental health evaluations. These evaluations occur when the inmate is continuously housed:

- In SHU for 6 months.
- In the ADX for 12 months.
- In a SMU for 18 months.

The mental health evaluation is completed by an institution psychologist and includes a review of the records, behavioral observations, clinical interview, and psychological testing if clinically indicated.

If the inmate refuses to cooperate with the interview or psychological testing, the evaluation proceeds and this refusal is noted in the report. The required protocols for the mental health evaluation reports are found in BP-A1057, Restrictive Housing Mental Health Evaluation – Initial Review, and BP-A1058, Restrictive Housing Mental Health Evaluation – Follow-Up Review; the results of these reports are documented in the Diagnostic and Care Level Formulation in PDS.

Updates are conducted for subsequent anniversaries; for example, an inmate continuously housed in SHU for 18 months would receive an evaluation when he/she has been housed in SHU for 6 months, with updates at 12 and 18 months.

The documentation associated with this review is entered in PDS under the note type "Restrictive Housing Mental Health Evaluation" and the results documented in PDS as an update of the

Diagnostic and Care Level Formulation note. This information is entered in PDS within 14 days of the applicable due date.

Based on the findings of this evaluation, the Chief Psychologist, in collaboration with the CCARE Team (if applicable) may immediately initiate local actions to address identified mental health concerns.

On a monthly basis, the Psychology Services Branch reviews Restrictive Housing Mental Health Evaluations to determine if mental health concerns are appropriately addressed. In conjunction with these reviews, Branch staff consult as necessary with institution staff and with the Bureau's Chief Psychiatrist. Branch staff also document concurrence with the evaluation findings or additional recommendations in PDS.

e. **SHU/SMU/ADX Removal Criteria.** If an inmate's mental health appears to have deteriorated during restrictive housing placement, the Mental Health Treatment Coordinator actively works with the CCARE Team (if applicable) and the Psychology Services Branch (if applicable) to mitigate the impact or identify an alternative placement. As necessary, the Psychology Services Branch will consult with the Bureau's Chief Psychiatrist. This deterioration may be identified through the mental health evaluation described above, or through more emergent factors; e.g., acute mental illness leading to the need for an emergency psychiatric transfer.

In addition, the Psychology Services Branch, in collaboration with the Chief Psychiatrist, Health Services Division, reviews inmates for possible removal from a SMU or the ADX in the following circumstances:

- Any inmate who is transferred from a SMU or the ADX to an MRC on an emergency psychiatric transfer.
- Any inmate who, upon arrival to a SMU or the ADX, is judged by the Chief Psychologist or Psychiatrist to have significant mental health issues or cognitive limitations that may make him/her inappropriate for this placement.
- Any inmate who begins to experience symptoms of a serious mental illness following placement in a SMU or the ADX.

f. **Discipline.** An inmate's mental health symptoms may contribute to institution rule infractions that could result in disciplinary sanctions, including SHU placement or the extension of SHU placement. In these cases it is the responsibility of the Mental Health Treatment Coordinator to provide consultation to the DHO to ensure the disciplinary process is applied appropriately to inmates with mental illness.

The DHO refers the following incident reports to a psychologist for determination of competence and responsibility:

- Any incident report received by a CARE3-MH or CARE4-MH inmate.
- Any incident report received by a CARE2-MH inmate where there appears to be a mental health concern.
- Any incident reports for Code 228 involving self-harm.
- Any incident report for Code 302, Misuse of Authorized Medication.

The Mental Health Treatment Coordinator indicates whether the inmate is competent or responsible and whether some types of sanctions are inappropriate based on his/her mental health needs. Sanctions that limit social support (e.g., SHU placement, loss of visits, or loss of phone calls) should be considered on a case-by-case basis and may not be appropriate for inmates with mental illness who use these supports as a component of their treatment or recovery.

## **9. MENTAL HEALTH TRAINING**

Mental health training for all staff is included in Introduction to Correctional Techniques I and II and Annual Training. Mental health training is also provided on a quarterly basis to SHU officers.

Additional Mental Health Specialty Training will be made available in select CARE2-MH, CARE3-MH, CARE4-MH, and administrative institutions. To support this specialized training, adequate Psychology Services staffing must be in place. With adequate Psychology Services staffing and sufficient staff interest, this training is offered annually. This program supports the development of an optimal environment for effective treatment and care of offenders with mental illness, in which mental health professionals and other staff work collaboratively to support treatment. The training promotes early identification of mental health problems and more effective de-escalation and support when problems arise. While this training is not required to work a post on a mental health unit, it will be especially beneficial for staff who work these posts.

Staff may apply to take advantage of this additional Mental Health Specialty Training by submitting an application to the Human Resource Manager following the announcement of this training opportunity.

This additional Mental Health Specialty Training will include 24 hours of specialized mental health training, including suicide prevention, understanding mental illness, cultural diversity and sensitivity, psychiatric medications, behavior management principles, confidentiality, communication skills, de-escalation skills, and building collaborative relationships.

## 10. MENTAL HEALTH COMPANION PROGRAM

Mental Health Companions are trained inmates who provide assistance and support to inmates with mental illness under the direction of the Psychology Services Department. Mental Health Companion Programs are initiated at the discretion of the Warden. They may take a variety of forms, including a cadre residing on a mental health treatment unit, supporting a drop-in center, or participating in individual pairings with inmates who need additional support.

The Mental Health Treatment Coordinator is responsible for the selection, training, assignment, and removal of individual companions. Inmates selected as companions are considered to be on an institution work assignment when they are on their scheduled shift and receive performance pay for time spent providing support to inmates with mental illness.

a. **Selection of Inmate Mental Health Companions.** Because of the sensitive nature of such assignments, the selection of Mental Health Companions requires considerable attention. They must be able to provide companionship and assistance to mentally ill inmates, protect their privacy, and report significant safety concerns and suicide warning signs to staff. In the Mental Health Treatment Coordinator's judgment, they must be reliable individuals who have credibility with both staff and inmates and are able to perform their duties with minimal need for direct supervision. In addition, any inmate who is selected as a Mental Health Companion must not:

- Have committed a 100-level prohibited act within the last three years.
- Be in Financial Responsibility Program (FRP), GED, or Drug Ed Refuse status.
- Have a history of sex offense against an adult.

As part of the selection process, the Mental Health Treatment Coordinator takes the following steps and documents the findings in PDS:

- Interview the inmate.
- Review the inmate's disciplinary history.
- Review the inmate's PSR.
- Review the inmate's PDS documentation.
- Consult with the Special Investigative Supervisor (SIS).
- Consult with the inmate's current work supervisor.
- Consult with the Unit Team.

b. **Training Mental Health Companions.** Each companion receives at least four hours of initial suicide prevention training and an additional four hours of initial Mental Health Companion training before assuming Mental Health Companion duties. Each Companion also

receives at least four hours of refresher training every six months. Each training session reviews policy requirements and instructs the inmates on their duties and responsibilities as a Mental Health Companion, including:

- Basic information about mental illness.
- Modeling and supporting recovery from mental illness.
- Reducing stigma.
- Communication skills.
- Warning signs for suicide and other mental health problems that should be reported to staff immediately.

An inmate may serve as both a Mental Health Companion and a Suicide Watch Companion. However, these are separate work assignments with different tasks and challenges. Therefore, some portions of training may be combined and others must be individualized. Mental Health Companions may participate in the initial Suicide Watch Inmate Companion training provided by the Suicide Prevention Coordinator to complete the suicide prevention portion of their initial training. In semi-annual training, the components common to both Suicide Watch Companions and Mental Health Companions may be covered in a combined two-hour training, if two additional hours of specialized training are provided to each group.

c. **Meetings with Mental Health Treatment Coordinator.** Mental Health Companions with an active work assignment meet at least weekly with the Mental Health Treatment Coordinator or designee to debrief their work, review procedures, discuss issues, and supplement training. This meeting may occur in a group setting.

d. **Records.** The Mental Health Treatment Coordinator maintains a record in PDS containing:

- An agreement of understanding and expectations signed by each Companion.
- Documentation of attendance and topics discussed at semi-annual trainings and weekly meetings.

Verification of pay for those who have an assignment is also maintained.

e. **Supervision of Inmate Mental Health Companions.** Although Mental Health Companions are selected on the basis of their emotional stability and level of personal responsibility, they still require staff supervision while performing their duties. This supervision is provided by the Mental Health Treatment Coordinator during meetings. In support of the program, the Mental Health Treatment Coordinator provides staff with a roster of Companions (e.g., via TRUSCOPE, memorandum, or Sallyport).



f. **Removal.** The Mental Health Treatment Coordinator or designee may remove any Inmate Mental Health Companion from the program at his/her discretion. Removal of a companion is documented in the PDS records.

## 11. PTP ACHIEVEMENT AWARDS

Mental Health PTPs offer achievement awards for inmates who participate in them, as defined in the Program Statement **Psychology Treatment Programs**. Achievement awards are offered to participants who demonstrate behaviors that reflect a commitment to treatment, conformity with program norms, progress on treatment plan goals, and behaviors that are expected in the general society.

a. **Earning Achievement Awards.** Inmates enrolled in PTPs must:

- Be on time for all treatment activities.
- Have no unexcused absences.
- Not leave treatment activities without approval from the facilitator.
- Dress appropriately.
- Be an active participant in treatment activities.
- Put forth positive efforts in accomplishing treatment plan goals, as determined by the treatment provider.
- Comply with education and FRP obligations.
- Not receive a sanction for a sustained incident report.

b. **Specific Achievement Awards**

- **Limited financial awards.** An inmate may earn a financial award to offset time lost from work. The amount is \$50 for each phase of treatment, as defined in the Program Statement **Psychology Treatment Programs**. A financial award may be reduced by the treatment team based upon the inmate's unsatisfactory participation and progress. However, a financial award is never to exceed \$50.
- **Nearer release transfer.** Formal consideration may be given for a nearer release transfer following successful program completion.
- **Local incentives.** Institutions may offer incentives such as preferred living quarters, "early chow," washer/dryer or exercise equipment on unit, etc.
- **Tangible incentives.** With the Warden's approval, tangible incentives may be given (e.g., books, t-shirts, notebooks, pencil pouches, mugs with program logo, food and hygiene items that are not sold in commissary).
- **Token economy.** Mental Health PTPs may choose to run a token economy in which inmates are able to earn tangible incentives based on their participation.

- **Transition ceremony/ritual.** For the completion of a Mental Health PTP, institutions may offer a structured transition ceremony for the inmates.

## 12. MENTAL HEALTH TREATMENT ACHIEVEMENT AWARDS

Achievement awards are available to CARE3-MH inmates in all settings and CARE2-MH/CARE3-MH inmates at the ADX. Achievement awards are offered to participants who demonstrate behaviors that reflect sustained efforts toward recovery, progress on treatment goals, and pro-social attitudes and behaviors.

### a. **Earning Achievement Awards.** Inmates must:

- Attend treatment activities on time.
- Make positive efforts in accomplishing treatment plan goals, as determined by the treatment provider.
- Comply with education and FRP obligations.
- Not receive a sanction for a sustained incident report.

### b. **Specific Achievement Awards**

- **Local incentives.** Institutions may offer incentives such as preferred living quarters, “early chow,” washer/dryer or exercise equipment on a unit where CARE3-MH inmates live, etc.
- **Tangible incentives.** With the Warden’s approval, tangible incentives may be given, (e.g., books, t-shirts, notebooks, pencil pouches, mugs with program logo, food and hygiene items that are not sold in commissary).
- **Token economy.** CARE3-Mental Health sites may choose to run a token economy in which inmates are able to earn tangible incentives based on their participation in treatment.

## 13. REDESIGNATIONS OF INMATES WITH MENTAL ILLNESS

Inmates with mental illness are transferred using specialized procedures to ensure they are housed in institutions that have resources to meet their needs.

a. **CARE3-MH Inmates.** Ordinarily, designations of CARE3-MH inmates are processed at the DSCC and reviewed by Psychology Services staff, who recommend a placement or placements that have appropriate resources to meet the inmate’s mental health needs.

CARE3-MH inmates are, on occasion, transferred via program completion transfers (325) in order to manage the CARE3-MH populations at sites with PTPs for the mentally ill, such as the Mental Health Step Down Program and STAGES Program.

If a CARE3-MH inmate needs a transfer to a psychiatric referral center to manage acute psychiatric symptoms, the BP-A0770 (Medical/Surgical and Psychiatric Referral Request) is submitted to the Office of Medical Designations and Transfers (OMDT), Health Services Division. The mental health care level code is not changed to CARE4-MH by the sending institution.

Inmates classified as CARE3 in regard to both physical and mental health are referred for transfer and designation through OMDT.

**b. Continuity of Care Between Bureau Institutions.** To promote continuity of care for inmates with mental illness as they transfer, a Mental Health Transfer Summary must be completed in PDS every time a mentally ill (CARE2-MH, CARE3-MH, and CARE4-MH) inmate transfers within the Bureau – to an RRC, home confinement, or directly to the community. Pretrial facilities are exempt from this requirement if the inmate has been at the facility for less than six months.

- **Transfers between mainline institutions.** A Mental Health Transfer Summary must be entered into PDS by the Mental Health Treatment Coordinator, or treating psychologist, for all CARE2-MH, CARE3-MH, and CARE4-MH inmates before submission to the DSCC for transfer.
- **Psychiatric transfers to MRCs.** If an inmate is accepted for Emergency or Routine Psychiatric Transfer, the BP-A0770 is submitted to OMDT and entered into PDS; the Mental Health Transfer Summary is not required.
- **Psychiatric transfers from MRCs.** When psychiatric treatment at an MRC is complete, Psychology staff complete a treatment summary and update the Diagnostic and Care Level Formulation in PDS.

#### 14. REENTRY

The Bureau is committed to helping inmates prepare for reintegration into their communities by transferring inmates with mental illness through RRCs or home confinement placements. However, each inmate should first be reviewed for suitability for community placement and continuity of care needs.

Each Warden is strongly encouraged to approve inmates who successfully complete Mental Health PTPs for RRC/Home Confinement placement, consistent with the recommendations of PTP staff.

**a. Assessment of Psychological Suitability.** The CCARE team considers community placement for all inmates with mental illness on an individual basis. However, some inmates may not be suitable for community placements. Others may be suitable, but may not benefit from community placements due to their mental health conditions, or may need special

consideration given to the type of community placement. The following conditions indicate an inmate is potentially unsuitable for RRC or home confinement placement:

- Ongoing inpatient psychiatric treatment.
- Uncontrolled mental health symptoms (e.g., psychosis with no insight, non-adherent with medication).
- Acute suicidal ideation with accompanying plans or recent attempts of moderate to high lethality.
- Inability to perform routine activities of daily living (bathing, dressing, eating, toileting, general hygiene, and mobility).

Continuity of care is also a primary consideration in placement decisions. For inmates who are particularly vulnerable to environmental changes or stressors, the following situations indicate caution should be taken regarding the inmate's placement and the inmate's needs, strengths, and weaknesses should be considered as part of the CCARE team planning process:

- There is no RRC in the inmate's community, causing him/her to have to relocate for RRC placement and again to return to his/her community.
- The inmate has a history of struggling to adapt to new environments.
- Community supports or mental health services are limited in the area to which the inmate is transferring.

At a minimum, the institution's CCARE Team assesses all CARE2-MH, CARE3-MH, and CARE4-MH inmates for suitability at the time of the RRC Referral Process and when the Mental Health Transfer Summary is prepared (30 to 60 days before RRC placement). If there are any concerns regarding the inmate's ability to be successful in a community placement, the team consults with CTS and Residential Reentry Management Branch staff.

Clinically manageable in the community is defined as having mental health symptoms that can be treated on an outpatient basis through pre-arranged linkages to family/community support, counseling, and psychiatric medications as needed.

When the CCARE Team determines the disposition for an inmate having one or more of the above-listed conditions, the team takes the actions below consistent with their decision:

- **Clinically manageable.** If an inmate's mental health needs are determined to be manageable in the community, the institution CCARE Team continues to monitor his/her status at intervals set by the team. If no complications arise, RRC or home confinement referral proceeds as planned by the Unit Team. If symptoms increase significantly, a reassessment occurs.
- **Clinically unmanageable.** If an inmate's mental health needs are determined to be unmanageable in the community, the Unit Manager will submit a request to Residential Reentry Management Branch staff to revoke or retard the RRC date. Clinically

unmanageable in the community is defined as not having the requisite family/social network, health care facility, clinical or specialty services, or access to prescribed medications to maintain or improve an inmate's mental health status as assessed at the time of release to RRC or home confinement placement. The institution CCARE Team continues to monitor the inmate's mental health at intervals set by the team and changes his/her status if his/her mental health improves such that he/she has clinically manageable needs.

If the inmate is releasing to supervision under the United States Probation Office (USPO) or Court Services Offender Supervision Agency (CSOSA), and his/her mental health needs remain unmanageable in the community up to the point of release from custody, the treating psychologist must ensure contact is made with USPO or CSOSA. The treating psychologist ensures they are informed of the inmate's status and provides the Mental Health Transfer Summary as documented in PDS. The treating psychologist then makes a referral to the social worker, who will develop a comprehensive release plan, as detailed below. If the inmate is releasing directly to the community with no supervision requirement, a Bureau social worker takes responsibility for coordinating a release plan, as detailed below.

If an inmate with mental illness is releasing from a CARE1-MH institution with no CCARE team, the Mental Health Treatment Coordinator coordinates with staff from other disciplines, as needed, and ensures continuity of care during the inmate's release is consistent with the practices described in this policy.

**b. Community Treatment Services.** CTS staff determine which inmates with moderate, serious, or acute mental health needs releasing to community placements are appropriate for community treatment services by consulting with institution CCARE teams and running rosters of CARE2-MH, CARE3-MH, and CARE4-MH and Psychology Alert assignments. CTS staff review inmate PDS files, including the Mental Health Transfer Summary, which recommend follow-up treatment in the community. They arrange appropriate services to support inmates with mental illness who are placed in RRCs or in home confinement.

**c. Social Workers.** Social workers, in collaboration with the inmate and the institution CCARE Team, create comprehensive release plans for inmates who are releasing from Bureau custody with no community placement. The release plan identifies community treatment providers in the areas of psychiatry, mental health treatment, family counseling, substance abuse, and sex offender treatment, as recommended by the treating psychologist and as available in the community. Some institutions have locally based social workers; those that do not rely on Regional Social Workers. Social workers may consult with CTS staff regarding resources available in the community to which the inmate is releasing.

**d. Continuity of Care to Community Placements.** Procedures for transfer to community placements are detailed below.

- **Transfers to RRCs and Home Confinement.** When CARE2-MH, CARE3-MH, and CARE4-MH inmates are between 30 and 60 days from an RRC date, the Mental Health Transfer Summary is completed by the treating psychologist and entered in PDS. If CTS staff determine this form is not present in PDS 30 days prior to the RRC date, they notify the Chief Psychologist of the discrepancy. The Chief Psychologist ensures the summary is completed before the inmate's transfer. If there is sufficient concern regarding the inmate's mental health condition, CTS staff also consult with the Residential Reentry Manager (RRM), who may retard the RRC date until adequate information is available to ensure continuity of care.
- **Release to the Community with Supervision.** When a CARE2-MH, CARE3-MH, or CARE4-MH inmate releases directly to the community under the supervision of the USPO or CSOSA, the treating psychologist completes the Mental Health Transfer Summary in PDS and ensures the supervising USPO or CSOSA receives a copy. The treating psychologist completes this summary 30-60 days before the inmate's release. If the inmate requires mental health aftercare services, the treating psychologist will make a referral to the institution Social Worker or Regional Social Worker, who will assist with reentry planning.
- **Release to the Community without Supervision.** When a CARE2-MH, CARE3-MH, or CARE4-MH inmate releases directly to the community with no supervision requirement, the treating psychologist completes the Mental Health Transfer Summary in PDS 30-60 days before the inmate's release. If the inmate requests, the treating psychologist forwards it to a community treatment provider, following completion of the release of information. Such a request can also be made by the inmate following his/her release. If the inmate is on psychiatric medication and needs linkage to community resources, the psychologist should make a referral to the institution Social Worker or Regional Social Worker to enhance continuity of care.

e. **Return to Custody Due to Mental Illness.** Sometimes inmates experience mental health crises or behavioral problems in an RRC setting and are no longer able to be managed in the community. When this occurs:

- The RRM staff must immediately notify and consult with CTS regarding any CARE2-MH, CARE3-MH, or CARE4-MH inmate **or** any CARE1-MH inmate exhibiting symptoms of mental illness, for whom the RRC placement or home confinement may be terminated.
- CTS staff in turn consult with Psychology Services Branch mental health staff and document the consultation in PDS.
- Psychology Services Branch mental health staff adjust the care level assignment, if necessary, by entering a mental health assignment that better approximates the inmate's need for services.
- Psychology Services Branch mental health staff make a recommendation regarding whether the inmate should be transferred to an MRC for treatment of acute mental illness, returned to

a mainline institution, continued in the current placement with additional supports, or housed in a contract facility until the end of his/her sentence.

- The RRM staff work with the OMDT or the DSCC to identify and return the inmate to the parent institution or, if necessary, identify an alternate institution. If the inmate needs emergency psychiatric care at a Psychiatric Referral Center, RRM staff prepare the BP-A0770 in consultation with CTS and the Psychology Services Branch.

If the inmate is returned to an institution, release planning begins again immediately upon his/her arrival.

## 15. AGENCY ACA ACCREDITATION PROVISIONS

- American Correctional Association Standards for Adult Correctional Institutions, 4th Edition: 4-4142, 4-4143, 4-4144, 4-4305, 4-4368, 4-4370, 4-4371, 4-4372, 4-4373, 4-4374, 4-4399, 4-4429, 4-4429-1.
- American Correctional Association Performance Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-2A-32, 4-ALDF-4C-8, 4-ALDF-4C-19, 4-ALDF-4C-27, 4-ALDF-4C-28, 4-ALDF-4C-29, 4-ALDF-4C-30, 4-ALDF-4C-31, 4-ALDF-4C-32, 4-ALDF-4C-34, 4-ALDF-4C-40, 4-ALDF-6B-05, 4-ALDF-6B-06, 4-ALDF-6B-07, 4-ALDF-6B-08.
- American Correctional Association Standards for Administration of Correctional Agencies, 2<sup>nd</sup> Edition: 2-CO-4B-04.

## REFERENCES

### *Program Statements*

P5070.12	Forensic and Other Mental Health Evaluations (4/16/08)
P5100.08	Inmate Security Designation and Custody Classification (9/12/06)
P5212.07	Control Unit Programs (2/20/01)
P5270.09	Inmate Discipline Program (7/8/11)
P5270.10	Special Housing Units (7/29/11)
P5290.14	Admission and Orientation Program (4/3/03)
P5310.12	Psychology Services Manual (8/13/93)
P5324.08	Suicide Prevention Program (3/15/07)
P5330.11	Psychology Treatment Programs (3/16/09)
P5370.11	Inmate Recreation Programs (6/25/08)
P6031.03	Patient Care (8/23/12)
P6340.04	Psychiatric Services (1/15/05)

### *Other References*

President's New Freedom Commission on Mental Health, 2003

National Consensus Statement on Mental Health, 2004

*Diagnostic and Statistical Manual of Mental Disorders*: Fifth Edition, 2013

*BOP Forms*

- BP-A0770 Medical/Surgical and Psychiatric Referral Request
- BP-A1055 Notice of Psychological Evaluation – ADX Control Unit
- BP-A1056 Notice of Psychological Evaluation – ADX General Population
- BP-A1057 Restrictive Housing Mental Health Evaluation – Initial Review
- BP-A1058 Restrictive Housing Mental Health Evaluation – Follow-Up Review

*Records Retention Requirements*

Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) on Sallyport.