NEBRASKA Good Life. Great Mission. DEPT OF CORRECTIONAL SERVICES	POLICY **SPECIAL NEEDS PROGRAMS**		
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SUMMARY OF REVISION/REVIEW

I.F. – Language updated. III.A. – Language updated. VI.A. – Language updated. VI.C. – Language updated. X.B. – Language updated. ATTACHMENTS – Attachment H. Gender Dysphoria – Attachment deleted. New Policy 115.11 *Gender Dysphoria* created. Minor grammar changes throughout.

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PURPOSE

To provide for the identification and provision of appropriate services for Nebraska Department of Correctional Services (NDCS) patients with special needs.

It is the policy of NDCS to ensure that adequate care is provided for patients with special needs. A wide range of services is necessary to identify, properly evaluate, diagnose, and treat these patients successfully. Clinical and facility team members shall refer patients who may have special needs to mental health, substance use treatment, violent offense treatment, or sex offense treatment review teams.

DEFINITIONS

For all health services definitions, see Policy 115.50 *Health Services Definitions*.

PROCESS

I. SERVICES

Designated facilities shall provide services directed toward patients who demonstrate the following needs:

A. Serious Mental Illness (SMI) or Serious Emotional Dysregulation (SED)

1. All patients with a current NDCS diagnosis of an SMI (as defined in Policy 115.23 *Mental Health Services*) are considered special needs for the purposes of this Policy.

2. Serious emotional dysregulation (SED) refers to mental illness of such intensity that suicidal, assaultive, or grossly disorganized behavior are evident, when an incarcerated individual is incapable of attending to basic physiological needs, and for which medication and therapeutic supervision are the primary treatment modalities.

B. Intellectual, Neurocognitive, or Developmental Disabilities (ACRS-6A-04)

1. Intellectual disability is a disorder with onset during the developmental periods that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains (DSM-5-TR).

2. Neurocognitive disorder is a general term that describes decreased mental function due to a medical disease other than a psychiatric illness (US National Library of Medicine, 2019).

3. Developmental disabilities are a group of conditions due to an impairment in physical, learning, language, or behavior areas. These conditions begin during the developmental period, may impact day-to-day functioning, and usually last throughout a person's lifetime (CDC, 2019).

C. Physical Handicap or Infirmed Condition

D. Substance Use Disorders

E. Violent Offense Treatment Services

F. Sexual Offense Treatment Services

II. COORDINATION

Each facility shall ensure that these programs are coordinated so that patients with multiple needs can receive individualized programming.

III. MENTAL HEALTH HOUSING

Designated facilities may maintain mental health housing within a housing unit.

A. The Reception and Treatment Center (RTC) offer patient stabilization and treatment services with the goal of transitioning to general population.

RTC stabilization and treatment services units will offer patients at a minimum, four hours per day of pro-social engagement and movement outside their cell as established by the facility and as clinically indicated.

The four hours per day of pro-social engagement 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).

B. The Nebraska Correctional Center for Women (NCCW) offers patient stabilization and treatment services in the Acute/Subacute (ASAMHU) and Chronic Care Mental Health Unit (CCMHU) with the goal of transitioning to general population.

CCMHU will offer patients diagnosed with a SMI, at a minimum, four (4) hours per day of pro-social engagement and movement time outside of their cell as established by the facility, and as clinically indicated.

The four hours per day of pro-social engagement 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).

In addition to the pro-social engagement and movement activities, incarcerated individuals with SMI assigned to the CCMHU may have access to extra clothing, property and cell furnishings as determined by the MDT, subject to discussion with the warden.

Incarcerated individuals with SMI assigned to the CCMHU will be governed by the activities, property, and movement parameters established for these units and in their individual treatment plan.

C. The Acute/Subacute Mental Health Unit (ASAMHU) or Chronic Mental Health Unit (CCMHU) assignments will be reviewed monthly by the MDT or more frequently if circumstances require.

The MDT will make recommendations regarding patient assignment or removal from the CCMHU. The admitting and discharging authority for the ASAMHU and CCMHU is a psychologist and/or psychiatric provider/designee in accordance with the Policy 115.22 *Levels of Care*.

D. The ASAMHU and CCMHU will have a determined number of cells and designated locations.

E. To the extent possible, all ASAMHU and CCMHU designated beds will be occupied by patients who meet the appropriate level of care.

IV. SINGLE OCCUPANCY CELLS/ROOMS

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

A. Patients with serious medical disabilities (ACRS-6A-04)

B. Patients suffering from SMI with significant functional impairment

C. Sexual predators

D. Patients likely to be exploited or victimized by others

E. Patients who have other special needs for single housing

V. INDIVIDUAL MENTAL HEALTH EVALUATION

A comprehensive individual mental health evaluation will be completed on specifically referred incarcerated individuals within 14 days from the referral date. The evaluation will include, but not be limited to, the following: (ACI-6A-33, ACI-6A-37)

A. Review of mental health screening and appraisal data

B. Direct observation of behavior

C. Collection and review of additional data from team member observation, individual diagnostic interviews and tests assessing personality, intellect and coping abilities (as clinically indicated)

D. Compilation of the patient's mental health history

E. Development of an overall treatment/management plan with appropriate referral.

VI. NDCS BEHAVIORAL HEALTH REVIEW TEAMS

A. Clinical Sexual Offense Review Team (CSORT) assists in making clinical recommendations for persons who have acted out sexually.

B. Clinical Violent Offender Review Team (CVORT) assists in making clinical recommendations for persons who have acted out violently

C. Clinical Substance Use Review Team (CSURT) assists in making clinical recommendations for persons with substance use disorder.

VII. SPECIAL NEEDS INCARCERATED INDIVIDUALS

Special needs patients identified as being SED or diagnosed with developmental disabilities, neurocognitive disabilities, and/or having an intellectual disability may be referred for placement in either appropriate programs or facilities, or in mission specific housing with team members who are trained to assist with basic life-functions. If these incarcerated individuals are housed in special units within a facility, they will have the necessary supports to educate and assist them in performing self-care and personal hygiene in a reasonably private area. When such patients are incapable of attending to basic physiological needs they are transferred to a non-correctional setting, due process procedures, as specified by law, will be affected prior to such transfer. In emergency situations, a hearing is held as soon as possible after transfer. (ACI-2C-12, ACI-2C-13, ACRS-6A-04)

VIII. JOINT CONSULTATION

Except in emergencies, joint consultation will occur between the warden and the responsible physician/psychologist prior to taking action regarding the identified special needs patients in the following areas: (ACI-6C-06)

A. Housing assignments

B. Program assignments

C. Disciplinary measures

D. Transfers to other facilities

E. Use of force including Chemical Agents

1. 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.

2. A subset of patients diagnosed with serious 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 facility mental health treatment team. Changes in a patient's status will be documented in the mental health record and on the departmental network/correctional data management system so that the warden/designee can review as needed.

IX. INVOLUNTARY TRANSFER PROCEDURES

When a physician, psychologist, or psychiatrist designated by the director is of the opinion that a patient of NDCS is suffering from an SMI, SED (or other special need as identified in this policy) that cannot be properly treated at NDCS, the chief psychologist for mental health treatment services shall initiate proceedings to have the incarcerated individual evaluated for possible placement at a Department of Health and Human Services (DHHS) facility. (ACI-6C-12)

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

To initiate an *Involuntary Transfer Hearing* the chief psychologist for mental health treatment services/designee shall prepare an *Involuntary Transfer Application* (Attachment B) and provide the required notice to the incarcerated individual using the *Involuntary Transfer Hearing Notice* (Attachment C).

X. INVOLUNTARY MEDICATION PROCEDURES

A. The involuntary admission of psychotropic medication(s) to an incarcerated individual 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 is of the opinion that an incarcerated individual 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 chief of psychiatry/designee for mental health treatment services shall initiate proceedings to determine whether the incarcerated individual 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 chief of psychiatry/designee shall prepare an *Involuntary Medication Application* (Attachment E) and provide the required notice to the incarcerated individual using the *Involuntary Medication Hearing Notice* (Attachment F). A standard format for the summary of the involuntary medication hearing shall be used (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 their professional judgment that the medication constitutes an appropriate treatment for the mental illness and less restrictive alternatives are not available or indicated or would not be effective.

XI. THERAPUTIC RESTRAINTS

Four/five-point restraints are used only in extreme instances and only when other types of restraints have proven ineffective, or the safety of the incarcerated individual is in jeopardy. See Policy 115.02 *Therapeutic Restraints*. (ACI-3A-18)

REFERENCE

I. STATUTORY REFERENCE AND OTHER AUTHORITY

A. Jones v. Vitek, 445 US 480 (3/25/80). Incarcerated individuals must be afforded procedural due process before being transferred to a mental facility, 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.

B. 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 incarcerated individuals have access to correctional programs, the court found that the plaintiff was not denied such access.

C. DSM-5-TR

D. US National Library of Medicine, 2019

E. Center for Disease Control (CDC), 2019

II. NDCS POLICIES

A. Policy 115.02 *Therapeutic Restraints*

B. Policy 115.23 *Mental Health Services*

C. Policy 115.50 *Health Services Definitions*

D. Policy 210.03 *Mission Specific Housing*

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

IV. AMERICAN CORRECTIONAL ASSOCIATION (ACA)

A. Expected Practices for Adult Correctional Institutions (ACI) (5th edition): 5-ACI-2C-12, 5-ACI-2C-13, 5-ACI-3A-18, 5-ACI-6A-33, 5-ACI-6A-37, 5-ACI-6C-06, 5-ACI-6C-12

B. Standards for Adult Community Residential Services (ACRS) (4th edition): 4-ACRS-6A-04