Good Life. Great Mission.

May 31, 2018

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STATEMENT OF AVAILABILITY

*This Administrative Regulation is to be made available in law libraries or other inmate resource centers.

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SUMMARY of REVISION/REVIEW

Changed Major to Severe throughout, Changed MMI to SMI throughout, Added section XI and changed 12 and 24 hour reviews to 4 hour reviews throughout. Added Attachment H.

APPROVED:

[Signature]
Harbans S. Deol, DO, PhD.
Deputy Director--Health Services

[Signature]
Scott H. Frakes, Director
Nebraska Department of Correctional Services
PURPOSE
To provide for the identification and provision of appropriate services for inmates with special needs.

GENERAL
It is the policy of the Nebraska Department of Correctional Services (NDCS) to ensure that adequate care is provided for inmates with special needs. Special needs inmates may include, but are not limited to, inmates who have substance use disorders, inmates who are emotionally disturbed or suspected of being mentally ill, inmates with intellectual disabilities, sex offenders, and those who pose high risk for violence or are considered vulnerable offenders. A wide range of services is necessary to identify, properly evaluate, diagnose and treat these inmates successfully. Clinical and institutional staff shall refer offenders who may meet these criteria to Mental Health, Substance Abuse, Violent Offender, or Sex Offender review teams.

PROCEDURES
I. Each institution or program shall provide services directed toward inmates exhibiting the following special conditions:
   A. Mental or Emotional Illness
   B. Intellectual or Developmental Disabilities
   C. Physical Handicap or Infirm Condition
   D. Substance Use Disorders

II. Each institution or program shall ensure that these programs are collaborated and coordinated so that multiple problem inmates can receive individualized programming tailored to their needs.

III. Each Institution that has a restrictive housing unit may maintain secure mental health housing within their housing unit.
   A. Designated male inmates will be offered stabilization and treatment services with the goal of transitioning to general population or the Mental Health Unit at the Lincoln Correctional Center.
   B. Designated female inmates will be offered stabilization and treatment services with the goal of transitioning to general population or the Strategic Treatment and Reintegration (STAR) Unit.
   C. Inmates diagnosed with a Severe Mental Illness (SMI) and living in the secure mental health unit will be offered, at a minimum, ten hours of association and movement time outside of their cell per week as established by the facility.
   D. The 10 hours of association and movement time outside of their cell may include access to exercise yards, showers, visits, phone calls, mental health contact and programming, and other activities as determined by the Multi-Disciplinary Team (MDT).
E. In addition to the association and movement activities, SMI inmates assigned to the SMHU may have access to extra clothing, property and cell furnishings as determined by the MDT, subject to discussion with the Warden.

F. SMI inmates assigned to the SMHU will be governed by the activities, property and movement parameters established for the SMHU and in their individual treatment plan.

G. The SMHU assignment will override any DS/AS status.

H. The SMHU assignment will be reviewed monthly by the MDT or more frequently if circumstances require.

I. The MDT will make recommendations regarding which inmates will be assigned to or removed from the SMHU. However the Mental Illness Review Team (MIRT) will be the final authority regarding such placements or removal, subject to discussion with the warden.

J. The MIRT will determine which SMI inmates will be assigned to or removed from the SMHU and maintain a prioritized transfer list.

K. Each facility with a SMHU will have a determined number of cells and location for the SMHU cells.

L. To the extent possible, all SMHU designated beds will be occupied at all times.

IV. Single occupancy cells/rooms may be made available, when indicated, for the following:

A. Inmates with severe medical disabilities

B. Inmates suffering from Major Mental Illness with significant functional impairment

C. Sexual predators

D. Inmates likely to be exploited or victimized by others

E. Inmates who have other special needs for single housing

V. A comprehensive individual mental health evaluation will be completed on specifically referred inmates within 14 days from the referral date. The evaluation will include, but not be limited to, the following:

-- Review of mental health screening and appraisal data.
-- Direct observation of behavior
-- Collection and review of additional data from staff observation, individual diagnostic interviews and tests assessing personality, intellect and coping abilities.
-- Compilation of the inmate’s mental health history
-- Development of an overall treatment/management plan with appropriate referral.
VI. NDCS Behavioral Health Review Teams

A. The Mental Illness Review Team (MIRT) assists in the process of making appropriate treatment recommendations for high risk and high need offenders with major mental illness who are sentenced to the NDCS. MIRT will review referred offenders who have a current diagnosis of major mental illness (as defined in AR 115.23, Mental Health Services).

B. Clinical Sex Offender Review Team (CSORT) makes clinical recommendations for sex offenders.

C. Clinical Violent Offender Review Team (CVORT) assists in making clinical recommendations for violent offenders.

D. Clinical Substance Abuse Review Team (CSART) assists in making clinical recommendations for substance abuse offenders.

All offenders with a current NDCS diagnosis of a major mental illness (as defined in AR 115.23) are considered special needs for the purposes of this Administrative Regulation.

VII. Intellectual disability is characterized by deficits in general mental abilities such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience. Severe disturbance refers to mental illness of such intensity that suicidal, assaultive, or grossly disorganized behavior are evident, and for which medication and therapeutic supervision are the primary treatment modalities, or when an inmate is incapable of attending to basic physiological needs. When such inmates are transferred to a non-correctional setting, due process procedures, as specified by law, will be effected prior to such transfer. In emergency situations, a hearing is held as soon as possible after transfer.

Those special needs inmates identified as being severely disturbed and/or having an intellectual disability will be evaluated for referral for placement in either appropriate non-correctional programs or facilities, or in specially designated units within institutions with staff who are trained to assist with basic life-functions. If these inmates are housed in special units within an institution they will have the necessary supports to educate and assist them in performing self-care and personal hygiene in a reasonably private area.

VIII. Except in emergency situations, joint consultation will occur between the Warden and the responsible physician or his/her designee prior to taking action regarding the identified mentally ill or inmates with Intellectual Disabilities in the following areas:

-- Housing assignments.
-- Program assignments.
-- Disciplinary measures.
-- Transfers to other institutions.
-- Use of force including Chemical Agents

- In cases where immediate action is necessary, consultation to review the appropriateness of the action will occur as soon as possible, but not later than 72 hours.
• A transfer that results in an offender’s placement in a non-correctional facility or in a special unit within a facility specifically designed for the care and treatment of the severely mentally ill or intellectually disabled will follow due process procedures as specified by federal, state and local law prior to the move being completed. In an emergency situation, a hearing will be held as soon as possible.

• A subset of inmates diagnosed with major mental illness will be identified as recommended for consultation prior to use of chemical agents. A list will be maintained by the Mental Health Supervisor at each facility. The list will be reviewed by the institutional mental health treatment team. Changes in an inmate’s status will be documented in the mental health record and on the Departmental network/correctional data management system so that the Warden or designee can review as needed.

When an emergency has occurred that requires immediate action, this consultation occurs as soon as possible, but no later than on the next workday to review the appropriateness of the action.

IX. INVOLUNTARY TRANSFER PROCEDURES

When a physician, psychologist, or psychiatrist designated by the Director of (NDCS) is of the opinion that an inmate of the NDCS is suffering from a mental disease or defect that cannot be properly treated at NDCS, the NDCS Behavioral Health Assistant Administrator for Mental Health shall initiate proceedings to have the inmate evaluated for possible placement at a Department of Health and Human Services (HHS) facility.

The proceedings shall be conducted in accord with the Involuntary Transfer Procedures (Attachment A).

• To initiate an Involuntary Transfer Hearing the Behavioral Health Assistant Administrator for Mental Health designee shall prepare an Involuntary Transfer Application (Attachment B) and provide the required notice to the inmate using the Involuntary Transfer Hearing Notice (Attachment C).

X. INVOLUNTARY MEDICATION PROCEDURES

A. The involuntary admission of psychotropic medication(s) to an inmate is governed by applicable laws and regulations of the jurisdiction. When administered, the following conditions must be met:

1. Authorization is by a physician who specified the duration of therapy;

2. Less restrictive intervention options have been exercised without success as determined by the physician;

3. Details are specified about why, when, where, and how the medication is to be administered;

4. Monitoring occurs for adverse reactions and side effects;
5. Treatment plan goals are prepared for less restrictive treatment alternatives as soon as possible.

B. Except in an emergency situation, when a physician, psychologist, or psychiatrist designated by the Director of the NDCS is of the opinion that an inmate of the NDCS suffers from a mental disorder and is gravely disabled or poses a likelihood of serious harm to self/others or their property and is refusing to take medication that is required to treat the mental disorder, the NDCS Behavioral Health Assistant Administrator for Mental Health or his/her designees shall initiate proceedings to determine whether the inmate should be placed on involuntary medication.

The proceedings shall be conducted in accord with the Involuntary Medication Procedures. (Attachment D)

- To initiate an Involuntary Medication Hearing the Behavioral Health Assistant Administrator for Mental Health/designee shall prepare an Involuntary Medication Application (Attachment E) and provide the required notice to the inmate using the Involuntary Medication Hearing Notice (Attachment F). The summary of the involuntary medication hearing and the order shall follow the format of Attachment G.

C. Emergency Psychotropic Medication

For purposes of this subpart, a psychiatric emergency is defined as one in which a person is suffering from a mental illness which creates an immediate threat of bodily harm to self or others, serious destruction of property, or extreme deterioration of functioning secondary to psychiatric illness. During a psychiatric emergency, psychotropic medication may be administered when a licensed physician determines in his/her professional judgment that the medication constitutes an appropriate treatment for the mental illness and less restrictive alternatives (e.g., seclusion or physical restraint) are not available or indicated, or would not be effective.

XI. USE OF THERAPEUTIC RESTRAINTS

A. It is the policy of NDCS to make provisions for the use of restraint devices (leather, metal, or approved alternative restraint devices) for medical and/or psychiatric purposes when it is clear that an inmate may injure himself/herself or others if not restrained. The intent in using therapeutic restraints is that they are used for the humane care of the inmate and the protection of staff. The use of therapeutic restraints will not be for an indefinite period of time; the discontinuation of the therapeutic restraints will be as soon as possible after the need for restraints is no longer present.

If this purpose is a result of disruptive hygiene behavior (i.e., the intentional smearing of any bodily fluid/substance, including but not limited to feces and urine, on one’s person or anywhere in the cell), staff will follow the Disruptive Hygiene Behavior Protocol as is outlined in Administrative Regulation 210.01 Restrictive Housing.

B. In circumstances where the past history and present behavior of an inmate demonstrates the likelihood that medical and/or psychiatric factors may result in the self-injury or injury to others, behavioral health and/or medical staff shall be contacted by the
Warden/designee. Behavioral health staff and/or medical staff will complete an assessment of the inmate to determine any restrictions necessary based on the individual circumstances.

1. The initial contact between the Warden/designee and behavioral health and/or medical staff may be conducted via telephone.

2. Initial consideration shall be given to placing the inmate into a “stripped” cell or room.

3. Therapeutic restraints (two, four or five point) should be used only in extreme instances and only when the safety of the inmate is in jeopardy.
   a. A psychologist or physician must be notified to assess the inmate’s medical and mental health condition prior to approving the use of therapeutic restraints with a face-to-face assessment being done within 4 hours.
   b. When a psychologist or physician is not readily available, therapeutic restraints may be initiated by licensed nursing personnel based on their assessment. Implementation of the restraints by nursing personnel requires a physician’s telephone order within one hour of the application of the restraints by nursing personnel.
   c. The authority for admittance to a licensed hospital bed must be a physician, physician’s assistant or nurse practitioner.

4. If therapeutic restraints are authorized, a face-to-face re-assessment to determine the need for continued restraint must be completed by a psychologist or physician at intervals not to exceed 4 hours. This assessment shall be based on the inmate’s current behavior and condition.
   a. If this reassessment results the decision to continue the use of therapeutic restraints, a new order for the continuation of therapeutic restraints shall be completed and this decision documented in the medical record. In such instances, documentation of behavior necessitating continued restraints will be completed on the Therapeutic Assessment and Restraint Form (Attachment H).
   b. If this reassessment results in the decision to modify the use of therapeutic restraints, a new order specifying the modifications shall be completed and this decision documented in the medical record. In such instances, documentation of behavior necessitating modified restraints will be completed on the Therapeutic Assessment and Restraint Form (Attachment H).
   c. If this reassessment results in the decision to discontinue the use of therapeutic restraints, an order discontinuing the therapeutic restraints shall be completed and this decision documented in the medical record. A face-to-face interview with the inmate is not necessary for the removal of therapeutic restraints, however, a specific order for change in restraint
status must be provided verbally or in writing by a psychologist or physician. In such instances, the psychologist or physician shall consider the need for a period of supplemental supervision and modifications (i.e., Plan A or Plan B) consistent with Administrative Regulation 115.30 Suicide Prevention/Intervention.

C. When inmates are restrained in a four-or-five-point position, the following minimum procedures will be followed:

1. Direct observation by staff must be continuous during the period prior to obtaining approval from the psychologist or physician.

2. After approval is received from the psychologist or physician, a staff member will be designated to conduct visual checks at least every 15 minutes on inmates who are in therapeutic restraints. A log of such checks will be maintained. A copy of the log will be retained in the medical record.

3. The shift supervisor and a health care provider/designee will observe the application of therapeutic restraints.

   a. The inmate’s arms will be secured at his/her sides rather than above the head.

   b. The torso belt may be used to limit the inmate’s ability to rise from the bed. The torso belt must not restrict the inmate’s breathing. Four point restraints may be used as medically indicated.

4. The inmate will be repositioned every 2 hours to prevent soreness, skin breakdown and promote circulation.

5. The inmate will be fed by staff at mealtime if it is not considered safe to remove an arm restraint and the torso restraint for self-feeding.

6. Restraint checks will be done at least every 30 minutes by a health care provider to assess circulation, offer fluids, bathroom/urinal and range of motion, along with a review of the custody restraint log. These checks will be documented. If the inmate demonstrates improved demeanor and is not self—harming, then removal of restraints will to be considered.

D. Placement of an inmate in therapeutic restraints constitutes a use of force and will be documented, reported and reviewed in accordance with Administrative Regulation 116.06 Use of Restraints reporting requirements.

E. In the event of a disagreement among the Warden or designee, the facility health authority or designee, and the mental health authority or designee with respect to either the application or removal of four- or five-point restraints, the Medical Director will be consulted and will make the final decision.

F. The use of leather or approved alternative restraints will be utilized. Metal restraints may be used as the primary device only when leather or approved alternative restraints have proven ineffective.
When an inmate is placed in four- or five-point restraint (both arms/legs and torso secured), or placed in a control situation less than a four- or five-point restraint, advance approval must be obtained from the Warden or designee.

REFERENCE

I. Jones v. Vitek, 445 US 480 (3/25/80). Inmates must be afforded procedural due process before being transferred to a mental institution, including (1) notice of contemplated transfer; (2) hearing, following notice of hearing, including the disclosure of evidence relied upon by the State; (3) an opportunity to present witnesses and evidence; (4) an independent decision maker; and (5) a written decision by the fact finder.

II. Journey v. Vitek, CV78-L-250 (7/20/81). Although the court found that the Rehabilitation Act of 1973 (29 USC Section 794) requires that handicapped inmates have access to correctional programs, the court found that the plaintiff was not denied such access.

III. ATTACHMENTS

A. Involuntary Transfer Procedures
B. Involuntary Transfer Application
C. Involuntary Transfer Hearing Notice
D. Involuntary Medication Procedures
E. Involuntary Medication Application
F. Involuntary Medication Hearing Notice
G. Summary of Involuntary Medication and Order
H. Therapeutic Assessment and Restraint Form

IV. AMERICAN CORRECTIONAL ASSOCIATION (ACA) STANDARDS

A. Standards for Adult Correctional Institutions (ACI) (4th edition): 4-4143, 4-4144, 4-4191, 4-4372, 4-4374, 4-4399, 4-4404, 4-4405