I. Purpose:
To establish procedures for mental health screening and assessment of all newly admitted inmates to identify inmates 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 professionals – 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 qualified mental health professional or mental health staff will conduct an initial Level 1 mental health screening through a structured interview process (see Intake Mental Health Screening [Level 1] form, attachment A) on each newly admitted inmate, including inmates returning from contract facilities, within 14 days of admission.
      b. The person conducting the screening will obtain a signed Disclosure and Consent for Services form (see 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 qualified mental health professionals 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 qualified mental health professional. These inmates will be referred as an emergency Level 2 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) Suicidal behavior
4) Violent behavior
5) Victimization
6) Special education placement
7) Cerebral trauma or seizures
8) Sex offenses
9) The current status of mental health symptoms and psychotropic medications, substantiated or unsubstantiated diagnosis, with or without records review.
10) Suicidal ideation
11) Drug or alcohol use
12) Orientation to person, place, and time
13) Emotional response to incarceration
14) 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 qualified mental health professional. The specific problem will determine the response time for the Level 2 evaluation, but in all cases the Level 2 evaluation must be conducted within 30 days of admission (see Clinical Intake Assessment [Level 2] form, link).
   b. The qualified mental health professional will review the mental health record, if it is available, before interviewing the inmate.
   c. Intra-system transfers:
      1) Qualified health professionals will review each transferred inmate’s health record or summary within 12 hours of arrival if records or summaries accompany the inmate to MSP.
      2) All intra-system transfer inmates will receive a Level 1 screening within 14 days of admission.
      3) In the event of a positive Level 1, the qualified mental health professional will review the mental health record and interview the client using a Level 2 form.
      4) If the inmate was assessed by a qualified mental health professional at Montana State Prison within the past year, and has a current (within the past year) Level 2 in the mental health file, the qualified mental health professional 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.
      5) Attention regarding medication continuity and new or recent changes in mental illness or diagnosis must be documented on the Level 2 form.
      6) 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.
   d. 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.

e. The qualified mental health professional 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.

f. 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.

3. Special Needs Treatment Plan
   a. Qualified mental health professionals will fill out the MSP Treatment Plan/Special Needs Treatment Plan form (attachment C) for all incoming inmates in MDIU.
   b. Mental Health Technicians fill out the form after negative Level 1 screens are completed.
   c. Qualified mental health professionals fill out the form after the Level 2 evaluations have been completed.
   d. The completed form is to be given to a designated staff person in MDIU for placement in the custody file.

4. Psychosocial History
   a. 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 mental health evaluation and subsequent referral to the psychiatrist, a psychosocial history will be completed prior to the psychiatry visit. This psychosocial history will be completed by a qualified mental health professional and will include but not limited to:
      1) Current complaint
      2) Psychiatric history including hospitalizations and suicide attempts
      3) Medical history
      4) Current medications and drug allergies
      5) Substance abuse history
      6) Family history
      7) Narrative of objective findings during the interview
   b. The psychosocial history will be documented in a DAP or SOAP type format and placed in the inmates permanent mental health record.
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 qualified mental health professional 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 Services Manager.

V. Attachments:
   Intake Mental Health Screening (Level 1) form attachment A
   Disclosure and Consent for Services form attachment B
   MSP Treatment Plan/Special Needs Treatment Plan form attachment C
INTAKE MENTAL HEALTH SCREENING (Level 1)
Mental Health Services - Montana State Prison
(page 1 of 3)

Last name: ___________________________ First name: ____________ ID number: __________

Intake date: _________ Time: _________ Status: _______________ Type: _______________

Screening date: _________ Time: __________

Mental Health Screening, Assessment, and Evaluation:

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

   If Yes, list the diagnosis, when they were diagnosed, and by whom?
   Diagnosis: ________________________________ 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: ________________ Who prescribed: ________________
   
   ____________________________________________________________
   ____________________________________________________________

3. Did you bring psychiatric medicines with you? Yes: [ ] No: [ ]

   If Yes, name the meds: __________________________
   
   ____________________________________________________________

4. Have you had outpatient mental health treatment including individual or group counseling? Yes: [ ] No: [ ]

   If Yes, what treatment have you had? ________________ When? ____________ Why? ________________
   
   ____________________________________________________________

5. Have you ever been a patient in a psychiatric or state hospital? Yes: [ ] No: [ ]

   If Yes, where? ____________________________ When? ____________ Why? ________________
   
   ____________________________________________________________

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: ____________________________________________________________
   
   ____________________________________________________________

No further follow-up needed: check here [ ]
Level 2 needed: Yes [ ] No [ ]
Routine [ ] Urgent [ ] Emergency [ ]
Transfer screen needed: Yes [ ] No [ ]
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:  
   Alcohol: Last use:  

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 abused medication, alcohol, or used illegal drugs?  
    Yes: □  No: □  
    If Yes, name of substance(s) and when was your last use?  
    Medication:  
    Illicit drug:  
    Alcohol: Last use:  

13. Were you in special education classes in school?  
    Yes: □  No: □  

14. Have you had head trauma in the past?  
    Yes: □  No: □  
    If Yes, how many times?  
    Did you lose consciousness?  
    Yes: □  No: □  

15. Were you ever convicted of a sex offense?  
    Yes: □  No: □  
    If Yes, when?  

16. Were you ever victimized?  
    Yes: □  No: □  
    If Yes, explain?  

Observations:  

General Appearance:  
□ Good  □ Fair  □ Unkempt  

Behavior:  
□ Cooperative  □ Uncooperative  □ Evasive  
□ Suspicious  □ Hostile  

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

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

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

Affect:  
□ Normal  □ Sad  □ Angry  □ Flat  
□ Blunted  

Mood:  
□ Normal  □ Sad  □ Anxious  □ Angry  □ Elevated  

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

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

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

Breathing problems:  
□ Yes, explain:  
□ No  

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?

Comments, recommendations, and referrals: __________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Screening Completed by:

Name: ____________________________________________________________________________ Title: ____________________________________________________________________________

Signature: ________________________________________________________________________ Date: ____________________________________________________________________________
DISCLOSURE AND CONSENT FOR SERVICES
Mental Health Services - Montana State Prison

Mental health services at Montana State Prison are provided by qualified mental health professionals. 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:
MSP - Treatment Plan

Special Needs Treatment Plan

Recommendations:

Mental Health Needs: Services Recommended: Correctional Management

☐ No Significant Needs ☐ None
☐ Moderate Needs ☐ Mental Health Treatment Unit
☐ Serious Needs ☐ Outpatient Psychotherapy
☐ Intellectual Impairment ☐ Outpatient Psychiatry
☐ Cognitive Impairment ☐ Case Management
☐ Suicide/Self-harm Risk ☐ Further Evaluation
☐ Other: ☐ Rounds
☐ Other: ☐ Discharge Planning

Comments:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Signature/Title ___________________________ Date ___________________________

Intelligence Testing

Test Date: _____ ☐ Above Average
☐ Average
☐ Below Average

Comments:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Signature/Title ___________________________ Date ___________________________

White – file   Canary – Counselor   Pink – inmate   Goldenrod – BOP