MONTANA DEPARTMENT OF CORRECTIONS

MONTANA STATE PRISON
HEALTH SERVICES OPERATIONAL PROCEDURE

Procedure No.: MSP HS E-05.0	Subject: **Mental Health Screening and Evaluation**
Reference: NCCHC Standards P-E-05, 2018	Page 1 of 4 and 3 attachments
Effective Date: November 1, 2010	Revised: December 31, 2019
Signature / Title: /s/ Steffani Turner CSD Mental Health Bureau Chief	
Signature / Title: /s/ Paul Rees, M.D./Medical Director	

I. Purpose:

To establish procedures for mental health screening and assessment of newly admitted inmates to identify offenders who have mental health needs and ensure timely referral to mental health services

II. Definitions:

Intra-system transfer – an inmate who is being admitted into MSP from a contract facility.

Mental health staff - include qualified health care professionals and others who have received special instruction and supervision in identifying and interacting with individuals who need mental health services, e.g., mental health technicians.

Qualified Mental Health Professional (QMHP) – includes psychiatrists, psychologists, psychiatric social workers, licensed professional counselors, psychiatric nurses, or others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients.

III. Procedures:

A. Structured Interview Screenings

1. Level 1 Initial Mental Health Screening

   a. A QMHP or mental health staff will conduct an initial Level 1 mental health screening through a structured interview process on an *Intake Mental Health Screening [Level 1] form (Attachment A*) on each newly admitted inmate, including inmates returning from contract facilities, soon as possible but no later than 14 calendar days after admission

   b. The person conducting the screening will obtain a signed *Disclosure and Consent for Services form (Attachment B)*.

   c. The person conducting the screening will prepare the necessary documentation, sign it, and ensure it is filed in the inmate's mental health and infirmary records.

   d. The person conducting the screening will ensure:

      1) Each inmate with a positive screening for mental health problems is referred to QMHP for further evaluation.

2) Each acutely suicidal and/or psychotic inmate is placed in a setting where they are closely monitored until a Level 2 evaluation is completed by a QMHP. These inmates will be referred as an emergency *Clinical Intake Assessment [Level 2] (Attachment C)* evaluation case.

e. The Level 1 screen will include, but is not limited to the following:
   1) Psychiatric hospitalization, psychotropic medication (including the name of the prescriber, if known), and outpatient treatment, current and past mental illnesses, as well as gathering releases of information from other facilities
   2) Hospitalization due to substance use
   3) Withdrawal seizures
   4) Sexual abuse
   5) Drug or alcohol withdrawal or intoxication
   6) Suicidal behavior
   7) Violent behavior
   8) Victimization
   9) Special education placement
   10) Cerebral trauma or seizures
   11) Sex offenses
   12) The current status of mental health symptoms and psychotropic medications, substantiated or unsubstantiated diagnosis, with or without records review.
   13) Suicidal ideation
   14) Drug or alcohol use
   15) Physical trauma or abuse
   16) Orientation to person, place, and time
   17) Emotional response to incarceration
   18) Screening for intellectual functioning

2. Level 2 Mental Health Evaluation
   a. Level 2 mental health evaluations will be conducted in accordance with the urgency of the problem identified from the Level 1 screen by a QMHP or mental health staff. The specific problem will determine the response time for the Level 2 evaluation, but in all cases the Level 2 evaluation must be completed within 30 days or sooner if clinically indicated.
   b. Emergent referrals require follow-up within 48 hours.
   c. The QMHP will review the mental health record, if it is available, before interviewing the inmate.
   d. Intra-system transfers:
      1) All intra-system transfer inmates will receive a Level 1 screening within 14 days of admission.
      2) In the event of a positive Level 1, the QMHP will review the mental health record and interview the client using a Level 2 form.

3) If the inmate was assessed by a QMHP at Montana State Prison within the past year, and has a current (within the past year) Level 2 in the mental health file, the QMHP can attach the old Level 2 with the new Level 2 and need only document changes in the assessment on the new Level 2. If, during the interview, it is found that there are no changes in each assessment item from the old Level 2, document "no change" on the new Level 2.
4) Attention regarding medication continuity and new or recent changes in mental illness or diagnosis must be documented on the Level 2 form.
5) The qualified mental health professional conducting the interview will prepare the Level 2, sign it, and ensure it is filed in the inmate's mental health and infirmary records.

e. The Level 2 evaluation will include, but is not limited to the following:
1) Reason for evaluation/chief complaint/current symptoms.
2) History of present illness.
3) Risk factors such as: suicide ideation, homicidal ideation, hallucinations, history of violence, recent chemical abuse.
4) Prescribed medication, dosage, and prescribing physician.
5) Legal history.
6) Past psychiatric history.
7) Alcohol and drug history.
8) Medical history.
9) Family medical and psychiatric history.
10) Social and developmental history.
11) Mental status exam.
12) Assessment and summary.
13) Plan of care, referrals, and information/patient instruction.
14) Obtaining releases of information from pertinent facilities.

f. The QMHP who conducts the Level II evaluation will prepare the necessary documentation, sign it, and ensure it is filed in the inmate's mental health and infirmary records.

g. If an inmate came in on psychotropic medications or is assessed as having a serious mental illness or developmental disability the mental health professional will refer him for further evaluation and/or psychological testing by the psychiatrist or psychologist as appropriate.

h. In the event that an inmate did not require a Level 2 evaluation, as indicated by a negative Level 1 Screening, and that inmate later during incarceration requires a mental health evaluation and subsequent referral to the psychiatrist, a Level 2 will be completed prior to the psychiatry visit.

B. Intelligence Screening
1) Mental health staff will conduct a screening for intellectual functioning during the Level 1 screening process.

2) Mental health staff refer inmates for further evaluation by a QMHP whose education and credentials allow them to perform such evaluations as determined by the developer of the specific instrument used during the evaluation.
3) Results of intelligence screening and evaluations are filed in the inmate's mental health file.

IV. Closing

Questions concerning this operational procedure will be directed to the Mental Health Clinical Services Manager.

V. Attachments:

Intake Mental Health Screening (Level 1) form	attachment A
Disclosure and Consent for Services form	attachment B
Clinical Intake Assessment	attachment C

INTAKE MENTAL HEALTH SCREENING

Mental Health Services
Montana State Prison

No further follow-up needed: check here ☐
Level 2 needed: ☐ Yes ☐ No
☐ Routine ☐ Urgent ☐ Emergency ☐PREA

Last Name: _____ First Name: _____ AO Number: _____

Intake Date: _____ Screening Date: _____ Status: _____ Type: _____

Mental Health Screening, Assessment, and Evaluation:

1. Have you ever been diagnosed with a mental illness, mental condition, or emotional problem? Yes: ☐ No: ☐

☐ **Schizophrenia** ☐ Substantiated with records ☐ Unsubstantiated with records ☐ Records unavailable
☐ Symptoms observed When: _____ Who: _____
(Describe under observations)

☐ **Schizoaffective** ☐ Substantiated with records ☐ Unsubstantiated with records ☐ Records unavailable
☐ Symptoms observed When: _____ Who: _____
(Describe under observations)

☐ **Bipolar Disorder** ☐ Substantiated with records ☐ Unsubstantiated with records ☐ Records unavailable
☐ Symptoms observed When: _____ Who: _____
(Describe under observations)

☐ **Depression** ☐ Substantiated with records ☐ Unsubstantiated with records ☐ Records unavailable
☐ Symptoms observed When: _____ Who: _____
☐ Mild ☐ Moderate ☐ Severe
(Describe under observations)

☐ Other: _____ When diagnosed: _____ Who diagnosed: _____
☐ Other: _____ When diagnosed: _____ Who diagnosed: _____

2. Have you ever been on medication for mental, emotional, or behavioral problems? Yes: ☐ No: ☐
If Yes, list medications, when they were prescribed, and by whom?

Medication:	When prescribed:	When last taken:	Who prescribed:
☐ Amitriptyline			
☐ Adderal			
☐ Ativan			
☐ BuSpar			
☐ Celexa			
☐ Depakote			
☐ Effexor			
☐ Haldol			
☐ Klonopin			
☐ Lithium			
☐ Paxil			
☐ Prozac			
☐ Remeron			
☐ Risperdal			
☐ Ritalin			
☐ Seroquel			
☐ Valium			
☐ Wellbutrin			
☐ Xanax			
☐ Zoloft			
☐ Other			
☐ Other			

3. Did you bring psychiatric medicines with you? Yes: ☐ No: ☐
If yes, Name the meds: _____

Updates approved by CQI Committee 8/13/2020 JWRN

Intake Mental Health Screening (Level 1)

Mental Health Services
Montana State Prison

4. Have you had outpatient mental health treatment including individual or group counseling? Yes: ☐ No: ☐
   If Yes, What treatment have you had? _____
   When? _____ _____

5. Have you ever been a patient in a psychiatric or state hospital? Yes: ☐ No: ☐
   If Yes, Where? _____
   When? _____ _____

6. Have you ever attempted suicide or tried to harm yourself? Yes: ☐ No: ☐
   If Yes, When was your last attempt? _____ How did you attempt? _____
   _____

7. Do you currently have any thoughts of killing or harming yourself? Yes: ☐ No: ☐
   If Yes, fill out the Emergency Interview Form and attach to this paper. ☐ Done.

8. Do you ever hear voices or sounds or see things which other people cannot or do not hear or see? Yes: ☐ No: ☐
   If Yes, Explain: _____
   _____

9. Do you have a history of violent behavior? Yes: ☐ No: ☐
   If Yes, Explain: _____
   _____

10. Are you presently experiencing withdrawal symptoms from drugs or alcohol? Yes: ☐ No: ☐
    If Yes, what drugs, and when was your last use?

    Illicit drug: _____ Last use: _____ Alcohol: _____ Last use: _____
    History of withdrawal seizures? Yes: ☐ No: ☐

11. Are you currently experiencing thoughts or emotions which you feel are too difficult to deal with on your own? Yes: ☐ No: ☐
    If Yes, Explain: _____

12. Have you ever received outpatient treatment for substance abuse or detoxification? Yes: ☐ No: ☐
    If Yes, Name of facility and provider? _____
    Were you ever hospitalized for substance use? Please describe: _____

13. What current feelings are you experiencing regarding your incarceration? _____

14. Have you abused medication, alcohol, or used illegal drugs? Yes: ☐ No: ☐
    If Yes, Name of substance(s), when was your last use and are they currently experiencing withdraw? (List Below)

Medication:	Last use:	Medication(s) Name:
☐ Opiates:	_____	_____
☐ Benzodiazepines:	_____	_____
☐ Psychotropic:	_____	_____
☐ Other:		_____

Illicit drug:	Last use:		Last use:		Last use:
☐ Meth:	_____	☐ Inhalants:	_____	☐ Cocaine:	_____
☐ Heroin:	_____	☐ Ecstasy:	_____	☐ Amphetamines:	_____
☐ Bath Salts:	_____	☐ PCP:	_____	☐ Hallucinogens:	_____
☐ Cannabis:	_____	☐ Spice:	_____	☐ Other:	_____
Alcohol:	Last use:		Last use:		Last use:
☐ Beer:	_____	☐ Wine:	_____	☐ Hard Alcohol:	_____
☐ Other:	_____				

Updates approved by CQI Committee 8/13/2020 JWRN

Intake Mental Health Screening (Level 1)

Mental Health Services
Montana State Prison

15. Were you in special education classes in school? Yes: ☐ No: ☐

16. Have you ever been diagnosed with a developmental disability or other conditions indicating difficulties with intellectual functioning? (If yes, initiate RAVEN testing of intellectual functioning) Yes: ☐ No: ☐

17. Have you had head trauma in the past? Yes: ☐ No: ☐
If Yes, How many times? _____ Did you lose consciousness? _____

18. Were you ever convicted of a sex offense? Yes: ☐ No: ☐
If Yes, When? _____

19. Were you ever victimized or sexually abused? Yes: ☐ No: ☐
If Yes, Explain? _____
_____

Observations: Alert to: ☐ **Person** ☐ **Place** ☐ **Time**

General Appearance:
☐ Good ☐ Fair ☐ Unkempt

Mood:
☐ Normal ☐ Sad ☐ Anxious ☐ Angry ☐ Elevated

Behavior:
☐ Cooperative ☐ Uncooperative ☐ Evasive
☐ Suspicious ☐ Hostile

Thinking: Level of Consciousness:
☐ Alert and Oriented ☐ Disoriented

Eye Contact:
☐ Appropriate ☐ Staring ☐ Glaring
☐ Infrequent ☐ None

Quality of Thinking:
☐ Logical ☐ Paranoid ☐ Delusional
☐ Disorganized ☐ Tangential

Speech:
☐ Normal ☐ Slow ☐ Rapid ☐ Loud
☐ Soft ☐ Pressured

Social Well-Being:
☐ Normal ☐ Isolates ☐ Frequent Disciplinary Action

Body Movements:
☐ Normal ☐ Restless ☐ Poor Balance
☐ Abnormal Movements

Breathing problems:
☐ Yes, Explain_____
☐ No

Affect:
☐ Normal ☐ Sad ☐ Angry ☐ Flat
☐ Blunted

Skin abnormalities:
☐ Yes, Explain_____
☐ No

Information on Mental Health Services:

1. Information on mental health services provided and questions answered: Yes: ☐ No: ☐ If no, why?
2. Information on mental health services understood and Disclosure and Consent form signed: Yes: ☐ No: ☐ If no, why?

☐ **Inmate refuses level 1** _____

Mental Health Tech's Comments: _____
_____
_____

☐ **Releases of information obtained**

Screening Completed by:

Name: _____ Title: _____

Signature: _____ Date: _____

Attachment A

Updates approved by CQI Committee 8/13/2020 JWRN

DISCLOSURE AND CONSENT FOR SERVICES

Mental Health Services
Montana State Prison

Mental health services at Montana State Prison are provided by QMHP. If necessary, you may receive services from a psychiatrist, a clinical psychologist, a mental health specialist, a psychiatric nurse, and/or mental health technician.

Mental health services available to you at Montana State Prison include:

- Mental health assessments
- Psychological testing
- Emergency mental health evaluations
- Psychiatric medication treatment
- Inpatient mental health treatment
- Outpatient mental health treatment
- Disciplinary segregation assessments
- Parole Assessments

You may participate in these services, depending on your individual needs. You have the right to refuse services at any time.

The information you provide to the mental health staff will be potentially available to all Montana State Prison staff members. The mental health staff have set up policies and procedures designed to keep the information confidential and only available to staff members with a need to know the information for treatment, classification, security, or parole purposes.

Mental health staff are obligated to break confidentiality and report any threat of harm to yourself, threat of harm to others, child abuse, elder abuse, or threat of escape.

The information you provide to mental health staff will be written down and kept in files. In general, the information will not be released to third parties without your written consent.

I have read or have had read to me, and understand, the above information. My questions about Mental Health Services have been answered. I consent to participation in Mental Health Services in Montana State Prison:

Printed Name: _____

Signature: _____ **Date:** _____

DOC/MSP #: _____

Witness Name: _____

Witness Signature: _____ **Date:** _____

Attachment B

Updates approved by CQI Committee 8/13/2020 JWRN

MONTANA DEPARTMENT OF CORRECTIONS
CLINICAL SERVICES DIVISION

Montana State Prison
Clinical Intake Assessment (Level 2)

ROUTE TO: ☐ Medical Records ☐ Psychiatrist ☐ Therapist ☐ PREA Coordinator

REFERRAL: ☐ Group Therapy ☐ Individual Therapy ☐ Dx. Clarification ☐ Psychiatrist ☐ PREA Coordinator

DEMOGRAPHICS:

LAST NAME:	FIRST NAME:	AO #:
DOB:	AGE:	RACE:
INTAKE DATE:	ASSESSMENT DATE:	COMPLETED BY:
STATUS: ☐ GBMI ☐ AT ☐ DOC	TYPE: ☐RETURN ☐NEW ☐ TRANSFER	

REASON FOR EVALUATION/HISTORY OF PRESENT ILLNESS:

Level 2 due to a positive level 1

INMATE'S SELF-REPORTED CHIEF COMPLAINT/CURRENT SYMPTOMS:

Click here to enter text.

PREA: Referred for a PREA evaluation due to a positive PREA Risk Assessment: ☐ No ☐ Yes

Does the offender identify as or present any concerns related to transgender/gender identity/gender dysphoria? ☐ **No** ☐ **Yes**

Is the offender currently taking any medications associated with treatment of gender identity/dysphoria (either legally or illegally obtained)? ☐ **No** ☐ **Yes**

Does the offender express any concerns about personal safety related to transgender/gender identity/gender dysphoria? ☐ **No** ☐ **Yes**

Has the offender EVER received any medical or mental health care related to **transgender/gender identity/gender dysphoria**? ☐ **No** ☐ **Yes**

What is the offender's preferred pronoun to be used when referring to the offender? He

Does the offender currently meet criteria for Gender Dysphoria as defined in the current edition of the DSM? ☐ **No** ☐ **Yes**

CURRENT PRESCRIBED MEDICATIONS: Please list ALL current

PSYCHIATRIC MEDICATIONS DISCONTINUED IN MDIU:

NAME	REASON FOR DISCONTINUATION

CURRENT SUICIDE/HOMICIDE IDEATION:

Current suicide ideation: ☐ **No** ☐ **Yes: please fill out a Suicide Risk Assessment form**

Current homicidal ideation: ☐ **No** ☐ **Yes**

HISTORY OF SUICIDE IDEATION/SELF-INJURIOUS BEHAVIOR/VIOLENCE:

History of suicide ideation/suicide attempt: ☐ **No** ☐ **Yes**

Number of previous attempts:

Methods:

Did attempts require medical attention: ☐ No ☐ Yes
Antecedent stressors: Click here to enter text.
History of self-injurious behavior: ☐ No ☐ Yes
Number of previous incidents:
Date of last incident:
Method(s) and location on body:
Did any incidents require medical attention: ☐ No ☐ Yes
Antecedent stressors:
History of violence: ☐ No ☐ Yes

PSYCHIATRIC HISTORY:

Outpatient psychiatric/mental health treatment:
Inpatient psychiatric treatment:
Past psychiatric medications:

NAME	Dr.	PURPOSE	REASON DISCONTINUED

Any negative or allergic reactions to psychiatric medications: ☐ No ☐ Yes

Past Psych. Diagnosis	Date	Location	Provider

Family history of suicide attempts or completed suicides (include who, how, when):
☐ No ☐ Yes
Family history of mental illness or psychiatric hospitalizations (include who, when, where):
☐ No ☐ Yes

SUBSTANTIATION OF PAST DIAGNOSIS:

Objective findings of current symptoms:
Subjective findings of current symptoms by other staff: N/A

Objective findings of current symptoms by chart review:

Other collateral information: N/A

DRUG USE HISTORY

Type of Drug or Alcohol Used	Method of administration:	Date of Last Use:	Days used per month:	Age at first use:	Years of regular use:	Treatment sought
☐ Amphetamines						

☐ **Benzodiazepines**						
☐ **Cannabis**		Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
☐ **Cocaine**						
☐ **ETOH**						
☐ **Hallucinogens**						
☐ **Hashish**						
☐ **Heroin**	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	
☐ **Inhalants**						
☐ **Methadone**						
☐ **Methamphetamine**						
☐ **Opiates**						
☐ **PCP**						
☐ **Suboxone**						
☐ **Synthetic drugs (spice, bath salts, salvia, "meow"):**						
☐ **Other**						
***Inmate denied additional substance use. ***						

CHEMICAL DEPENDENCY TREATMENT HISTORY:

Outpatient chemical dependency treatment:

Inpatient chemical dependency treatment: Click here to enter text.

Substance Abuse in Family (what/whom): ☐ No ☐ Yes

MEDICAL HISTORY:

Current Illnesses: ☐ No ☐ Yes

Head Injuries/Loss of Consciousness: ☐ No ☐ Yes

Number of injuries:

Method of injury:

Did the injury result in hospitalization or other medical follow up: ☐ No ☐ Yes

Past medical prescription medications:

NAME	Dr.	PURPOSE	REASON DISCONTINUED
Denied	Denied	Denied	Denied

Any negative or allergic reactions to medical prescription medications: ☐ No ☐ Yes
Family history of significant medical issues including allergies or negative reactions to prescription medications: ☐ No ☐ Yes

LEGAL HISTORY:

Adult History:
Past Offenses:

Current Offense and Sentence:

Number of imprisonments/locations:

Juvenile History:
Age of first crime/trouble with the law:
Offenses/Sentences/Probation/Parole:
Number of juvenile imprisonments/locations:

SOCIAL AND DEVELOPMENTAL HISTORY:

Adverse Childhood Experiences: ☐ No ☐ Yes
History of physical or sexual abuse: ☐ No ☐ Yes
Exposure to alcohol or other drugs in utero: ☐ No ☐ Yes
Developmental delays: ☐ No ☐ Yes
Living Situation Prior to Incarceration:
Marital and Relational History:
Education (last grade completed):
IEP while in school: ☐ No ☐ Yes
Work History:
Military History (branch, dates of service, type of discharge): ☐ No ☐ Yes
Spiritual and Cultural Alliances: ☐ No ☐ Yes
Enrolled tribal member: ☐ No ☐ Yes

FINANCIAL RESOURCES: Select all that apply and describe

☐ Disability benefits ☐ Food stamps ☐ Medicaid ☐ Medicare ☐ MHSP ☐ Savings ☐ SSI ☐ VA benefits ☐ Other

MENTAL STATUS:

Affect:	**☐ Within normal range**	**☐ Outside normal range***
Appearance:	**☐ Within normal range**	**☐ Outside normal range***
Behavior:	**☐ Within normal range**	**☐ Outside normal range***
Cognition:	**☐ Within normal range**	**☐ Outside normal range***
Consciousness:	**☐ Within normal range**	**☐ Outside normal range***
Cooperation:	**☐ Within normal range**	**☐ Outside normal range***
Memory:	**☐ Within normal range**	**☐ Outside normal range***
Mood:	**☐ Within normal range**	**☐ Outside normal range***
Orientation:	**☐ Within normal range**	**☐ Outside normal range***

Speech:	☐ **Within normal range**	☐ **Outside normal range***
Thought Content:	☐ **Within normal range**	☐ **Outside normal range***
Thought Process:	☐ **Within normal range**	☐ **Outside normal range***
Other Observations:	☐ **Within normal range**	☐ **Outside normal range***

OFFENDER'S STRENGTHS

ASSESSMENT AND SUMMARY:

Provisional Diagnosis:

Reported History of:

Testing:
Adverse Childhood Experiences (ACE):
PTSD Checklist:
Montreal Cognitive Assessment (MOCA):
PQH-9:

SUD: *(consideration: remission due to being in a controlled environment):*

[NAME] *is / is not being* referred on to the psychiatrist for follow up due to current psychiatric medication prescriptions, observed/reported behaviors/symptoms, and/or diagnostic clarification.

Vulnerability factors to consider: ☐ No ☐ Yes

PLAN OF CARE: MENTAL HEALTH LEVEL/SMI_____00000_____

Recommended follow up	Referral	Information/Patient Instructions
☒**Psychiatric Evaluation/Treatment/Med Review**	MSP Psychiatrist	Kite for any mental health concerns, talk to staff immediately for emergencies
☒ **Diagnostic Clarification**	MSP Mental Health Therapist	As needed
☒ **Mental Health Group**	MSP Mental Health Therapist	As appropriate
☒ **Individual Psychotherapy**	MSP Mental Health Therapist	Kite for any mental health concerns, talk to staff immediately for emergencies
☒ **Wellness Checks (***Frequency***)**	MSP Mental Health	As needed

☒ **Discharge Planner**	MSP Case Manager	Kite for any mental health concerns, talk to staff immediately for emergencies
☒**Psychological Testing**	MSP Mental Health Therapist	
☒**Mental Health, as needed** **(***via mental health request form)*	MSP Mental Health	Kite for any mental health concerns, talk to staff immediately for emergencies

RELEASES OF INFORMATION OBTAINED:

Name	Agency	Location	Purpose
N/A	N/A	N/A	N/A

Completed By: **Credentials:** Click here to enter text.

Signature Date

Co-Signature/Clinical Licensure Supervisor Date

Co-Signature/Mental Health Services Manager Date