

**OREGON DEPARTMENT OF CORRECTIONS**  
**Operations Division**  
**Health Services Section Policy and Procedure #P-G-04**

SUBJECT: BASIC MENTAL HEALTH SERVICES

POLICY: The ODOC provides a comprehensive mental health program to meet the needs of all inmates. The mental health program provides services for inmates with acute mental health crises, short term needs and long term needs, including co-occurring substance abuse issues and behavioral disorders. Mental health services are coordinated through Behavioral Health Services (BHS). Substance abuse treatment is coordinated through the Transitional Services Division.

REFERENCE: NCCHC Standard P-G-04  
Health Services Policy P-E-03, Transfer Screening  
Health Services Policy P-G-05, Suicide Prevention Program  
ODOC Rule #47  
Diagnostic and Statistical Manual – Fourth Edition – Text Revision (DSM-IV-TR)

DEFINITIONS:

**Treatment Provider:** A Case Manager, Mental Health Counselor, Prescribing Practitioner, or BHS clinical supervisory staff.

**MH-codes (previously called “A” codes):** A system of classification to determine the allocation of mental health resources provided to inmates. MH-codes also provide information to other corrections staff about an inmate’s need for services. MH-codes are:

**MH-0** Assigned to an inmate who has been assessed by a BHS treatment provider and does not meet criteria for a diagnosis that requires mental health services.

**MH-1** Assigned to an inmate who has been assessed by a BHS treatment provider and, based on diagnosis with mild acuity, does not meet criteria for mental health services (see table two).

**MH-R** Assigned to an inmate who has been assessed by a BHS treatment provider and meets diagnostic criteria for a code of MH-1 and is prescribed psychotropic medications by a BHS prescriber or the inmate’s acuity level is assessed as moderate or severe. The inmate will be restricted to institutions where mental health services are available.

**MH-2** Assigned to an inmate who has been assessed by a BHS treatment provider and, based on diagnosis as outlined in table one, meets criteria for mental health services (see table two). The inmate will be restricted to institutions where mental health services are available.

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**MH-3** Assigned to an inmate who has been assessed by a BHS treatment provider and, based on diagnosis as outlined in table one, meets criteria for mental health services (see table two). The inmate will be restricted to institutions where mental health services are available.

**Acuity:** An individual's clinical presentation based on his/her current and past Global Assessment of Functioning (GAF) score as well as the BHS treatment provider's clinical judgment. The acuity levels are:

Mild: GAF score of 61-100

Moderate: GAF score of 31-60

Severe: GAF score of 1-30

If an inmate has made a suicide attempt (as defined in the Suicide Prevention Procedure) within the previous three years, the acuity will be elevated to at least moderate until there has been a three year period with no attempts.

When an inmate has a significant medication change (including discontinuation of meds), the acuity will be elevated to at least moderate for 90 days to ensure that he stays at a facility with BHS services and that AIP placements are prevented without BHS clearance.

### PROCEDURE:

- A. The Medical Services Manager, or designee, at each facility, with the institution Superintendent, is responsible for establishing a location to house inmates who are in need of Mental Health Services but do not require acute mental health services so that frequent observation can be maintained until BHS staff evaluates the inmate and establishes a treatment plan, releases the inmate from mental health observation or the inmate is transferred to another facility with the appropriate level of service.

#### Routine referrals to BHS:

1. Routine referrals to BHS are made using the "Request for Medical/Psychiatric Evaluation" form (attachment 1) and may be made for the following circumstances:
  - a. The inmate requests mental health services.
  - b. Health care staff request an evaluation based upon observed behaviors that indicate mental health services may be needed.
2. A copy of the referral form is maintained in the Mental Health section of the inmate's health care record.

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3. Following consultation with BHS, inmates who are assessed as medically stable and who are requiring acute level mental health services may be transferred to a Mental Health Infirmary.

### Crisis intervention:

1. During regular working hours, contact the Mental Health Case Manager or when not available, another Mental Health Treatment Provider.
2. Emergency referrals on weekends, holidays or at facilities without regular mental health staff, are to be made in accordance with the BHS Mental Health On-Call Procedures. These types of referrals, in addition to any other pertinent information or outcomes, are to be documented on the progress notes of the inmate's health care record, and tracked in the 400 under BHUN.

### Transfer:

1. Inmates may be transferred to another facility for mental health care in consultation with the Medical Services Manager or designee and BHS Manager or designee.

- B. A code is assigned to an inmate based on the current DSM diagnosis. An acuity level (mild, moderate, or severe) is assigned based on the inmate's current Global Assessment of Functioning.

1. Initial Assessment: When an inmate is evaluated by a BHS treatment provider, a diagnosis will be determined and an MH-code with an Acuity level will be assigned. Diagnoses which determine an MH-code can be provisional but not rule-outs. Justification for the diagnosis should be noted. The MH-code is based on the most severe diagnosis. However, the most prevalent diagnosis will drive the treatment approach.
3. Discrepant Diagnoses: If one treatment provider disagrees with another treatment provider about a diagnosis, such as a prescriber and a case manager, there will be a consultation between the providers to determine which diagnosis will be assigned. If a consensus cannot be reached regarding diagnosis, the BHS Manager will make the determination.
4. Follow-up Assessment: Each time an inmate is seen for follow-up services, the diagnosis and acuity level will be reviewed.
5. Changing a diagnosis: If the inmate no longer meets criteria for his/her previous diagnosis, the new diagnosis and MH-code will be assigned with justification appropriately documented.
6. Changing Acuity Levels: Each time an inmate is seen by a BHS treatment provider, the acuity level will be changed to reflect the most current level of functioning. This will be documented in the progress note and entered into the BHS data system.

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7. Treatment Services Schedule: Mental health services will be allocated according to an inmate's MH-code and Acuity level (see table two). Allocation of services for inmates with MH-1 and MH-R codes is as follows:

Contractors can provide up to four individual and eight group therapy sessions with approval by the mental health case manager. The case manager may request additional individual and group treatment with the approval of the local BHS manager.

**Table One MH-codes based on the current DSM diagnoses**

<b>MH-3</b>	
298.9	Psychosis NOS
295.xx	Schizophrenia
296.xx	Bipolar Disorder
300.12	Dissociative Disorders
296.3	Major Depressive Disorder, Recurrent
295.70	Schizoaffective Disorder
295.40	Schizophreniform
<b>MH-2</b>	
307.1	Anorexia
307.51	Bulimia
307.50	Eating Disorder NOS
301.83	Borderline PD
297.1	Delusional Disorder
294.xx	Dementia
299.80	Pervasive Developmental Disorders
296.2x	Major Depressive Disorder, Single Episode
301.22	Schizotypal PD
307.23	Tourette's
301.3	Cyclothymia
300.22	Agoraphobia
300.01	Panic Disorder
300.3	Obsessive-Compulsive Disorder
311.0	Depression NOS
296.90	Mood Disorder NOS
300.4	Dysthymic Disorder
301.0	Paranoid Personality Disorder
309.81	Post Traumatic Stress Disorder
298.8	Brief Psychotic Disorder

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<b>MH-R</b>	
799.9	Deferred Axis I diagnosis
Any MH-1 Diagnosis that is being treated with medication	
Any MH-1 Diagnosis with a moderate or severe acuity level	
<b>MH-1</b>	
301.7	Antisocial PD
314.xx	ADHD
309.xx	Adjustment Disorders
300.23	Social Phobia
300.29	Specific Phobia
308.3	Acute Stress Disorder
300.02	General Anxiety Disorder
300.00	Anxiety Disorder NOS
301.6	Dependent PD
312.34	Intermittent Explosive Disorder
312.30	Impulse Control Disorder NOS
313.81	Oppositional-Defiant Disorder
312.33	Pyromania
312.xx	Conduct Disorder
310.1	Personality Change Secondary to Medical Cause
300.81	Somatoform
301.50	Histrionic PD
301.20	Schizoid PD
301.81	Narcissistic PD
301.4	Obsessive-Compulsive PD
307.22	Tic Disorder
312.32	Kleptomania
301.82	Avoidant PD
312.31	Pathological Gambling
302.6	Gender Identity and Sexual Disorders
30.19	Personality Disorder NOS
292.91	Substance abuse related disorders
294.91	Cognitive Disorder NOS

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**Table Two: Allocation of MH Services based on MH-code and Acuity level**

	Mild (GAF=61-100)	Moderate (GAF=31-60)	Severe (GAF=01-30)
<b>MH-3</b>	Recommended case mgmt contact at least every 90 days  Group	Recommended case mgmt contact at least every 30 days  Group  Individual	Recommended case mgmt contact at least weekly  Group  Individual
<b>MH-2</b>	Recommended case mgmt contact at least every 120 days  Group	Recommended case mgmt contact at least every 60 days  Group  Individual	Recommended case mgmt contact at least weekly  Group  Individual
<b>MH-R</b>	Prescriber only if referred through case mgr	Prescriber only if referred through case mgr  Group	Prescriber only if referred through case mgr  Group  Individual
<b>MH-1 MH-0</b>	No services		

Effective Date: \_\_\_\_\_

Review date: August 2014

Supersedes P&P dated: May 2014

## BHS REFERRAL FORM

**REFERRAL FROM** \_\_\_\_\_ (MD, DO, NP, PA, RN, HST) **DATE:** \_\_\_\_\_  
(Please Print Name)

MH CODE: \_\_\_\_\_ DD CODE: \_\_\_\_\_

**PRESENTING SYMPTOMS (Please check if present)**

- Observable anxiety
- Observable signs of responding to visual or auditory hallucinations
- Expressing odd or delusional thoughts
- Reports victim of physical assault, sexual assault or sexual harassment
- Reports sexual victimization of a child or adult
- Reports sleep disturbance
- Observed or reported depressed mood
- Medication concerns (side effects, expiration dates, etc.) \_\_\_\_\_  
\_\_\_\_\_
- New transfer that needs follow-up \_\_\_\_\_
- Requests to see BHS (Please identify specific reason for request) \_\_\_\_\_  
\_\_\_\_\_
- Other \_\_\_\_\_

**DURATION:** Symptoms have been occurring for the: (Please check)

- Last 24 hours
- Last 7 days
- Last 14-28 day

**DATE RECEIVED BY BHS:** \_\_\_\_\_

**ACTION TAKEN BY BHS (Please check)**  EMERGENT  NON –EMERGENT

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Inmate Name: \_\_\_\_\_

Inmate SID: \_\_\_\_\_

DOB: \_\_\_\_\_

	<b>BEHAVIORAL HEALTH SERVICES</b>
<b>Title: Emergent and Urgent Access to Mental Health Consultation Procedure</b>	<b>Procedure: BHS MH E-1</b>

**I. PURPOSE:**

The purpose of this procedure is to identify the steps in accessing and utilizing Behavioral Health Services consultation. This policy addresses the NCHC standard MH-E-06

**II. DEFINITIONS:**

**BHS:** Behavioral Health Services

**Mental Health Professional:** Employee or contracted mental health provider.

**Prescribing Practitioner:** A licensed psychiatrist or psychiatric nurse practitioner.

**Treatment Provider:** A Mental Health Specialist, Mental Health Professional, Prescribing Practitioner, or BHS clinical supervisory staff.

**III. PROCEDURE:**

**A. Overview:**

BHS mental health professionals provide consultation regarding urgent and emergent mental health concerns 24 hours per day, 7 days per week. Regular working hours when case managers provide on-site consultation and intervention vary from institution to institution based on available resources. Outside of regular working hours for a given institution, the on-call prescribing practitioner provides consultation by telephone.

**B. On-call Need Levels:**

1. An emergency mental health concern requires immediate action to prevent physical harm to the inmate or other persons.
2. An urgent mental health concern requires action within a short time to protect the safety and security of the inmate or other persons. Safety can be maintained in the short run, but a response cannot wait until the assigned mental health professional is available on site.

**C. During regular working hours:**

1. The mental health case manager who is responsible for the particular inmate is available for urgent and emergent situations within the institution.
2. Institutions that do not have assigned mental health case managers will contact the Mental Health Services Supervisor or the BHS Administrator.
3. During regular working hours the Mental Health Services Supervisor and BHS Administrator are available for consultation to any DOC institution. .
4. For medication related concerns, the mental health case manager or BHS manager will arrange consultation as needed with a prescribing psychiatric practitioner.
5. In responding to requests for consultation, the case manager will avoid interruption of regular mental health treatment services as much as possible. Interruption of individual or group treatment will occur only for emergencies.
6. When the case manager is not available during regular working hours, the BHS manager for that institution will ensure backup by another mental health professional.
7. When there is an urgent or emergent situation within the institution, the case manager will notify the other treatment providers and/ or Medical Services at the institution of the situation along with the related recommendations before going off duty.

**D. Outside of regular working hours:**

1. A Psychiatric Mental Health Nurse Practitioner employed by BHS is on call by cell phone. The current BHS on-call schedule is located in Outlook Public Folders.
2. When the primary BHS on-call NP will not be available for his or her scheduled on-call hours, the NP will:
  - a. Make arrangements for on-call backup by another NP,
  - b. Receive approval from the BHS Supervisor for that particular institution and Chief Psychiatrist, or designee, and
  - c. Notify the Medical Services manager and OIC at the institutions where he or she is the primary on-call practitioner.

**E. Procedure for contacting the mental health professional on call:**

1. A Medical Services nurse on site will:
  - a. assess the inmate face-to-face shortly before calling,

- b. the nurse should have the chart in hand and read the most recent chart notes, SMU discharge summary, and treatment plan, then
  - c. contact the on-call prescribing practitioner by telephone.
2. When no Medical Services nurse is on site, the OIC or designee will contact the on-call Prescribing Practitioner.
  3. When the primary on-call prescribing practitioner cannot be reached after calling twice (allowing 15 minutes after leaving a voice mail), then the secondary on-call prescribing practitioner may be contacted.
  4. If you cannot reach either the primary or secondary prescriber after two calls (leave messages) each, then any other prescribing practitioner may be contacted.

F. **Documentation:**

The on-call Prescribing Practitioner will document in the mental health section of the medical chart and notify the facility mental health case manager on the next working day.

G. **Consistency in treatment is a critical factor determining effectiveness.**

On-call prescribing practitioners should make recommendations consistent with the treatment plan and previous interventions unless there is a clear clinical need to diverge.

## Behavioral Health Services On-Call Schedule (Revised 04/25/14)

**BHS ADMINISTRATORS ON CALL AFTER HOURS AND SUICIDE/CRISIS REPORTING**  
**JANA RUSSELL: 503 932-6989   CLAUDIA FISCHER-RODRIGUEZ: 541 561-6609**  
**CHRISTY HENNING: 503 602-2458   DARYL RUTHVEN: 503 385-7020**

### Central Admin On-Call Schedule:

**2014 – January - Claudia   February – Jana   March – Christy   April - Claudia**  
**May - Christy   June - Jana   July – Claudia   August- Christy   September – Jana**  
**October-Claudia   November- Christy   December - Jana**

When there is a mental health crisis **after hours, on weekends or holidays**, please contact the person who is the **primary** on-call Psychiatric Mental Health Nurse Practitioner (PMHNP) for your institution. If you cannot reach that person within **15 minutes**, then you may contact the **secondary** on-call PMHNP for your institution. If you cannot reach either assigned PMHNP within **30 minutes**, you may call any other PMHNP on this list. Please do not call the backup or the next PMHNP until you have waited for the primary on-call PMHNP to return your call. They may simply be in a “dead spot” for cell phone coverage at the time you call. If you get their voice mail, make sure to leave a message, the time of your call, and also your call-back number, Remember that all they will see on their phone is the facility phone number, as the DOC system does not allow extension numbers to appear on the recipient’s phone.

**During regular weekday, daytime work hours**, in crisis situations, for assistance please contact a Mental Health Specialist, or BHS manager assigned to your institution. However, for institutions that do not have on-site BHS staff, contact Claudia Fischer-Rodriguez, Clinical Director, at 503 378-6376 (office) or 541 561-6609 (cell). **Please do not contact the PMHNP during regular work hours.** They have heavy patient schedules and must fulfill those responsibilities during their regularly scheduled work hours.

BHS Prescriber On Call Schedule		
ODOC West Side Institutions		
Institution	Primary	Backup
CCIC	Casey Dugan	Scott Haynes
CCCF	SID ending ODD: Lynne Clark	Melanie Parker
	SID ending EVEN: Melanie Parker	Lynne Clark
CCCM	Scott Haynes	Casey Dugan
CRCI	Becki Sauer	Casey Dugan
OSCI	Barbara Miller	Casey Dugan
OSP	Barbara Miller	Becki Sauer
SCCI	Barbara Miller	Becki Sauer
SCI/MCCF	Barbara Miller	Scott Haynes
SCCF	Becki Sauer	Casey Dugan

BHS Prescriber On Call Schedule		
ODOC East Side Institutions		
Institution	Primary	Backup
DRCI (E Units)	Rosanne Harmon	Rachel Fiocchi
DRCI (F Units)	Rachel Fiocchi	Rosanne Harmon
EOCI	Ted Chase	Trudy Evans
PRCF	Trudy Evans	Rosanne Harmon
SRCI	Trudy Evans	Rachel Fiocchi
TRCI	Ted Chase	Trudy Evans
WCCF	Rosanne Harmon	Rachel Fiocchi

Westside BHS Prescriber Contact Numbers	
Lynne Clark	(503) 477-2576
Casey Dugan	(503) 572-5243
Scott Haynes	(503) 551-6939
Barbara Miller	(503) 887-1919
Melanie Parker	(503) 477-2842
Becki Sauer	(503) 510-2988

Eastside BHS Prescriber Contact Numbers	
Rachel Fiocchi	(541) 325-6601
Ted Chase	(541) 240-4094
Trudy Evans	(541) 215 2699 (after hours (541-566-2265)
Rosanne Harmon	(541) 279-7916

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