ERIE COUNTY FORENSIC MENTAL HEALTH SERVICES

STANDARD OPERATING PROCEDURES

Authors/Editors: Ronald M. Schoelerman, LCSW, CCTP; Daniel Antonius, PhD

Contributors: FMH SOP Committee 2020, 2019, 2018, 2017, 2015-2016
Michael Ranney, CRC-R, LMHC; Jeffrey Metzner, MD; Evelyn Coggins, MD

Version: 5th Edition

STANDARD OPERATING PROCEDURES

1. Mental Health Referral Process
2. Referral Triage Process
3. Forensic Mental Health Designee: Peak and Off-Peak Coverage
4. Forensic Mental Health On-Call
5. Forensic Mental Health: Refusal of Initial Services for Initial Intake/Referral
6. Mental Health Assessment and Admission Summary
7. Comprehensive Suicide Risk Assessment
8. Levels of Mental Health Care
9. Psychiatric Referrals
10. Use of Sleep Medications
11. Forensic Mental Health: Refusal of Active Case Treatment/Medication
12. Admission Intake and Medication Clinic for Intermittently Sentenced Inmates (Weekenders) with Psychiatric Needs
13. Treatment Plan
14. Progress and General Notes
15. Residential Treatment Unit
16. Constant Observation Treatment Team
17. Constant Observation Progress Note
18. Constant Observation Follow Up Assessment
19. Erie County Medical Center Lock Up Unit
20. Erie County Medical Center 9.43 Admission
21. Forensic Mental Health: Discharge Planning
22. Discharge Plan for Scripts
23. Continuation of Care
24. Confidentiality
25. Community Meeting
26. Interdisciplinary Team Meeting
27. Morbidity and Mortality Review Committee
28. Use of Restraints
29. Disciplinary Committee and Disciplinary Unit Rounds
30. Assisting in Psychiatric Medication Clinic
31. Referrals to Medical
32. Supervision and Training of Qualified Mental Health Professionals
33. Training for Forensic Mental Health Interns
34. Credentialing for Risk Assessment, Referrals, and Crisis Care Admissions
35. Forensic Mental Health Quality Management Program
36. Psychiatric Emergency

37. Substance and Alcohol Use Assessment Tool
38. Forensic Mental Health Counselor Assignment/Transfer
39. Stabilization Treatment Unit
40. Interdisciplinary Collateral Information
41. Quality Assurance and Quality Improvement reporting
42. Mental Health Record Requests

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Mental Health Referral Process	
	Policy #: 1	Dates: org. 12/15/2011; last rev. 09/02/2015
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

Individuals are referred for mental health services within the Erie County Holding Center and Erie County Correctional Facility by way of security, medical staff, self referral, court/criminal justice personnel and the community.

Individuals referred will receive a Mental Health Assessment and actions resulting from that assessment will be based on the individual case needs and circumstances.

Referrals are based on level of acuteness and medication management needs, and timelines within which an inmate referred to the FMHS must be seen. Levels of referral are categorized as Emergent, Urgent and Routine Referrals.

Levels of Referrals and Timeframes are defined as:

A. Emergent Referrals will be seen by a Qualified Mental Health Professional within 4 hours. The inmate will be seen by a psychiatrist or psychiatric nurse practitioner within 24 hours (or next business day), or sooner, if clinically indicated. Emergent Referrals must be placed on constant observation by the referring party until seen by a Qualified Mental Health Professional.

B. Urgent Referrals will be seen by a Qualified Mental Health Professional within 24 hours. Patients will be scheduled with a psychiatric provider when clinically indicated (e.g., for medication and/or diagnostic assessment).

C. Routine Referrals will be seen by a Qualified Mental Health Professional within 5 business days. Patients will be scheduled with a psychiatric provider when clinically indicated (e.g., for medication and/or diagnostic assessment).

PROCEDURE:

Referrals from Booking

1. Referrals generated at Booking are screened by a Health Professional and referred based upon level of need and acuteness (*see Mental Health Referral Guidelines*). If referral is of emergent nature, inmate will be seen per *SOP: Mental Health Designee Peak/Off-Peak Coverage*, FMH designee will be alerted. Referral is to be submitted through the electronic system *(see Mental Health Referral Guidelines)* and include:

    a. Date and Time
    b. Inmate Name
    c. ICN
    d. Date of Birth
    e. Housing Unit
    f. Reason for Referral
    g. Level of Referral

2. Additionally, the Health Professional will provide additional information as needed, consistent with the Medical Department's "Referrals Training".

3. MH referral list is placed in the designated MH referral box located within the FMH work area(s) following each nursing shift.

4. MH staff will retrieve MH referral list from referral box daily, at the end of each lock down period, enter the referrals through the electronic system and respond to referrals per established timeframes based on triaged level of acuteness stated above**.** Any change in referral level or necessary clarifications surrounding the referrals will be presented at the Interdisciplinary Team meetings.

Referrals from Medical (Sick call and staff)

5. Referrals generated from medical sick call as well as referrals related to issues identified by medical/health staff will be referred electronically as stated above in #1-4. If of emergent nature, FMH designee or the on call service will also be alerted.

Referrals from Security

6. Referrals generated from security staff are provided by:

    a. Direct verbal communication to MH staff
    b. Indirect notification of MH staff
        i. Voice message, or
        ii. Notification to medical unit who will place referral in electronic system as stated above in #1-4.

    Mental health staff members receiving verbal referral are to enter information in the electronic system with pertinent information regarding the reason for the referral.

    If of emergent nature, FMH designee will be alerted per SOP, and the assigned QMHP will attend to the issue if available and appropriate

7. Security is to provide:

    a. Name
    b. ICN
    c. Housing Unit
    d. Nature of Concern
    e. Staff name making referral

8. MH staff receiving/retrieving referral will enter information into electronic system as a referral and respond to referrals per established timeframes based on triaged level of acuteness stated above.

Self Referrals: (received via Principle Guard (PG) Slips, Erie County Forensic Mental Health (ECFMH) Request form, and/or Inmate Sick Call Request forms)

9. An individual can self-refer to mental health service at any point during incarceration requesting to be seen.

10. Methods for referral is:

    a. Inmate submits written request on “Sick Call Request” form (as provided by Health Department) , or
    b. Inmate submits written request using P.G. (Principal Guard) Slip *(as provided by Security)*
    c. Inmate submits written request using ECFMH Request form

11. All referral slips are expected to be

    a. Collected daily from locked box by Health Department staff from all housing units
    b. Reviewed for emergent needs/issues
    c. Triaged and
    d. Placed in MH referral box

12. Referrals are triaged by the QMHP in order to assess intake/case assignment needs based upon level as defined by the *Mental Health Referral Guidelines Tool* and seen within timeframe as stated above.

    a. Referral is entered in the electronic system.
    b. If case is already active, referral is assigned to existing QMHP. If assigned QMHP is not scheduled and/or available according to the defined timeframes, QMHP will assign according to FMH referral triage process.
    c. After referral is entered in the electronic records, paper form will be timestamped and processed.
    d. Response to self-referral will be documented in a progress note in the electronic record. The date of the response (the date entered as progress note in electronic record) will be noted on the timestamped paper form.
    e. Supervisors are to regularly monitor and assess the electronic record MH referral list.
        i. If referral is not responded to according to established timeframes, QMHP to have supervisory conference and document reason and perform response as determined with supervisor.

Referrals from External Sources

13. Referrals to Forensic Mental Health services can be generated from court, attorneys, community agencies, probation, parole, family members, significant others. Requests are made by way of telephone, letter or walk-in basis. Responses are based upon nature of request and handled per above defined level and timeframe for response. If referral is made to the Forensic MH office at 120 W. Eagle St, clerical staff is to transfer message to Jail, FMH supervisors, or Correctional Facility MH office.

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Referral Triage Process	
	Policy #: 2	Dates: org. 12/20/2011; last rev. 09/09/2015
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

To identify individuals in need of mental health care, to establish level of care, and to ensure continuity of care, the Forensic Mental Health Services have established a triage referral process. Priority is defined based on needed level of care, with those who are acutely ill or presenting with suicidal behavior being of highest priority. Case referrals are triaged on a daily basis and individuals are seen within established timelines determined by case priority level. The triage process includes review of referrals from within the facility, including from booking, security staff, medical staff, self-referred and court-referred, as well as referrals through daily review of mental health housing census.

PROCEDURE:

1. Forensic Mental Health/QMHP prepares daily reports for clinical staff. Reports are generated through the Jail Management System (SallyPort). Using these reports, triage activities are to include:

    a. Review reports for forensic housing, active status and non-sentenced status

    b. Review reports for Mental Health housing and all Constant Observation units to be reviewed and QMHP initials placed on list for each inmate assigned

    c. Review for movements from ECHC to ECCF

    d. QMHP collects referrals on a daily basis from Forensic Mental Health referral box and processes based on SOP Mental Health Referral Process for entry into electronic system

    e. QMHP is to review and verify all mental health referrals in the electronic system based on SOP for Mental Health Referral Process

    f. Referrals are reviewed according to priority level and established time frames. Referrals are made based on Health Professional use of *Mental Health Referral Guidelines*

    g. Delays in triage process, such as court appearances or if the individual is receiving medical care outside of the facility, are to be documented within the electronic system

    h. Levels of referrals and timeframes are defined in SOP Mental Health referral process. Timelines are listed in *Mental Health Referral Guidelines*

2. Interdisciplinary Team Meeting

    a. Specific issues related to referrals are identified and reviewed in the morning by the Interdisciplinary Team that consists of a QMHP, Health Professional, and Delta Sergeant. Assigned QMHP takes minutes and finalizes the Interdisciplinary Team report.

    b. Mental Health will attend Interdisciplinary Team meetings in the afternoon on a daily basis at shift change (approximately 2:30pm) to provide continuity of supervisory, medical, and mental health care from shift to shift within the Holding Center. Security takes minutes and generates reports to Interdisciplinary Team report.

c. Both meeting agendas are as follows:
    i. All persons on suicide watch are discussed and restrictions are reviewed.
    ii. Persons cleared from suicide watch are discussed as well as housing recommendations made.
    iii. Problem cases and management recommendations are made and discussed.
    iv. Any issues relevant to the continuity of care for a particular inmate or the stability of a delta unit are addressed and recommendations are discussed.
    v. Inmate housing and cell movement are addressed and every effort made to maintain stability on all delta units.
    vi. Medical concerns are reviewed with the representative nurse

3. Case Assignment

    a. Cases can be assigned from the triage process and/or existing referrals already in the electronic system

    b. Case assignment can occur by FMH supervisors or the designee

    c. Cases are to be seen by QMHP according to priority and professional judgement using the *Mental Health Referral Guidelines*

Mental Health Referral Guideline

Risk Level	Emergent	Urgent	Routine
Housing	Const. Obs., *Notify FMH Designee to assess	May need MH housing on Delta	General Population Housing
Suicide Screen Score	*8 or any shaded box on screen and/or:*		
Behaviors: not all need to be present **Level of Referral is Dependent on Situation**	SUICIDAL PLANS/INTENT NOW OR IN PAST 30 DAYS HISTORY OF SELF INJURY.MUTILATION NOW OR IN PAST 30 DAYS *CSRA needed Suicide attempt within past 1 year Active psychosis some signs *may* include: talking to self hearing voices responding to voices in head hallucinations (seeing things) impulsive/unpredictable behavior delusions (bizarre ideas/thoughts) Feelings of hopelessness, signs may include: states there is no tomorrow nothing to look forward to wishes to be dead Profoundly depressed, signs may include: not talking no eye contact no emotion/expressionless nonverbal-will not speak due to level of distress	HISTORY OF SUICIDE ATTEMPT IN PAST 2 YEARS HISTORY OF MAJOR MENTAL ILLNESS REPORTS ACTIVE MH TREATMENT History of Schizophrenia History of Bipolar Disorder History of Schizoaffective Disorder Self injurious behavior in past 1 year Currently on psychotropic medications Active Homicidal Ideation/Thought If behavior changes are observed that indicate a change in mental state, this could trigger change in level of priority and observation for mental health assessment. Examples of behavior change may be: not coming out of cell change in eating patterns withdrawal/increased crying decline in personal hygiene bizarre or unusual behavior	GENERAL MENTAL HEALTH TREATMENT MILD ADJUSTMENT ISSUES MENTAL HEALTH HISTORY/DIAGNOSIS Increased depression (not currently suicidal) some signs *may* include: tearfulness during interview, able to calm self report of low mood decreased energy decreased appetite Increased anxiety (not currently suicidal) some signs *may* include: pacing rapid fire/repetitious questioning or speech agitation/crankiness Special population ***may*** require MH referral if prone to victimization Developmentally disabled Sex Offender Dementia patient Traumatic Brain Injured **REMIND INMATES THAT IF THEY HAVE A MEDICAL OR MENTAL HEALTH CONCERNS THAT THE INMATE HANDBOOK TELLS THEM HOW TO ASK TO BE SEEN BY PUTTING IN A SICK CALL SLIP OR PG SLIP.**
Mental Health sees inmate within:	4 hours or sooner	24 hours or sooner	5 business days or sooner

Mental Health Referral Guideline is a tool to assist with prioritization of level of referral to Forensic Mental Health and assistance in determining initial housing placement.

*** CSRA to be completed by QMHP**

**** Mental health consultation is available through FMH Designee during Peak and Off-Peak Coverage**

(Rev. 02/2021)

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Forensic Mental Health Designee: Peak and Off-Peak Coverage	
	Policy #: 3	Dates: orig. 02/21/2012; rev. 09/16/2015, 10/30/2020
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

The Forensic Mental Health Services provides mental health coverage where a Qualified Mental Health Professionals (QMHP) is specifically assigned to Erie County Holding Center Booking/ Reception Center. This is provided during peak and off-peak hours for inmates who present with an "Emergent" need as defined by the *Mental Health Referral Guidelines*.

PROCEDURE:

1. **Peak Period Coverage:** During peak coverage hours, a Qualified Mental Health Professional will act as the FMH Designee. The hours for peak period coverage are:

   7 days a week: 8:30am-5:30pm

2. **Assignment and Notification of FMH Designee is as follows:**

   The FMH Service will assign the Designee and maintains the schedule of designee staff.

   i. At the start of the peak period, the FMH Service will notify medical booking reception and the Delta Sergeant of coverage.

   ii. FMH Service will make all attempts to not assign new cases to FMH Designee to enable a timely response to new Emergent referrals throughout the day.

   iii. At the discretion of the FMH supervisor, in certain circumstances new cases may be assigned to the FMH Designee.

   iv. When medical booking reception or a member of security identifies an Emergent case, they will alert the FMH Designee via the On call system.

   v. FMH Designee will respond within 15 minutes to advise of receipt of notification and coordinate when and where the inmate will be seen.

   vi. Inmate identified as Emergent will be observed by security staff until FMH Designee is present to conduct evaluation including, at minimum, the Comprehensive Suicide Risk Assessment. Level of case will be identified and recommendations for treatment and housing will be made accordingly.

   vii. FMH Designee will communicate information regarding Constant Observation cases to Constant Observation Treatment Team and FMH supervisor.

3. **Off-Peak Period Coverage:** During off-peak coverage hours, an On-Call FMH Designee is available to the facilities. Off peak coverage hours include hours outside of peak coverage period including evenings, weekends, and holidays.

4. **Notification of FMH Designee for Off-Peak hours is as follows:**

   a. When On-Call services are utilized, the On-Call Designee will be provided specific information regarding reason for contact, including identifying information and critical medical and mental health information.

   b. Based upon the presented information, the On-Call Designee will make a clinical determination regarding level of care for housing and treatment recommendations.

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Forensic Mental Health On-Call	
	Policy #: 4	Dates: orig. 12/20/2011, rev. 10/17/2017, 12/12/2018, 10/30/2020
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

A Forensic Mental Health director, supervisor and a psychiatrist will be available for consultation 24 hours a day. An on-call procedure is in place to cover the hours a psychiatrist or other Forensic Mental Health staff are not on site at the Erie County Holding Center and Erie County Correctional Facility. The following are guidelines to be used with professional judgment.

This protocol is to be used only for inmates with an **emergent concern.** This applies to those who are at imminent risk of harm to self or others, actively psychotic and/or acting out where uncertainty exists regarding risk of harm to self or others, or they have harmed themselves or others and safety and security within the jail setting is unable to be maintained.

Issues related to emergent, serious concerns/side effects regarding medications or question regarding starting bridge medications could also require a consultation with the On Call Service.

PROCEDURE:

1. **Refer to SOP - Forensic Mental Health Designee: Peak and Off-peak**

   Peak Coverage on site**:**
   7 days a week: **8:30am-5:30pm**

2. **Inmate case of Emergent Nature during Peak Coverage:**

   Correctional Health Staff to notify Security who will communicate to FMH On-Call Designee

   Contact to Forensic On-Call Designee via pager or direct face to face consultation. Forensics designee directs mental health decision making using clinical judgment that included contact to on call psychiatrist if necessary or if not Credentialed.

3. **Inmate case of Emergent Nature during Off-Peak Coverage:**

ECHC	ECCF
7 days a week 5:30pm-8:30am	7 days a week 5:30pm-8:30am

   Medical staff contacts on-call psychiatrist via answering service (898-4857). When contacting on call service ask to have the Erie County Sheriff's Office on call psychiatrist contacted. Give Answering service:

   a. Name of inmate
   b. Date of birth
   c. Nature of Problem

4. **On Call Forensic Mental Health Designee: Health and Security departments will maintain contact and telephone numbers provided by ECFMH, which have been distributed to Erie County Holding Center and Erie County Correctional Facility.**

5. **The FMH On-Call Designee** will require specific information regarding reason for contact, inmate name, Suicide Screen results, history (if known); to include material provided at time of arrest, within the jail data system, and from the Electronic Medical Record (EMR) if the inmate is presently incarcerated.

   The FMH On-Call Designee will use the supplied information to make a clinical determination to either come into the facility to perform an in-person assessment and render a decision regarding housing and care or:

   a. Based upon information presented, have the individual placed on constant observation and
   b. Make an emergent referral where an assessment by a QMHP will be completed based on the FMH Mental Health Referral Guidelines, or
   c. Refer to Erie County Medical Center/Psychiatric Emergency Room for assessment, or
   d. Make a non-emergent referral to the Forensic Mental Health Service, and
   e. If not yet credentialed, the FMH On-call Designee will perform a phone consultation with a psychiatrist or doctoral level mental health clinician

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: FMH: Refusal of Initial Services for Initial Intake/Referral	
	Policy #: 5	Date: 11/20/2015
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

An inmate has the right to refuse mental health services. FMH will meet with all inmates who refuse assessment to discuss refusal of services.

PROCEDURE:

1. Following the refusal of services the FMH staff person will perform a face-to-face brief interview.
    i. Request person to come to interview room.
    ii. If unwilling, staff person must go to housing unit to see the individual.
2. An explanation of FMH services and reason for referral will be offered.
3. The Refusal of Forensic Mental Health Service Form will be completed.
    i. FMH staff to list referral information of Intake Assessment form and document refusal on form. Any inmate who refused will be assessed for lethality, current use of psychotropic medications, and current mental state. This information will be documented in a general note in the EMR and refusal form with signature will be scanned in the EMR as well.
    ii. If the person does not sign the refusal form, it is to be noted on the form by the staff witness. “refused to sign” is written in signature space.
4. Sound clinical judgement will be used when assessing an inmate who is refusing services
    i. If an inmate poses a risk to self or others or presents with diminished capacity to care for self, it is necessary to continue attempts at engagement and counsel inmate on the consequences of refusing treatment
    ii. Counselors will consult with supervisors or psychiatric providers as needed.

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Mental Health Assessment and Admission Summary	
	Policy #: 6	Dates: org. 11/15/2011, rev. 06/06/2016, 08/29/2019
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

Each inmate referred to the Forensic Mental Health Services will receive an initial Mental Health Assessment and Admission Summary, which will be completed within the appropriate time frames, dependent upon type of referral. The Mental Health Assessment and Admission Summary includes appropriate questions to identify mental health concerns and/or needs, and questions related to presenting problems, psychiatric history, criminal history, relevant medical issues, brief risk assessment, and treatment recommendations. Based upon the information obtained, decisions will be made accordingly, including additional referrals, appropriate supervision/housing suggestions and a determination regarding the need to follow the case and appropriate treatment planning.

Mental health referrals will be identified as "Emergent", "Urgent", or "Routine" based upon referral source, triage process and/or outcome of Comprehensive Suicide Risk Assessment (see SOP Comprehensive Suicide Risk Assessment, SOP Referral Process, and SOP Triage Process)

PROCEDURE:

Following Triage and/or case assignment, a QMHP will perform a clinical interview and complete the Mental Health Assessment and Admission Summary.

The clinical interview is conducted in a free flowing, dialogue-style with the aim to diagnose and plan treatment for the client. It is semi-structured such that the clinician focus on the sections outlined below. Additional relevant information is also obtained by the clinician when necessary to obtain a broader clinical picture and assist in treatment planning. The clinician can decide, when appropriate, to not follow the outlined order of sections; e.g., in order to establish or ensure rapport with a particular client it may be decided that it is important to focus on certain sections of the assessment before returning to other sections later on.

The Brief Risk Assessment part of the Mental Health Assessment and Admission Summary is also completed in a free flowing, dialogue-style with the client, with acute threat in mind. The Mental Status Exam uses information reported and observed during the clinical interview to assess behaviors, appearance, and movements.

Mental Health Assessment and Admission Summary:

1. **Referral Reason** – Assesses the reason for referral as stated by inmate or reported by referral source, such as nursing or security.
   - Referral reason/ information (e.g. per referral sheet, PG slip, via conference, etc.)
   - Facility at time of evaluation (ECHC or ECCF)

2. **General Information** – This section provides some general information about the inmate.
   - Date of birth
   - Gender
   - Current address (the address they were living at when arrested/incarcerated)
   - Aliases
   - Do you live with anyone? (e.g., wife, husband, family)
   - Does the inmate have insurance?

    - Select type (of insurance)
- Emergency Contact(s)
- Identified Race
- Religion
- Primary language

3. **Legal History** – Information about prior and current legal involvement.
    - Date of inmate's current arrest
        - Return dates (to court)
    - Does inmate have bail?
        - Bail amount
    - Court (what court/level of court)
    - Judge
    - Defense attorney (who is the defense attorney?)
    - Charges
    - Review of current arrest (brief narrative of the alleged offense or what the inmate is accused of)
    - Sentenced?
        - Outdate
        - Probation/parole
    - Have you been arrested before?
    - Have you ever been convicted of a violent crime?
        - Were you incarcerated?
        - What type of incarceration?
            - Duration
            - Type (federal, state, county)
    - Have you ever been convicted of any other crime?
        - Were you incarcerated?
        - What type of incarceration?
            - Duration
            - Type (federal, state, county)

4. **Educational History** – Information about education and special educational services.
    - How far did you go in school (last grade completed; highest grade)
    - Currently a student?
    - Any special education in school?
        - Specify for what and how many years
    - History of behavioral issues?
    - Any other early developmental problems (e.g., did the person reach all developmental milestones on time or were there delays in walking, talking)

5. **Family History** – Assesses a person's support system as it relates to his or her family.
    - Is your father alive?
        - Maintaining contact
        - Is Father supportive?
        - If not alive, client age when deceased
    - Is your mother alive?
        - Maintaining contact?
        - Is Mother Supportive?
        - If not alive, client age when deceased
    - Are/Were your parents married?
    - Do you have any siblings?
        - Number of brothers?
        - Number of sisters?
    - Do you have any step siblings?
    - Where do you fall in the birth order?
    - Do you know of any psychiatric history in any family members?

- Notes: narrative to summarize family history and constellation (who the client was raised by, last contact with family, etc.)

6. **Relationship History** – Information about relationships and children.
   - Current relationship status
   - Do you have any children?
     - # of children
     - Age range
   - Do you have custody
   - Notes (provide extra narrative about relationship/children if needed)

7. **Occupational History** – Work history and current employment and/or benefits.
   - Current employment status
     - Benefits
   - Supported by disability?
   - Notes (provide extra narrative if needed)

8. **Military History**
   - Have you ever served in the military?
     - What branch?
     - Years of service
     - Type of discharge
     - Linked with services through the military/VA

9. **Mental Health and Medical History** – Information about present and past psychiatric and medical problems.
   - List any relevant medical conditions inmate has
   - Are you currently taking any medications for your medical condition?
   - Any allergies?
   - Are you currently on any mental health medications?
   - Primary diagnosis (self-reported)
   - Past psychiatric treatment
   - Age of first treatment
   - Past psychiatric hospitalizations
   - Age of first hospitalization
   - Total # of Hospitalizations
   - Longest Hospital stay (in days)
   - Age of last hospitalization
   - Past outpatient treatment

10. **Mental Health Treatment (as reported by inmate or collateral)** – Specific information about mental health treatment.

    Mental Health Treatment
    - Agency /Hospital/Program
    - Admitted
    - Discharged
    - Reason for referral
    - Treatment
    - Psychoactive medication history
    - Comments

Trauma History – Information about past trauma is assessed, which can include information about physical, verbal, emotional, or sexual trauma experiences. Impact of trauma, especially on present mental health, is also assessed.

- Does the inmate specify any trauma history? (the client should be asked whether he/she has experienced any significant trauma in their lifetime and whether it impacts them currently)
    - Comments (type, nature of trauma, symptoms attributed to trauma, treatment, etc.)

Substance Abuse History – Information about substance abuse. All substances abused should be addressed.

Substance Use Select

- Current and past substance use, AND specify:
    - Type
    - Within 30 days
    - Duration
    - Frequency
    - Amount
    - How you took it
    - Other comments

Inpatient substance abuse treatment? (when/where)

Outpatient substance abuse treatment? (when/where)

Are there any reported past or present detoxification issues?

Describe worst period

Longest "clean" time

11. **Brief Risk Assessment** – The threat of harm to self or others is assessed with the Brief Risk Assessment. If suicidality is, in the clinician's judgment' considered to be high or questionable, the Comprehensive Suicide Risk Assessment will also be administered.

    Items on the Brief Risk Assessment are rated according to whether it is a **Low impact factor, Moderate impact factor, High impact factor, or a Non-factor** according to the inmate's/patient's **current level** of suicide risk or protection.

    Example: A rating of High impact on a risk factor is given when there is a high level of **current** threat that affects/increases the individual's suicide risk.

    Risk for Self-Harm / Suicide Risk
    - Suicide Ideation- Current
    - Suicide ideation- last 30 Days
    - Suicide Ideation- last 1 year
    - Suicide Plan- current
    - Suicide Plan-Last 30 days
    - Suicide Plan- Last 1 year
    - Suicide Attempt- Current
    - Suicide Attempt- last 30 days
    - Suicide Attempt- Last 1 year
    - Suicide Attempt- Any History
        - Impact Factors
    - Self-Injurious Behavior- Current
    - Self-Injurious Behavior- last 30 days
    - Self-Injurious Behavior- Last 1 year
    - Extreme Anger-Current

- Family history of suicide
- History of impulsivity
    - Impact Factor
- Depression/ Loss of interest
    - Impact Factor
- Feelings of Guilt/ Shame
- Feelings of Hopelessness
- Lack of future plans
- Sadness/ Crying
- Recent losses/ Bad news
- Insomnia
- Excessive sleep
- Weight change related to stress
- Mental illness-active
- Command hallucination-Last 30 days
- Lack of support in Community
    - Impact Factor
- First Arrest
- Concerns Related to Charges
- Sentenced
- Withdrawing from Alcohol/Drugs

Harm to Others/ Aggressive Behavior
- History of violence- last 30 days
    - Impact Factor
- History of Violence-Last 1 year
    - Impact Factor
- History of violence-any history
    - Impact Factor
- History of threats
    - Impact factor
- History of violence related arrests
- Hx of mandated Tx for Domestic Violence
- Hx of mandated TX for anger
- Antisocial (or Borderline) Pers. Traits
    - Impact Factor
- Violent Ideation in the past month
- Impulsivity
    - Impact Factor
- Directed Anxiety/ Hostility
- Paranoia or other Psychotic Sx
- Brain Injury (e.g. TBI)
- Withdrawing from Alcohol/ Drugs
- Most recent episode of violence:
    - Describe
    - Additional notes

Summary of Risk Assessment
- Suicide Attempts- how many
- Date of last attempt
- Date of last self-injurious behavior
- Describe any history of suicide attempts/ gestures/ ideations, as well as assaultive ideation/ behavior
- Describe supportive/protective factors

12. **Mental Status Exam/ Clinical Observations** – The mental status examination assesses a person's current state of mind as observed by the evaluator and expressed by the inmate. The purpose is to obtain a comprehensive cross-sectional description of the patient's mental state, which allows the clinician to make an accurate diagnosis and formulation required for treatment planning.

    - Appearance
    - Motor behavior
    - Relationship during contact
    - Sleep
    - Mood description
    - Range of affect
    - Affect to thought content
    - Appetite
    - Perception
    - Flow/Rate of Speech
    - Thought content
    - Thought process
    - Sensorium
    - Orientation
    - Memory
    - Intellect
    - Insight & Judgment

    Comments/ Plan:

13. **DSM-V Diagnosis**
    - Previous DSM-V Diagnosis
    - Updated DSM-V diagnosis
    - Additional comments and elaboration

14. **Mental Health Treatment Plan**
    - Will this case be followed?
    - Added problems
    - Presenting problem(s)
    - Goal(s) with treatment
    - Interventions (e.g. Individual Therapy)
    - Refer to/or Maintain on Constant Observation
    - Housing Level
    - Schedule Follow-up
    - Individual has been instructed to self-refer if needing to be seen sooner than next visit, or if inmate is not to be followed, to self-refer when needing services?

15. **Mental Health Housing Recommendations and Level of Care**
    - Indicate appropriate housing level for individual
    - Identify frequency of sessions (Level of Care)

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Comprehensive Suicide Risk Assessment	
	Policy #: 7	Dates: org. 01/31/2013; last rev. 06/06/2016
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

Suicide risk is a documented and significant concern within the forensic/incarcerated population. Therefore, inmates who are considered to be at risk for suicidal behavior are evaluated with the Comprehensive Suicide Risk Assessment to ensure inmate/patient safety, provide timely appropriate interventions, and maximize positive inmate/patient outcomes. Upon entry into Booking/Reception, all inmates are assessed of suicide risk by nurses utilizing the New York State Commission on Corrections (NYSCOC) ADM 330Form. Any inmate that receives a "positive" screen (suicide risk factors are present) is referred for further evaluation and the Comprehensive Suicide Risk Assessment is completed within 4 hours of ECFMH identification by a Qualified Mental Health Professional (who has completed the mandatory risk assessment training and been certified in conducting risk assessment evaluations, in accordance with Standard Operating Procedures). The Comprehensive Suicide Risk Assessment may also be used to determine suicide risk in inmates/patients who are already placed on a housing unit, but who have been deemed to be a potential risk. The Comprehensive Suicide Risk Assessment evaluates chronic and acute risk factors, as well as protective factors, and provides an overall risk for suicide assessment (Low, Moderate, or High). Results and recommendations from the Comprehensive Suicide Risk Assessment are taken into consideration when developing and updating the Treatment Plan, and in making determinations regarding whether to admit to a higher level of care.

REFERENCES:

- U.S. Department of Justice – Office of Justice Programs
- New York State – Office of Mental health – Suggested Guide for Risk Assessment for Suicide in Jails
- American Association of Suicidology – www.suicidology.org
- Central New York Psychiatric Center – Comprehensive Suicide Risk Assessment form
- Ruiz, A. Dvoskin, J. Scott, C.L. Metzner, J.L. (2010). Manual of Forms and Guidelines for Correctional Mental Health. American Psychiatric Publishing, Inc.

PROCEDURE

The Comprehensive Suicide Risk Assessment can take place at (a) Booking/Reception or (b) any time an inmate/patient is deemed to be a potential (self-referred or staff-referred) suicide risk. Suicide risk assessment is an ongoing process from admission to discharge.

The Comprehensive Suicide Risk Assessment is completed in a free flowing, dialogue-style with the client, with acute threat in mind, and uses information reported and observed during this clinical contact to assess behaviors, appearance, movements, and overall risk.

1. Assessment of chronic and acute risk factors, and protective factors

The risk and protective factors are divided into subcategories of Biological, Psychological, Environment, Socio-Cultural, and Demographic factors. Within each category, individual items are rated according to whether it is a **Low impact factor, Moderate impact factor, High impact factor, or a Non-factor** according to the inmate's/patient's current level of suicide risk or protection.

Example: A rating of High impact on a risk factor is given when there is a high level of **current** threat that affects/increases the individual's suicide risk. A rating of High impact on a protective factor is given when there is a high level of **current** evidence that reduces the individual's suicide risk.

An overall rating of **Low**, **Moderate**, or **High Risk** is also given based on the overall clinical impression of the client. **Low risk** is considered when there are no or a few modifiable low level risk factors, and strong protective factors. **Moderate risk** is considered when there may be multiple risk factors that are relatively low in current severity (e.g., they are not currently suicidal, but may have been in the past), and few protective factors. **High risk** is considered when there are acute suicidal ideation, gestures and/or plan, and protective factors are not relevant.

The CSRA:

Biological Factors:

Risk factors

- Assess impact of any serious mental health history, Axis I history, substance abuse/dependence history (incl. length of sobriety, number of completed rehab/detox), and psychiatric hospitalizations.
- Assess impact of any serious physical illness, chronic pain (also assess for abusing pain medication), and/or Insomnia/weight loss.
- Assess impact of current withdrawal from substances.

Protective factors

- Assess the impact of maintained sobriety; list duration in days, months, and/or years (current/past, treatment, rehab, etc.).
- Assess the impact of effective pain management, and the absence of acute physical and/or psychiatric symptoms that may have interfered with suicide risk.
- Assess the impact of medication compliance (in the community, in past custody/controlled settings).

Psychological:

Risk factors

- Assess impact of any borderline and/or antisocial personality features/traits.
- Assess impact of victimization; has the individual been a victim (recent or historically) of violence or sexual abuse.
- Assess impact of family history of mental illness and suicidal behavior (and does the inmate identify with it).
- Assess impact of past suicide ideation, threats, gestures, and attempts (list number of attempts and the date of last attempt). *****Any current and recent (last 6 months) suicidal ideation or attempts should be carefully evaluated and documented in the Clinical Assessment section.**
- Assess impact of self-injurious behavior and list the last time the individual engaged in self-injurious behavior.
- Assess impact of recent (last 6 months) release from inpatient treatment, particularly psychiatric and detox.
- Assess impact of depression symptoms including diminished self-esteem, psychological Isolation, feelings of Guilt/Shame, feelings of Hopelessness.
- Assess impact of impulsive behavior and extreme anger (current).
- Assess impact of psychotic symptoms, particularly command hallucinations.
- Assess whether the person is giving away prized possessions, and the reason.

Protective factors

- Assess impact of stress resilience, treatment compliance (attending counseling, psychotherapy, and other treatment in the community; NOT medication which is assessed under Biological Factors), and therapeutic alliance (with either outside or in-jail clinician).
- Assess the person's verbalization of coping skills and the reality of these.
- Assess whether there is a genuine resolved feeling of loss.
- Assess the impact of insight and awareness into mental health issues and need for treatment.
- Assess whether the person is psychologically future oriented and verbalizes plans for the future.

Environment:

Risk factors

- Assess impact of treatment noncompliance, whether the inmate/patient might be hoarding/cheeking medication.
- Assess impact of any disciplinary action, recent restrictions (e.g. keep lock).
- Assess impact of housing/unit transfers, expected/pending transfers.

Protective factors

- Assess impact of attending treatment programs and groups.
- Assess impact of being in detox housing – a controlled/monitored environment.
- Assess mental health medication compliance while in custody.

Socio-Cultural:

Risk factors

- Assess impact of prior convictions, specifically crimes related to violent/sexual offences.
- Assess whether inmate/patient views suicide as problem-solving.
- Assess impact of immigration status.
- Assess whether anniversary of crime (e.g. murder of significant other) or another important event may have an impact.
- Assess impact of being in protective custody (e.g. high profile case) or on a segregated unit.

- Assess impact of recent rejection/loss or perceived lack of support system.
- Assess impact of being sentenced for the first time, being early in a sentence, or receiving a long or life sentence.
- Assess impact of disciplinary sanctions.
- Assess impact of adverse court/parole hearing outcome.
- Assess impact of perceived harassment by staff, bullying/teasing by peers, and gang-related threats/fears.

Protective factors
- Assess impact of cultural/religious beliefs that discourage suicide.
- Assess impact of a support system (e.g. family / friends) and having children.
- Assess impact of reality processing, and future plans/goals, including job/school assignment - both in jail or outside.
- Assess impact of resilience to intimidation.
- Assess impact of expected outdate/release.

Demographic:

Risk factors
- Assess impact of demographic factors that may affect suicide risk, including being male (for completions), female (for gestures/attempts), gay, lesbian, transgender, or bisexual (for identity issues), Caucasian (White)/Native American, older male, young adolescent, or having no family

Protective factors
- Please list any relevant demographic protective factors.

2. Clinical assessment of suicide risk

In this section, briefly document any previous suicide attempts, including the preceding factors (triggers), as well as current suicidal ideation, intent, and/or plan. Also, provide a brief narrative of current suicide risk, which incorporates relevant risk and protective factors. **DO NOT** complete this section with a one-word/truncated summary (e.g. “denies” or “patient denies”). Make sure to document the reason, and support the findings/determinations.

a. Provide an overall assessment of suicide risk: **Low risk** is considered when there are no or a few modifiable low level risk factors, and strong protective factors. **Moderate risk** is considered when there may be multiple risk factors that are relatively low in current severity (e.g., they are not currently suicidal, but may have been in the past), and few protective factors. **High risk** is considered when there are acute suicidal ideation, gestures and/or plan, and protective factors are not relevant.

b. Previous or recent suicide attempts: describe the nature and triggers in a narrative form.

c. Current suicidal ideation/plan/intent: describe any current suicidal ideation/behavior in narrative form.

d. Describe current suicide risk: using a narrative form describe prominent risk and protective factors, as well as suicidal behaviors and identifiable triggers.

3. Treatment Recommendations

Indicate specific treatment recommendations here, including location (if transfer to other housing unit is necessary), and consultation and therapy/treatment needs. Also, include a S.O.A.P. note (see SOP PROGRESS NOTES in regard to completion of S.O.A.P.).

Indicate frequency of visits. Inmates deemed to be at High risk must be placed on constant observation and seen daily.

Be sure to update the Treatment Plan to reflect any changes that are a result of the Comprehensive Suicide Risk Assessment.

- **If CSRA is completed at the same time as the intake, the initial treatment plan should include information/planning related to suicide evaluation/risk. If this information is included in the initial treatment plan, the CSRA section for treatment recommendation (SOAP) can refer to the initial treatment plan (e.g. “see initial intake”)**

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Levels of Mental Health Care	
	Policy #: 8	Date: 05/10/2012, 01/27/2016, Rev 09/17/2018
	Prepared by: Forensic Mental Health SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

Experiencing an arrest and entering a jail setting can be a stressful experience and result in mental health concerns, and/or exacerbate existing mental health issues. Some individuals may also enter the jail setting with acute psychiatric problems. In order to maximize treatment planning and care based on needs, individuals identified as having a mental illness and/or requiring treatment for mental health problems, will be classified according to the level of mental health care required. The determination of level of care will be assessed upon initial mental health assessment; however, it is re-assessed and determinations for change may occur during other assessments.

Five levels of care exist within the Erie County Correctional Settings for individuals identified as mentally ill and/or requiring mental health treatment:

1. Outpatient Level of Care
2. Residential Level of Care
3. Stabilization Level of Care
4. Crisis Level of Care (Constant Observation)
5. Crisis Stabilization Level of Care (inmates admitted to the Sheriff's Lock-Up Unit at the Erie County Medical Center, 9 Zone 2).

PROCEDURE:

Following a Mental Health Assessment SOP MH Assessment and Admission Summary (#6) by a QMHP or a FMH clinician and based upon a clinical determination; patients will be classified according to level of care, or deemed to not require mental health services. Regardless of level of care classification, all individuals will receive a comprehensive individualized treatment plan that will be completed within the established time frames as defined in SOP Treatment Plan (#13). To best meet the needs of those requiring higher level of services, treatment planning and care will be provided by specialized treatment teams for individuals assigned to Residential Level of Care, Stabilization Level of Care, and Crisis Level of Care [see SOP Constant Observation Treatment Team (#16), SOP Residential Treatment Unit (#15), and FMH SOP Stabilization Treatment Unit (# 39)].

Levels of care	Description	Policy
1. Outpatient level of care	Lowest level of mental health care provided to individuals in custody. These individuals may receive psychotropic medication and/or individual counseling as determined by their clinical needs and/or treatment plan. They will be evaluated by a psychiatrist or nurse practitioner, when clinically indicated, at a frequency of no less than once every 30 days if prescribed psychotropic medication, until stabilized on medication, and every 90 days thereafter or sooner when clinically indicated.	For more information refer to SOP: #6 SOP MH Assessment and Admission Summary #9 SOP Psychiatric Referrals #13 SOP Treatment Plan

Levels of care	Description	Policy
2. Residential level of care	Individuals assigned to residential level of care may receive psychotropic medication, individual counseling, and/or group therapy as determined by their clinical needs and/or treatment plan. They will be evaluated by a psychiatrist or nurse practitioner, when clinically indicated, at a frequency of no less than once every 30 days if prescribed psychotropic medication, or sooner when clinically indicated.	For more information refer to SOP: #6 SOP MH Assessment and Admission Summary #9 SOP Psychiatric Referrals #13 SOP Treatment Plan #15 SOP Residential Treatment Unit
3. Stabilization Level of Care	Individuals assigned to stabilization level of care may receive psychotropic medication, individual counseling, and/or co-facilitated groups (mental health/security) as determined by their clinical/behavioral needs and/or through treatment plan and ECSO Unit Conduct Expectation (UCE) sheet. They will be evaluated by a psychiatrist or nurse practitioner, when clinically indicated, at a frequency of no less than once every 30 days if prescribed psychotropic medication, or sooner when clinically indicated.	For more information refer to SOP: #6 SOP MH Assessment and Admission Summary #9 SOP Psychiatric Referrals #13 SOP Treatment Plan # 39 SOP Stabilization Treatment Unit
4. Crisis level of care	Individuals assigned to crisis level of care are placed on Constant Observation. Here, they will be seen by a Qualified Mental Health Professional daily, 7 days/week, and/or by a psychiatrist, psychologist, or psychiatric nurse practitioner daily during the 5 days of the week for which there is psychiatric coverage (Monday through Friday). Individuals discharged from the crisis level of care will receive a follow-up assessment and, at minimum, clinical contact with a QMHP on a weekly basis for two weeks.	For more information refer to SOP: #6 SOP MH Assessment and Admission Summary #7 SOP FMH Comprehensive Suicide Risk Assessment #9 SOP Psychiatric Referrals #13 SOP Treatment Plan #16 SOP Constant Observation Treatment Team #17 SOP Constant Observation Progress Note #18 SOP Constant Observation Follow Up Assessment
5. Crisis-Stabilization level of care	Individuals requiring Crisis-Stabilization level of care will be transferred within 72 hours, or as soon as possible, to the Sheriff's Lock-Up Unit at the Erie County Medical Center, 9 Zone 2. Individuals discharged from the custodial unit at ECMC and transferred back to ECHC or ECCF will be seen by a QMHP within the same day or upon arrival of the next FMH Staffing period. The current treatment plan will be reviewed and modified as clinically appropriate at that time	For more information refer to SOP: #6 SOP MH Assessment and Admission Summary #9 SOP Psychiatric Referrals #19 SOP ECMC Lock Up Unit #20 SOP ECMC 943

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Psychiatric Referrals	
	Policy #: 9	Dates: org. 12/23/2011; rev. 04/06/2016, 1/20/2021
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

Individuals are referred to a psychiatrist or nurse practitioner following assessment by a Forensic Mental Health Specialist/QMHP. This determination is based upon need and urgency level as defined within the established level of care and time frame that has been determined by the individual's treatment needs and plan. Urgency is based upon lethality, psychiatric symptoms, need for hospitalization and medication needs. Refer to Mental Health Referral Process SOP for time frames.

PROCEDURE:

1. Determination for psychiatric referral is based upon level of care and individual need through clinical determination of the QMHP, and level of urgency that is consistent with level of referral
    a. Emergent – Psychiatric Medication Clinic within 24 hours or next business day
    b. Urgent – Psychiatric Medication Clinic within 2-3 days
    c. Routine – Psychiatric Medication Clinic within 14 days

2. Case is scheduled for Medication Clinic within EMR. If immediate need exists and/or during off peak hours, contact On-Call Psychiatrist.

3. QMHP completes psychiatric referral in EMR for initial and follow-up appointments noting reason for referral and a short clinical summary based on the intake and assessment of the inmate.

    a. If medication verification not performed at time of booking, QMHP will, with consent of patient, contact appropriate entity *(typically pharmacy)* and document in EMR.

4. Psychiatrist completes contact and documents the Psychiatric Medication Consultation/ Psychiatric Medication Follow-up note in EMR using SOAP format, mental status exam, diagnostic impressions, medication, plan for revisit/renewal, and other recommendations as appropriate.

5. Psychiatrist documents in EMR for medical staff to process medications.

    a. If changing, adding or discontinuing medications:
        i. Prescriber will inform patient of reason
        ii. Explain risks, benefits, and side effects
        iii. Attempt to obtain signed consent

6. If unable to be seen by psychiatrist due to schedule and/or inmate availability, QMHP should use appropriate clinical judgment and consult with prescriber to reschedule client and prescribe/order medications if needed.

7. Assigned Forensic Mental Health staff working with prescriber will assist to schedule follow-up according to return to clinic plan.

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Use of Sleep Medications	
	Policy #: 10	Date: 02/05/2103, rev. 08/02/2019
	Prepared by: FMH Chief Psychiatrist	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

Inmates complaining of insomnia who are determined by Forensic Mental Health Staff to have a serious mental health problem will be treated by a Psychiatrist or Psychiatric Nurse Practitioner.

Sleep disturbance is a common complaint in correctional health. Insomnia seen in inmates in general population and substance abuse populations is treated by the general medical clinic as outlined by Policy # ECSO CHD: 06/02/05.

PROCEDURE:

1. Insomnia related to mental illness should be managed by treating the underlying mental illness and teaching basic sleep hygiene.

    a. **Assistance for Problems with Sleep – Behavior/Routine Changes** sheet can be provided to the person

2. A hypnotic agent may be necessary during treatment initiation with antidepressant, antipsychotic, anxiolytic or mood stabilizing medications.

3. Sleeping medications should be limited to 5 to 7 days. This is consistent with the Sleep Medication policy for general insomnia referenced above.

4. Preferred agents for insomnia include:

    a. Trazodone (Desyrel) 50-100 mg for 5-7 days. Rare but potentially serious side effect is priapism.
    b. Diphenhydramine (Benadryl) 25-50 mg for 5-7 days. Doses above 50 mg should be avoided due to potential for urinary retention, fall risk and cognitive side effects.
    c. Melatonin 1-5 mg for 5-7 days.
    d. Doxepin (Sinequan) 10-20 mg for 5-7 days

5. Seroquel (Quetiapine), Ambien (Zolpidem), benzodiazepines, and other controlled substances should be avoided.

6. Exceptions to the duration of sleep medications may be granted when there are extenuating circumstances in the treating clinician's opinion. All orders for sleep medications more than 7 days must be reviewed and approved by the Chief Psychiatrist within 5 days of writing the order.

Assistance for Problems with Sleep – Behavior/Routine Changes

A person's body is like a machine, and it is programmed to get tired. *Stress, Drugs, and Alcohol are some of the things that may alter your body to function and sleep*. Many people have been educated that "everyone" should get eight hours of sleep a night. However, five to six hours of sleep is pretty good. If a person is taking daytime naps, that person may actually sleep less than five hours a night.

A nighttime routine defined: "A prescribed, detailed course of action to be followed regularly; a standard procedure."

Do the same activities night after night before going to bed in order to improve upon your ability to have a restful night's sleep. This pattern will help quiet and calm both the body and mind and prepare it for sleep. Knowing what to expect is comforting to most individuals and nighttime routine fulfills this need.

To follow are some suggestions to assist a person to improve their sleep patterns:

- Establish and maintain regular bedtime and wake-up time patterns, including weekends – the clock in our brain helps to balance sleep time and wake time
- **Do not sleep** during the day – If you are feeling like taking a nap – ***Get up and do something different!***
- **Stay as active as possible during the day!** Use recreation time, go to the library, etc.
- Avoid thinking about or trying to solve or discuss problems before bedtime
- Practice relaxation techniques to attempt to reduce stress and anxiety
- Eat as healthy as possible – include all fruits and vegetables
- Exercise regularly as it helps to fall asleep easier – when possible, exercise at least 3 hours before sleep time - Sleep experts recommend thirty minutes of exercise approximately three to four times a week.
- Attempt to maintain a healthy weight as being overweight or obese affects sleeping patterns
- Avoid stimulants such as caffeine (coffee/tea) that may interfere with the sleep cycle
- Establish bedtime rituals such as relaxing, read a book or magazine, etc. Establish a regular schedule for your body
    - When your body starts to feel tired, that is your signal to begin your bedtime routine; even if you are not ready to fall asleep
    - Keep the routine the same every evening – a good routine might include taking five minutes to put your things away, then brush your teeth, then use the toilet and any other activities that prepare you for bed.
- If you followed your routine and do not feel tired enough for sleep, then *do not lie down on the bed*. Instead, sit on the bed and do a quiet activity.
- When you are feeling ready to fall asleep, then lie down to sleep
- If you do not fall asleep in about 15 minutes – sit up again and go back to a quiet activity until you are again feeling ready to fall asleep.

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Forensic Mental Health: Refusal of Active Case Treatment/Medication	
	Policy #: 11	Date: orig. 10/21/2015; rev. 10/30/2020
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

An inmate has the right to refuse mental health medication/treatment while incarcerated even though they may be identified as a potential candidate needing mental health services or are receiving active services through FMH. All inmates refusing services will be advised of potential impact of refusing medication/treatment. FMH will attempt to attend to any concerns/issues related to specific refusal where possible.

1. Refusal of Medication – includes the inmate decision to not take medication prescribed as a Bridge Medication order through Correctional Health, or prescribed by FMH Psychiatrist/FMH Nurse Practitioner following medication clinic and consent

2. Refusal of Treatment – includes the inmate decision to not attend scheduled appointments in medication clinic, referral to FMH Discharge Planning, or follow up contact with their assigned QMHP for individual services/therapy

REFUSAL OF MEDICATION PROCEDURE:

1. Refusal of Medication referrals are made to FMH by Correctional Health. Initial referral level (Emergent, Urgent, Routine) and other relevant information will be provided by Correctional Health.

2. FMH QMHP will review refusal of medication and information received from Correctional Health, and use professional/clinical judgment in order to verify/modify level of referral.

3. FMH QMHP will attend to referrals based on verified level and document in the record all activity as follows:

    i. Emergent – FMH QMHP will take steps within 4 hours of verified level in order to accomplish ***one or all*** of the following:

        a) face to face contact by FMH QMHP to encourage medication compliance and coordinate shared effort with Correctional Health to resume medication dosing

        b) face to face contact by FMH QMHP to identify information to communicate to FMH psychiatrist or nurse practitioner to discuss course of action

        c) Immediate scheduling for FMH medication clinic to provide assessment by FMH psychiatrist or nurse practitioner

    ii. Urgent – FMH QMHP will make face to face contact or cell side contact within 24 hours of verified level in order to accomplish one or all of the following:

        a) face to face contact by FMH QMHP to encourage medication compliance and coordinate shared effort with Correctional Health to resume medication dosing

        b) face to face contact by FMH QMHP to identify information to communicate to FMH psychiatrist or nurse practitioner to discuss course of action

c) Schedule for FMH medication clinic to provide assessment by FMH psychiatrist or nurse practitioner within 24 hours of verification

d) Case Management Note can be completed by FMH QMHP when clinically appropriate (i.e. if an inmate refuses one time, but then takes medication daily since the initial refusal, if an inmate gives a reason for refusal not clinical based or related to side effects (was in shower, playing cards, on the phone, etc.))

iii. Routine – FMH QMHP will make face to face contact within 5 business days of verified level in order to accomplish one or all of the following:

a) face to face contact by FMH QMHP to encourage medication compliance and coordinate shared effort with Correctional Health to resume medication dosing

b) face to face contact by FMH QMHP to identify information to communicate to FMH psychiatrist or nurse practitioner to discuss course of action

c) Case Management Note can be completed by FMH QMHP when clinically appropriate (i.e. if an inmate refuses one time, but then takes medication daily since the initial refusal, If an inmate gives a reason for refusal not clinical based or related to side effects (was in shower, playing cards, on the phone, etc.))

4. If an inmate poses a risk to self or others or presents with diminished capacity to care for self, continued attempts at engagement and counseling the inmate regarding consequences of refusing medication are necessary.

5. In circumstances where the inmate provides conflicting information regarding medication compliance, compared to Correctional Health, FMH QMHP will review MAR/EMAR in order to address validity/accuracy of information

6. In circumstances where the inmate continues to refuse medication prescribed by FMH and is considered to be a routine outpatient level of care in general population, FMH QMHP will schedule and attempt to have the inmate cooperate in order to be seen by the prescriber and document the inmate decision to continue treatment without medication intervention, and/or close out FMH case activity.

i. The closing of case activity must include the following:

a) description of the refused services

b) documentation that the inmate has been made aware of any consequences to his/her health that may occur as a result of the refusal

REFUSAL OF TREATMENT PROCEDURE:

1. Refusal of treatment is evidenced through attempts during FMH QMHP case activity, documented refusal by the inmate of FMH medication clinic, and documented refusal by the inmate of Discharge Planning activity.

2. FMH QMHP will define the level of refusal of treatment based on clinical judgment (Emergent, Urgent, Routine), as well as attend to the refusal based on that level and document in the record all activity as follows:

i. Emergent – FMH QMHP will take steps within 4 hours of refusal in order to accomplish the following:

a) face to face contact by FMH QMHP to encourage treatment compliance and coordinate shared effort with other FMH staffing (i.e. medication clinic) to resume compliance

ii. Urgent – FMH QMHP will make face to face contact or cell side contact within 24 hours of refusal in order to accomplish one or all of the following:

a) face to face contact by FMH QMHP to encourage treatment compliance and coordinate shared effort with other FMH staffing (i.e. medication clinic) to resume compliance

iii. Routine – FMH QMHP will make face to face contact within 5 business days of refusal in order to accomplish the following:

a) face to face contact by FMH QMHP to encourage treatment compliance and coordinate shared effort with other FMH staffing (i.e. medication clinic) to resume compliance

3. If an inmate poses a risk to self or others or presents with diminished capacity to care for self, continued attempts at engagement and counseling the inmate regarding consequences of refusing treatment are necessary.

4. In circumstances where the inmate continues to refuse treatment by FMH and is considered to be a routine outpatient level of care in general population, FMH QMHP will document a discussion with FMH supervisor, and advise the inmate of any decision to close FMH case activity.

i. The closing of case activity must include the following:

a) description of the refused services

b) documentation that the inmate has been made aware of any consequences to his/her health that may occur as a result of the refusal

Mental Health Medication Refusal Guideline

Correctional Health Department makes referral regarding medication refusal following Correctial Health Department P&P

ECFMH Referral level Consideration(s)	Emergent	Urgent	Routine
	Housed on Constant Observation Correctional Health reports severe medication side effects Arrived or returned from Inpatient Hospitalization within last 7 days Correctional Health reports not attending to ADLs and/or apparent mental health decompensation	Housed on Delta/Mental Health unit Correctional Health reports moderate medication side effects Arrived or returned from Inpatient Hospitalization within last 14 days Correctional Health reports declining ADLs	Currently Housed on General Population unit Correctional Health reports mild medication side effects
Mental Health verifies referral level and addresses contact	4 hours or sooner	24 hours or sooner	5 business days or sooner

Mental Health Medication Refusal Guideline is a tool to assist with prioritization of level of referral to Forensic Mental Health for follow up

(Rev. 10/2021)

Mental Health Treatment Refusal Guideline

FMH staff will refer based on inmate refusal of Medication Clinic, Follow Up Contact, etc. for active cases

ECFMH Referral level Consideration(s)	Emergent	Urgent	Routine
	Housed on Constant Observation Arrived or returned from Inpatient Hospitalization within last 7 days Reports are the client is not attending to ADLs and/or apparent mental health decompensation As directed by treating prescriber from refused clinic	Housed on Delta/Mental Health unit Arrived or returned from Inpatient Hospitalization within last 14 days Reports are the client is presenting with declining ADLs As directed by treating prescriber from refused clinic	Currently Housed on General Population unit
	As directed by FMH Supervsior related to reported concerns (i.e. IDT meeting information)	As directed by FMH Supervsior related to reported concerns (i.e. IDT meeting information)	
Mental Health verifies referral level and makes contact	4 hours or sooner	24 hours or sooner	5 business days or sooner

Mental Health Medication Refusal Guideline is a tool to assist with prioritization of level of referral to Forensic Mental Health for follow up

(Rev. 10/2018)

Erie County Forensic Mental Health Services	Policy: Intermittently Sentenced Inmates (Weekenders) w/ Psych Needs	
	Policy #: 12	Dates: org. 08/04/2015; last rev. 09/16/2015
Standard Operating Procedures	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

A small portion of inmates may receive an intermittent sentence in which they are expected to serve on weekends only (so-called "weekenders"). Some of this population report existing mental health problems for which they receive treatment, including psychotropic medication. To accommodate this populations' sentencing requirement and mental health needs, Forensic Mental Health will reserve space in medication clinics to coincide with the first day of sentencing, which is expected to be on a Friday, and evaluate their psychiatric history and needs.

PROCEDURE:

A new weekender with psychotropic medication will be identified by Medical and/or Security, and referred to the Forensic Mental Service at the time of booking. The weekender will be scheduled for medication clinic of the first day of serving their sentence, which is expected to be on a Friday. At this time, their psychotropic medications and needs, as well as other available information (e.g. records, collateral information), will be reviewed by a Nurse Practitioner or a Psychiatrist (the prescriber). The prescriber will document bridge orders, changes in medications, and new medications.

Forensic Mental Health Staff will receive information obtained through admission procedures of Security and Medical Departments regarding the weekender to be seen in clinic. The Forensic Mental Health Staff will verify/seek clarification of (at minimum) the following information as needed to permit the prescribers to provide mental health consultation and medication orders:

1. Confirmation of current medical and psychotropic medication(s) – to include prescriber and pharmacy information in the community

2. Confirmed allergies and medical problems based on Medical Department screening

3. Potential Substance/Alcohol related abuse/dependence issues based on Medical Department screening

4. Anticipated Length of Sentence based on Security Department information

Additionally, weekenders with psychotropic medication needs that are referred to the Forensic Mental Health Service will receive an evaluation and intake by a Qualified Forensic Mental Health counselor during the first weekend that they are serving their sentence (the first Friday, Saturday or Sunday). Recommendations will be made accordingly, on a case-by-case basis.

For intermittently sentenced inmates being admitted on other days than Friday, the Forensic Mental Health Services will follow standard operating procedures in place for regularly sentenced inmates.

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Treatment Plan	
	Policy #: 13	Date: 10/21/15, Rev. 09/17/2018
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

Each inmate on the forensic mental health services will receive a written initial treatment plan at the time of the admission/Intake evaluation. Inmates who remain in the facility will receive a comprehensive treatment plan based on treatment plan schedule. Treatment plan will address medication management, interventions, as well as discharge planning as clinically appropriate. The treatment plan will also include determination of the need for frequency of QMHP interaction. The treatment plan will be reviewed regularly (annually or sooner if clinically indicated for inmates on outpatient level of care; once every 30 days for the first three months and thereafter once every 90 days for inmates on residential or higher patient level of care). The treatment plan will be developed and reviewed by an interdisciplinary team. Treatment plan review and updates is an ongoing process from admission to discharge. The treatment plan has been developed in accordance with New York State Office of Mental Health standards.

Treatment Plan Schedule	Treatment Plan Due Dates	Review of Treatment Plans
Any inmate on FMHS caseload	Initial treatment plan must be completed **at time of evaluation or immediately after** (i.e. immediately following an admission interview).	Follows schedule below, or sooner, if clinically indicated.
Inmate at **residential level of care, stabilization level of care, or higher** **(RTU, STU, COBS)**	Updated comprehensive treatment plan must be completed within **14 days** of admission to residential, stabilization, and constant observation treatment program(s). Thereafter, updates to treatment plan are due once every 30 days for the first three months, and thereafter once every 90 days.	Once every 30 days for the first three months and thereafter once every 90 days, or sooner, if clinically indicated.
Inmate at **outpatient level of care**	Updated comprehensive treatment plan must be completed within **30 days** of completion of the initial comprehensive treatment plan.	Annually, or sooner, if clinically indicated.

REFERENCE:

- New York State Office of Mental health – 14 NYCRR Part 599, Clinical Treatment Programs, 8-17-2010

PROCEDURE FOR COMPREHENSIVE TREATMENT PLAN (SEE MENTAL HEALTH INTAKE/ ASSESSMENT SOP FOR GUIDELINES ON INITIAL TREATMENT PLAN)

1. Treatment Goals and Course

Presenting Problems: Indicate the problem and the manifested symptoms/behaviors. For example, specify what the overall problem is (e.g. danger to self), and the specific symptoms, behaviors and/or thoughts (e.g. verbalizes thoughts about hurting self; superficially cut his arm).

Goals: State what the overall goal is for the presenting problem, and what the patient/treatment team hopes to accomplish.

Objectives: Provide quantifiable specific, measurable condition that must be attained in order to accomplish the particular goal (e.g. inmate will not engage in self-injurious behavior for 7 days).

Time Frame: Provide a time frame for resolving the presenting problem.

Interventions: Indicate all interventions involved in addressing the presenting problem.

Frequency: Indicate the frequency of clinician visits to target the presenting problem.

Clinician/Treatment Team: List all staff involved in the treatment of presenting problem; each staff involved in the treatment plan must sign/approve the plan.

2. Signatures

- Treatment plan signature sheet will be signed by inmate, primary QMHP, FMH supervisor, and psychiatric/treatment team leader.
- Treatment plan signature sheet will be scanned and attached to the EMR

County of Erie

MARK C. POLONCARZ

DEPARTMENT OF MENTAL HEALTH
MARK O'BRIEN, LCSW-R
COMMISSIONER

FORENSIC MENTAL HEALTH SERVICE
RONALD M. SCHOELERMAN, LCSW
DIRECTOR OF INTENSIVE ADULT M H SERVICES

Treatment Plan Signature Sheet

Name: _____ ICN: _____

The Treatment Plan Dated ___/___/____ has been reviewed and accepted related to interventions to be provided by Erie County Forensic Mental Health Services while in the custody of the Erie County Sheriff Department at the Erie County Holding Center and/or Erie County Correctional Facility.

An updated treatment plan may be revisited based on any changes in mental health service needs while in custody, with the next scheduled review expected to occur on ___/___/____.

Patient Signature: _____ Date: _____

Primary QMHP Signature: _____

ECFMH Supervisor Signature: _____

Psychiatric/Tx Team Leader Signature: _____

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Progress and General Note	
	Policy #: 14	Dates: org. 05/04/2012, last rev. 05/05/2016
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

Progress and/or general notes will accompany the provision of any procedure completed with an inmate by ECFMH staff. In accordance with New York State Office of Mental Health, a progress and/or general note will document: date of service, duration of service, participant(s), goals and objectives that were addressed, progress since last appointment, and interventions that were discussed/provided. Progress notes of this nature must comply with the Electronic Data Interchange standards established in HIPAA.

REFERENCE:

- New York State Office of Mental health – 14 NYCRR Part 599, Clinical Treatment Programs, 8-17-2010

PROCEDURE:

ECFMH staff will regularly utilize notes to document any contact with an inmate, as well as document any work on the case. Clinical date and clinical time should be adjusted appropriately to document the actual contact date and time for each note that is entered into the EMR. If face to face contact has been made, staff will check the appropriate box to show interview location and duration of interview. Type of progress note will be noted as well. All notes must be signed in a timely manner by primary clinician and supervisor (if required). There are four notes that will be used regularly as described below:

1. Mental Health Progress Note

A mental health progress note is used to document individual therapy, compliance with interventions, as well as application of treatment plan, discussion and follow-up. It is imperative to include the information below:

Goals and Objectives Addressed

If applicable, specify the goals/objectives, as indicated on the treatment plan, that are being addressed during the interview.

Narrative/S.O.A.P.

All staff will follow the S.O.A.P. narrative format:

- Subjective: A direct quote of what the client says, e.g. “I am feeling depressed.”
- Objective: What the therapist observed (could be the MSE), e.g. “the inmate was observed to be melancholic and crying.”
- Assessment: The current situation based on the judgment of the therapist, e.g. “the inmate is at increased risk of depression”, as well as diagnostic impressions.
- Plan: A suggestion how to address the problem or situation, e.g. “the inmate will be referred for medication clinic for evaluation of need for pharmacological treatment.”

Brief Mental Status Exam

Provide a brief assessment by checking appropriate material in mental status exam and providing additional details regarding the inmate's current mental status if needed.

2. Mental Health General Note

A mental health general note will be used to document general information into the inmates EMR which is not relevant to MH case management activities (i.e. cell movement, attempted contacts, security advising of change in classification level). "Mental Health" is to be selected as the general note type, and staff can then document a "brief subject" which will become the title of the note.

3. Mental Health Case Management Note

A mental health case management note is used to document non-clinical contact with an inmate, as well as other contact during which the mental health case is being discussed. These include:

- Residential Treatment Unit (i.e. screening and important information discussed in RTU case conference)
- Collateral Contact
- Discharge Planning
- Interdisciplinary Treatment Team
- Case Management (all other pertinent information)

4. Mental Health Case Closure Note

A mental health case closure note is used to document when an inmate is released from custody or mental health concerns are resolved.

- Clinical date and clinical time should be adjusted appropriately to document the actual date and time of the inmate's release.
- The note will be titled "MH Case Closure Note". "Mental Health" is to be selected as the general note type in the drop down within the document.
- The narrative of the note should include the date that the inmate was released and the reason for release (e.g. ROR, bail, time served, etc.).
- Staff will utilize the quick text entry ".close" at the end of the narrative in order to ensure consistent documentation by all staff.

Erie County Forensic Mental Health Services	Policy: Residential Treatment Unit	
	Policy #: 15	Date: 01/27/2016
Standard Operating Procedures	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffery Metzner	

POLICY:

Individuals with severe mental illness represent a significant portion of people who are incarcerated in the United States compared to the general population. Moreover, those identified with severe psychiatric illness may have a higher incidence of criminal justice system contact following an initial arrest, are more likely to be homeless at the time of arrest, have longer criminal histories, and tend to serve longer sentences. Thus, providing mental health services that meet the needs of those with severe mental illness is important. To that extent, the FMH Residential Treatment Unit (RTU) provides specialized treatment and care services to seriously mentally ill individuals assigned to that unit. The RTU provides a clinical focus that can assist in behavior management, skills building, and empowerment exercises, and staff provides education, material, and information in order to assist in the successful transfer from the correctional setting to community. The RTU offers structured programs used to accommodate specific needs of promoting self-sufficiency, wellness, improved mental health compliance, and effective decision-making in the effort to empower clients toward increased positive outcomes.

PROCEDURE:

A referral to the RTU can be initiated by Psychiatrist(s), Psychiatric Nurse Practitioner(s), and Qualified Mental Health Professionals within FMH. The FMH Residential Treatment Unit team will determine appropriateness of referral and consult with the referring individual as needed.

The criteria for program referral are as follows:

- SPMI with current stability and ability to participate and function in group situation without disruptive or aggressive behavior.
- The inmate must be able to live in the specialized mental health housing designated for the program through the cooperation of FMH and ECHC Security/Administration.
- The inmate is expected to remain in custody for a substantial enough period of time that will allow them benefit from RTU group sessions.

In addition to individual counseling, the FMH RTU program curriculum will consist of eight weekly modules. Additional group treatment, cognitive behavioral, general social skills, and psychoeducational interventions, will be incorporated based on identified group problems, stressors, issues, and needs.

The FMH RTU Team will conduct regular meetings in order to discuss programming, treatment needs, and address treatment planning. This team consists of two QMHPs (i.e., LMSW, LMHC), the Chief Psychiatrist, a Psychiatric Nurse Practitioner, and FMH Discharge Planning.

As per SOP, a comprehensive treatment plan will be developed for each inmate at the residential level of care or higher, and will be targeted for completion within 14 days of admission to the RTU.

The comprehensive treatment plan will be developed by the FMH RTU team, with shared input of medical and security staff in targeting goals and monitoring objectives. The client will be encouraged to participate in the

development of treatment planning through 1:1 and group contact. Nursing staff will be encouraged to participate when clinically appropriate.

The FMH RTU Team for residential or higher level of care will meet to discuss and review client's treatment no less than once every 30 days for the first three months of care, and once every 90 days thereafter. Security and Medical staff are encouraged to provide input into this process.

Whenever there is a change to a client's level of care, the treatment plan will be reviewed by the appropriate treatment team

ECFMH staff will conference with the security staff of the RTU as follows:

- ECFMH RTU staff and Delta Sgt will conference weekly following the morning triage to review and discuss security and treatment issues/needs. One meeting a month will include FMH RTU staff, Delta Sgt, and Deputies from the RTU

There will be weekly contact with RTU Deputies through RTU Group Sessions.

ECFMH staff will seek conference with medical staff as needed to maintain treatment plan goals and to monitor medication compliance. Contact will be further established upon Correctional Health designating a regular contact/staff.

Additional aspects of the ECFMH Residential Treatment Unit include:

- In order to provide pertinent information to the Residential Treatment Unit, the ECFMH Community Discharge Planner will be invited to present on a monthly basis through group module interactions.

- Security will be provided by the unit assigned to the designated housing unit.

- Consultation will be made with the Medical Staff within the ECHC as needed.

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Constant Observation Treatment Team	
	Policy #: 16	Date: org. 01/13/2016, rev. 10/11/2018
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

The Constant Observation Treatment Team consists of mental health staffing to include a psychiatrist, psychiatric nurse practitioner, and three QMHP's. Consultation with security staff team members include the Delta sergeant assigned to the mental health unit, deputies assigned to constant observation areas, and the Classification sergeant. Consultation with medical/nursing staff conducted through the Director of Nursing.

PROCEDURE:

1. The Constant Observation Treatment Team meets two times per week to review all inmates that are on constant observation and who have been discharged from constant observation.

2. The Constant Observation Treatment Team will review and discuss all inmates on constant observation and make any recommendations for their care while in constant observation

3. The Constant Observation Treatment Team will conduct a review regarding any/all individuals who enter constant observation. ***Those who have experienced two or more constant observation placements within a three month period will receive a case conference***. The case conference is to permit the COTT to consider referral for the most appropriate level of care (i.e. STU, RTU) upon the individual being cleared from constant observation.

4. The Constant Observation Treatment Team will review the initial or comprehensive treatment plan for all inmates cleared from constant observation and review any recommendations/services needed.

    a. A QMHP will add a MH Case Management Note in the Electronic Medical Record to indicate that the inmates' treatment plan was reviewed and include any recommendations from the Constant Observation Treatment Team.

5. The Constant Observation Treatment Team will complete meeting minutes for each meeting. The hard copy of the meeting minutes will be kept by the Constant Observation Treatment Team supervisor and the electronic version will be uploaded to the county shared drive.

    a. The meeting minutes will detail current inmates on constant observation and any recommendations/concerns/issues with them as well as a treatment plan review of inmates who have been discharged from constant observation.

6. The Constant Observation Treatment Team will communicate any recommendations regarding inmates reviewed during the meeting to all ECFMH staff as needed

7. If a psychiatrist, psychologist, or psychiatric nurse practitioner is unable to see an inmate for constant observation contact on a day that the Constant Observation Treatment Team meets, a member from the Constant Observation Treatment Team will update the QMHP scheduled to complete the constant observation progress note to any case discussions or concerns regarding the inmate.

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Constant Observation Progress Note	
	Policy #: 17	Dates: orig. 03/29/2012; rev. 01/14/2016, 10/30/2020
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

All individuals on Constant Observation status/crisis level of care will be seen by a Qualified Mental Health Professional daily, 7 days/week, with primary contact by a psychiatrist, psychologist, or psychiatric nurse practitioner daily during the 5 days of the week for which there is psychiatric coverage.

PROCEDURE:

Documentation of the daily contacts consists of:

1. Sign in the unit log book

2. Document changes to restrictions as needed
   a. Notation is brief and states the level of care on Constant Observation, whether status is maintained or changes recommended, and documentation of restrictions, as needed.

3. Complete a progress note using the **Constant Observation Progress Note** in the Electronic Medical Record (EMR).

The note should be brief and concise and include:

a. Open the patient's chart in the EMR (be certain that ICN # and patient name match)
b. Ensure the date, time, location and setting reflect where patient was seen
   i. Address any issues regarding confidentiality and privacy
   ii. Cell side interviews are only done due to specific circumstances (i.e. staff safety, escort unavailable, inmate refusal)
c. Address reason (precipitant) for constant observation,
d. Provide a brief assessment of the inmate's current mental status.
e. Note changes: court, family visits, bad news/good news, feedback from security staff
f. If the QMHP seeing the person is a prescriber and sees a medication issue that needs to be addressed, that prescriber will make the change at time of contact. Note this in the EMR and complete a Psych Med Consultation or Psych Med Follow-Up Note in the EMR.
g. Document plan: i.e. refer to doctor, plans for contact, issues to be addressed by the QMHP. (Document in the log book and on the suicide watch form that contact was made with the inmate).
h. Provide all necessary signatures from primary rater/clinician, note date and time.
i. Route the document to the assigned counselor through the EMR.
j. If change in status occurs (discontinuance, change in restrictions), note on form and inform QMHP responsible for oversight to enter change in SallyPort alerts if applicable.

***QMHP= psychiatrist, psychologist, psychiatric nurse practitioner, FMH specs, MICA Specialists.

***Note: If person is being seen by another QMHP (for example, doctor doing rounds or in a med clinic, then the person does not need to be seen twice, unless seen for a planned counseling session).

If a psychiatrist, psychologist, or psychiatric nurse practitioner is unable to see an inmate for constant observation contact on a day that the Constant Observation Treatment Team meets, a member from the Constant

Observation Treatment Team will update the QMHP scheduled to complete the constant observation progress note to any case discussions or concerns regarding the inmate.

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Constant Observation Follow Up Assessment	
	Policy #: 18	Dates: org. 05/08/2012; rev. 01/14/2016, 08/22/2019
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

Inmates discharged from constant observation (needing crisis level of care) will receive a follow up assessment and, at minimum, clinical contact with a Qualified Mental Health Professional (QMHP) on a weekly basis for two weeks of being cleared from constant observation or more when clinically indicated. Similarly to the Comprehensive Suicide Risk Assessment, the constant observation follow up assessment is used to evaluate acute risk factors, as well as protective factors, and provides an overall risk for suicide assessment (Low, Moderate, or High). Results and recommendations from the follow up assessment are taken into consideration when developing and updating the Treatment Plan, and in making determinations regarding level of care.

PROCEDURE

1. Top Section(s)

Open the patient's chart in the EMR (be certain that ICN # and patient name match) Ensure the date, time, location and setting reflect where patient was seen

2. Assessment of chronic and acute risk factors, and protective factors

Items are rated according to whether it is a **Low impact factor, Moderate impact factor, High impact factor, or a Non-factor** according to the inmate's/patient's current level of suicide risk or protection.

Example: A rating of High impact on a risk factor is given when there is a high level of **current** threat that affects/increases the individual's suicide risk. A rating of High impact on a protective factor is given when there is a high level of evidence that reduces the individual's suicide risk.

For information about the individual items please see the SOP for the Comprehensive Suicide Risk Assessment.

If an inmate verbalizes current suicidal ideations during one of the follow up assessments, the Constant Observation Follow Up Assessment documentation would not be used and a Comprehensive Suicide Risk Assessment would be initiated to document contact.

3. Summary

In this section, briefly document your overall finding(s) with a brief narrative of current suicide risk, which incorporates relevant risk and protective factors.

Provide an overall assessment of suicide risk (Low Risk, Moderate Risk, or High Risk), based on information obtained during the interview.

4. Mental Status Exam

Check the appropriate boxes (all that apply) in regard to behavior, mood and affect, thought, and cognition.

5. Treatment Recommendations

Indicate specific treatment recommendations here, including location (if transfer to other housing unit is necessary), and consultation and therapy/treatment needs. Also, include a S.O.A.P. note (see FMH SOP #14 Progress Notes for how to complete a S.O.A.P.).

Indicate frequency of visits. Inmates deemed to be at High risk must be placed back on constant observation and seen daily. If deemed at High Risk, a Comprehensive Suicide Risk Assessment must be completed in order to place the client on constant observation.

Be sure to update the Treatment Plan to reflect any changes that are a result of the Comprehensive Suicide Risk Assessment.

6. Signatures

Provide all necessary signatures from primary rater/clinician and supervisor if required.

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Erie County Medical Center Lock Up Unit	
	Policy #: 19	Date: 11/23/2015, Rev. 09/17/2018
	Prepared by: FMH SOP Committee with information from the ECSO and Physician(s) of ECMC Lock Up	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

The Lock Up Unit (Zone 9-2) at the Erie County Medical Center is primarily used for those inmates who are in the custody of the Erie County Sheriff Office and who need inpatient psychiatric care, and the use of the Adult Forensic (9-2) beds are prioritized first for ECHC and ECCF inmates based on consultation with Attending Physician at ECMC or Designee and at the discretion and clinical judgment of the Director of Adult Intensive Mental Health Services (FMH). Circumstances may arise when an ECMC patient may be pending criminal charges and/or is in a pre-arraigned status. In such cases a Courtesy Hold on the Lock Up unit will be considered on a case-by-case basis and coordinated based on the discretion and clinical judgment of Attending Physician at ECMC or Designee and consultation with the Director of Adult Intensive Mental Health Services (FMH).

PROCEDURE:

1. Crisis-Stabilization through use of Adult Forensic (9-2) beds

    a. FMH QMHP identifies inmates in potential need of inpatient psychiatric care while in custody at the Erie County Holding Center and/or the Erie County Correctional Facility.
        i. Consultation with FMH Psychiatrist regarding mental health status and verification of need for potential Adult Forensic (9-2) admission
        ii. Following verification of need for Adult Forensic (9-2) admission, notification of Director of Adult Intensive Mental Health Services (FMH) or designated FMH supervisor

    b. FMH Nurse Practitioner identifies inmates in potential need of inpatient psychiatric care while in custody at the Erie County Holding Center and/or the Erie County Correctional Facility.
        i. Consultation with FMH Psychiatrist regarding mental health status and verification of need for potential Adult Forensic (9-2) admission
        ii. Following verification of need for Adult Forensic (9-2) admission, notification of Director of Adult Intensive Mental Health Services (FMH) or designated FMH supervisor

    c. FMH psychiatrist identifies inmates in potential need of inpatient psychiatric care while in custody at the Erie County Holding Center and/or the Erie County Correctional Facility.
        i. Notification is to be made to the Director of Adult Intensive Mental Health Services (FMH) or designated FMH supervisor

    d. Mental Health housing within ECHC [primarily through use of the Stabilization Treatment Unit (STU) or Residential Treatment Unit (RTU)] and Constant Observation with appropriate restrictions may be temporarily used while waiting to transfer an inmate to an Adult Forensic (9-2) bed

    e. FMH will maintain a record of inmates identified as in need of a crisis-stabilization level of care if no beds are available, and track wait times and lengths of stay for crisis-stabilization bed use

    f. The Director of Adult Intensive Mental Health Services (FMH) will consider mental health need, medical issues, and security concerns, and use clinical judgment in consultation with Attending

Physician at ECMC or Designee and direct FMH to prepare transport of designated inmate for transfer to Adult Forensic (9-2) bed

g. FMH will advise individuals designated by ECSO within the ECHC/ECCF of need to arrange transportation, to include any information related to assist in expediting transfer
    i. FMH will notify ECSO of transport
        1. Transport to be discussed at IDT meeting (AM/PM) to advise all collaborative teams of necessary information (Security, Medical, Forensic)
        2. Call to Central Control (x7015) and request to speak to the Transport Supervisor in order to advise of transport
            a. If advised Transport Supervisor is unavailable in the facility - Call to Transport Supervisor at 716-207-5498
        3. Inform transport of anticipated time for patient to be at ECMC
        4. Coordinate delivery of sealed envelope of patient information directly to the Transport Supervisor

h. FMH will prepare two copies of Physician Certificate paperwork, initial mental health assessment, most recent documentation of medication clinic contact, information regarding medication compliance/MAR, and medical screening and/or physical form(s) requested by ECMC for transfer – one copy will be provided in sealed envelope to ECSO for transport to accompany the inmate, and the other will be sent through secure electronic transmission to ECMC

i. FMH will monitor Adult Forensic (9-2) beds through review of reporting on status within ECSO custody, as well as ongoing consultation between the Director of Adult Intensive Mental Health Services (FMH) and Attending Physician at ECMC or Designee

j. Patients discharged from the custodial unit at ECMC and transferred back to ECHC or ECCF will be primarily housed on the STU or RTU (unless COBS is recommended) until seen by a FMH QMHP within the same day or upon arrival of the next FMH staffing period. The current level of care and treatment plan will be reviewed and modified using clinical judgment at that time

2. 730 CPL Designation to ECMC Civil Beds through use of Adult Forensic (9-2) beds

a. A 730 Mental Health order is received from any court where an inmate has been evaluated and found not competent by two doctors and has other than felony charges

b. FMH Front Office staff follow through with processing cases for a Final Order of Observation and Dismissal of Accusatory Instrument, which may lead to designation for Buffalo Psychiatric Center or Erie County Medical Center

c. In cases with designation to Erie County Medical Center, FMH Front Office staff will advise the Director of Intensive Adult Mental Health Services (FMH)

d. Mental Health housing within ECHC [primarily through use of the Stabilization Treatment Unit (STU) or Residential Treatment Unit (RTU)] and Constant Observation with appropriate restrictions may be temporarily used while waiting to transfer a prisoner to an Adult Forensic (9-2) bed

e. The Director of Adult Intensive Mental Health Services (FMH) will consider mental health need, medical issues, and security concerns, and use clinical judgment in consultation with Attending Physician at ECMC or Designee and direct FMH to prepare transport of designated inmate for transfer to Adult Forensic (9-2) and Final Designation to civil bed unit; or as Direct admit for Final Designation to Civil Bed unit at ECMC

f. FMH will prepare two copies of initial mental health assessment, most recent documentation of medication clinic contact, information regarding medication compliance/MAR, medical screening and/or physical, court reports, final order, and accusatory instrument(charges) requested by ECMC for transfer – one copy will be provided in sealed envelope to ECSO for transport to accompany the inmate, and the other will be sent through secure electronic transmission to ECMC

g. FMH will advise ECSO within the ECHC/ECCF of need to arrange transportation, to include any information related to assist in expediting transfer
    i. FMH will notify ECSO of transport
        1. Transport to be discussed at IDT meeting (AM/PM) to advise all collaborative teams of necessary information (Security, Medical, Forensic)
        2. Call to Central Control (x7015) and request to speak to the Transport Supervisor in order to advise of transport
            a. If advised Transport Supervisor is unavailable in the facility - Call to Transport Supervisor at 716-207-5498
        3. Inform transport of anticipated time for patient to be at ECMC
        4. Coordinate delivery of sealed envelope of patient information directly to the Transport Supervisor

h. FMH will verify transport and monitor inmates designated to Adult Forensic (9-2) beds through review of reporting on status within ECSO custody, as well as ongoing consultation between the Director of Adult Intensive Mental Health Services (FMH) and Attending Physician at ECMC or Designee

i. In circumstances where an inmate has entered an Adult Forensic (9-2) bed at ECMC pending Final Designation to civil bed unit:
    i. ECMC will notify FMH that an inmate in Adult Forensic (9-2) bed is pending transfer, and that a civil bed is available
    ii. FMH will advise ECSO Records of Date of Release to civil bed at ECMC, and include copy of Final Designation with signed final order
    iii. FMH will verify transfer from Adult Forensic (9-2) to civil bed has occurred
    iv. FMH will maintain a record of inmate use of Adult Forensic (9-2) beds and track length of stay/transfer time to civil bed use

3. Courtesy Hold through use of Adult Forensic (9-2) beds

a. **Adult Forensic (9-2) beds at ECMC are prioritized first for ECHC and ECCF inmates who are deemed in need of psychiatric attention based on consultation between the Director of Adult Intensive Mental Health Services (FMH) and Attending Physician at ECMC or Designee. Courtesy Hold use will occur only if:**

    i. One or both Adult Forensic (9-2) beds are unoccupied by ECHC or ECCF inmates
    ii. There is no imminent transfer of an inmate to an Adult Forensic (9-2) bed

b. Attending Physician at ECMC or Designee and/or Behavioral Health Management Team of ECMC identifies a psychiatric patient who commits an offense on a civil unit that leads to an arrest/legal charges

c. Attending Physician at ECMC or Designee and/or Behavioral Health Management Team of ECMC coordinates with hospital police to determine the following:

i. Level of potential charges
ii. If the person can be safely managed within the jail system based on mental health status
iii. If the person requires Adult Forensic (9-2) bed placement based on mental health status

d. In circumstances where clinical judgment is that the person can be maintained within the jail system, the person is arrested and transported to Buffalo Lockup through coordination between Behavioral Health Management Team of ECMC, Buffalo Lockup and ECSO

e. In circumstances where clinical judgment is that the person requires Adult Forensic (9-2) bed placement admission occurs as follows:
    i. Attending Physician at ECMC or Designee is contacted
    ii. Upon agreement by Attending Physician at ECMC or Designee of need for Adult Forensic (9-2) admission, bed availability is determined, and consultation with the Director of Intensive Adult Mental Health Services (FMH) occurs to insure consideration of Adult Forensic (9-2) bed needs
    iii. Director of Intensive Adult Mental Health Services (FMH) or designee to notify ECSO Classifications unit of patient admission
        a. Name
        b. Date of birth
    iv. ECSO Classifications to notify 9-2 ECSO staff of pending admission

f. In circumstances where a Courtesy Hold occupies an Adult Forensic (9-2) bed at the same time that FMH is coordinating a referral from ECHC/ECCF, the Director of Intensive Adult Mental Health Service (FMH) will use clinical judgment in consultation with Attending Physician at ECMC or Designee in order to prioritize and expedite appropriate plans that considers maximizing the safety of the patient, medical staff, mental health staff, and security based on all available information

g. ECSO and ECMC has agreed to six patients per calendar year
    i. FMH to track usage and provide ECSO and ECMC with quarterly reports.

h. Courtesy Hold patients discharged from the Adult Forensic (9-2) bed at ECMC and transferred to ECHC or ECCF will be primarily housed on the STU or RTU (unless COBS is recommended) until seen by a FMH QMHP within the same day or upon arrival of the next FMH staffing period.

Erie County Forensic Mental Health Services	Policy: Erie County Medical Center 9.43 Admission	
	Policy #: 20	Dates: org. 11/09/2014; last rev. 11/23/2015
Standard Operating Procedures	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

9.43 admissions are utilized through collaborative management between the Courts, Erie County Forensic Mental Health (ECFMH), Erie County Medical Center (ECMC), and the Erie County Sheriff Office (ECSO), and involve cases where it is determined a person will have psychiatric benefit through inpatient admission to a civil bed unit at the Erie County Medical Center (ECMC)

PROCEDURE:

1. ECFMH will evaluate a person in custody of the ECSO in the Erie County Holding Center (ECHC) or Erie County Correctional Facility (ECCF) and render a clinical opinion regarding the benefit for inpatient care at ECMC, Civil unit under MHL 9.43 (See (A) MH Law 9.43)

2. ECFMH will prepare a report with recommendation to the court for a 9.43 evaluation, and provide appropriate paperwork to permit the court to process and complete a 9.43 order

    a. ECFMH to conference case with Director of the University of Buffalo Psychiatry Diversionary Services, or designee who will inform ECMC CPEP of possible 9.43 case

3. In circumstances where the court agrees with the recommendation, the court will provide ECFMH and the ECHC Record Room with a copy of the 9.43 commitment order (See paperwork provided to the court).

4. Following the communication of the 9.43 commitment order to ECMC and ECSO, the person will be involuntarily transported to ECMC/CPEP by the ECSO at the request of the court for involuntary admission under MHL 9.39

5. Upon confirmation of the court enacting the 9.43, ECFMH will notify the ECMC civil unit and/or ECMC CPEP of the case information and 9.43 commitment order

    a. ECFMH will send supporting paperwork including initial mental health assessment, most recent documentation of medication clinic contact, information regarding medication compliance/MAR, and medical screening and/or physical.

6. Communication between ECFMH and ECMC will occur in order to obtain disposition of the 9.43 evaluation

    a. If the person is admitted, ECFMH designee and ECMC designee will communicate at a minimum of once per week regarding case status/progress

    b. ECFMH will update the court of case status, progress, and release/return to jail or community
        i. Person to return to custody upon conclusion of 9.43 evaluation if not admitted or post-release, or
        ii. The case is dismissed against the person receiving 9.43 evaluation, and is able to be released to the community at discharge, or
        iii. The case is not dismissed against the person receiving the 9.43 evaluation, and is able to be released to community at discharge

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Forensic Mental Health: Discharge Planning	
	Policy #: 21	Dates: org. 12/23/2011; last rev. 02/24/2016
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

Forensic Mental Health Discharge Planning (FMHDP) consists of providing services and paraprofessional social work to those individuals who require follow up mental health linkage and intervention within the community upon release from incarceration from the Erie County Holding Center (ECHC) and the Erie County Correctional Facility (ECCF). FMHDP works directly with inmates (and family) who are linked to FMH Services and identified to be in need of follow up services, planning for continuation of medication, and assistance in linking to appropriate outpatient service agencies. FMHDP activity is maintained and under the oversight of licensed level professional staff within FMH.

Services are a collaborative effort between the assessing QMHP and FMHDP and may include assistance by information/linkage/referral to:

- Outpatient Mental Health Treatment
- Inpatient Psychiatric Care (if involuntary commitment is warranted)
- Co-occurring Substance Abuse Treatment
- Public Assistance
- Medicaid
- Medication Prescription
- Medication Grant Program
- Housing referrals:
    - Community Residences (group homes)
    - Supported Housing (single room occupancy)
- Interventions for Homeless:
    - Transitional Housing (such as shelters)
    - Emergency Housing Programs
- Care Coordination
- Peer Services

PROCEDURE:

The identification and referral of inmates in need of discharge planning services will be initiated based on specific criteria, as well as a collaborative process between FMH QMHPs, FMH Prescribers, and FMHDP in providing the level, assessment, and referrals in effort toward the continuation of mental health care/intervention for inmates released while receiving FMH services.

1. The following categories necessitate an Immediate Referral to FMHDP:

    - Inmate is Housed on Mental Health Unit (Delta)
    - Inmate is prescribed and receiving medication through FMH prescriber
    - Inmate is being seen in FMH Medication Clinics and is identified as will benefit from Discharge Planning Assistance

    a. The QMHP for each inmate will complete an Electronic Discharge Planning Referral to FMHDP

b. FMHDP will make contact with inmate in order to complete assessment of Discharge Planning need(s) – referrals, applications, handouts, need for assistance to maintain medication upon release (out scripts), etc.

2. The following is activity related to FMHDP direct involvement:

   a. In all cases the inmate meets Category for Immediate Referral (see above) and has been referred to FMHDP.

   b. In all additional cases where an inmate is identified as Seriously Mentally Ill and/or Developmentally Impaired and receiving mental health services housed in:

      i. Crisis Stabilization Beds ECMC 9-2
      ii. Crisis Beds (Constant Observation)
      iii. Residential Treatment Unit

   c. In all additional cases where a QMHP has assessed client needs and potential immediate intervention possibilities, and following conference with a FMH Supervisor, receives approval to refer to the FMHDP due to the presence of Serious Mental Illness and/or Developmental Impairment with complex linkage needs (defined as needing at least a referral to care coordination and/or housing within the SPOA), and receiving mental health services in general population at the Erie County Holding Center or the Erie County Correctional Facility.

   d. The FMHDP will complete the following for all referred cases:

      i. Review referral information
      ii. Seek any additional information as required to complete discharge planning activity from QMHP
      iii. Meet 1:1 with the inmate
      iv. Formulate necessary discharge planning activity

   e. The FMHDP will provide any information, applications, and complete appropriate referrals and linkages based upon the discharge planning needs.

   f. The FMHDP will document all case management activities and discharge planning within the inmate's record, and advise the QMHP as needed to meet ongoing mental health treatment planning activity.

   g. The FMHDP will maintain monthly record and track all discharge planning services for quality management purposes, specifically to include:

      i. Record of discharge planning referrals.
      ii. Outcome of referral
      iii. Current active discharge planning caseload
      iv. Current anticipated outdates of discharge planning caseload
      v. Record if Out Scripts are needed
      vi. Record if Out Scripts were prepared

   h. The FMHDP will address the following areas as needed:

      i. Linkages (may include verification with referral to care coordination and housing)
      ii. Obtain out scripts (medication prescription) from FMH prescriber and provide for inmate property, or provide instructions how inmate is to obtain at FMH office (120 West Eagle Street).
      iii. Check Medicaid status (if applicable) and seek to issue a Medication Grant Program (MGP) Card as needed.

iv. In circumstances where inmate would benefit from application to Medicaid, FMHDP will provide and assist in completion of the application, as well as submit to the Erie County Department of Social Services.

3. The following is discharge planning activity to be performed by QMHP:

   a. The QMHP is to identify and use best clinical judgment as to when/if an inmate's (not already referred to FMHDP) Discharge Planning needs can be addressed through providing direct information, and will seek to provide the information, material, and assistance during 1:1 contact with the inmate through electronic resources (V: drive – electronic resource manual), documents on file, and informational packets developed by FMHDP.

      Example(s):

      i. Leaving custody within 5 business days.
      ii. Imminent release related to bail, release, court outcomes, etc.
      iii. Inmate reports recent linkage to services that will remain in place upon release.
      iv. Inmate expresses interest in services, but demonstrates the capability to plan and self-advocate when provided appropriate information/documents.
      v. Inmate has been encouraged by QMHP to consider discharge planning and treatment.

   b. The QMHP is to identify potential community based needs, and possible discharge planning activities based on the use of professional judgment regarding the possibility of release.

   c. The QMHP is to identify discharge planning needs and willingness to accept services with the inmate, and clarify goals to prevent duplication of services should the inmate be involved in other system(s) such as parole, mental health court, etc. that provide planning for release.

   d. The QMHP is to attempt to clarify court case status, as needed to provide Discharge Planning through the following:

      i. defense attorney
      ii. assistant district attorney
      iii. court clerk

   e. QMHP will communicate efforts made at direct discharge planning activity through the Electronic Discharge Planning Referral and in documentation within the Inmate's record.

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Discharge Plan for Scripts	
	Policy #: 22	Dates: org. 01/02/2016; last rev. 02/24/2016
	Prepared by: FMH SOP Committee and Discharge Planning Team	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

Inmates in custody at ECHC/ECCF who are currently on psychiatric medication(s) through Forensic Mental Health Services will be assessed for the need, and if necessary, offered outscripts for up to a 30 day supply of prescribed medication(s).

PROCEDURE:

A collaborative effort between FMH Discharge Planning (FMHDP) and QMHP staff will occur to determine appropriate need for outscripts and plan for distribution to client. This collaborative effort will include communication with client regarding possible release date.

The FMH provider will be advised of any refusals of outscript services. If an inmate in custody at ECHC/ECCF is receiving medications from FMH providers, but is refusing FMH Discharge Planning, FMHDP will remain responsible to provide diligent collaborative efforts in obtaining and providing outscripts for the inmate.

FMH Discharge Planning will maintain a spreadsheet in the V: drive, of clients that are in need of outscripts upon release, and indicating the following:

- Client Name
- ICN
- Potential release date
- Primary counselor
- FMH Discharge Planner
- Where the script will be available for pick-up (Court, Property, 120 W. Eagle, etc.)

Outscripts are classified as either scheduled or unscheduled.

1. **Scheduled Scripts**
   Scheduled scripts are defined as prescriptions that will be written by FMH providers when a specific release date is known. FMHDP and QMHP will discuss to collaborate.

   a. FMHDP will manage and obtain outscripts through communication with coordinating FMH prescriber. If coordinating prescriber is not available, FMHDP will diligently attempt to have an available prescriber write outscripts.
   b. FMHDP will maintain the spread sheet on V: drive to include the name of prescriber, the date outscripts were written, as well as how client will be receiving outscripts (i.e. court, property, 120 W. Eagle).
   c. FMHDP will enter case management note into client's Electronic Medical Record (EMR) to include the name of FMH prescriber, the date outscripts were written, as well as how client will be receiving outscripts (i.e. court, property, 120 W. Eagle).
   d. FMHDP will make a copy of the written outscripts and scan copy into client's EMR.
   e. Once above procedures are completed, FMHDP will place outscripts for client at determined location (i.e. court, property, 120 W. Eagle).
   f. FMHDP will coordinate with front office staff regarding QA/QI of outscript process

2. **Unscheduled Scripts**

Unscheduled scripts are defined as prescriptions that will be written by FMH a provider when an inmate is unexpectedly released from custody and requires outscripts. FMHDP will advise clients will have up to 14 days from date of release to request outscripts from FMH providers.

a. FMHDP will manage and obtain outscripts through communication with any available prescriber.
b. FMHDP will update spreadsheet on V: drive to include the name of prescriber, the date outscripts were written, as well as how client received outscripts (i.e. pick up at 120 W. Eagle, or sent by mail).
c. FMHDP will enter case management note into client's Electronic Medical Record (EMR) to include the name of prescriber, the date outscripts were written, as well as how client received outscripts (i.e. pick up at 120 W. Eagle, or sent by mail).
d. FMHDP will make a copy of the written outscripts and scan copy into client's EMR.
e. Once above procedures are completed, FMHDP will process outscripts for client as determined (i.e. pick up at 120 W. Eagle, or sent by mail).
f. FMHDP will coordinate with front office staff regarding QA/QI of outscript process

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Continuation of Care	
	Policy #: 23	Date: orig. 06/06/2016; rev. 02/24/2021
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

Erie County Forensic Mental Health is concerned with providing necessary ongoing care and treatment for inmates who receive mental health care while in custody. It is essential for ECFMH to communicate, coordinate, and share information to permit a successful service transfer with providers external to the Erie County Holding Center and Erie County Correctional Facility. ECFMH seeks to maintain case-management, discharge planning, and multidisciplinary efforts for inmates in custody, and has a goal to maximize appropriate planning, secure necessary releases, and provide pertinent information that permits and enhances continuity of care upon release. ECFMH will make available and provide relevant information to authorized health providers. In the event that psychiatric medication needs arise, after business hours or on weekends, while the inmate is in custody, FMH staff will first contact the on-call psychiatrist, or if unavailable, contact the chief psychiatrist.

ECFMH will follow established Standard Operating Procedures, and specifically

- County of Erie Policies – HIPAA Privacy Policy – Effective July 31, 2013
- FMH SOP Confidentiality

In order to provide case management, discharge planning, and multidisciplinary efforts, as well as communicate, secure necessary releases, coordinate and ensure:

- Attention to individual case management needs
- Shared information that is in the individual's best interest
- Shared information that promotes mental health and empowerment for the individual upon release
- Shared information that promotes ongoing treatment and continuation of care for the individual upon release

PROCEDURE:

1. All FMH staff (QMHP, Discharge Planners, Prescribers, etc.) will collaborate with each other and with the inmate to define needs, develop plans, and identify areas that require shared information to promote continuity of care.

2. All FMH staff will collaborate with the inmate to obtain necessary releases/consents to permit the sharing of information to promote continuity of care.

3. All FMH staff will cooperate in order to share information for emergent situations, and in non-emergent situations, following obtaining necessary releases/consents, with community based mental health and substance use treatment providers to meet individual mental health goals.

4. FMH staff will share information from other professionals and/or agencies obtained during incarceration, for emergent situations, and in non-emergent situations, following obtaining necessary releases/consents and when/if the material is pertinent to the inmate receiving ongoing treatment and continuity of care.

5. If psychiatric medication needs arise, FMH staff will consult/collaborate with UPP on-call Psychiatrist and, if determined at the time of consult to contact Chief Psychiatrist, FMH staff is to contact Chief Psychiatrist for continuity of care.

Erie County Forensic Mental Health Services	Policy: Confidentiality	
	Policy #: 24	Dates: org. 12/22/2011; last rev. 06/01/2016
Standard Operating Procedures	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

It is the professional and ethical responsibility of all staff to maintain the confidentiality of all information obtained regarding an inmate. It is recognized that sharing of information between mental health staff and custody/security staff is crucial for effectively treating and managing inmates with mental illness. It is also recognized that it is the responsibility of both mental health staff and custody/security staff to keep inmate information confidential. Confidentiality of inmate information will be protected. That information relates to paper records, as well as staff knowledge of an inmate and their history. Protection of confidentiality also relates to storage of records, disposal of paperwork, need for consent to release and share information, privacy during inmate contacts and all communications, including facsimile transmissions, telephone calls, written communications and mental health housing lists.

REFERENCE:

County of Erie Policies – HIPAA Privacy Policy – Effective July 31, 2013

PROCEDURES:

1. Documentation

Documentation in the inmate record should be directly related to the treatment process, and should be nonjudgmental and factual in entry.

2. Access to Information

Access to information in the record is permitted to direct service staff of the FMHS, including consultants and student/resident support(s), for the purpose of treatment planning, supervision, and record keeping. Access is permitted to representatives from the Office of Mental Health and the Erie County Department of Mental Health for the purposes of clinical and administrative audit and review. FMHS Clerical staff are permitted access to the inmate records for record keeping and statistical work, as needed.

3. Privacy in Rooms

Inmates followed by Forensic Mental Health Services will be seen by forensic mental health staff (FMHS) in private rooms, without the presence of security unless otherwise indicated.

Exceptions include:

a. Risk of harm to others

b. Where a cell side contact may be necessary due to inmate clinical presentation

c. Where security presence in room is necessary due to inmate presentation as highly agitated, aggressive, and/or impulsive

d. When security reports inability to escort the inmate

e. Inmate refusal

For safety precautions, all rooms will be furnished such that FMHS sits closest to the door, and inmate is seated at rear of the room.

4. Storage of Confidential Materials/Record Keeping

All inmate information obtained by FMHS regarding inmates receiving care is considered confidential, unless otherwise noted. Documentation will be scanned or entered into the Electronic Record, stored in locked offices/cabinets within the FMH office, or record storage areas of the facilities.

All records of those individuals who are no longer in custody are stored in the Electronic Record and/or part of Correctional Health Archives, and held for 15 years after which time they are destroyed.

5. Shredding of Confidential Materials

Information that is to be discarded will be put in locked confidential bins that are then removed regularly and shredded. The Mental Health Offices within the facilities have shredders to destroy any paperwork with inmate identifiers on them that are not being filed (i.e. daily MH housing lists, duplicate copies of forms, written paperwork/notes).

6. Electronic Information

All electronic information (i.e. electronic record) as it relates to inmates, will be kept strictly confidential with access limited to only FMHS staff, with the possible exception of state or federal regulatory personnel.

Email of information regarding inmates by FMHS will use minimal identifying information, e.g. first name and last name initial, ICN number.

7. Obtaining and Sharing of Inmate Information

All information that is either obtained or shared with outside entities is done with the written and signed consent of the inmate.

Under no circumstances will FMH staff release information from the inmate record, which was obtained by inmate consent from another professional or agency, unless the information provided is directly related to ongoing treatment or a continuation of care. Any material not related to ongoing treatment or continuation of care (i.e. for an attorney) must always be released by the originating source.

FMHS records are subject to release by court order (subpoena). When a subpoena is presented, the Director of ECFMH or designee must be notified immediately to arrange for an appropriate disposition. **Under no circumstances is FMH staff to release subpoenaed material directly.**

8. Violations and Issues with Confidentiality

Any violation of policy, or any circumstances placing confidentiality at risk, should be reported to a FMH Supervisor or ECFMH Director immediately. Failure by any staff member to report such knowledge may result in disciplinary action.

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Community Meeting	
	Policy #: 25	Dates: org. 02/23/2012; last rev. 10/21/2015
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

A community meeting will be performed in all areas of mental health housing. Mental health staff will facilitate meetings and housing security staff (sergeant or deputy) will be present and participate as appropriate. The purpose is to have a regular check-in with individuals on housing units to determine unit functioning as it relates to questions, concerns, and/or policy of the unit/facility.

PROCEDURE:

1. Method:

Mental health staff will conduct a weekly meeting, and when possible will establish a regular day to perform the meeting. The community meeting will be conducted with assistance from housing deputy who will request inmates to come into the common area of the housing unit.

2. Time Frame:

The community meeting is meant to be brief, lasting no longer than 30-45 minutes.

3. Topic(s):

Topics are meant to be general issues that are of a concern to the inmates but can vary. The purpose of the topics is to assess the community/environment within the housing unit that they live in. Questions regarding rules of the facility, policy of mental health and security may be raised and suggestions for available activities within the facility may be discussed.

4. Rules of the Community Meeting:

Forum is for general group information. If individual case issues arise from the inmate, the inmate will be encouraged and educated regarding how to request to self-refer to their individual counselor or other relevant staff in order to discuss the matter.

5. Documentation for Community Meeting:

a. Documentation from community meetings will be entered into the Community Meeting Electronic Notes/Log, and stored in the shared drive of FMH. Each housing unit will have a designated file folder within the shared drive.

b. All finalized Community Meeting Electronic Notes/Log will have the date and time noted. Mental health staff will document topics in summary format. Each entry will designate mental health staff and security that facilitated meetings.

c. Mental health staff will follow the format of the Community Meeting Electronic Notes/Log on a weekly basis within 48 hours of the community meeting, and the completed entry will be forwarded via email (or printed version as needed) to appropriate security and FMH staff.

d. If a concern is raised that involves security or medical entities, the housing deputy and mental health staff will make best effort to: (1) direct concerns to the appropriate entity, and (2) report back on action taken at next Community Meeting.

e. If there is an emergent mental health concern, or urgent care is identified as necessary by FMH staff, appropriate action is to be initiated. If there are general mental health requests made by the person, that person will be guided to fill out a referral slip to be seen individually.

f. All Material will be stored in the shared (V:) Drive/120 West Eagle/Community Meeting folder

HOUSING UNIT:	Choose an item.
DATE:	Click here to enter a date.
TIME:	Click here to enter text.
NUMBER OF PARTICIPATING INMATES:	Click here to enter text.
STAFF PRESENT (FMH/ECHC):	**ECFMH:** Click here to enter text. **Security:** Click here to enter text.

MEETING NOTES:
Click here to enter text.

OLD BUSINESS:
Click here to enter text.

NEW BUSINESS:
Click here to enter text.

PLAN(S) OF ACTION:
Click here to enter text.

FMH STAFF ELECTRONIC SIGNATURE: Choose an item.

FOLLOW UP INFORMATION:

Click here to enter text.

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Interdisciplinary Team Meeting	
	Policy #:26	Date: orig. 01/11/2016; rev. 11/2/2017, 10/30/2020
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

The Interdisciplinary Team (IDT) meeting is a daily forum conducted during morning and afternoon shifts that permit Mental Health, Medical, and Security to identify issues as they relate to referrals, emergent needs/planning, Constant Observation, mental health housing, and appropriate responses to shared concerns. This meeting also permits each department to initiate discussion surrounding specific inmate/case needs, problem solving activity, and coordination of efforts, and management of difficult case situations.

PROCEDURE:

Interdisciplinary Team (IDT) Meeting

1. FMH Supervisor(s) or assigned QMHP are to attend all scheduled IDT meetings

2. FMH Supervisor(s) or assigned QMHP should be prepared to discuss inmates pending hospitalizations, inmates returning from hospitalization, 730 cases, problem cases, and areas where shared efforts between Mental Health, Medical, and Security may be necessary

3. FMH Supervisor(s) or assigned QMHP should be prepared to discuss the following:

    a. Specific issues related to referrals are identified and reviewed in the morning by the Interdisciplinary Team that consists of a QMHP, Health Professional, and Sergeant. Assigned QMHP takes minutes and finalizes the Interdisciplinary Team report.

    b. Mental Health will attend Interdisciplinary Team meetings in the afternoon on a daily basis at shift change (approximately 2:30pm) to provide continuity of supervisory, medical, and mental health care from shift to shift within the facilities. Security takes minutes and generates reports to Interdisciplinary Team report.

    c. Both meeting agendas are as follows:
        i. All persons on suicide watch are discussed and restrictions are reviewed.
        ii. Persons cleared from suicide watch are discussed as well as housing recommendations made.
        iii. Problem cases and management recommendations are made and discussed.
        iv. Any issues relevant to the continuity of care for a particular inmate or the stability of a delta unit are addressed and recommendations are discussed.
        v. Inmate housing and cell movement are addressed and every effort made to maintain stability on all delta units.
        vi. Interdisciplinary plan to provide and document identified cases for medication re-approach or encouragement regarding individuals identified as exhibiting a mental health status (i.e. decompensation, poor insight related to mental health medication).
        vii. Medical concerns are reviewed with the representative nurse.

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Morbidity and Mortality Review Committee	
	Policy #: 27	Dates: org. 07/14/2010; last rev. 11/30/2015
	Prepared by: FMH SOP Committee	
	Approved by: Dr. Jeffrey Metzner and Michelle Parker, Erie County Attorney	

POLICY:

The Morbidity/Mortality committee is created pursuant to the court Order Approving Stipulated Settlement Agreement Concerning Suicide Prevention and Related Mental Health Issues, dated June 18, 2010. The purpose of the Morbidity and Mortality Review Committee (M&M) is to provide an open, collaborative, and transparent process for an interdisciplinary review by Security, Medical, and Mental Health to identify areas for improvement and to promote professionalism. The Committee evaluates incidents to engage in discussion of department and system management, training opportunities/needs, targeted review of overlapping system activities, and identification of areas for improvement in safety and care.

ECFMH will fulfill all obligations necessary for the Morbidity and Mortality Review Committee to produce written interdisciplinary reviews of all suicides and serious suicide attempts (e.g., those incidents requiring hospitalization for medical treatment). The Morbidity and Mortality Review Committee is interdisciplinary and includes the ECSO Superintendent (or designees), Chief Medical Officer, Director of Intensive Adult Mental Health Services, Director of Correctional Health and may include other qualified medical professionals and mental health professionals.

The activities of the Morbidity and Mortality Review Committee include:

1. To convene within 30 days of each suicide or serious suicide attempt (e.g., those incidents requiring hospitalization for medical treatment).

2. Representatives from each discipline provide relevant reports, records, and a summary of their department involvement surrounding the scheduled review.

3. Review incidents to examine:
    i. Circumstances surrounding the incident;
    ii. Facility procedures relevant to the incident;
    iii. All relevant training received by involved staff;
    iv. Pertinent medical and mental health services/reports involving the victim;
    v. Possible precipitating factors leading to the suicide; and recommendations, if any, for changes to policy, training, physical plant, medical or mental health services, and operational procedures; and
    vi. When appropriate, the review team shall develop a written plan (and timetable) to address areas that require corrective action.

4. Reports will be completed within 14 days and submitted to the Technical Compliance Consultants and to United States Department of Justice. (*See* Stipulated Order of Dismissal, Part V, ¶H.)

PROCEDURE:

The Director of Intensive Adult Mental Health Services and/or designee will prepare a summary to present for the Morbidity and Mortality Review Committee by completing the following:

1. Obtain Identifying information of inmate that is the source of review (i.e. ICN, Name, DOB)

2. Obtain general information regarding nature of the incident and current status of the inmate that is the source of review

3. Review the medical record in order to assess following information for review (as needed):

    a. Medical/Nurse intake – note date and time
        i. Client reported mental health history and medication information
        ii. Client reported suicidal ideation
        iii. Client reported past suicide attempts
        iv. Client reported substance/alcohol use and/or treatment
        v. Determine if referral to ECFMH – or if information supports no referral
        vi. Level of referral to ECFMH – and if it is appropriate to information
        vii. Housing determination following intake

4. Review the mental health record in order to assess following information for review (as needed):

    a. FMH referral and processing (refer to guidelines)

    b. Mental Health Assessment

    c. Comprehensive Suicide Risk Assessment

    d. Housing and treatment level by FMH

    e. Client Self-Referrals

    f. Progress notes

    g. Psychiatric Medical Clinic/Consultation(s)

    h. Medication and reported compliance with FMH treatment

    i. History of mental health and treatment in custody by FMH

5. Identified areas of system collaboration between Security and Medical Department specific to ECFMH surrounding the case that include(s):

    a. Identified areas where collaboration was successful and purposeful to providing services/treatment

    b. Identified areas where there was any deficit in collaboration that may have impeded providing services/treatment

        i. Provide proposed plan of action to address/improve area of deficit

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Use of Restraints	
	Policy #: 28	Dates: org. 12/23/2011, 06/27/2016, last rev. 09/25/2019
	Prepared by: Correctional Oversight Committee	
	Approved by: FMH SOP Committee, and Dr. Jeffrey Metzner	

Refer to Erie County Sheriff's Office Policy # 04-09-02

AUTHORIZATION:

The use of an approved Restraint Chair is to provide safe and secure temporary restraint of an inmate exhibiting violent uncontrollable behavior, to prevent self injury or suicide, or to prevent damage to property, when other control methods have proven or are reasonably believed not to be effective. This authorization is restricted to the terms and conditions set forth in this policy which complies with the standard set forth by the New York State Commission of Corrections and the American Psychiatric Association.

POLICY:

1. The Restraint Chair may only be recommended, ordered, supervised or utilized by properly trained staff members.

2. The Restraint Chair may only be utilized as designed and equipped by the manufacturer. No substitute equipment is permitted.

3. The Restraint Chair may only be utilized for the purposes set forth in this policy and shall never be utilized for the convenience of staff or as punishment. The restraints may not inflict unnecessary pain or disability. Inmates shall not be restrained in unnatural positions or in such a fashion as would result in the impairment of circulation, hyperextension or torsion of the extremities.

4. Hoods, bags or other devices covering the head and face, which may interfere with normal breathing are prohibited.

5. Inmates shall not be held in the restraint chair longer than necessary.

6. No inmate shall be continuously held longer than twelve (12) hours under any circumstances.

7. Chemical Agents may NOT be utilized against an inmate held in the restraint chair. Any inmate against whom chemical agents have been deployed must be thoroughly decontaminated and examined by facility medical staff prior to placement in the restraint chair.

8. Restrained inmates shall be provided regularly scheduled meals and shall be permitted to utilize the toilet as necessary. Restraints shall be removed to the extent necessary to provide for such purposes.

DEFINITIONS:

Restraint Chair: A padded metal chair with ankle, wrist and shoulder restraint straps, manufactured and equipped for the express purpose of safely and securely restraining inmates who are violent, a danger to themselves or unruly and that has been approved for use by the Superintendent.

Currently the Restraint Chair approved for use by the Erie County Sheriff's Office is:

Emergency Restraint Chair, U.S. Patent # 5,758,892, manufactured by: **ERC** Inc. P.O. Box 421 Denison, IA 51442 Telephone: 712-263-5291 Fax: 712-263-4633.

Properly Trained: All QMHP's and QHP"s will receive training regarding the Restraint Chair Policy.

QHP: Registered Nurse fully credentialed in Use of Restraint Chair.

Credentialing: the process of reviewing the documentation that the QMHP and QHP are fully trained and confirming so.

QMHP: LMSW or LMHC fully credentialed in the use of the Restraint Chair.

Snug: Tight enough to secure the inmate in place and prevent escape, while not restricting circulation.

Spit Mask: a mask hood which when placed over inmates head blocks his ability to spit but in no way blocks inmates ability to see and breath.

Forensic Mental Health Service Contacts:
During Staffing Hours: ECHC MH office 8045, or use pager/designee system during peak hours
ECCF MH office 3012 or ECCF Forensic Security 3016
After Staffing Hours: Psychiatric On-Call Service; Call 898-4857

PROCEDURE:

A. PROCEDURES FOR USE (GENERAL)

1. Use of the Restraint Chair may only be ordered by the Watch Commander in conjunction with and/or following interdisciplinary discussion between Security, Correctional Health, and ECFMH staff.

    a. **Recommendation for Use**: The following properly trained staff members may recommend to the Watch Commander that an inmate be placed in the restraint chair when the staff member reasonably believes that such use is necessary to provide safe and secure temporary restraint of an inmate exhibiting violent uncontrollable behavior, to prevent self injury or suicide, or to prevent damage to property, when other control methods have proven or are reasonably believed not to be effective.

        1. Supervisory security staff
        2. Medical staff (RN)
        3. Forensic Mental Health (QMHP)

2. Security staff to notify medical and forensic mental health immediately whenever a person is placed in restraints.

3. During MH staffing hours: notification to a psychiatrist or NP (Forensic Mental Health Service) to obtain a verbal order for use of restraint within 1 hour, unless the person is clearly known to not have a mental disorder. Under such circumstances, restraints will be used via Erie County Sheriff's Office Policy #04-09-02. If it is not clear whether the person has a mental disorder, the following should occur:

    a. The psychiatrist/psychiatric nurse practitioner must see the person within 4 hours and determine if the person has a mental disorder that requires the use of restraints

        If criteria for are met for use of restraints due to mental illness, a treatment plan must be developed that includes the following:

        i. The treatment plan must include justification/reason person placed in restraint chair.

ii. Actions needed by inmate to be released from restraints.
iii. What needs to be done while restraints in use.
iv. Plan may include medication order if inmate willing and clinically appropriate.
v. Psychiatric order in effect for 12 hours maximum if needed.

b. If person does not have a mental health disorder, restraints used for mental health purposes will be discontinued. If restraints are continued to be used, Erie County Sheriff's Office Policy #04-09-02 will be followed.

4. After hours: If restraints needed for person due to a known mental disorder or a suspected mental disorder, QHP/RN to notify on-call psychiatrist immediately (within 1 hour) to consult and provide history.

a. Plan is developed to either restrain or send to Erie County Medical Center Psychiatric Emergency Room.
b. If restraints used, psychiatrist to develop a treatment plan specific to use of the restraint chair.
   i. Psychiatrist to come facility to see the person within 4 hours, ***or***
   ii. Psychiatrist to develop plan with QHP trained in use of restraint chair. QHP to review patient record and jail data system for history and provide to psychiatrist.
   iii. QHP to document consult in patient record.
   Documentation must include:
   1. Outcome of inmate interview.
   2. Justification/reason person placed in restraint chair.
   3. Actions needed by inmate to be released from restraints.
   4. What needs to be done while restraints in use.
   5. Plan may include medication order if inmate willing and clinically appropriate.
   6. Psychiatric order in effect for 12 hours maximum if needed.

c. If person does not have a mental health disorder, restraints used for mental health purposes will be discontinued. If restraints are continued to be used, Erie County Sheriff's Office Policy #04-09-02 will be followed.

5. Under normal circumstances the use of the Restraint Chair shall be considered a **planned use of force** and shall be accomplished by a properly briefed and equipped Emergency Response Team. This Emergency Response Team shall be commanded by a Lieutenant or above and all briefings, extractions and restraint activities shall be videotaped by a Sergeant, pursuant to **JMD 06-09-00 Planned use of Force**.

a. In every case, a Sergeant or higher authority shall be physically present and supervise the placement of the inmate into the restraint chair, all security checks of the restraints, all medical and mental health evaluations and any time the inmate is released to for meals or to use the bathroom. The Supervisor shall sign the log book each visit.

b. In emergency situations in which a delay in the use of the restraint chair would likely result in serious injury or death, in which prior consultation with the facility medical and/or mental health staff is not practical, such consultation shall occur within one hour of placement in restraint chair.

c. In such case, the specific reasons that consultation(s) was delayed and the time the consultation(s) was made shall be documented in the log book and on the Erie County Sheriff's Office Use of Force/Firearms Report, in addition to the information required in section 1.a. above.

d. Inmates placed in the restraint chair shall be held in an area segregated from other inmates and shall be kept under "Constant Observation" subject to all provisions of **JMD 13.11.90 Constant Observation.**

6. The Restraint Chairs have been labeled **A** & **B**. A corresponding log book has been established specifically for inmates confined to each restraint chair. These Log books shall be utilized to document all activities, including all medical and mental health visits.

a. When in use, this log book shall be maintained in accordance with Policy **JMD 13.11.90 Constant Observation.**

b. When not in use, this log book shall be secured in the Watch Commanders' Office.

7. Immediately after an inmate has been secured into the Restraint Chair, he / she shall be Examined by a Registered nurse of the medical staff to insure that the inmate's ability to breath and circulation to the extremities have not been impaired, that the inmate has not been restrained in unnatural positions or in such a fashion as to cause unnecessary pain, hyperextension or torsion of the joints. Such examination shall be conducted at least every 30 minutes and documented in the log book along with the name(s) and title(s) of the medical staff conducting the examination.

8. Restraints shall be examined to insure that they remain secure and properly applied, every 15 minutes. Such examination shall be documented in the log book, along with the name & title of the security staff member conducting the examination.

9. Facility medical staff shall insure that the inmate's breathing is unrestricted and that circulation to the hands and feet is maintained and perform range of motion at least every 2 hours of each extremity unless clinically contraindicated. Such examination shall be documented in the log book along with the name(s) and title(s) of the medical staff conducting the examination.

a. In addition to the information documented in the log book, thorough and complete documentation of all examinations, including specific notations related to the inmate's airway, breathing & circulation, any vital signs taken, food intake, use of toilet, and any nursing observations made, shall be made in the inmate's medical chart *on Restraint Chair Checklist Form*

b. Should the facility medical staff observe any sign or symptom suggesting that continued restraint in the chair would likely result in serious physical injury or the exacerbation of any serious medical condition, such observation shall immediately be reported to the Watch Commander who shall cause the inmate to be released from the restraint chair.

QHP to contact psychiatrist (if placed due to a mental health condition) and MD for notification/consultation.

10. Forensic Mental Health/QMHP shall evaluate the inmate's mental health status hourly for the first two (2) hours and every two (2) hours thereafter.

a. If after mental health staffing hours, contact Forensic Mental Health Psychiatric On-Call Service
    1. Psychiatrist will provide further instructions pertaining to use of the restraint chair.

11. Should the Forensic Mental Health staff observe signs or symptoms suggesting that continued restraint in the chair would likely cause deterioration in the mental health condition of the inmate, such observation shall immediately be reported to the Watch Commander who shall cause the inmate to be released from the restraint chair.

a. All mental health evaluations shall be documented in the log book along with the name(s) and title(s) of the mental health staff conducting the examination.

b. All specific mental health observations made by forensic mental health staff and all recommendations made shall be thoroughly documented within the inmate's EMR in the form of a Mental Health Progress Note.

12. Officers assigned to provide constant observation shall remain constantly alert to any signs or symptoms suggesting that the inmate's ability to breathe or circulation to the extremities may be impaired and immediately report any unusual observations to the facility medical staff. Such symptoms may include:

a. Choking
b. Excessive coughing
c. Inability to speak
d. Changes in facial skin color or changes in the color of the lips.
e. Inmate reports that his/her hands or feet feel cold, numb or "tingly".
f. Changes in the color of the inmate's hands and/or feet.

13. All such observations shall be thoroughly documented in the log book, along with the name and official title of the member of the medical staff notified.

B. USE OF SPIT MASK

A spit mask maybe used when an inmate is attempted to spit on staff placing the inmate in a restraint chair. Only a mask specifically designed as a spit mask is authorized. NO improvised masks are permitted.

The spit mask should be placed over the inmates head and tied in the back. It should not be tied tightly around the inmates face or neck. At all times the inmates ability to see and ability to breath comfortably must not be obstructed.

C. REPORTING REQUIREMENTS:

1. The use of the Restraint Chair shall be considered as an Unusual Incident involving the use of force and shall be reported to the Superintendent via an Unusual Incident Report (ECSO J-28) and to the New York State Commission of Corrections pursuant to NYSCOC Reportable Incident Guidelines.

a. These reports shall contain the specific reasons requiring the use of the Restraint Chair, the names, titles and signatures of the persons authorizing such use, the names, titles and signatures of the Emergency Response Team members securing the inmate into the chair, the specific actions of each team member and the name(s) title(s) and signatures of the Lieutenant, Sergeant(s) and medical staff supervising such use.

2. The use of the Restraint Chair shall also be thoroughly documented in writing on an Erie County Sheriff's Office Use of Force/Firearms Report.

D. STORAGE & MAINTENANCE

1. When not in use, the restraint chair shall be stored in a safe and secure location to be determined by the Superintendent.

2. After each use, the restraint chair shall be inspected to determine if any component has suffered any damage or wear requiring repair or replacement.

a. The restraint chair shall only be returned to storage if found to be intact and serviceable.

b. Any component found in need of repair or replacement shall immediately be reported in writing to the Watch Commander who shall forward a request for needed repairs or replacement to the Superintendent's Office.

c. Any restraint chair found to be in need of repair shall be removed from service until repaired or replaced.

3. All surfaces, straps and components of the restraint chair shall be thoroughly cleaned and disinfected after each use and prior to the chair being returned to storage.

4. All inspections and cleaning of the restraint chair(s) shall be documented in the corresponding log book.

E. INSPECTION PRIOR TO USE:

1. Prior to each use, the restraint chair shall be inspected to insure that all straps, buckles and other components are intact, free of wear, damage or defect, move freely and operate properly.

   a. Should any component be found to be missing, damaged, worn or fail to operate properly, the restraint chair may not be used and shall be removed from service until repaired or replaced.

   b. The inspection, along with the name and title of the staff member conducting the inspection shall be documented in the corresponding log book.

F. APPLICATION PROCEDURES:

1. The restraint chair shall only be used in the upright position and may never be positioned on its side or back.

2. When possible, the inmate should be handcuffed (behind the back) and placed in leg shackles prior to being placed into the restraint chair.

3. When practical, all loose jewelry, glasses and belt should be removed from the inmate prior to his / her placement in the restraint chair. In circumstances in which prior removal is not practical, all loose jewelry, glasses and belt must be removed immediately after the inmate has been placed in the restraint chair.

4. Have the inmate sit in the seat, secure the lap belt into the lap belt clevis (buckle) and pull the handle until snug. (Note - this strap may need to be adjusted after the inmate's arms are secured.)

5. Remove the inmate's shoes and socks.

6. If the inmate is wearing leg shackles, place the leg iron chain behind the chain retainer located behind the foot pad.

7. Attach the handcuff tether to the handcuff chain.

8. Release the right wrist from the handcuffs and secure it to the arm of the restraint chair with the right wrist strap. Pull the strap until it is snug.

9. Release the left wrist from the handcuffs and secure it to the arm of the restraint chair with the left wrist strap. Pull the strap until it is snug.

10. Re - adjust the lap belt if necessary.

11. Fasten the shoulder straps by passing the free ends over the shoulders, under the armpits and securing them to the shoulder strap clevises located on the back of the restraint chair. Tighten by pulling down on the shoulder strap handle until snug. (NOTE: *Never wrap the shoulder straps around the chest, head or neck.)*

12. Secure the ankle straps by passing the free end around the front of the ankles and securing the straps to the ankle strap clevises. Pull the ankle strap handles until snug.

13. To loosen any of the restraint straps, insert a standard handcuff key into the buckle and push the key in, while pulling slack back into the restraint strap.

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Disciplinary Committee and Disciplinary Unit Rounds	
	Policy #: 29	Dates: org. 12/22/2011, 07/01/2016, last rev. 08/29/2018
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

The Forensic Mental Health Service is involved with the Disciplinary Committee if individuals who are within mental health housing and/or have an active mental health alert while in the Erie County Holding Center and Erie County Correctional Facility come to the attention of the Committee. The FMH Service will provide input in the event that a person within mental health housing and/or active mental health alert is involved in disciplinary action. The FMH Service will also be available to the Hearing Officer if mental health issues are suspected to be related to an action brought to the attention of the hearing officer. The FMH Service will also perform weekly rounds within the Disciplinary units of Erie County Holding Center and Erie County Correctional Facility. *See Erie County Sheriff's Office, JMD, Policy 04-04-00, Disciplinary Hearings.*

PROCEDURE:

Disciplinary Hearing Committee:

1. Hearing Officer will review Jail Management System to determine if person is in a mental health housing unit and/or if person is on a FMH case load. If a person is within mental health housing, including those within Delta and Constant Observation, or if person is suspected of having a mental illness, and becomes the subject of disciplinary action, the Hearing Officer will:

    a. Notify FMH staff by way of the FMH Disciplinary Recommendation Report *(see Document)* and request input prior to hearing. Disciplinary write-up is attached for mental health to review. Mental Health response within 2 days.

2. Forensic Mental Health will review: (reviewer will be FMH Supervisor level [QMHP] other than the assigned clinician)

    a. Status of person and any mental health condition or symptoms that may be related to the action under review.

    b. Based upon information, FMH staff may recommend consideration that consequence be mitigated.

        i. FMH staff will be provided access to:
            1.Incident Report (only if situation has risen to this level)
            2.Opportunity to interview the patient/inmate

    a. FMH staff will make recommendations:
        i. Treatment alternatives
        ii. Housing changes
        iii. Action by inmate related to mental illness, behavior, or both

3. Forensic Mental health will enter a scan copy of the completed FMH Disciplinary Recommendation Report in the Confidential Section of the Electronic Medical Record (EMR).

4. Hearing Officer will maintain a log of matters that involve individuals within mental health housing or with a mental health condition that were involved with the disciplinary committee.

a. Information logged will include:
    i. Inmate name and ICN
    ii. Reason for discipline action
    iii. Outcome (FMH staff provided copy of Disciplinary Hearing Summary)

Rounds:

5. FMH will perform <u>weekly</u> rounds on the disciplinary units at both Erie County Holding Center and Erie County Correctional Facility.

    a. FMH staff/QMHP will sign in unit log book on unit upon arrival and departure.

    b. Rounds will consist of:

        i. QMHP will have face-to-face contact and attempt to briefly interview each resident of unit.

        ii. QMHP Interview will consist of inquiry as to:
            1. How person is doing
            2. Are there any problems of mental health nature
                a. If MH referral warranted and of emergent or urgent nature, QMHP will make referral at appropriate level. If routine, QMHP will advise person to self-refer.

6. Documentation for FMH Disciplinary Unit Rounds:

    a. Documentation from FMH Disciplinary Unit Rounds will be entered electronically within the Community Meetings Folder stored in the shared drive of FMH. Specifically, a folder designating the unit with identifier "*(Disc Rounds*)" - ex. Gulf East (Disc Rounds)

    b. All finalized FMH Disciplinary Unit Rounds Notes/Log will have the date and time noted. Mental health staff will document topics in summary format. Each entry will designate mental health staff and security that facilitated meetings.

    c. Mental health staff will follow the format of the FMH Disciplinary Unit Rounds Notes/Log on a weekly basis within 48 hours of completion. The completed entry will be forwarded via email (or printed version as needed) to appropriate security and FMH staff.

    d. If a concern is raised that involves security or medical entities, security and mental health staff will make best effort to: (1) direct concerns to the appropriate entity, and (2) report back on any action(s) taken on next FMH Disciplinary Unit Rounds.

    e. All Material will be stored in the shared (V:) Drive/120 West Eagle/Community Meeting folder

Erie County Forensic Mental Health Services	Policy: Assisting in Psychiatric Medication Clinic	
	Policy #: 30	Date: 08/10/2016
Standard Operating Procedures	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

ECFMH psychiatric medication clinics are provided at both the ECHC and ECCF, and conducted with a psychiatrist or forensic nurse practitioner with ECFMH staff support. Psychiatric medication clinics are offered and occur on a regularly scheduled basis, Monday through Friday, with various mornings, afternoon, and evening times offered during normal inmate movement periods designated by the Erie County Sheriff at both facilities.

The purpose of the psychiatric medication clinic is to provide FMH QMHPs and inmates in custody an opportunity:

- to obtain emergent assessment for decompensated inmates
- for evaluation in consideration of potential 9-2 use (ECMC)
- for evaluation of inmates identified as constant observation
- to permit a QMHP to have an inmate evaluated related to their need/desire for mental health medication intervention
- for continuation of mental health medication compliance that is established in the community
- for continuation of mental health medication compliance that has been established in custody
- to reestablish/resume mental health medication compliance while in custody
- to attend to any mental health medication concerns (i.e. side effects, administration, prescriptions)

Psychiatric medication clinics are a crucial aspect to maintaining mental health stability while in the ECHC and ECCF, and an important service provided to inmates in custody, that permit them to be evaluated regarding the opportunity to receive medication intervention as part of their treatment planning.

Staff members assigned to assist prescribing providers (psychiatrist or nurse practitioner) in the management of the daily (week days) medication clinic will be required to follow general procedures as outlined below, as well as additional tasks and directives provided by ECFMH Supervisors necessary to maintain documentation, continuation of care, and mental health services for inmates.

Staff members assigned to assist in medication clinics include full-time, part-time, and other designated trainees (Interns), who have been satisfactorily trained and are supervised by a full-time ECFMH staff member to meet proper procedures.

PROCEDURES:

1) FMH staff will obtain or print clinic schedule for the assigned psychiatric provider.
    a) Court Ordered Forensic Evaluations are noted at the top of the schedule/calendar listing (only completed by psychiatrists or psychologists).
        i. If there is a Court Ordered Forensic Evaluation scheduled, FMH staff will ensure any electronic device and material needed to complete the evaluation are available to the provider.

2) FMH staff will review inmate housing (SallyPort/JMS) in order to ensure the individual remains in custody, as well as in the appropriate facility to be evaluated.

3) FMH staff will complete the following steps:
    a) Obtain and maintain control of prescriptions and stamper
    b) Make copies of the clinic list, and provide to appropriate security staff
    c) Check with front office staff for any Court Order paperwork necessary for clinic.

4) FMH staff will verify that appropriate Psychiatric Medication Referrals (Psych Med Referral) have been completed in the Electronic Medical Record (EMR)
    a) If a Psych Med Referral has not been completed in EMR, FMH staff will attempt to locate the assigned clinician to complete the referral. If the assigned clinician is unavailable, FMH staff will review notes in EMR and complete Psych Med Referral.

5) FMH staff will supply Court Ordered Forensic Evaluation paperwork to psychiatric provider for the clinic.

6) Prior to beginning clinic, FMH staff will assist the psychiatric provider to triage for the clinic based upon clinical judgment related to inmates' mental health needs. And communicate any specific priority levels associated with calling scheduled inmates to clinic.

7) FMH staff will ensure that psychiatric provider has completed and signed off on all documents in the EMR.

8) FMH staff will review all printed eMAR prescriptions to ensure that all necessary items have been attended to and properly written/documented (i.e. start/stop date, duration of medications, quantity, medication titrations).

9) FMH staff will ensure any provider recommendation is communicated to appropriate ECFMH supervisory staff as needed, as well as with the assigned clinician (9-2 considerations, mental health housing, special instructions, etc.).

10) In circumstances when an inmate had been scheduled for clinic and not seen, FMH staff will complete a "Med Psych Clinic Delay" note within the EMR to document the reason that the inmate was not able to be seen during clinic (e.g. lack of escort, at court, inmate refusal).
    a) FMH staff will consult with psychiatric provider regarding any and all inmates not seen in clinic and will reschedule within an appropriate time frame and attend to any medication/prescription needs, based on shared clinic judgment/determinations.

11) FMH staff will reschedule inmates in the EMR scheduler. All return to clinic time frames will be noted/updated (including recommendations for an "as needed" (PRN) basis)
    a) ECHC and ECCF staff will use the shared v:drive to document all return to clinic time frames
        i. ECCF will use - V: drive – "120 West Eagle/ECCF/ECCF Med Clinic Schedules"
        ii. ECHC will use – V:drive – "120 West Eagle/ECHC MED CLINIC SCHEDULES"

12) When any paper prescriptions are written by prescribers during clinic FMH staff will complete the following:
    a) Make a copy of the original written prescription
    b) Provide the copy of the original written prescription to be scanned into the EMR
    c) Provide the original written prescription to the discharge planning team to be provided to the inmate upon release from custody

13) When an electronic prescription is printed, FMH staff will ensure the provider signs off on printed document (the prescription) and places the document in the Medical/Correctional Health order box.

14) FMH staff will return all unused prescriptions to an appropriately designated secure area/front office, immediately following clinic and provide information regarding the prescriptions used during clinic to ensure proper accounting for all prescriptions (e.g. front office staff, v: drive).

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Referrals to Medical	
	Policy #: 31	Date: orig. 7/29/2016; rev. 10/30/2020
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

Inmates frequently bring up medical concerns during their interactions with Erie County Forensic Mental Health staff during contact. FMH staff will encourage inmates to be autonomous in self-referring to Correctional Health when clinical judgment indicates that the inmate is capable, via a Sick Call slip provided by Correctional Health. However, when clinical judgment is used, and it is determined that due to mental illness, intellectual disability, traumatic brain injury, or other neurocognitive concerns, an inmate requires assistance and/or advocacy through FMH to address medical issues, FMH will make a medical referral on behalf of the inmate through established instructions provided by Correctional Health.

PROCEDURE:

1. Clinical judgment is utilized during contact to determine the need to potentially assist and/or advocate for the inmate.
    a. If Inmate is capable of autonomous advocacy, FMH will advise inmate on ability to self-refer to Correctional Health.
    b. If inmate is found to be in need of assistance/advocacy proceed to procedure (2).

2. FMH selects a new document and chooses the encounter type “referral” within the EMR.

3. Referral type is then selected as “medical”.

4. FMH staff enters the following:
    a. Summary for the referral
    b. Name of person making referral
    c. Chief complaint
    d. Known and/or inmate self-reported History of Presenting Illness

******* According to Correctional Health instructions; if the referral is from a FMH provider or physician who would like the inmate seen by a medical provider or physician, it should be specified in the referral *******

5. FMH QMHP will complete the document, and according to Correctional Health instructions, **“FMH is *to select a priority level”*** based on Medical Referral Acuity Level Guidelines. The charge nurse will be monitoring on a regular basis in order to triage and appropriately assign referrals to medical staff according to the Correctional Health Policy & Procedures.

Acuity Level	EMERGENT	URGENT	ROUTINE
	-Medical care that directly addresses threats to life, limb, or eyesight	-A condition that is not life threatening but requires care in a timely manner.	-Care for a stable patient whose condition will not deteriorate over time and/or will resolve on his or her own.
	Examples of reported/observed symptomatic complaints requiring immediate attention: • Chest Pain • Allergic Reaction • Shortness of Breath • Neurological signs/symptoms ➢ Blurry vision ➢ Sudden numbness or weakness in arms or legs ➢ Facial drooping ➢ Sudden onset of Confusion ➢ Problems with coordination ➢ Slurred Speech • Pt report of "I feel like I am going to have a seizure? • Abdominal Pain (with or without Nausea/Vomiting/Diarrhea • New onset of detox withdrawal-not currently in detox housing	Examples of reported/observed symptomatic complaints requiring urgent attention: • Urinary complaints • Toothache • Earache • Skin Condition/Rash • Cold/Flu-like Symptoms • Sore throat • Muscle Pain • STD • Minor Eye Problems (e.g. pink eye, stye) • Medication Verification	Examples of reported complaints: • Operational Questions • Lab Values • Provider Visit Questions • ADA/Medical Aid Request • Commissary/Dietary Concerns • Medical Equipment Questions • Anything else that does not require medical treatment • Medication Refill
Directions: **Utilize the referral form in Centricity and route the document to the desktop** **ECCF** -"Desktop, ECCFOrders" **ECHC** – "Desktop, ECHCOrders"	A medical referral routed to the desktop along with a Face to face or phone call to the Charge Nurse/Go-To RN for an immediate assessment * (ECCF 937-5551) (ECHC 858-8090)	Route the medical referral to the desktop for an RN assessment within 24 hours	Route the medical referral to the desktop so an RN can assess the patient need(s) within the next day up to 48 hours.

*CHD Nursing staff will facilitate movement with JMD for the reported Emergent Complaints once the Charge Nurse/Go-To is notified either face to face or via phone.

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Supervision and Training of Qualified Mental Health Professionals	
	Policy #: 32	Dates: orig. 12/21/2011; rev. 08/14/2016, 10/30/2020
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

Supervision and training of qualified mental health professionals (QMHPs) working under Forensic Mental Health Services and providing services to inmates at Erie County Holding Center and Erie County Correctional Facility will receive comprehensive training on specific established topics. Training will include topics specified below, a record of attendance, and a post-test to assess staff comprehension of training topics.

PROCEDURES

Licensure

All QMHPs must maintain their appropriate state licensure to be able to provide services to inmates at Erie County Holding Center and Erie County Correctional Facility. In the case of QMHP's having a "restricted license" or "limited permit"(e.g. the QMHP recently completed their training and are still accumulating clinical hours before sitting for the licensure exam, or have taken the exam and are accumulating clinical hours), these staff will work under the supervision of a licensed and qualified QMHP, psychologist or psychiatrist. For QMHPs with a "restricted license," it is required that they obtain full licensure privileges within the minimum time frame of eighteen(18) months if accruing clinical hours, or six (6) months to arrange and sit for exam if clinical hours already accrued, of starting their employment with Erie County Forensic Mental Health Services.

Other Requirements:

QMHPs will participate in and complete the **mandatory** training protocols defined by ECDMH/ECFMH, which includes:

1. Introductory training (new hires only) and Annual refresher training on topics related to Standard Operating Procedures (SOP), referral and triage processes, treatment and care of prisoners with mental illness, disciplinary procedures, risk assessment and prevention.

2. ECFMH Credentialing Process with annual refresher (All QMHPs must be credentialed in suicide and violence risk assessment (*for additional information, see SOP Credentialing for Risk Assessment, Referrals, and Crisis Care Admissions)*.

3. Annual Refresher for Suicide Prevention, Substance and Alcohol Abuse that includes discussion of Co-occurring Mental Health issues (MICA)

4. Appropriate and Timely Referrals to Psychiatrist/Psychiatric Nurse Practitioner

5. Recognizing Signs and Responsibilities surrounding Sexual Abuse and Inmate Sexual Assault training material provided by the Erie County Sheriff Sexual Abuse Response Team

6. Crisis Intervention and Trauma (2 QMHP staff will receive specialized training adapted from Crisis Services, Inc., Trauma Response training program)

7. Monthly supervision with assigned Forensic Mental Health Specialist II or MICA Specialist to include at least one case review. Supervisee is to be provided with goals for improvement, at least one clinical

goal (i.e. Interview style, building rapport, etc.) and one administrative goal (i.e. Documentation, time management, etc.).

Licensure, credentialing, and training of QMHP are all areas that are tracked for Quality Management purposes, and continued employment is contingent on satisfactory licensure/credentialing and attendance in mandatory training.

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Training for Forensic Mental Health Interns	
	Policy #: 33	Dates: org. 02/05/2013, last rev. 08/14/2016
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee, and Dr. Jeffrey Metzner	

POLICY:

Training of future forensic mental health clinicians/professionals is an important objective of the Erie County Forensic Mental Health Services. To address this goal, the Forensic Mental Health Services has an established training practicum for students/trainees (interns) with interest in careers in the field of forensic mental health services (social work, psychology, psychiatry, law etc). This practicum aims to provide interns the opportunity to work with professionals and trainees from other fields, gaining valuable clinical knowledge, and have an irreplaceable interdisciplinary experience, with the ultimate goal of providing interns with comprehensive training that will lead to competency as future forensic mental health clinicians/professionals. Through didactic and experiential components, the interns will gain experience in two broad areas: forensic clinical assessment and/or forensic clinical care. Due to the clinical setting and the high-risk nature of the client population, adequate training of interns is a priority.

PROCEDURES FOR TRAINING

1. All interns must receive security clearance and photo identification through the Erie County Sheriff's Department. Interns without security clearance cannot be accepted into the practicum.

2. All interns will attend and complete training on security awareness (i.e. working in a correctional setting such as the Erie County Holding Center), which will be provided by the Erie County Sheriff's Department (or training materials will be provided by Erie County Sheriff's Department).

3. All interns will attend and complete training on sexual assault and satisfactorily complete a quiz. This training will be provided by Erie County Forensic Mental Health Services / Erie County Sheriff's Department.

4. All interns will attend and complete the New York State Commission on Corrections Suicide and Prevention training. This training will be provided by Erie County Forensic Mental Health Services.

5. All interns will attend an orientation session in which they will be trained in the mental health assessment and documentation used by the Erie County Forensic Mental Health Services. They will also receive a Practicum Training Manual. This session will be tailored to the responsibilities of each intern (which varies according to program requirements and level of experience).

6. For interns responsible for clinical assessment and care, the following steps have to be deemed adequately completed before seeing individual clients:

    a. Training on all clinical assessment and standard operating procedures for clinical care.
    b. Assignment to a credentialed QMHP who the intern will shadow on clinical assessment and care until the supervisor deems the intern is ready for the next step.
    c. Conducting and completing clinical assessment under the observation of credentialed QMHP. When the intern has been deemed by the supervisor to satisfactorily complete clinical assessment, he/she will be allowed to conduct clinical assessment without the supervisor present; however, all clinical work completed by interns will be reviewed and co-signed by the supervisor(s).

7. All completed training for interns will be logged in a database for quality management.

Erie County Forensic Mental Health Services	Policy: Forensic Mental Health: Quality Management Program	
	Policy #: 35	Dates: org. 12/23/2011, last rev. 08/14/2016
Standard Operating Procedures	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

The Quality Management Program of the Forensic Mental Health Service will review data and trends related to conditions established in the Standard Operating Procedures (SOP) the Erie County Forensic Mental Health Service, which reflect the conditions set forth by the agreements between the United States Department of Justice and Erie County. Data reports will be used for the purposes of supervision, quality assurance, and quality improvement, as well as incorporated into the Mental Health Review Subcommittee and Suicide Prevention Subcommittee (representation is multidisciplinary).

The Quality Management program involving the Forensic Mental Health Service involves representation in the Suicide Prevention Leadership Committee, Mental Health Review Subcommittee, Training and Education Committee, Pharmacy and Therapeutics Committee, all of which are overseen by the Correctional Oversight Committee.

See Organizational Chart developed by Correctional Oversight Committee for hierarchy of committees.

PROCEDURE:

1. **Suicide Prevention Leadership Committee**

    a. Chair – First Deputy Superintendent of Compliance
    b. Members – Director of Adult Intensive Mental Health Services, Chief Medical Officer, Director of Correctional Health, Supervising Psychiatrist, other designees as appropriate.
    c. Frequency – Quarterly at minimum or increased frequency if needed.
    d. Reports to Mental Health Review Subcommittee

    Responsibilities

    - Review numbers of attempts, completions or other incidents (if any) for the quarter
    - Review results from Morbidity and Mortality Review Committee as they become available
    - Identify trends from aggregate review (year to date and year to year).
    - Review data from mental health review committee if applicable
    - Develop, implement and review quality improvement action plans as identified through the data review process (and Morbidity and Mortality Review Committee)

2. **Mental Health Review Subcommittee**

    a. Chair - Director of Intensive Adult Mental Health Services
    b. Members- Supervising Psychiatrist, Senior Forensic Mental Health Specialist, Senior Level Custody Representative, Attending Psychiatrist from ECMC Program, Representative from Health Dept. when appropriate, Representative from CCNY, Inc. when appropriate
    c. Frequency – quarterly at minimum, however included below are multiple work groups that will meet weekly to biweekly.
    d. Reports to Health Review Committee

Responsibilities

- Manage implementation of mental health Standard Operating Procedures (SOP)
- Review data reports provided by QA/QI process
- Review reports and recommendations from M&M committee as needed
- Referral patterns to all levels of mental health services from booking and general population
    a. This includes crisis stabilization/constant observation, inpatient, outpatient and residential levels of care
- Analysis of timely access to mental health care
- Analysis of lengths of stay
- Analysis of trends in risk of harm
- Analysis of inter-rater reliability of staff in screening and assessment process
- Review of the use of psychotropic medication and prescribing practices
- FMH collaboration with security on any development of appropriate notification processes that include a tracking mechanism
- A quarterly review of disciplinary measures and use of force taken against prisoners with identified or suspected mental illness will be completed to determine if process has been effective and measures approved have been appropriate
- QI and corrective actions plans will be developed, implemented, and monitored as needed
- Quarterly review of data using pharmacy reports and chart reviews
- Quarterly peer case review process
- A written annual performance report will be compiled by Director of Adult Intensive Mental Health Services to include:
    a. CCNY – data analysis
    b. Credentialing and training
    c. Peer review process, disciplinary measures review
    d. Psychotropic medication review, psychiatrist supervision and peer review
- Clinical Staff and the Clinical Psychologist will perform a quarterly case record review on a sample (CCNY will assist with determining the exact sample)
    a. A format will be provided for this review in advance
    b. Data will be entered directly into a database
    c. Report will be generated from the case record reviews
    d. Reports provided to Director for review
    e. The supervisory team will meet to discuss outcome of the report and feedback will be presented to mental health team at a scheduled staff meeting
    f. Results from chart reviews will inform professional development, training and quality improvement process program needs

3. Training Subcommittee

a. Chair – Erie County Sheriff's Office Training Coordinator
b. Members- Senior Forensic Mental Health Specialist and Forensic Psychologist, Representative from Health Dept. when appropriate, Representative from CCNY, Inc. when appropriate
c. Frequency – quarterly at minimum
d. Reports to respective entity and ultimately to Correctional Oversight Committee

Responsibilities

- Plan, develop, and implement all necessary training
- Maintain and review training roster to assure that training is current

4. **Health Review Committee** (see Correctional Health/DOH policy)

    a. Chair – Chief Medical Officer
    b. Mental Health membership – Director of Intensive Adult Mental Health Services, Chief Psychiatrist or designee
    c. Frequency – biweekly

5. **Pharmacy and Therapeutics Committee** (see Correctional Health/DOH policy)

    a. Chair - Chief Medical Officer
    b. Mental Health membership – Chief Forensic Psychiatrist

6. **Detox Subcommittee** (see Correctional Health/DOH policy)

    a. Chair – Chief Medical Officer
    b. Mental Health membership – Forensic Mental Health MICA Specialist, Forensic Mental Health Specialist
    c. Frequency – monthly

7. Correctional Oversight Committee

    a. Chair – 1st Deputy Superintendent , ECCF
    b. Members – 1st Deputy Superintendent of Compliance, 1st Assistant County Attorney, Director of Intensive Adult/Forensic Mental Health Services, Chief Psychiatrist (as needed). Chief Medical Officer, Director of Correctional Health.
    c. Frequency – biweekly, monthly, quarterly dependent on need
    d. Reporting – all above committees report to this overseeing committee

    Responsibilities

    - Reviews data elements reflective of practice standards established by way of policies and procedures that includes:
        i. Training status
        ii. QI Reports
        iii. Committee reports
    - Makes recommendations for quality improvement projects based on review of data
    - Assesses effectiveness of Standard Operating Procedures (SOP) and policies and procedures

Erie County Forensic Mental Health Services **Staff Operations Procedures**	Policy: Psychiatric Emergency	
	Policy #: 36	Dates: org. 04/13/2017; last rev 10/17/2017
	Prepared by: FMH SOP Committee and Correctional Oversight Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

Psychiatric emergencies include, but are not limited to:

1. Suicidal behavior or threats of imminent self-harm.

2. Violence or threatened imminent violence as a result of mental illness.

3. An inability to attend to basic needs (e.g., hygiene, nutrition, safety) as a result of mental illness, placing the person in immediate danger.

4. Bizarre and/or psychosis-induced behavior that places the patient or others at significant risk of injury.

Any psychiatric emergency shall be immediately referred to the mental health service for evaluation and treatment and will be prioritized over any non-emergency clinical responsibilities. When mental health staff is not available, general medical staff will respond to psychiatric emergencies.

Emergency psychiatric care for inmates is available 24 hours a day, seven days a week at Erie County Holding Center, Erie County Correctional Facility and at the Comprehensive Psychiatric Emergency Program at Erie County Medical Center.

PROCEDURE:

1. Forensic Mental Health Services should be contacted immediately when a psychiatric emergency occurs. Refer to ECFMH SOP Forensic Mental Health Designee: Peak and Off-Peak Coverage, and ECFMH SOP Forensic Mental Health On-Call.

2. Coordination between Security and Forensic Mental Health Services will occur so the patient can be brought to the health/mental health area for assessment with sufficient supervision and security. When it is not safe to transport a patient to the health/mental health clinic, medical or mental health staff shall respond to the patient's housing area.

3. When no Forensic Mental Health staff is on site, the On-Call procedures should be followed. Refer to ECFMH SOP Forensic Mental Health On-Call.

4. Any clinical staff responding to an emergency shall ensure that an appropriate plan for assessment and intervention is made for the patient and that, if necessary, the plan is clearly communicated and documented as needed to staff arriving for the next shift.

5. Medical and/or mental health staff will evaluate the patient as soon as possible and assess the patient's need for medication, alternate housing or clinical disposition, special precautions such as suicide watch, and mental health follow-up.

6. Providers will not administer emergency medication if the inmate is unknown and a reasonable assessment cannot occur or if there are physical health concerns which need evaluation before emergency administration of psychotropic medications.

7. If the patient requires an evaluation in the hospital, the inmate will be transported to the hospital.

8. If the patient requires emergency medication, the following protocol shall apply:

    a. Whenever possible, a psychiatrist or a psychiatric nurse practitioner shall be responsible for prescribing the medication and shall only do so after evaluating the patient in person. A psychiatric nurse practitioner should consult with a psychiatrist before or shortly after prescribing emergency medication.
    b. If no on-site psychiatric staff is available, a general medical physician or nurse practitioner may prescribe the medication after first consulting with the on-call psychiatric staff.
    c. Oral medication shall be offered as a first medication intervention, and the outcome of that offer shall be documented in the medical record.
    d. Emergency intramuscular (IM) medication shall only be used in the event that the patient is an acute danger to him/herself as a result of psychosis or serious mental health symptoms and is not cooperative with oral medication. If intramuscular medication must be given:

        i. The use of IM medication may require physical restraint by Sheriff Department officers for its successful administration. Refer to Erie County Sheriff's Policy #04-09-02 and ECFMH SOP Use of Restraints.
        ii. Correctional Health staff provides primary responsibility for administration of emergency medication.
        iii. Following administration of IM medication, the patient shall be placed on constant observation status and clinically monitored by nursing staff, after 30 minutes and at least hourly for 3 hours or until the patient is taken to the hospital.
        iv. Nursing assessment shall include:
            - Assessment of injection site
            - Assessment of mental status and lethargy
            - Monitoring for muscular side effects including stiffness, rigidity, spasm, tremor
            - Observation of behavior
            - Monitoring for autonomic instability, diaphoresis, altered consciousness, and dehydration
            - Respiration and other vital signs as clinically indicated
        iv. Any concerning change in the patient's clinical condition will be immediately referred to the facility physician.
        v. Patients whose clinical conditions warrant IM medication should be strongly considered for acute hospitalization at Erie County Medical Center.
        vi. No more than two doses of emergency medication may be given in a 24-hour period. If an additional dose is needed the same week, the inmate must be taken to ECMC for evaluation, unless determined inappropriate by the psychiatrist.

9. All of the above procedures shall be appropriately documented in the patient's medical record in a timely fashion, but must be done prior to the completion of any participating staff members' shifts. Documentation shall include the nature of the emergency, the assessment involved, any interventions initiated, and the treatment plan. If emergency medications were administered or physical restraint used, clear justification for such action must be documented and counter-signed by a supervisor.

10. Correctional Health Service/Forensic Mental Health do not administer non-emergency medication over objection in the jail facilities. Absent an emergency, Inmates must be transferred to a psychiatric hospital where Medication over Objection judicial proceedings can be pursued.

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Substance/Alcohol Use Assessment Tool (Texas Christian University Drug Screen V – TCUDS V)	
	Policy #: 37	Dates: orig. 10/09/2017; rev. 10/30/2020
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee, and Dr. Jeffrey Metzner	

POLICY:

Substance and alcohol use are significant area of concern within incarcerated populations, as well as additional treatment concerns for individuals with co-occurring Mental Illness and Chemical Addiction (MICA) who come in contact with Erie County Forensic Mental Health (ECFMH). The Texas Christian University Drug Screen V (TCUDS-V) scoring is based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The TCUDS-V provides a screening to determine a mild, moderate, to severe substance use disorder, and is particularly useful for identification of placement needs and level of care in treatment. Some questions and supplemental sections that do not directly impact severity scoring within the TCUDS-V provide additional information that may prove useful in guiding decision making in order to improve assessments, treatment planning, development of appropriate interventions, and maximizing positive inmate/patient outcomes.

REFERENCES:

- TCU Institute of Behavioral Research, Fort Worth, Texas
  - https://ibr.tcu.edu/wp-content/uploads/2017/09/TCU-Drug-Screen-5-v.Aug17.pdf
  - https://ibr.tcu.edu/wp-content/uploads/2017/09/TCU-Drug-Screen-5-sg-v.Aug17.pdf
  - https://ibr.tcu.edu/wp-content/uploads/2017/09/TCU-Drug-Screen-5-PLUS-Opioid-Supplement-v.Sept17.pdf

PROCEDURE:

The TCUDS-V can be provided and take place at any time during the incarceration of an inmate/patient. ECFMH will encourage the use of the TCUDS-V as part of the initial MHAAS and/or when the inmate/patient communicates a potential need for assessment surrounding the severity of substance/alcohol use.

ECFMH establishes that specific populations receiving mental health services will receive mandated efforts by QMHPs to incorporate use of the TCUDS-V assessment as follows:

- For all inmate/patients on Constant Observation status
- For all inmate/patients on mental health housing in the ECSO
- For all inmate/patients on the Residential Treatment Unit (RTU) in the ECSO
- For all inmate/patients referred and seen by ECFMH while housed on the ECSO detoxification unit
- For all inmate/patients on an ECFMH caseload that are identified with a substance/alcohol use diagnosis

Moreover, ECFMH encourages QMHPs to utilize clinical judgment in implementing the TCUDS-V to maximize effectiveness for assessment with outpatient general population level of care inmate/patients, in order to assist in diagnostic formulation, “willingness/readiness to change” discussions, identification of treatment planning goals, and communicating severity of (substance/alcohol) presenting problems.

Texas Christian University Drug Screen V

Scoring:

- The Sum 1-point “yes” responses for items 1 through 11 yield the total score ranging between 0 and 11.

- The items 12 through 17 and other additional incorporated supplements do not sum into the TCUDS-V total score; they provide additional information that may be useful in guiding treatment decisions, as well as provide data for advocacy, program development, and improved intervention efforts.

Interpreting Scores:

- The TCUDS-V score corresponds with the DSM-5 criteria

    - Mild Disorder = Score of 2-3 points (presence of 2-3 symptoms)
    - Moderate Disorder = Score of 4-5 points (presence of 4-5 symptoms)
    - Severe Disorder = Score of 6 or more points (presence of 6 or more symptoms)

Erie County Forensic Mental Health Services	Policy: SOP FMH Counselor Assignment/Transfer	
	Policy 38	Dates: org. 09/21/2018
Standard Operating Procedures	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

Individuals followed by Forensic Mental Health Services may experience changes in Level of Care, as well as movement of their physical custody between correctional settings (ECHC/ECCF). Moreover, there may also be staffing change(s) and clinical decision-making surrounding cases that require transfer of ongoing mental health care. Such circumstances may necessitate FMH to conduct changes in counselor assignment or transfer of cases between FMH staff, or between correctional settings, and require proactive activity.

PROCEDURE:

1. In case of staffing change(s)

    a. FMH Supervisory Team or designee will identify case in need of Counselor Assignment/transfer
    b. FMH Supervisory Team or designee will review case for any timely casework/case management activity that must be addressed by the new assigned counselor
    c. FMH Supervisory Team or designee will document any timely casework/case management activity (i.e. Treatment plan due) needed within the "MH Counselor Assignment" document of the Electronic Medical Record (EMR) ***AS WELL AS*** route the "MH Counselor Assignment" document to assigned counselor
    d. Newly assigned counselor will acknowledge receipt of assignment/transfer to FMH Supervisory Team or Supervisory Team Member by appending the "MH Counselor Assignment" document and utilizing the quick text entry ".append" to ensure all necessary case management tasks will be/are completed per SOP, and route the document to the appropriate FMH Supervisory Team or Supervisory Team Member

2. In case of changes in Level of Care (i.e. Outpatient to Residential Treatment Unit)

    a. FMH staff will identify case in need of counselor assignment/transfer related to a change in Level of Care
    b. FMH staff will review case for any timely casework/case management activity that must be addressed by the new assigned counselor
    c. FMH staff will document any timely casework/case management activity (i.e. Treatment plan due) needed within the "MH Counselor Assignment" document of the Electronic Medical Record (EMR), as well as document any plans to complete, and/or the completion of, timely casework/case management activity required; and route the "MH Counselor Assignment" document to their immediate supervisor, as well as the original counselor of the case

3. In case of clinical decision-making/case management (i.e. Transfer of case for clinical reasons)

    a. FMH Supervisory Team or designee will approve case transfer in need of Counselor Assignment
    b. FMH Supervisory Team or designee will review case for any timely casework/case management activity that must be addressed by the new assigned counselor
    c. FMH Supervisory Team or designee will document any timely casework/case management activity (i.e. Treatment plan due) needed within the "MH Counselor Assignment" document of the Electronic Medical Record (EMR) ***AS WELL AS*** route the "MH Counselor Assignment" document to assigned counselor
    d. Newly assigned counselor will acknowledge receipt of assignment/transfer to FMH Supervisory Team or Supervisory Team Member by appending the "MH Counselor Assignment" document and utilizing

the quick text entry ".append" to ensure all necessary case management tasks will be/are completed per SOP and route the document to the appropriate FMH Supervisory Team or Supervisory Team Member

4. FMH Counselor Assignment related to client transfer between correctional settings (ECHC/ECCF) Assignment

    a. FMH Supervisory Team or designee will identify case(s) in need of counselor assignment/transfer related to movement between correctional settings
    b. FMH Supervisory Team or designee will review case(s) for any timely casework/case management activity that must be addressed by the new assigned counselor
    c. FMH Supervisory Team or designee will document any timely casework/case management activity (i.e. Treatment plan due) needed within the "MH Counselor Assignment" document of the Electronic Medical Record (EMR), and route the "MH Counselor Assignment" note to the new counselor
    d. FMH staff who is assigned the case will review "MH Counselor Assignment" within the EMR and append the "MH Counselor Assignment" document by utilizing the quick text entry ".append" to ensure all necessary case management tasks will be/are completed per SOP; and route the "MH Counselor Assignment" document to their immediate supervisor, as well as the original counselor of the case

Erie County Forensic Mental Health Services	Policy: Stabilization Treatment Unit	
	Policy #: 39	Date: org. 09/17/2018
Standard Operating Procedures	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffery Metzner	

POLICY:

Individuals with severe mental illness represent a significant portion of people who are incarcerated in the United States compared to the general population. Moreover, those identified with severe psychiatric illness may have a higher incidence of criminal justice system contact following an initial arrest. In a correctional setting, acute mental health symptoms and concerns may disrupt general mental health unit functioning and/or cause unintended consequences for other stabilized individuals dealing with incarceration. It is essential to establish an environment that permits security and safety concerns to be addressed, while offering therapeutic interventions in order to increase client stability.

The population of the Stabilization Treatment Unit (STU) will primarily consist of seriously and persistently mentally ill, including individuals with psychosis spectrum disorders, mood disorders, dementia with psychiatric complications, and co-morbid substance use disorders, with a major area of focus being impulsive, unpredictable, aggressive and violent behavior. Treatment will incorporate evidence-based pharmacological, psychotherapeutic, psycho-educational, and behavior management interventions, with expectations to reduce disruptive thoughts, emotional dysregulation, and unhealthy behavioral responses. In order to achieve this, individuals will receive assistance to avoid behavior that would lead to disciplinary outcomes in other areas of custody, and cognitive functioning can be targeted to build insight, compliance, and to engage in decision-making that increases stability and successful outcomes while in custody.

PROCEDURE:

1. A referral can occur to the STU based upon specified inclusion criteria that are targeted to assist with **any or all** following categories of diagnostic/clinical need:

    a. Individuals identified as returning or entering custody of the ECSO from an inpatient hospital setting(s)
        I. ECMC 9-2 Mental Health
        II. NYSOMH designated inpatient hospital
        III. Arrest and transfer from inpatient mental health hospitalization (BPC/ECMC)

    b. Individuals entering ECSO custody who are identified during initial booking process as in need of mental health evaluation via ECMC/CPEP and return to the facility pending ECFMH assessment

    c. Individuals in ECSO custody who are identified by facility staff as in need of mental health evaluation via ECMC/CPEP and returned to the facility pending ECFMH assessment

    d. Individuals who are currently in ECSO custody and identified by ECFMH as pending inpatient ECMC 9-2 Mental Health hospitalization **with no identified need for constant observation (i.e. crisis level of care)**

    e. Individuals who are currently in ECSO custody and identified by ECFMH as pending inpatient ECMC 4-3 Mental Health hospitalization **with no identified need for constant observation (i.e. crisis level of care)**

f. Individuals who are currently in ECSO custody and identified by ECFMH as pending inpatient NYSOMH Mental Health designation/hospitalization **with no identified need for constant observation (i.e. crisis level of care)**

g. Individuals who are currently in ECSO custody and receiving ECFMH services who are identified as in need of specific housing and behavior management to avoid negative outcomes in custody (i.e. threats/actions with liquid/bodily fluid, impulsivity/unpredictability, inability to be successful in linear housing, mental health client with disciplinary needs), and **with no identified need for constant observation (i.e. crisis level of care)**

2. Referrals can also be initiated by the ECSO Delta Deputies, ECSO Delta Sergeants, ECSO STU Sergeant, and ECSO Classification, as well as Psychiatrist(s), Psychiatric Nurse Practitioner(s), and Qualified Mental Health Professionals within FMH. The FMH Stabilization Treatment Unit team will determine appropriateness of referrals and consult with referring individuals as needed during the STU Screening Procedure.

   The assigned ECSO STU Sergeant and FMH Specialist III (or designated staff) are responsible for final determination surrounding if an individual will enter/remain on STU in consultation with the STU team

3. FMH Staff will co-facilitate intervention with ECSO assigned personnel in order to communicate expectations related to the specific Unit Conduct Expectation (UCE) goals (see ECSO Unit Conduct Expectation Sheet) for individuals entering the STU that includes:

   a. Development of a UCE Sheet and Unit Conduct Record (UCR) to communicate to the individual.

   b. Face to Face contact with the individual to explain STU as described in the STU Screening Procedure attended by ECSO and FMH personnel.

      I. ECSO Personnel will communicate purpose and expectations related to the UCE.

      II. ECFMH Staff will engage in clinical contact to encourage healthy outcomes surrounding the UCE and assist the individual to understand how Mental Health Treatment Plan goals assist toward success.

4. The ECFMH STU will offer the following:

   a. Structured psycho-educational groups co-facilitated by assigned ECSO STU personnel and ECFMH staffing.

   b. Programming that occurs on the STU at least (2) times per week and can include various topics identified by ECSO STU personnel and ECFMH staffing (i.e. social skills, mental health insight/awareness, adaptive custody behavior, adaptive court room behavior).

   c. Programming that promotes personal wellness, improved in-custody compliance, improved mental health compliance, and effective decision-making in order to achieve increased healthy outcomes.

5. The ECSO STU Sergeant and FMH Specialist III (or designated staff) will use appropriate security and clinical judgment in order to communicate information and share necessary discussion for IDT meeting(s).

6. The STU Team will conduct regular (weekly) meetings in order to discuss unit operations, programming, potential treatment needs, and address individualized UCE issues/goals. This team consists of FMH Specialist III (or designated staff), The ECSO STU Sergeant, STU Psychiatrist, and

STU psychologist. Additional ECSO and ECFMH staff may attend in areas where their attendance will promote STU agenda/discussion.

7. The following will be expected for individuals on the STU:

    a. ECFMH will follow FMH SOP #13 Treatment Plan and a comprehensive treatment plan will be developed for each client (inmate) at the stabilization level of care. Completion of the comprehensive treatment plan will occur within 14 days of admission to the STU, and consider input from the STU team, as well as encouraged participation of the individual in development.

    b. ECSO will document and maintain:
        i. An ECSO Initial Screening targeted for completion within (24) hours of admission to STU. The initial screening will identify observed behaviors, and current concerns to aid in the development of UCE Sheet.
        ii. A UCE Sheet and documentation of daily and weekly unit conduct through the UCR, targeted for completion within two business days of admission to the STU. The ECSO UCE Sheet will identify and target specific custodial behavior needs (i.e. maintain safety pending 9-2, maintain safety pending FMH contact, decrease threatening behavior toward other inmates) and targeted goal of the UCEs (i.e. safe transfer to 9-2, cooperate to safely receive assessment by ECFMH, permit housing on linear mental health housing).

    c. The ECSO STU Sergeant and FMH Specialist III (or designated staff) will discuss and review individual UCE Sheets no less than once every week, and consider recommendations from the STU team discussion(s).

8. The STU staff will seek to conference with correctional health staff as needed to maintain UCEs, mental health treatment plan goals and to monitor medication compliance.

9. Additional aspects of the ECFMH STU include:

    a. STU activity will be conducted through “co-facilitation” and shared effort between ECFMH and the ECSO.

    b. UCE Sheet(s) and UCR(s) surround custodial behavior needs, and the ECSO will maintain as a security/classification record. ECFMH will consider the UCEs in relation to mental health diagnoses, status, and goals in the FMH Comprehensive Treatment Plan that support behavior management.

    c. ECFMH Discharge Planning team will be invited to present material as needed.

    d. ECFMH prescribers will be invited to present material related to mental health medication as needed.

    e. ECFMH Mental Illness Chemical Addiction (MICA) Team will be invited to present material related to MICA as needed.

    f. ECSO will be invited to present security/safety related material as needed.

Erie County Forensic Mental Health Services	Policy: SOP FMH Interdisciplinary Collateral Information	
	Policy #40	Dates: Org. 09/21/2018
Standard Operating Procedures	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

Refer to Erie County Sheriff's Office Policy # 05.13.01- Procedure II, A, 1 & 2 that states:

"1. Requests from Divisions or entities within the Erie County Sheriff's Office, including Police Services, Correctional Health, and Forensic Mental Health shall be made to the Chief of Operations or designee in writing, and shall include:

- ***a. The name and ICN of the inmate***
- ***b. The specific information requested***
  - ***i. For telephone information, the specific date, time, telephone number called, specific information or topic requested, etc.***
  - ***ii. For correspondence information, the name of the sender, date(s) if known, and the specific information or topic of information requested.***
  - ***iii. information or topic of information requested.***

2. In an emergency, where a delay in accessing the information may threaten the safety and security of the institution, an inmate, a staff member, or the public, those divisions and entities identified in Section (1) of this part may request information by contacting the Watch Commander on duty via telephone. In all such circumstances, the requesting division or entity shall submit a written request to the Chief of Operations or designee within 12 hours of the verbal request."

POLICY:

Individuals in the ECSO custody may be referred to the Forensic Mental Health Service due to collateral information supplied to other disciplines of the correctional facilities (i.e. Security, Correctional Health) as well as within various components of each interdisciplinary group (i.e. front desk, on unit, booking reception). Following referral to Forensic Mental Health Services, clinical judgment of individual FMH Staff (QMHP, Psychologist, etc.), FMH Teams (COTT, RTU, etc.), and FMH Administration may determine the need exists to obtain material/information (i.e. phone recording, reported suicide note, mail) from another interdisciplinary group that initiated referral. Such circumstances may necessitate Forensic Mental Health Service staff to request access to the collateral information in order to provide assessment of the individual, and that properly explores accuracy and veracity of the individual's (i.e. Detainee) perception.

PROCEDURE:

1. FMH receives a referral (routine/urgent/emergent) that necessitates contact with an individual in ECSO custody, which include(s) reference to potential collateral information, and where clinical judgment through review of the referral and/or during/following a clinical interview the collateral information will assist in assessment and decision-making.

2. FMH staff will complete a current and subsequent Case Management Note(s) that will document/include the following:
   a. The information requested
   b. The clinical reasoning to support specific review of the information requested
   c. The interdisciplinary group from whom the information is requested
   d. The individual within the Interdisciplinary group to whom request is made
   e. The response/plan provided by the interdisciplinary group (i.e. provided, pending, denied access)
   f. The reasoning provided should FMH be denied access by the interdisciplinary group

3. Upon completion of the Case Management Note(s), the writer of the note will ensure that FMH staff, for the following day(s), is aware of the request for collateral information by routing the Case Management Note(s) to the individual's assigned counselor and FMH Supervisory Team. A Supervisory team member or designated staff will address the specific collateral information request per **Erie County Sheriff's Office Policy # 05.13.01 – Procedure II, A, 1 & 2**, and include as an agenda item within the daily Interdisciplinary team meeting.

4. In circumstances where clinical judgment deems collateral information is necessary to attend to emergent situations and a potential assessment of need for constant observation, FMH Staff, Team, Administration will provide necessary housing and level of care determination using clinical judgment to ensure safety, security, and decision-making. This includes the use of constant observation, mental health housing, and the least restriction(s) necessary for the individual. Such clinical decision-making will be documented within the appropriate document(s) related to the individual contact (i.e. MHAAS, CSRA, Progress Note), ***AS WELL AS*** the outcome and information surrounding the request for collateral information.

   (example – "The individual will be placed on constant observation with no restrictions pending receipt and review of recorded phone call security reports will be available for FMH by (date) for assessment.")

5. In circumstances where decision-making and/or receipt of collateral information to FMH is pending another interdisciplinary group, FMH staff/supervisors will include the specific collateral information request as an agenda item within the daily IDT meetings until resolved.

6. Hard copy of collateral information may require ECFMH storage as follows:
   a. Via electronic storage device(s) (i.e. Compact Disc) – to be labeled and stored in a secure cabinet within FMH office(s) space in a room that can be locked for at least 7 years.
   b. Via hard copy paper (i.e. transcript, written notes) – to be scanned as attachment within the EMR under the appropriate ICN and as it relates to FMH documentation for the case.

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Forensic Mental Health: Quality Assurance and Quality Improvement Reporting	
	Policy #: 41	Dates: 10/14/2019
	Prepared by: FMH SOP Committee	
	Approved by: FMH SOP Committee and Dr. Jeffrey Metzner	

POLICY:

Quality Assurance and Quality Improvement (QA/QI) practices of the Erie County Forensic Mental Health (ECFMH) service are essential in order to assess data, trends, and effectiveness of practices established through the use of Standard Operating Procedures (SOP). Consistent reports and evaluation activity are utilized to maintain service delivery, monitor activity within specific areas of practice, and to inform supervision. Moreover, QA/QI activity permits proactive information for potential use in modifications to services, reporting to auditing agencies (i.e. NYSOMH), budget processes, grant submission, and advocacy, as well as any other application that may necessitate communication of ECFMH outcomes/practice. Reporting will be audited, managed, and processed to a final product through the FMH Supervisory Team and the Director of Intensive Adult Mental Health Services.

The Director of Intensive Adult Mental health services will receive and utilize QA/QI reporting prepared and provided by an ECDMH contracted agency to identify possible practice modifications, program development, and communication to the ECDMH related to the ECFMH service.

PROCEDURE:

1. **Monthly QA/QI activity/efforts will occur each month of the calendar year, and consist at minimum of the following:**

    a. Constants Observation (COBS) Database Information Report
    b. Crisis Bed/COBS Trending Review
    c. Erie County Holding Center (ECHC) Quantitative Report
    d. Erie County Correctional Facility (ECCF) Quantitative Report
    e. Quality Management Report (QMR)
    f. FMH Staff Case List Review
    g. Psychiatric Medication Refusal Review
    h. Treatment Planning Review
    i. Texas Christian University Drug Screening (TCUDS) Review
    j. Discharge Planning Review and Outscript Data

2. **(6) Month Quantitative QA/QI will occur as follows:**

    a. Due at the **end of July** each calendar year, with exception related to the Treatment Planning Review that will be due at the **end of the second week in August** due to data pull requirements:
        - Covering the time frame of **January 1st through June 30th**
    b. Due at the **end of January** each calendar year, with exception related to the Treatment Planning Review that will be due at the **end of the second week in February** due to data pull requirements:
        - Covering the time frame of **July 1st through December 31st**

c. (6) Month Quantitative QA/QI will consist at minimum of the following:

- Constants Observation (COBS) Database Information Report
- Crisis Bed/COBS Trending Review
- Erie County Holding Center (ECHC) Quantitative Report
- Erie County Correctional Facility (ECCF) Quantitative Report
- Quality Management Report (QMR)
- FMH Staff Case List Review
- Psychiatric Medication Refusal Review
- Treatment Planning Review
- Texas Christian University Drug Screening (TCUDS) Review
- Discharge Planning Review and Outscript Data
- Comprehensive Suicidal Risk Assessment (CSRA) Review
- ECFMH Staffing/Training/Credentialing Analysis
- ECFMH 943/730/9-2 Data and Summary
- ECFMH Front Office/Court Order Data and Summary
- ECFMH Budget Data/Information

3. Annual Quantitative QA/QI will occur as follows:

a. Due at the **end of January** each calendar year, with exception related to the Treatment Planning Review that will be due at the **end of the second week in February** due to data pull requirements:
   - Covering the time frame of **January 1st through December 31st (of the previous year)**

b. Annual Quantitative QA/QI will consist at minimum of the following:

- Constants Observation (COBS) Database Information Report
- Crisis Bed/COBS Trending Review
- Erie County Holding Center (ECHC) Quantitative Report
- Erie County Correctional Facility (ECCF) Quantitative Report
- Quality Management Report (QMR)
- FMH Staff Case List Review
- Psychiatric Medication Refusal Review
- Treatment Planning Review
- Texas Christian University Drug Screening (TCUDS) Review
- Discharge Planning Review and Outscript Data
- Comprehensive Suicidal Risk Assessment (CSRA) Review
- ECFMH Staffing/Training/Credentialing Analysis
- ECFMH 943/730/9-2 Data and Summary
- ECFMH Front Office/Court Order Data and Summary
- ECFMH Budget Data/Information

4. (6) Month Qualitative QA/QI will occur as follows:

a. Due at the **end of October** each calendar year:
   - Covering the time frame of **April 1st through September 30th**

b. Due at the **end of April** each calendar year:
   - Covering the time frame of **October 1st through March 31st**

c. (6) Month Qualitative QA/QI will consist at minimum of the following:

- Summary of Levels of Care and Overall ECFMH Program Review
- Residential Treatment Unit (RTU) Review

- Constant Observation Treatment Team (COTT) Review
- Non-Serious Mental Illness (SMI) Outpatient Care Review
- Serious Mental Illness (SMI) Outpatient Care Review
- ECHC Psychiatric Medication Refusal Review
- ECCF Psychiatric Medication Refusal Review
- UPP/Prescriber Peer Review

5. **Completed and Final PDF document(s) will be stored in an appropriately named folder (ECFMH QA/QI) and in files labeled "Qualitative Audits" and "Quantitative Audits" with time period of audits designated**

Erie County Forensic Mental Health Services **Standard Operating Procedures**	Policy: Mental Health Record Requests	
	Policy #: 42	Date: 12/24/2020
	Prepared by: FMH SOP Committee	
	Approved by: Erie County Attorney's Office, FMH SOP Committee, and Dr. Jeffrey Metzner	

POLICY:

Erie County Forensic Mental Health (ECFMH) maintains a procedure for reasonable access to mental health records for clients who are currently receiving, or have in the past received, mental health care in custody of the Erie County Sheriff's Office (ECSO). The processing of record requests takes into account appropriate exceptions to Standards of Disclosure, while respecting the need to provide the client right of access through the least restrictive method(s).

ECFMH will follow established Standard Operating Procedures as outlined here and in accordance with:

- Freedom of Information Law (FOIL)
- NY Public Health Law §18 and NY Mental Hygiene Law §33.16
- County of Erie Policies – HIPAA Privacy Policy – Effective July 31, 2013
- FMH SOP Continuation of Care
- FMH SOP Confidentiality

PROCEDURES:

Request Procedure:

1. Clients in custody (inmates) and past clients of ECFMH may request, in writing and with appropriate signature(s), to view or obtain copies of their mental health records. The request must reasonably describe the record(s) sought (i.e. time frame), and will be accepted during the normal course of business by ECFMH staff within the Erie County Correctional Setting, as well as the front office of ECFMH at 120 West Eagle Street.
    a. Clients in custody will be provided a document (In Custody Record Review Request Document) to complete and submit to ECFMH staff in order to process record requests.
    b. Clients no longer in custody may provide (in person/facsimile/mail) a written request and/or complete a document (Community Record Review Request Document) that can be provided by ECFMH services

Response Procedures:

1. Requests will be reviewed as follows:
    a. Initially submitted and reviewed by the Director of Intensive Adult Mental Health/Forensic Services, or his/her designee, for authorization and release of information, and;
    b. Forwarded by the Director of Intensive Adult Mental Health/Forensic Services, or his/her designee, for Treatment Team review for determination in cases where a potential limitation to access is to be considered. The Treatment Team consists of the Primary Mental Health Counselor, Mental Health Medication Prescriber, Director – Division of Forensic Psychiatry/UPP, and;
    c. Consultation with the Office of the Erie County Attorney in cases in which decisions will place limitation to access of requested information.
2. Clients in custody (inmates) will be advised of determination regarding disclosure and will be advised of the following:
    a. The request for records has been reviewed and processed and he/she provided copies of requested material

b. The request for records is being reviewed/processed in order to provide copies of requested material with an estimated completion date to the request. Following review and processing, the client may be provided ***full records***, a ****redacted version*** of requested material, a ****reasonable limitation*** related to access to the requested material, a ***prepared summary** of requested material with an estimated completion date to the request, or be advised ****access is being denied in whole or in part*** for material requested
(*see below for explanations)

3. Past clients will be advised of determination regarding disclosure and will be advised of the following:
   a. The record has been reviewed and processed and is provided copies of requested material
   b. The request for records is being reviewed/processed in order to provide copies of requested material with an estimated completion date to the request. Following review and processing, the client may be provided ***full records***, a ****redacted version*** of requested material, a ****reasonable limitation*** related to access to the requested material, a ***prepared summary** of requested material with an estimated completion date to the request, or be advised ****access is being denied in whole or in part*** for material requested
   (*see below for explanations)

* ***redacted version –*** Provided in the event that there is a professional determination (based on Review Procedure #1 above) that information within the requested record cannot be disclosed. The redacted version will be provided with an explanation of the grounds for redacted items, as well as the right to appeal the determination.
* ***reasonable limitation*** - Occurs in the event that there is a professional determination (based on Review Procedure #1 above) that there is a reason to place reasonable limitation on the time, place, and frequency of the requested information. Such a determination will be provided with an explanation of the grounds for the limited access, a communicated plan of how to provide the limited access, as well as the right to appeal the determination.
***** ***prepared summary*** - Occurs in the event that there is a professional determination (based on Review Procedure #1 above) that denial in whole or in part of the requested information is reasonable; however, that access is permitted through a prepared summary of the requested information. Such a determination will be provided with an explanation of the grounds for the decision, as well as the right to appeal the determination.
***** ***access is being denied in whole or in part*** – Occurs in the event that there is a professional determination (based on Review Procedure #1 above) that there are reasons for denial in whole or in part of requested information that outweighs the access to the information. Such a determination will be provided with an explanation of the grounds for the decision, as well as the right to appeal the determination.

Appeal Procedures:

1. Responses will include notice of the right to appeal decisions pertaining to record requests to the Commissioner of Erie County Department of Mental Health and provided mailing information:

   County of Erie
   Commissioner of the Department of Mental Health
   95 Franklin St
   Buffalo, NY 14202

In-Custody Access Procedures:

Pursuant to Erie County Sheriff Office policy ECFMH will, while adhering to restrictions determined in the above review process, facilitate to the best of their ability and in collaborative steps access for clients who are in custody to the disclosed material (e.g., through reviewing relevant information/chart in an office/room) and comply in providing a final product of disclosed material for (client/inmate) personal property for the ECSO to maintain and provide at the conclusion of incarceration/time of release.

APPLICATION TO INSPECT FORENSIC MENTAL HEALTH INFORMATION

Federal and State law provide you the right to inspect certain medical/mental health and billing records. To make a request to inspect your mental health information, please complete and return this form to:

Erie County Director of Intensive Adult/Forensic Mental Health Services
120 West Eagle Street
Buffalo, NY 14202

Patient Name: _____

Date of Birth: _____

Phone Number: _____

Mailing Address: _____

_____

Please Describe the Specific Information you are requesting (Include specific Dates of Service):

_____

_____

_____

☐ I am requesting an opportunity to INSPECT the above information as permitted by the ECSO while in custody
- OR-
☐ I am requesting to obtain a COPY of the records as described above:
- ☐ Be provided in my property upon release from custody of the ECSO
- ☐ Be provided to the following individual/address: _____

_____

_____

☐ ***I understand that I will be charged $.25 per page***, and that this charge may be reported to the ECSO Lobby Cashier for deduction prior to receipt of requested record(s). Indigent inmates may request to view a copy at facility expense.

***The facility provider(s) will review your request and inform you of the outcome/decision**

Signature: _____ Date: _____

Name of Personal Representative (If Applicable): _____

Personal Representative Authority (supporting documentation is required):
☐ Parent ☐ Guardian ☐ Health Care Agent ☐ Administrator/Executor

☐ Other _____

FOR AGENCY USE ONLY Received by ECFMH: / / ECFMH Review Complete: / /

Federal and State law provide you the right to inspect certain medical/mental health and billing records. To make a request to inspect your mental health information, please complete and return this form to:

Erie County Director of Intensive Adult/Forensic Mental Health Services
120 West Eagle Street
Buffalo, NY 14202

Patient Name: _____

Date of Birth: _____

Phone Number: _____

Mailing Address: _____

_____

Please Describe the Specific Information you are requesting (Include specific Dates of Service):

_____

_____

_____

☐ I am requesting to obtain a COPY of the records as described above:

☐ Be provided to the patient:

☐ In person through contact with the ECFMH Front Office

☐ Through mailing to the following address: _____

_____

_____

☐ Be provided to the following individual/address: _____

_____

_____

ECFMH will review your request and inform you of the outcome/decision

Signature: _____ Date: _____

Name of Personal Representative (If Applicable): _____

Personal Representative Authority (supporting documentation is required):

☐ Parent ☐ Guardian ☐ Health Care Agent ☐ Administrator/Executor

☐ Other _____