Steve Lathrop

From: Chris Triebsch <ctriebsch@leg.ne.gov>
Sent: Tuesday, October 04, 2016 2:48 PM
To: Steve Lathrop
Cc: Patty PansingBrooks
Subject: LR 34 Behavioral Health Testifiers

Steve,

For the sake of time, we have already invited certain individuals to testify for the LR 34 Hearing next week. We figured we could always rescind the invites if you felt their testimony wasn't necessary.

These individuals include:

Director Frakes - Questions could be geared more toward restrictive housing.

Dr. Kohl - Director of all of Health Services at Corrections for the last 15 years. Oversaw Behavioral Health and Psychiatry (Mitwaruciu and Wetzel. Retiring this week, but has agree to come back and testify. He can talk about challenges of hiring, filling vacancies, historical changes in health services during his tenure. Challenges, resources and priorities 15 years ago as opposed to today.

Dr. Mitwaruciu - Behavioral Health. Provide information on core programs, sex offender programs, violence programs, substance abuse programs. And she will provide information on treatment and interventions in the facility. She can talk about how vacancies, understaffing and space issues provide challenges to programming.

Dr. Wetzel - Chief Psychiatrist. Can talk about what goes at LCC, relationships between Dept. and Regional Center and the distance between the psychology and psychiatry folks.

Kasey Moyer and Amie Jackson (Mental Health Association) - testify jointly about their work in restrictive housing with their WRAP (Wellness Recovery Action Programs) They can share what they are seeing in "real life" and talk about their efforts to improve the conditions Kasey is on the external work group on restrictive housing as well and Amie has actually experience restrictive housing, so could testify from a personal perspective.

Jerall Moreland or James Davis - We have asked Marshall Lux to choose which one he wants to send. Both could offer a great detail on both restrictive housing and behavioral health and talk about what they have seen.

We have not invited Diane Sabatka-Rine, even though James Davis really wants to see her testify again and Senator Chambers would probably want to ask her questions. Doug does not believe Frakes would send her back because she didn't do well last time. Not sure if you want to try and include her or not.

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Chris Triebsch
Legislative Aide
State Senator Patty Pansing Brooks
District 28
Room 1523, Nebraska State Capitol
402-471-2633
ctriebsch@leg.ne.gov

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Steve Lathrop

From: Chris Triebsch <ctriebsch@leg.ne.gov>
Sent: Wednesday, October 05, 2016 10:00 AM
To: Steve Lathrop; Patty PansingBrooks
Subject: Fwd: LR 34 Hearing

Dr. Wetzel isn't available and I am told by Doug that there isn't really a replacement for him. We may want to have consider having Wetzel at the following hearing since his testimony will also relate to programming.

---------- Forwarded message ----------
From: **Wetzel, Martin** <martin.wetzel@nebraska.gov>
Date: Tue, Oct 4, 2016 at 3:04 PM
Subject: RE: LR 34 Hearing
To: "Triebsch, Chris" <ctriebsch@leg.ne.gov>
Cc: "Beaty, Jeffry" <jeffry.beaty@nebraska.gov>

Chris,

Thank you for the invitation. I will be unavailable to testify due to my obligations providing patient care, and duties in Omaha on that date.

Thank you,

Martin Wetzel MD

From: Chris Triebsch [mailto:ctriebsch@leg.ne.gov]
Sent: Tuesday, October 04, 2016 11:59 AM
To: Wetzel, Martin
Cc: Beaty, Jeffry
Subject: LR 34 Hearing

Dr. Wetzel,

Please see the attached invitation to testify before the LR 34 Special Investigative Committee next Wednesday.

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Chris Triebsch

Legislative Aide

State Senator Patty Pansing Brooks

District 28

Room 1523, Nebraska State Capitol

402-471-2633

ctriebsch@leg.ne.gov

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Legislative Aide
State Senator Patty Pansing Brooks
District 28
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402-471-2633
ctriebsch@leg.ne.gov

Questions from the LR 34 Committee

1. **A roster of mental health and length of employment for each individual, and vacancies by position and facility.**
   Attachment 1 includes the requested mental health staff and vacancy information.

2. **The number of treatment positions created from July 1, 2013 through June 30, 2016 by year and by facility, as well as the number of treatment positions that have been eliminated from July 1, 2013 through June 30, 2016, by year and by facility.**

   See attachment 1 for new positions created. There have been two chemical dependency counselor positions at the work ethic camp which were reclassified to other positions in July of 2013 and October of 2014.

3. **Which evidenced based models are used for the clinical mental health and substance abuse programs offered at NDCS facilities including, but not limited to, SAU Intensive Outpatient Treatment, IHELP, and Drug and Alcohol Education? When were they last updated to reflect new science?** See Attachment 2 for a description of the evidence based treatment models in use by the Department.

4. **Policies and procedures regarding the appropriate protocol after a suicide attempt or self-harm action, including information on how quickly mental health treatment should be administered and how "stabilizer" and "prevention of deterioration" services are provided**
   A copy of the Department's Suicide Prevention/Intervention Administrative Regulation 115.30 is attached.

5. **Data on number of inmates reviewed by Discharge Review Team and the number who have been recommended for Civil Commitment?**

   The Discharge Review Team reviewed 201 inmates prior to discharge during 2015. Ten of those inmates were referred for to a mental health board for civil commitment under the Nebraska Mental Health Commitment Act. Of those 10, 4 were ordered to outpatient commitment, 3 for inpatient commitment, two referrals were declined by the County Attorney and one inmate was placed under a 90 day continuance for evaluation.

6. **Number of inmates designated as "seriously mentally ill" by gender, and any policy that defines the term "seriously mentally ill" for purposes of the mental health coding system.**

There are currently 1,100 inmates with a serious mental illness diagnosis within NDCS. Of those 1,100, 140 are female and 952 are male.

Serious mental illness is defined as any mental health condition that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with the serious mental illness. Serious mental illness includes, but is not limited to (i) schizophrenia, (ii) schizoaffective disorder, (iii) delusional disorder, (iv) bipolar affective disorder, (v) major depression, and (vi) obsessive compulsive disorder.

7. **Number of inmates who have been transferred to the Lincoln Regional Center while in NDCS custody, from January 2006 to the present. Please include the date of the last direct transfer from an NDCS facility to a Regional Center while the inmate was still serving a sentence. Number of inmate cases that have been served by LRC staff while remaining in an NDCS facility?**

Between January 1, 2006 and September 30, 2016, 66 inmates, 3 county safe keepers, and 6 lifetime sex offenders were transferred to the Lincoln Regional Center while serving their NDCS sentence. The most recent date of direct transfer was September 28, 2016. We are still gathering the information regarding the number of inmates treated by LRC at an NDCS facility.

8. **Number of inmates for whom involuntary transfer proceedings have been initiated from January 2011 to the present, including the number completed.**

We requested clarification on this request and were told it was asking for the number of requests for civil commitment filed by the Department over the time period in question. We are still gathering this information and will provide it as soon as it is available. It is important to note that NDCS only makes a referral to the County Attorney does not control what the County Attorney's final decision is or the outcome of the mental health board hearing.

ATTACHMENT 2

Question: Which Evidence Based Models are used for the clinical MH and substance abuse programs offered at NDCS? When were the models last updated to reflect new science?

Answer:

For sex offenders, Mental Health uses the Good Lives Model by Tony Ward and Ruth Mann published in 2004. The materials for this model have been updated to those published in 2010 and 2011. There are also numerous articles ranging from 2004 through 2011 that Mental Health uses to help develop their model. The Nebraska Department of Correctional Services (NDCS) sex offender programs are also using Recidivism Risk Reduction Therapy (3RT) as part of their sex offender program. The 3RT material is Dialectical Behavior Therapy (DBT) based. This was last updated in 2011.

For substance abuse, Mental Health uses the New Directions model by Hazelden published in 2002. This Cognitive Behavioral Treatment Curriculum is a collaboration of Chemical Dependency Professionals from the Minnesota Department of Corrections and the Hazelden Foundation. The material is updated annually, as the company updates their material, Mental Health will replenish and replace with the most current material available. This occurs every one-two years.

For violence, Mental Health uses the Violence Reduction Program (VRP) model by Dr. Stephen Wong & Dr. Audrey Gorden. A modified Stages of Change (SOC) Model is used in the VRP to guide the selection of strategies, techniques, and interim objectives that are consistent with the responsivity characteristics of VRP participants. Since 2009, the year VRP started at NDCS, Dr. Wong and Dr. Gorden have responded to questions and provided updated literature and studies published in 2012-2013 on Violent Offender Programming to NDCS Mental Health staff. NDCS has scheduled a training session with Dr. Stephen Wong and Dr. Audrey Gordon on October 31, 2016- November 4, 2016 to focus on treatment principles with high violence individuals, the facilitation or operation of a Violence Reduction Program, and how to administer the Violence Risk Scale.

NEBRASKA CORRECTIONAL SERVICES *Making A Difference*	**ADMINISTRATIVE REGULATION** **Department of Correctional Services State of Nebraska**	**NUMBER** 115.04	**Page 1 of 7**
		ACCESS TO HEALTH SERVICES	

This Administrative Regulation is to be made available in law libraries or other inmate resource centers.

EFFECTIVE:	May 6, 1992
REVISED:	September 30, 2005
REVISED:	November 10, 2006
REVISED:	October 8, 2007
REVISED:	September 26, 2008
REVISED:	September 24, 2009
REVISED:	September 30, 2010
REVIEWED:	September 27, 2011
REVISED:	September 21, 2012
REVISED:	October 25, 2013
REVIEWED:	November 24, 2014
REVISED:	September 30, 2015

SUMMARY of REVISION/REVIEW

Annual review completed with change in Director name. Updated reference to AR 210.01.

APPROVED:

RANDY T. KOHL, M.D.
Deputy Director, Health Services

SCOTT FRAKES, Director
Nebraska Department of Correctional Services

PURPOSE

To ensure inmates are provided unimpeded access to health care services.

GENERAL

It is the policy of the Nebraska Department of Correctional Services (NDCS) that inmates be provided unimpeded access to health care services. This policy applies to all institutions.

PROCEDURES

I. ACCESS and GRIEVANCES (secure institutions and community corrections centers as specified)

Inmates are provided unimpeded access to health care and a system for processing complaints regarding health care. These policies are communicated orally and in writing to inmates upon arrival at the reception facility and are translated into a language clearly understood by each inmate.

II. SICK CALL

A. The process for all offenders to initiate requests for health services on a daily basis is the utilization of the Inmate Interview Request Form. Health Services Request form will be used in place of the Inmate Interview Request Form in those institutions employing Open Sick Call. These requests are triaged daily by health professionals per a priority system that addresses routine urgent and emergency complaints. Clinical services are available to inmates in a clinical setting at least five days a week and are performed by a physician or other qualified health care professional.

B. If an inmate's custody status precludes attendance at sick call, arrangements are made to provide sick call services in the place of the inmate's detention.

III. RESTRICTIVE HOUSING STATUS

A. Custody staff shall inform health care personnel immediately upon transfer of an inmate to any restrictive housing status as defined in A.R. 210.01, *Conditions of Confinement – Special Management Inmates.*

B. Custody Staff shall announce and record the presence of health care personnel upon entrance into the restrictive housing unit.

C. Health Care professionals will provide an assessment or review within the unit upon being notified of the transfer.

D. Health care professionals shall perform daily rounds in restrictive housing units, unless medical attention is needed more frequently.

E. Health Care professionals will make a door to door visit within restrictive housing units to assure each inmate has the opportunity to access Health Services daily.

F. A Physician's Assistant, Nurse Practitioner or Physician shall visit restrictive housing units at least monthly. A Physician shall visit restrictive housing units annually at a minimum.

IV. CONTINUITY of CARE (secure institutions and community corrections centers)

(Secure institutions) Continuity of care is required from admission to transfer to discharge from the facility, including referral to community care when indicated.

V. SPECIALIST CARE (secure institutions)

Arrangements are made with health care specialists in advance of need.

VI. HOSPITAL, INFIRMARY and OTHER HEALTH CARE FACILITIES

A. Patients who need health care beyond the resources available in the facility, as determined by the responsible physician, are transferred under appropriate security provisions to a facility where such care is on call or available 24 hours per day. A written list of referral sources includes emergency and routine care. The list is reviewed and updated annually.

B. Inmates are provided access to NDCS infirmaries which includes at a minimum:

1. Definition of the scope of infirmary care services available.

2. A physician on call 24 hours a day.

3. Health care personnel with access to a physician or Registered Nurse.

4. Health care personnel on duty 24 hours per day.

5. All inmates/patients within sight or sound of a staff member.

6. A manual of nursing care procedures.

7. An infirmary record that is a separate and distinct section of the medical record.

8. Compliance with applicable State statutes and local licensing requirements.

VII. TRANSPORTATION FOR ACCESS TO HEALTH SERVICES

A transportation system that assures timely access to services that are only available outside the correctional facility is required. Such a system needs to address the following issues:

- prioritization of medical need
- urgency (for example, an ambulance versus a standard transport)
- use of a medical escort to accompany security staff
- transfer of medical information

The safe and timely transportation of offenders for medical, mental health, and dental clinic appointments, both inside and out the correctional facility (for example, to the hospital, health

care provider, or another correctional facility) is the joint responsibility of the Warden or Program Administrator and the Health Services Administrator (TSCI) or Chief Operating Officer.

VIII. CHRONIC (see Medical Protocol 16) and CONVALESCENT CARE

A. Chronic and convalescent care will be made available to inmates.

There is a plan for the treatment of offenders with chronic conditions such as hypertension, diabetes, and other diseases that require periodic care and treatment. The plan must address the monitoring of medications, laboratory testing, the use of chronic care clinics, health record forms, and the frequency of specialist consultation and review.

B. Medical preventative care is provided to inmates of the facility when medically indicated.

IX. INDIVIDUAL TREATMENT PLANS

A. Secure institutions provide a special health program for inmates requiring close medical supervision. A written individual treatment plan for those inmates requiring close medical supervision, including chronic and convalescent care.

The plan includes directions to health care and other personnel regarding their roles in the care and supervision of the patient, is developed for each such inmate by the appropriate physician, dentist, or qualified mental health practitioner. Exercise areas are available to meet exercise and physical therapy requirements of individual offender treatment plans.

B. (As appropriate) Program staff is informed of inmates' special medical problems. Staff is also informed of any physical or mental problems that might require attention.

C. NDCS is not responsible to correct every medical condition of each inmate, unless otherwise approved by the Deputy Director, Health Services.

X. MEDICAL and DENTAL ADAPTIVE DEVICES

Medical or dental adaptive devices (eyeglasses, hearing aids, dentures, wheelchairs, or other prosthetic devices) are provided when the health of the inmate would otherwise be adversely affected, as determined by the responsible physician or dentist.

XI. ORGAN DONATION BY INMATES

This procedure only applies to living inmates.

A. Organ donations by inmates are only permitted when the recipient is an immediate member of the inmate's family. The inmate must request consideration as a donor in writing to the NDCS Deputy Director, Health Services. A written request must be received from the potential recipient's physician requesting consideration of the inmate as a donor. Authorization to screen the inmate as a potential donor will be made through a joint decision of the NDCS Director and Deputy Director, Health Services.

B. The inmate must sign a statement indicating the desire to donate an organ to the specific relative prior to the initiation of the evaluation. The consent must state the inmate understands the potential complications of the procedure and the inmate agrees to the procedure at his/her own free will.

C. When a surgical procedure is planned, all costs including preoperative evaluation, transportation, surgery, hospitalization, post-operative expenses, etc. are not the responsibility of the NDCS Medical Department unless prior approval by the NDCS Director and Deputy Director, Health Services is documented. (See Medical Protocol #2)

XII. ORGAN TRANSPLANT

A. NDCS ordinarily will not provide organ transplantation to inmates if other means of treatment are available and effective.

B. If medically indicated, the attending physician will submit a medical summary and written request to the NDCS Deputy Director, Health Services. This request will include a complete documentation of the inmate's history, present status, medical diagnosis, prognosis and request for consideration of transplant procedure.

C. The case will be presented to the NDCS Medical Staff.

D. The final disposition on organ transplantation will be a joint decision between the NDCS Director and Deputy Director, Health Services.

XIII. ELECTIVE SURGERY

Elective surgery shall not occur unless approved by the NDCS. Deputy Director, Health Services. All expenses incurred for the elective procedure will be the responsibility of the inmate unless otherwise approved. (See Medical Protocol #2)

A. Elective medical and dental services are those which:

1. Are provided for cosmetic reasons.

2. Are not necessary to maintain an inmate's basic physical health.

B. Non-elective medical and dental services are those which:

1. Are necessary to prevent death, or

2. Are necessary to prevent or treat acute traumatic injury, or

3. Are necessary to prevent or treat a chronic or acute disease, or

4. Are necessary to treat a physical disability which seriously impairs the inmate's use of sight, hearing, limbs, or otherwise seriously impairs ability to engage in gainful activity.

5. Are necessary to alleviate pain which is substantiated by some objective findings

6. Are necessary to monitor the inmate's health and evaluate health care needs

XIV. INFORMED CONSENT

All informed consent standards in the jurisdiction shall be observed and documented for inmate care in a language understood by the inmate. In the case of minors, the informed consent of a parent, guardian, or a legal custodian applies when required by law. When health care is rendered against the patient's will, it is in accord with State and Federal laws and regulations. Otherwise, any inmate may refuse (in writing) medical, dental, and mental health care.

A. Before rendering medical treatment to an inmate, a medical professional should inform the inmate of the potential adverse consequences of such medical treatment and give the inmate an opportunity to refuse the medical treatment or to accept the treatment. Where the potential adverse consequences of the proposed medical treatment are significant or the probability that adverse consequences are high, then the physician should note the potential adverse consequences in writing and obtain the inmate's signature on the notification, acknowledging its receipt and his/her consent to submit to the treatment. The decision of when such information or notifications should be given rests with the treating medical professional.

B. The informed consent of an inmate in a correctional facility shall be obtained before medical treatment is rendered. Medical treatment may be given to an inmate against his/her will only by court order or as provided in paragraph XIV.C.

C. The right of a mentally competent inmate to refuse medical treatment must be respected, no matter how seriously threatened his/her health may be as a result of that refusal except that under one or more of the following conditions, treatment may proceed without such informed consent:

1. Where the inmate has contracted a contagious illness or venereal disease which, in the opinion of the physician, represents a health threatening condition for the general inmate population of the facility, or

2. Where the inmate is suicidal or not mentally competent to render a reasonable decision on his/her own behalf, or

3. Emergency care involving patients who do not have the capacity to understand the information given.

XV. OBSTETRICS, GYNECOLOGICAL, FAMILY PLANNING and HEALTH EDUCATION

When and where applicable, obstetrical, gynecological, family planning and health education services should be provided. Pregnancy management shall include pregnancy testing, routine prenatal care, high-risk prenatal care, management of the chemically addicted pregnant inmate, comprehensive counseling and assistance, appropriate nutrition, postpartum follow-up and postpartum discharge family planning. No abortion services shall be provided to inmates and no public funds shall be expended to assist inmates in community centers to receive abortions in the community.

XVI. CONDOMS and BIRTH CONTROL PILLS

A. Condoms

1. Condoms will be made available to inmates by request only when discharged, paroled or furloughed from NDCS Institutions and will be dispensed by personnel from a central point determined by the Warden within the Institution. The primary reason for distribution is to prevent disease transmission and for purposes of family planning and birth control.

2. Within NDCS Institutions, condoms are considered to be contraband and will be confiscated from all inmates entering NDCS Institutions whether new admissions, returns from discharge, parole, or furloughs.

3. Inmates transferring from NDCS Institutions to Community Corrections Centers will not be issued condoms.

4. Pre-release education programs will be offered to all inmates regarding infectious disease control and use of condoms.

B. Birth Control Pills

1. Birth Control Pills may be issued to female inmates within institutions for health reasons upon a doctor's order, and not for the purpose of family planning or birth control.

2. Additionally, upon request, inmates may access the Elective Procedure Protocol (#2) to receive family planning and prescribed birth control pills 30 days prior to discharge or parole. They are not to be made available to inmates in anticipation of a furlough.

XVII NURSERY

In institutions where nursing infants are allowed to remain with their mothers, provisions are in place for a nursery, staffed by qualified persons, where infants are placed when they are not in the care of their mothers.

REFERENCE

I. ATTACHMENTS - None.

II. AMERICAN CORRECTIONAL ASSOCIATION (ACA) STANDARDS

A. Standards for Adult Correctional Institutions (ACI) (4th edition): 4-4344, 4-4346, 4-4347, 4-4348, 4-4349 4-4350, 4-4352, 4-4353, 4-4359 4-4375, 4-4397, 4-4398. 4-4400, 4-4407

B. Performance Based Standards for Adult Community Residential Services (ACRS) (4th edition): 4-ACRS-4C-01, 4-ACRS-4C-03, 4-ACRS-4C-14, 4-ACRS-4C-19, 4-ACRS-7D-26

NEBRASKA CORRECTIONAL SERVICES *Making A Difference*	**ADMINISTRATIVE REGULATION** **Department of Correctional Services State of Nebraska**	**NUMBER** **115.23**	**PAGE** **1 of 9**
		MENTAL HEALTH SERVICES	

This Administrative Regulation is to be made available in law libraries or other inmate resource centers.

EFFECTIVE: March 18, 1983
REVISED: February 27, 2004
REVISED: October 31, 2005
REVIEWED: August 31, 2006
REVISED: November 30, 2007
REVISED: October 22, 2008
REVISED: October 27, 2009
REVISED: October 27, 2010
REVISED: October 31, 2011
REVISED: December 7, 2012
REVISED: November 20, 2013
REVISED: December 5, 2014
REVISED: October 30, 2015

SUMMARY of REVISION/REVIEW

Added Parole Administrator to section XI.I.b.

APPROVED:

Dr. Randy Kohl,
Deputy Director Health Services

SCOTT FRAKES, Director
Nebraska Department of Correctional Services

PURPOSE

To provide for the mental health needs of inmates including the detection, diagnosis, treatment and referral of inmates with mental health problems.

GENERAL

It is the policy of the Nebraska Department of Correctional Services (NDCS) that there is written policy, procedure, and practice, approved by the appropriate mental health authority, to provide for all activities carried out by mental health services personnel, which specify the provision of mental health services for inmates. These services include but are not limited to those provided by qualified mental health professionals who meet the educational and license/certification criteria specified by their respective professional disciplines or mental health trained staff. Mental Health employees who work for other public or private agencies shall have their duties and responsibilities specified in a contract or other type of agreement. Students or interns delivering mental health services in any institution shall work under Mental Health staff supervision commensurate with their level of training. There is a written agreement between the facility and training or educational facility that covers the scope of work, length of agreement, and any legal or liability issues.

There is a written suicide prevention and intervention program that is reviewed and approved by the Medical Director. (Administrative Regulation (AR) 115.30, *Suicide Prevention/Intervention*). All staff with responsibility for inmate supervision are trained in the implementation of the program.

Operational Memoranda, specifically addressing mental health services, policies and practices shall implement this AR in specific facilities/programs within NDCS.

PROCEDURE

I. The Behavioral Health Assistant Administrator for Mental Health shall report to the Behavioral Health Administrator.

II. The operation and administration of the Mental Health Department shall comply with facility procedure. Security regulations applicable to facility personnel shall apply to mental health personnel.

III. A documented external peer review program for mental health professionals is used by facilities every two years.

IV. Internal peer review is completed approximately annually at each facility that provides mental health services per the procedures specified in Medical Protocol 36.

V. Each institution shall ensure that appropriate physical facilities and professional mental health staff are available to provide mental health services. The mental health program that includes at a minimum:

A. Screening for mental health problems on intake as approved by the mental health professional.

B. Outpatient services for the detection, diagnosis, and treatment of mental illness.

C. Crisis intervention and the management of acute psychiatric episodes.

D. Stabilization of the mentally ill and the prevention of psychiatric deterioration in the correctional setting.

E. Elective therapy services and preventive treatment where resources permit.

F. Provision for referral and admission to licensed mental health facilities for inmates whose psychiatric needs exceed the treatment capability of the facility.

G. Procedures for obtaining and documenting informed consent.

When mental health care services are rendered against an inmate's will, it is in accordance with state and federal laws and regulations. Otherwise, any inmate may refuse (in writing) mental health care services.

H. Mental health care encounters, interviews, examinations, and procedures should be conducted in a setting that respects the inmate's privacy.

VI. Each institution shall provide written policy and procedure for the identification of special needs inmates (AR 115.12, *Special Needs Inmate Programs*). Each institution shall ensure that psychiatric consultation is available for the management and treatment of inmates with special needs. Each institution shall ensure the availability of appropriate resources either within the institutions or within the community for treating those inmates who are diagnosed with major mental illness by a qualified psychiatrist, psychologist or licensed independent mental health practitioner.

Major mental illness is defined as one of the following:

A. A DSM-IV-TR diagnosis of one or more of the following: psychotic disorder, schizophrenia-spectrum disorder, or a mood disorder with psychotic features.

B. A DSM-IV-TR diagnosis of one or more of the following and meeting the threshold for high severity as defined in 2a: bipolar disorder, depressive disorder, other mood disorder, posttraumatic stress disorder, obsessive compulsive disorder, panic disorder, or other anxiety disorder.

High severity is defined as one or more of the following: functional impairment as defined as a DSM-IV-TR global assessment of functioning (GAF) score of 30 or below, multiple prior hospitalizations for mental illness, prior mental health board commitment, multiple suicide attempts and/or high lethality attempt(s).

VII. All intersystem and intrasystem transfer inmates will receive an initial mental health screening at the time of admission to the facility by mental health trained or qualified mental health care personnel. The mental health screening includes, but is not limited to:

A. Inquiry into:

1. Whether the inmate has a present suicide ideation

2. Whether the inmate has a history of suicidal behavior

3. Whether the inmate is presently prescribed psychotropic medication

4. Whether the inmate has a current mental health complaint

5. Whether the inmate is being treated for mental health problems

6. Whether the inmate has a history of inpatient and outpatient psychiatric treatment

7. Whether the inmate has a history of treatment for substance abuse

B. Observation of:

1. General appearance and behavior

2. Evidence of abuse and/or trauma

3. Current symptoms of psychosis, depression, anxiety, and/or aggression

C. Disposition of inmate:

1. To the general population

2. To the general population with appropriate referral to mental health care services

3. Referral to appropriate mental health care services for emergency treatment

VIII. During an inmate's initial medical/mental health screening, if it is determined that the inmate was receiving psychiatric and /or psychological services and/or psychotropic medication immediately prior to incarceration, the inmate will be requested to sign a release of information for prior treatment records. Any inmate determined to have been under psychiatric or psychological care immediately prior to incarceration shall be referred to the consulting or staff psychiatrist or Behavioral Health Assistant Administrator for Mental Health/designee to determine the need for continued mental health treatment and subsequent provision of such services. Psychotropic medications will be continued as prescribed upon incarceration or placement in NDCS custody from parole status until the inmate is seen by a NDCS employed or contracted prescriber (psychiatrist preferred, if available).

When an inmate is transferred to another facility within NDCS, psychotropic medication will be continued as ordered until the patient is seen by the facility employed or contracted prescriber (psychiatrist preferred, if available).

IX. All intersystem inmate transfers will undergo a mental health appraisal by a qualified mental health person within 14 days of admission to a facility. If there is documented evidence of a mental health appraisal within 90 days, a new mental health appraisal is not required, except as determined by the designated mental health authority. Mental health examinations include, but are not limited to:

A. Assessment of current mental status and condition

B. Assessment of current suicidal potential and person-specific circumstances that increase suicide potential

C. Assessment of violence potential and person-specific circumstances that increase violence potential

D. Review of available historical records of inpatient and outpatient psychiatric treatment

E. Review of history of treatment with psychotropic medication

F. Review of history of psychotherapy, psychoeducational groups, and classes or support groups

G. Review of history of drug and alcohol treatment

H. Review of educational history

I. Review of history of sexual abuse-victimization and predatory behavior

J. Assessment of drug and alcohol abuse and/or dependence

K. Use of additional assessment tools, as indicated

L. Referral to treatment, as indicated

M. Development and implementation of a treatment plan, including recommendations concerning housing, job assignment, and program participation

X. Inmates referred for mental health treatment (Attachment A - Mental Health/Medical Referral Form) will receive a comprehensive evaluation by a licensed mental health professional. The evaluation is to be completed within 14 days of the referral receipt date and include at least the following:

A. Review of mental health screening and appraisal data.

B. Direct observation of behavior.

C. Collection and review of additional data from individual diagnostic interviews and tests assessing personality, intellect, and coping abilities.

D. Compilation of the individual's mental health history.

E. Development of an overall treatment/management plan with appropriate referral to include transfer to mental health facility for inmates whose psychiatric needs exceed the treatment capability of the facility.

XI. The Behavioral Health Assistant Administrator for Mental Health shall maintain a Mental Health Care Record for each inmate that provides complete and accurate information on all mental health contacts during the course of his/her incarceration. The Mental Health Care Records and mental health client information are confidential and are to be treated as such by all personnel.

Those charged with the responsibility for collecting, assembling, maintaining or releasing information have a duty to respect and protect that confidentiality.

A. A Mental Health Care Record is the responsibility of the Behavioral Health Assistant Administrator for Mental Health or designee.

B. The Mental Health Care Record shall be maintained separately from the Inmate Master Record File that is maintained in the Records Office at the institution in which the inmate resides. Mental Health Care Records are maintained in a location within the Mental Health department at the institution in which the inmate resides.

C. The Mental Health staff shall include the following, as appropriate, when recording entries in the record:

1. Summary of what the inmate states is the problem;
2. Observation of the inmate's behavior;
3. Assessment of the inmate's problem;
4. Plan of action.

D. The Mental Health Care Record shall be used whenever Mental Health staff interviews the inmate. An entry shall be logged on the Mental Health Contact Notes form for each inmate therapy contact (Attachment B - Mental Health Contact Notes).

1. All therapeutic contacts with inmates shall be documented in the inmate's Mental Health Care Record on the date the contact occurs. If the inmate's Mental Health Care Record is not available, such documentation shall occur on a blank Mental Health Contact Note or record form as soon as possible following the contact.
2. Group contact notes shall be completed as soon as possible following the contact.
3. It is mandatory that all crisis contacts (i.e., with an inmate with possible suicidal ideation, homicidal ideation) be documented in writing the day of the contact. If the inmate's Mental Health Care Record is not available, the documentation can be made in the Psychiatric section of the Health Care Record, with a copy being placed in the Mental Health Care Record at least by noon the first workday following the contact.
4. Mental Health Contacts with inmates in one of the Department's skilled nursing facilities shall be made in the Psychiatric section of the Health Care Record, with a copy being placed in the Mental Health Care Record as soon as possible following the contact, but at least by noon of the first workday following the contact.
5. The complete Mental Health Care Record may contain information from the following areas: Individual contact notes, group therapy notes, psychiatric consultations, psychological evaluations, psychological testing data, classification study including medical reports, treatment plans, summaries of treatment, review notes, and other pertinent data.

6. Electronic Mental Health Care Records are considered equivalent to paper records.

E. Outside information and all information not generated by NDCS shall be kept in a separate file inside the Mental Health file and labeled "Outside Information".

F. When an inmate is transferred from one correctional facility to another, the original Mental Health Care Record for that person shall be transferred to the Mental Health Department of the receiving facility at the time of transfer, provided there is qualified mental health staff to receive the record.

G. When an inmate is discharged from a correctional facility, paroled, dies or is placed in a community corrections program, the Mental Health Care Record shall be maintained in a secure setting as specified by the Behavioral Health Assistant Administrator for Mental Health.

H. Inactive Mental Health Care Records shall be filed and retained as permanent records. They will be maintained and stored in a secure area as determined by the Behavioral Health Assistant Administrator for Mental Health. Inmates who have been discharged from NDCS shall have their Mental Health files maintained per the NDCS approved records retention schedule.

I. Confidentiality and Release of Mental Health Information:

1. The principle of confidentiality applies to an inmate's Mental Health Care Record and information about an inmate's mental health status.

2. Access to the Mental Health Care Records shall be controlled by the Behavioral Health Assistant Administrator for Mental Health or designee and shall not be granted without a court order except as stated below.

a. All NDCS and NDCS contract medical and mental health personnel, including psychiatrists and treating physicians, with a demonstrated need to know may have professional access to mental health records without authorization from the inmate.

b. The Behavioral Health Assistant Administrator for Mental Health or designee shall also share information regarding an inmate's management, security and ability to participate in programs with the Warden/ designee of the facility or the Parole Administrator on a demonstrated need-to-know basis. The Warden/designee or Parole Administrator with a demonstrated need to know may have access to the Mental Health Care Records without authorization from the inmate. Only information necessary to preserve the health and safety of an inmate, other inmates, volunteers, visitors, or NDCS staff is provided.

c. Attorneys representing NDCS in litigation are free to examine the Mental Health Care Record without the inmate's written or verbal permission.

d. The release of departmental-generated information from Mental Health Care Records shall be controlled by the Behavioral Health Assistant Administrator for Mental Health or designee and shall not be granted without a court order or as stated below.

1) Other State Agencies

A release of information shall be obtained from the inmate using either the Nebraska Department of Correctional Services' 'Consent to Disclosure of Information' (Attachment C) or appropriate release form received from the requesting agency.

2) Physicians and Health Care Institutions

Requests for Mental Health Care Record information by outside physicians or health care institutions may be granted upon proper written authorization from the inmate.

3) Workers' Compensation Claims

Mental Health Care Record information may be released to an employee (present or former), an employer, the carrier, and the Workers' Compensation Court in accordance with Nebraska's Workers' Compensation Act. (Neb. Rev. Stat. §48-120(4)).

4) Nursing Homes

Mental Health Care Record information may be released to nursing homes with a written authorization from the inmate.

3. An inmate may request access to his/her psychological and Mental Health Care Record, and the Department will allow inmates access to their psychological and mental health records upon request unless any treating physician, psychologist, or mental health practitioner determines in their professional opinion that release of the records would not be in the best interest of the patient unless the release is required by court order. (Neb. Rev. Stat. §71-8403).

4. Original Mental Health Care Records Leaving Mental Health Department

a. The original Mental Health Care Record or information contained therein is not to leave the Mental Health Department unless so specified by Court Order (Neb. Rev. Stat. §83-287). If a copy is acceptable as evidence, the original shall be returned to the Mental Health office.

b. No original documentation of Mental Health contacts with an inmate shall be removed from the Mental Health area of the facility at which the inmate is housed.

XI. Mental Health employees who work for other public or private agencies shall have their duties and responsibilities specified in a contract or other type of agreement. An outside employment form shall be completed and reviewed per NDCS policy. Students or interns delivering mental health services in any institution shall work under direct mental health staff supervision commensurate with their level of training.

REFERENCE

I. STATUTORY REFERENCE:

A. Neb. Rev. Stat. §71-8403

B. Neb. Rev. Stat. §48-120

II. ADMINISTRATIVE REGULATIONS

A. AR 115.12, *Special Needs Inmate Programs*

B. AR 115.30, *Suicide Prevention/Intervention*

III. ATTACHMENTS

A. Mental Health/Medical Referral Form DCS-A-mnh-004 (11/98)

B. Mental Health Contact Notes DCS-A-mnh-005 (6/99)

C. Consent to Disclosure of Information DCS-A-adm-009 (11/00)

IV. AMERICAN CORRECTIONAL ASSOCIATION (ACA) STANDARDS

A. Standards for Adult Correctional Institutions (ACI) (4th edition) 4-4368

B. Performance Based Standards for Adult Community Residential Services (ACRS) (4th edition): 4-ACRS-4C-15, 4-ACRS-4C-16

NEBRASKA CORRECTIONAL SERVICES *Making A Difference*	**ADMINISTRATIVE REGULATION** **Department of Correctional Services State of Nebraska**	**NUMBER** 115.30	**Page 1 of 9**
		SUICIDE PREVENTION/INTERVENTION	

OFFICIAL USE/DISTRIBUTION ONLY

EFFECTIVE: April 17, 1998
REVISED: May 14, 2007
REVISED: May 14, 2008
REVISED: April 18, 2009
REVIEWED: April 22, 2010
REVISED: April 25, 2011
REVISED: May 7, 2012
REVISED: April 30, 2013
REVISED: August 11, 2014
REVISED: April 30, 2015
REVIEWED: April 30, 2016

SUMMARY of REVISION/REVIEW

Section III.A.1. added d. Identification of follow-up. Attachments re-lettered.

Randy T. Kohl, M.D.
Medical Director,
Nebraska Department of Correctional Services

APPROVED:

Scott R. Frakes, Director
Nebraska Department of Correctional Services

PURPOSE

To establish guidelines for a suicide prevention/intervention program, this includes a notification and review process.

GENERAL

It is the policy of the Nebraska Department of Correctional Services (NDCS) that there is a written Suicide Prevention/Intervention Program that is reviewed and approved by a qualified medical or mental health professional; that all staff with responsibility for inmate supervision will be trained in the implementation of the program; that there is a uniform process of review for incidents of suicide/attempted suicide; and that there is a process for notification of appropriate staff, law enforcement and next of kin.

Each institution shall develop its own version of this regulation within the limits and guidelines, which follow.

PROCEDURE

I. SUICIDE PREVENTION PROCEDURES

A. Training

1. All new hires will participate in at least four hours of pre-service suicide prevention/intervention training.

2. All staff having direct inmate contact will participate annually in one hour of in-service suicide prevention/intervention training.

3. All staff having direct inmate contact will receive training on the use of all equipment in the Emergency Response Kits.

4. Training will include information about the demographic and cultural parameters in suicide precipitating factors so there is an understanding of these issues.

B. Intake Screening and Assessment

1. All newly admitted inmates to the Diagnostic and Evaluation Center (DEC), the Nebraska Correctional Youth Facility (NCYF), and to the Nebraska Correctional Center for Women (NCCW) will undergo a structured inquiry of potential suicidal history, thinking and behavior. (Attachment A - Behavioral observations and Suicide Assessment)

2. Potentially suicidal inmates will be referred to the Mental Health Department.

C. Restrictive Housing Admissions

1. Upon admission to restrictive housing, the Shift Supervisor shall review with the inmate the Restrictive Housing Admission Self-Report Suicide Screening (Attachment B). Designated staff will be trained in the utilization of this instrument. This screening instrument is utilized to determine the level of follow up Mental Health Services needed. If the inmate indicates suicidal ideations

upon admission to restrictive housing, staff will maintain constant supervision and will notify their supervisor. The screening instrument will be forwarded to Mental Health within 24 hours of inmate admission into the Restrictive Housing Unit. This form will be added as an attachment to the Shift Supervisor's Post Orders and will also be included with each Inmate's Immediate Segregation packet.

D. To facilitate the recognition of a suicidal inmate, all staff will be alert to the following behaviors, which may indicate suicidal ideation.

1. Loss of interest in activities or relationships in which the inmate had previously engaged and enjoyed.

2. Depressed state, indicated by withdrawal, periods of crying or lethargy, sleep disturbance, sudden shift in mood from depressed to elevated, restlessness, such as pacing in a robot-like manner.

3. Active discussion of suicide plans, such as when, where and how suicide might occur.

4. Giving away possessions, saying good-bye or other behavior suggestive of arranging for the end.

5. Experience of great personal loss, such as loss of spouse, child, business or freedom, due to incarceration or denial or revocation of parole.

6. History of suicidal gestures.

7. Suicidal manipulations/gestures, which could result in death.

E. Emergency Response Kits

1. An Emergency Response Kit, comprised of the institutions' regular first aid kit and the following items, will be made available in every housing unit.

   a. Hook knife (1).

   b. Latex gloves (1 pair).

   c. Scissors (1 pair).

   d. One-way CPR mask (1).

   e. Compression dressings.

   f. Checklist outlining Emergency Response Procedures (1) (Attachment C).

2. Hook knives also will be carried by designated staff and/or kept in designated areas of each institution, which will allow prompt and easy access in emergency situations.

II. SUICIDE INTERVENTION PROCEDURES

A. Staff identifying an inmate exhibiting suicidal ideation/behavior shall:

1. Notify other staff

a. Shift Supervisor or designee.

b. Medical.

c. Mental Health Supervisor or designee, or Mental Health Officer of the Day (MHOD).

2. Follow the guidelines listed below, until supervisory staff instructs otherwise.

a. Maintain constant supervision/observation of the inmate.

b. Remain calm, supportive and kind – yet firm.

c. Tell the inmate you do not want him/her to hurt himself/herself.

d. Reassure the inmate that you are there to help him/her.

e. Keep the inmate away from those person(s) or situation(s) who/that may have precipitated the event.

f. Remove potentially harmful items from the inmate and the room in which he/she is placed (e.g., razor blades, belts, pens, pencils, glasses and any other sharp items).

g. Isolate the inmate from the general prison population to a controlled area.

h. Give the inmate time to regain his/her composure.

i. Ask specific questions and talk directly about suicide. Avoid euphemisms, philosophical, moral or religious discussion about suicide.

j. Focus on what is stopping the inmate from committing suicide.

k. Offer reassurance about the <u>temporary</u> aspect of the inmate's problem.

l. Confront inconsistencies in what the inmate is telling you, and listen for ambivalence. Point these out.

m. Do not abuse, tease, deceive or threaten the inmate in any way.

3. Document the Incident

a. Record the incident on an Incident Report giving all pertinent information including, but not limited to, name and number of inmate, other inmates

and staff involved and/or knowledgeable of the situation, date and time of day, precipitating events, method of self-harm and other behavior exhibited by the inmate, action taken, and your name and position.

b. The Incident Report will be provided to the Warden of the institution, Behavioral Health Assistant Administrator for Mental Health, the Medical Director, or their designees.

B. Staff identifying an inmate engaged in a suicide attempt shall:

1. Assess the situation, being cognizant of an attempt of diversion.

2. Call for assistance.

3. Begin appropriate medical procedures.

C. The shift supervisor or designee, Medical staff and the Mental Health Supervisor, designee, or MHOD will consult to determine whether the inmate should remain in the current living location, be moved or transferred to another housing and/or institutional assignment, or placed in a community facility (i.e., hospital), as well as the need for supplemental supervision aids and/or clothing modification.

1. When standard issued clothing presents a security or medical risk (e.g., suicide observation), provisions are made to supply the offender with a security garment that will promote offender safety in a way that is designed to prevent humiliation and degradation.

2. Those inmates who are determined to be actively suicidal may be placed in an infirmary or placed in a segregation observation room and monitored under constant or intermittent supervision (15 minute staggered checks) on Plan A or Plan B Suicide Watch as determined by Medical, Mental Health, and Security staff. Medical, Mental Health, and Security staff, in joint agreement, may modify Plan A and Plan B based on clinical judgment. Plan A and Plan B Suicide Watch are defined as follows:

<u>PLAN A</u>
Security blanket (one or two depending on thermal need) (only a non-moveable bed frame)
No Mattress
No Linens
No pillows
No reading material
No furniture
No personal effects
Only paper clothing
No hot drinks
Flexible plastic spoons with meals
Finger toothbrush/flexible toothbrush/security toothbrush, wash cloth, and towel offered twice a day by staff (must be returned in original condition)
No shower outside of cell
No sharps

No daily exercise period outside cell
15 minute checks
Sergeant or Lieutenant must be present to open door

PLAN B
Security blanket (one or two depending on thermal need)
One mattress
One pillow without a pillowcase
One piece of reading material with no staples
No furniture
No personal effects
No sharps
One T-shirt, one pair of shorts, and one pair of socks
Plastic spoon or spork with regular tray (must be returned in original condition)
Shower under direct supervision
Regular toothbrush offered twice a day (must be returned in original condition)
No daily exercise period outside of cell
15 minute checks
Sergeant or Lieutenant must be present to open door

3. The application and removal of restraints for a suicidal inmate will be a joint decision among Medical, Security and Mental Health staff.

4. Mental health staff will determine the need for psychiatric consultation and/or intervention.

5. For those inmates who are placed on segregated status or returned to the general prison population, Medical and Mental Health staff may authorize intermittent supervision (15 minute staggered checks), or any other plan closely monitoring his/her behavior.

6. The discharge of the suicidal inmate from the hospital or other segregated areas will be a joint decision among Medical, Security and Mental Health staff.

D. In case of a suicide attempt resulting in hospitalization or a suicide, the Central Office Officer-of-the-Day (OD), Behavioral Health Assistant Administrator for Mental Health and the institutional MHOD shall be notified by telephone as soon as possible. The Central Office OD shall notify the Deputy Director of Institutions (for the secure institutions), the Deputy Director of Programs and Community Services (for the community corrections centers and the Work Ethic Camp), and the Director.

III. REVIEW PROCESS

A. The institutional Warden shall conduct an administrative review of all suicides and life threatening suicide attempts requiring infirmary placement

1. A packet will be developed, consisting of the following:

a. A cover sheet: Administrative Review of Suicides/Attempted Suicides form. (Attachment D)

b. Compilation of and review of all staff reports regarding the incident.

c. Inmate name and number, time, date and place of the incident.

d. Identification of any follow-up action initiated based on the specifics of the incident.

2. The packet will be reviewed through the institution's chain of command and then forwarded to the Deputy Director of Institutions (for the secure institutions) or the Deputy Director of Programs and Community Services (for the community corrections centers and the Work Ethic Camp) within 10 working days of the incident, with a copy to the Behavioral Health Administrator, the Behavioral Health Assistant Administrator for Mental Health and the Deputy Director for Health Services.

3. The packet received by the Deputy Director of Institutions or Programs and Community Services will be shared with the other Deputy Directors and with the Director.

B. The institution's Warden, in consultation with Mental Health staff, will determine whether or not a Critical Incident Stress Debriefing (AR 115.24, *Critical Incident Stress Management (CISM)*) is appropriate for suicidal incidents, suicide watch and suicides. A CISM intervention may also be performed for other incidents such as serious assault.

1. Indication that such services are in process shall be recorded in the cover sheet of the Warden's written report.

2. Details of such debriefing services will remain confidential, in accordance with AR 115.24; however, conclusions of a general nature, arrived at by the debriefing team, may be shared with the institution's Warden.

C. The Behavioral Health Assistant Administrator for Mental Health will designate a Mental Health staff person to complete a Psychological Autopsy for all suicides and, as he/she deems appropriate, for attempted suicides.

1. The Psychological Autopsy will include, but not necessarily be limited to, the following areas:

a. Identifying information.

b. Background information.

c. Antecedent circumstances.

d. Clues of suicide/attempt prior to incident.

e. Description of suicidal act/attempt.

f. Conclusions/recommendations.

g. List of documents examined.

2. Mental Health staff shall have full and complete access to institutional staff reports, administrative review reports, institutional staff, and the inmate (in the case of a suicide attempt). In addition, Mental Health staff may initiate contact with the inmate's family and friends, including other inmates, to obtain additional information.

3. The report shall be completed within 30 working days. Upon completion of the Psychological Autopsy, the Behavioral Health Assistant Administrator for Mental Health shall forward the report to the Behavioral Health Administrator and the Medical Director.

4. Upon receipt of the Psychological Autopsy, the Medical Director will share the report with the Director, the Deputy Director of Institutions, the Deputy Director for Administrative Services, and the Deputy Director of Programs and Community Services.

D. Policy/Procedure Changes and Feedback

1. Following the review of the Psychological Autopsy and/or the Administrative Review, the Deputy Directors may recommend changes to relevant institutional procedures or initiate relevant policy changes.

2. The Psychological Autopsy will be shared with the Warden following Deputy Director/Director review. Comments from the Deputy Directors and/or the Director, stemming from the Administrative Review, will also be shared with the Warden.

E. Notification of Law Enforcement and Next-of-Kin

1. In the event of a suicide, the relevant law enforcement agencies and next-of-kin will be notified, in accordance with AR 115.13, *Serious Illness or Injury, Advance Directives and Death,* Section V.

2. The process of conducting the Administrative Review and the Psychological Autopsy will proceed separately from law enforcement investigations.

3. At the request of the investigating law enforcement agency, copies of Administrative Review and Psychological Autopsy materials may be made available through the Director's office.

REFERENCE

I. Administrative Regulation 115.13, *Serious Illness or Injury, Advance Directives and Death*
Administrative Regulation 115.24, *Critical Incident Stress Management (CISM)*

II. ATTACHMENTS

A. Behavioral Observations and Suicide Assessments, DCS-A-adm-071

B. Restrictive Housing Admission Self-Report Suicide Screening

C. Emergency Response Kit Checklist/Check Card,

D. Administrative Review of Suicides/Attempted Suicides.

III. AMERICAN CORRECTIONAL ASSOCIATION STANDARDS

A. Adult Correctional Institutions (fourth edition): 4-4373,

B. Adult Community Residential Services (fourth edition): 4-ACRS-4C-16

NEBRASKA CORRECTIONAL SERVICES *Making A Difference*	**ADMINISTRATIVE REGULATION** **Department of Correctional Services State of Nebraska**	**NUMBER** **115.02**	**Page 1 of 3**
		HEALTH PERSONNEL MANAGEMENT	

OFFICIAL USE/DISTRIBUTION ONLY

EFFECTIVE:	May 6, 1991
REVIEWED:	August 31, 2006
REVIEWED:	July 31, 2007
REVISED:	September 26, 2008
REVISED:	September 24, 2009
REVISED:	September 30, 2010
REVIEWED:	September 27, 2011
REVISED:	September 21, 2012
REVIEWED:	October 25, 2013
REVISED:	November 24, 2014
REVIEWED:	September 30, 2015

SUMMARY of REVISION/REVIEW

Annual review completed with Director name change.

APPROVED:

RANDY T. KOHL, M.D.
Deputy Director, Health Services

SCOTT FRAKES, Director
Nebraska Department of Correctional Services

PURPOSE

To protect the health of inmates within the Nebraska Department of Correctional Services (NDCS) by ensuring health care providers are properly licensed, trained and/or supervised.

GENERAL

It is the policy of NDCS that all health care professionals comply with applicable federal, state and/or local licensure and/or certification requirements; that standing and direct orders be adhered to as appropriate; and that appropriate supervision and limitations govern the use of students, interns, health trained staff and inmate assistance. This policy applies to all institutions, unless specified differently.

If the facility provides health care services, they are provided by qualified health care personnel whose duties and responsibilities are governed by written job descriptions that are on-file in the facility and are approved by the health authority. If offenders are treated at the facility by health care personnel other than a licensed provider, the care is provided pursuant to written standing or direct orders by personnel authorized by law to give such orders.

PROCEDURES

I. QUALIFICATIONS

Appropriate state and federal licensure, certification or registration requirements and restrictions shall apply to personnel who provide health care services to inmates. The duties and responsibilities of such personnel are governed by written job descriptions approved by the NDCS health authority. Verification of current credentials and job descriptions are on file in the facility and consists of copies of credentials or a letter confirming credential status from the State licensing or certification body.

II. STAFFING

The facility uses a staffing analysis to determine the essential positions needed to perform the health services mission and provide the defined scope of services. A staffing plan is developed and implemented from this analysis. There is an annual review by the Health Authority to determine if the number and type of staff is adequate.

III. ADMINISTRATION of TREATMENT

All treatment by health care personnel other than a physician, dentist, psychologist, optometrist, podiatrist, or other independent provider shall be performed pursuant to written standing or direct orders by personnel authorized by law to give such orders. Nurse practitioners and physician's assistants may practice within the limits of applicable laws and regulations.

IV. STUDENTS and INTERNS

Any students, interns, or residents delivering health care in the facility, as part of a formal training program, work under staff supervision, commensurate with their level of training. There is a written agreement between the facility and training, or educational facility that covers the scope of work, length of agreement, and any legal or liability issues. Students or interns agree in writing to abide by all facility policies, including those relating to the security and confidentiality of information.

V. HEALTH TRAINED STAFF

When institutions do not have full-time, qualified health-trained personnel, a health-trained staff member coordinates the health delivery services in the institution under the joint supervision of the responsible NDCS health authority and warden.

VI. INMATE ASSISTANTS/VOLUNTEERS

If volunteers or assistants are used in the delivery of health care, there is a documented system for selection, training, staff supervision, facility orientation, and a definition of tasks, responsibilities, and authority that is approved by the health authority. Volunteers may only perform duties consistent with their credentials and training. Volunteers agree in writing to abide by all facility policies, including those relating to the security and confidentiality of information.

Unless prohibited by state law, inmates (under staff supervision) may perform familial duties commensurate with their level of training. These duties may include the following:

A. Peer support and education;

B. Hospice activities;

C. Assisting impaired inmates on a one-on-one basis with activities of daily living; and/or

D. Serving as a suicide companion or buddy if qualified through a formal program that is part of a suicide prevention plan

Inmates shall not be used for the following duties:

A. Performing direct patient care services, unless trained and certified to provide such services.

B. Scheduling health care appointments.

C. Determining access of other inmates to health care services.

D. Handling or having access to surgical instruments, syringes needles, medications, or health records.

E. Operating diagnostic or therapeutic equipment.

REFERENCES

I. ATTACHMENTS - None.

II. AMERICAN CORRECTIONAL ASSOCIATION (ACA) STANDARDS

A. Standards for Adult Correctional Institutions (ACI) (4th edition): 4-4382, 4-4383, 4-4384,4-4391, 4-4392, 4-4393, 4-4412

B. Performance Based Standards for Adult Community Residential Services (ACRS) (4th edition): 4-ACRS-4C-17 4-ACRS-4C-18

om: Carbaugh, Abby L
ent: Tuesday, July 12, 2016 12:16 PM
To: Kate Bolz
Cc: Beaty, Jeffry
Subject: RE: Mental Health Staff Question
Attachments: BH.FTE.overview.6-30-16.xlsx; BH.orgchart.6-30-2016.pdf; ACA Memo RE Staffing.pdf

Good afternoon, Senator Bolz,

I received some feedback for your original request and have included it below:

NDCS Administrative Regulation (AR) 115.02, Health Personnel Management, Procedures, II. Staffing, states:

"The facility uses a staffing analysis to determine the essential positions needed to perform the health services mission and provide the defined scope of services. A staffing plan is developed and implemented from this analysis. There is an annual review by the Health Authority to determine if the number and type of staff is adequate."

This is policy language is specific to an American Correctional Association (ACA) standard and refers specifically to medical staffing. The documentation used for ACA audits is attached. The documentation suffices to meet the standard during the accreditation audit.

In reviewing this language and our documentation, we have determined a more in-depth review of our practice is in order. The chief operating officer for Health Services will be identifying what the best practice should be and developing more specific language and process to meet this standard and make it useful to the agency, recognizing that a review coinciding with the biennium budget process would likely be more useful.

That said, we have also included information below, organizational charts for Behavioral Health and a spreadsheet listing all behavioral health positions, identifying those that are filled/vacant.

While acknowledging NDCS continues to struggle with vacancies, recruitment has been enhanced by the credibility and strength of our new Psychiatric & Behavioral Health leadership team.

Chief of Psychiatry position created by Legislature filled 8/24/15 by Martin Wetzel, MD
Behavioral Health Administrator filled 8/24/15 by Lisa Jones, PhD
Assistant B.H. Admin–Mental Health filled 9/7/15 by Alice Mitwaruciu, PhD

Recruitment Successes of this leadership team include:

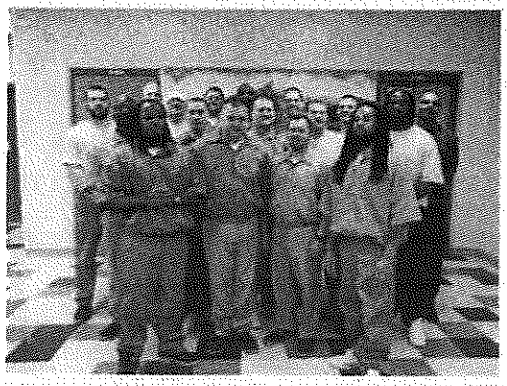
1. Staff Psych Nurse Practitioner hired from LRC 9/28/15 @ DEC
   - Returned to LRC 6/6/16
2. Contract Psych Nurse Practitioner hired part time (4-6 days/month) @ LCC 10/8/15 to direct bill BCBS
3. Staff Psychiatrist –hired on staff full time @ OCC/NCCW 1/4/16 (after 14 years as part time Contractor)
4. Staff Psychologist –hired on staff full time @ NCCW 2/22/16 (provisionally licensed/needs supervision hours)

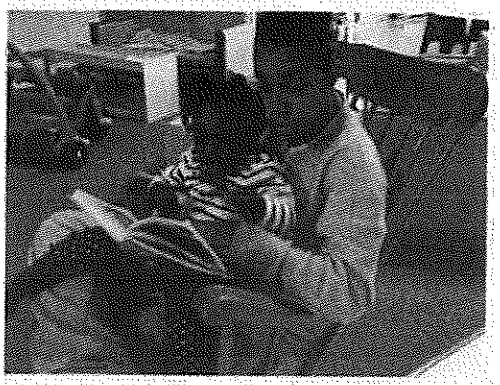
035

ATTACHMENT 40

Health Services

Inmate Health Plan





July 1, 2016

036

Nebraska Legislature http://nebraskalegislature.gov/laws/statutes.php?statute=83-4,153

Nebraska Revised Statute 83-4, 154

Nebraska Correctional Health Care Services Act:

Terms, defined.

For purposes of the Nebraska Correctional Health Care Services Act:

- Community standards of health care means medical care of type, quality and amount that any individual residing within the community in question could expect to receive in that community.
- Department means Department of Correctional Services;
- Health care services means medical care provided by or on behalf of the Department to inmates and includes practice of medicine and surgery; the practice of pharmacy, nursing care, dental care, optometric care, audiological care, physical therapy, mental health care and substance abuse counseling and treatment;
- Inmate means an individual in custody of the Department; and
- Medical doctor means a person licensed to practice medicine and surgery in NE.

This *Inmate Health Plan* outlines NDCS's commitment to comply with Nebraska Correctional Health Care Services Act. *NDCS Community* is made up of ten correctional facilities located across Nebraska and the standard of care is reflective of services typically found in Nebraska communities of 5000 or more people. Specialized services are provided when medically indicated.

For more detailed information:

Click on referenced Administrative Regulations (A/R) links - Table of Contents page 26

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HEALTH SERVICES – Mission, Vision & Values

MISSION

Provide humane, comprehensive and integrated health care; including program opportunities consistent with standards of quality and scope of services found in communities to promote health and well-being of individuals placed in our custody.

VISION

Strive to continually improve health of individuals placed in our custody by developing integrated delivery systems that efficiently provide a continuum of needed, accessible and quality services.

VALUES

Excellence:

Fostering excellence through:

- Continuous Quality Improvement
- Cooperative partnerships and teamwork
- Cost efficiency, effectiveness and appropriate utilization of resources
- Diversity
- Flexibility
- Open communication and mutual respect
- Ownership and commitment
- Recruiting and retaining high quality staff

Service:

Delivering services:

- Which encourage inmates to share responsibility in their health care and well-being
- Which promote rehabilitation and re-entry into society
- In partnership with community resources
- Responsively
- With care and compassion
- In a seamless continuum
- In an efficient and effective manner
- Through holistic and preventative philosophies

Personal and Professional Growth:

- Building and expanding knowledge, skills and abilities through educational and training
- Developing leadership potential
- Fostering accountability

Credibility:

- Community Standards of Care
- Integrity
- Professionalism
- Quality services
- Reliable, consistent service

Index
Inmate Health Plan (IHP)
Effective 7/01/2016 Until Revised

Nebraska Depart of Correctional Services (NDCS)

Inmate Health Plan (IHP)

Introduction

Nebraska Department of Correctional Services (NDCS) provides medically necessary behavioral health and medical care to inmates incarcerated in our ten (10) facilities.

The Inmate Health Plan (IHP) defines which services are medically necessary; but is not a contract or a guarantee of services to inmates.

The IHP describes behavioral health and medical care services available to inmates; as well as services that are limited, elective or not available.

To be covered by the IHP, services must be:

- Medically necessary OR
- Necessary for the health and safety of the incarcerated community for public health reasons (for example, treatment for head lice) OR
- Required by law, regulation or NDCS policy AND
- Ordered by a NDCS health care Provider/Practitioner AND
- Authorized according to NDCS policies and procedures AND
- Delivered in the most cost-effective manner and location consistent with safe, appropriate care

If a facility is unable to provide any of the services listed below, an inmate may be transferred to another facility to assure access to the medically necessary services.

Definitions

Activities of Daily Living (ADLs)

Activities related to personal care including but not limited to: bathing/showering, dressing, eating, getting in/out bed/chair, using toilet, walking or assisted mobility

APRN - NP

Advanced Practice Registered Nurse - Nurse Practitioner

Authorization for Medically Necessary Care

- Approval authorization granted by NDCS Deputy Director – Health Services (Medical Director) is initiated by NDCS facility Providers.
- Automatically implies NDCS will pay expenses associated with authorized care; except as otherwise defined by contract or statute,
- Medically Necessary Care is a United States legal doctrine, related to activities which may be justified as reasonable, necessary and/or appropriate, based on evidence-based clinical standards of care.

Behavioral Health Administrator & Assistant Behavioral Health Administrator

Licensed Clinical Psychologists

Care (Health Care)

Includes collecting historical and current health care information, physical and/or psychological examination, diagnostic tests, treatments and communicating assessment and plans with the patient.

Chief of Dental Services

Licensed Doctor of Dental Surgery or Doctor of Dental Medicine who acts as statewide dental health authority

Chief Operating Officer (COO) – Health Services

Masters level Administrator who may also serve as Nursing Home Administrator for Three (3) Skilled Nursing Facilities (SNF)

Chief of Psychiatry

New position created by Legislature that started 8-24-2015

Licensed Doctor of Medicine or Osteopathy

- Board Certified by American Board of Psychiatry

Deputy Director - Health Services (Medical Director)

Licensed Doctor of Medicine or Osteopathy who acts as statewide clinical health services authority

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Director of Nursing (DON)

Registered nurse who supervises care of all patients at our ten (10) health care facilities including direct supervision of three (3) DONs at Skilled Nursing Facilities. This position has special training that pertains to health care management, facility operations, fiscal budget, and is responsible for communication between nursing staff and physicians/providers.

Durable Medical Equipment (DME)

- Non-expendable materials including, but not limited to braces, splints, walking aids, prostheses, orthotics, respiratory assistance machines and wheel chairs.
- NDCS will provide patients with medically necessary equipment and training for: prosthetics, orthotics and supplies as ordered by NDCS health care Practitioners to treat or correct specific covered conditions.
- Equipment provided under this IHP will be considered NDCS property.
- Patient's signature confirms his/her receipt of information. If the patient refuses to sign, NDCS will provide service according to guidelines.
- Refusal to sign should be documented in medical chart.
- NDCS will replace or repair medically necessary DME at state expense when replacement or repair is required due to:
    - normal wear and tear.
    - circumstances not preventable by the patient and outside their control.
- DME replacement or repair cost may include professional fees, testing, labor, travel and associated custody fees.

Emergency

- Health care situation in which most similarly trained and experienced persons would agree immediate intervention is necessary for effective treatment of a medical condition.
- **AND** it would be significantly dangerous to the patient to postpone care until authorization obtained from Deputy Director - Health Services.
- Emergencies are not limited to life-threatening situations and may include serious evolving infections; severe pain; psychiatric conditions; and significant allergic reactions.
- Medically necessary emergency assessment, treatment and related services will be available at all times. Services will be consistent with the needs of the inmate as determined by a NDCS healthcare Provider.

- An inmate may be transferred to a community hospital or emergency room for care, if the level of service required cannot be adequately provided in the facility.
- If medically necessary, an inmate may be transported by ambulance, including air ambulance, to expedite transfer to the most appropriate care setting.

Health Care

- Sum of all action taken, preventive and therapeutic, to provide for the physical and mental well-being of a population. It includes medical, dental, mental health, substance abuse, nursing, personal hygiene, dietary and environmental conditions.

Inmate Patient

- Person incarcerated under NDCS jurisdiction (not on escape status) assigned to total confinement in a max, medium or minimum facility.
- Includes inmates boarding in NDCS community facilities.
- NDCS inmate receiving health care from or approved by NDCS.

Intractable Pain

Pain that is moderate to severe in intensity

- **AND** frequent or constant in occurrence
- **AND** physiologically plausible based on objective evidence from examination or tests
- **AND** unresponsive to conservative measures including, but not limited to: reasonable trials of various analgesics; discontinuation of potentially exacerbating activities such as sports and work; physical therapy or a reasonable trial of watchful waiting.

Major Mental Illness

When a patient's mental illness appears to be the cause of severe disability (impairment in social, occupational or other important areas of functioning) the Mental Illness Review Team (MIRT) will decide - based on DSM 5 (or current DSM edition) diagnosis, functioning and other factors - which inmates are added or removed from Major Mental Illness list.

Major Mental Illness is defined as one of the following:

A. DSM 5 diagnosis of one or more of the following: Schizophrenia, Delusional Disorder, Schizophreniform Disorder, Schizoaffective Disorder, Brief Psychotic Disorder, Substance-induced Psychotic Disorder (excluding intoxication and withdrawal), Other Specified Schizophrenia Spectrum and Other Psychotic Disorder, Major Depressive Disorder and Bipolar Disorder I and II.

B. DSM 5 diagnosis of one or more of the following and meeting the threshold for high severity as defined in depressive disorder, other mood disorder, posttraumatic stress disorder, obsessive compulsive disorder, panic disorder or other anxiety disorder.

C. High severity is defined as one or more of the following: current functional impairment which causes clinically significant distress or impairment in social, occupational or other important areas of functioning; multiple prior hospitalizations for mental illness, prior mental health board commitment, multiple suicide attempts and/or high lethality attempt(s).

Mental Disorder American Psychiatric Association DSM-5 definition

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotional regulation or behavior that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational or other important activities.

Mentally ill Nebraska Mental Health Commitment Act definition

Having a psychiatric disorder that involves a severe or substantial impairment of a person's thought processes, sensory input, mood balance, memory or ability to reason which substantially interferes with such person's ability to meet the ordinary demands of living or interferes with the safety of others.

Mentally Ill & Dangerous Nebraska Mental Health Commitment Act definition

A person who is mentally ill or substance dependent and because of such mental illness or substance dependence presents:

- Substantial risk of serious harm to another person or persons within the near future as manifested by evidence of recent violent acts or threats of violence or by placing others in reasonable fear of such harm; or
- Substantial risk of serious harm to himself or herself within the near future as manifested by evidence of recent attempts at, or threats of, suicide or serious bodily harm or evidence of inability to provide for his or her basic human needs, including food, clothing, shelter, essential medical care or personal safety.

Medical Necessity

Medically necessary care meets **one** or more of the following criteria for a given patient at a given time:

- Is essential to life or preservation of limb
- **OR** reduces intractable pain
- **OR** prevents significant deterioration of ADLs

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- **OR** is of proven value to significantly reduce risk of one of three outcomes above (e.g. certain immunizations)
- **OR** immediate intervention is not medically necessary, but delay of care would make future care or intervention for intractable pain or preservation of ADLs significantly more dangerous, complicated, or significantly less likely to succeed
- **OR** reduces severe psychiatric symptoms to a degree that permits engagement in programming
- **OR** is described as part of NDCS policy or health care protocol or guideline and delivered according to such policy, protocol, or guideline
- **OR** from a public health perspective is necessary for the health and safety of a community of individuals and is medically appropriate; but may not be medically necessary for the individual (example - treatment for head lice)

Any medically necessary care provided shall:

- **NOT** be considered experimental or lacking in medically recognized professional documentation of efficacy
- **NOR** be administered solely for convenience of inmate or health care Provider

Nebraska Department of Correctional Services (NDCS)

NDCS acronym and "Department" are used interchangeably in IHP to mean: NDCS Health Services **and** Nebraska Department of Correctional Services

PA or PA-C

Physician Assistant **or** Physician Assistant - Certified

Peer Review Committee

- Group of NDCS primary care physicians, mental health professionals, dentists, PAs and APRNs and/or other NDCS leadership staff appointed by Deputy Director - Health Services to review internal & external peer review reports.
- As part of NDCS efforts to improve clinical quality processes within NDCS health care system, patient charts by individual Practitioners may be reviewed by Internal and External Peer Review Process.

Program

- Plan or system through which a correctional agency works to meet its goals. This program may require a distinct physical setting: such as a correctional institution, community residential facility, group home or foster home.

Provider/Practitioner

Person licensed, certified, registered or otherwise duly authorized by law or rule in the state of Nebraska (or another state when patients are cared for in that state) to

NAC

practice in their profession. This, generally, will include Advanced Practice Registered Nurse–Nurse Practitioner, Consulting Specialists, Dentists, Mental Health Professionals, Pharmacists, Physicians, Physician Assistants, Physical Therapists, Psychiatrists, Psychologists, Podiatrists, Social Workers and Optometrists.

Primary Care Provider/Practitioner

Specialist in Family Medicine (employee of NDCS OR contracts with NDCS) who provides definitive care at the point of first-contact and takes continuing responsibility for providing inmate patient's comprehensive care in NDCS facilities.

Primary Care Services

Inmate patient's main source for regular medical care providing continuity and integration of health care services.

Programming

Assessments, interventions and educational programs delivered by non-clinical staff.
Note: Not medically necessary

Social Function

Function or functions that may affect an individual's activities or interactions with other persons or the environment in prison or society.

Treatment NDHHS Chapter 206 NAC 2

Recovery-oriented and person-centered clinical evaluations and/or interventions provided to consumers (inmates) to ameliorate disability or discomfort and/or reduce signs and symptoms of a behavioral health diagnosis delivered by licensed clinical staff.
Note: Individualized based on inmate's clinical presentation, level of functioning, level of cognitive ability, custody, safety and other individual factors.
Note: Medically necessary

Treatment Plan

Series of written statements that specify the particular course of therapy and the roles of medical and non-medical personnel in carrying it out. A treatment plan is individualized, based on assessment of the individual patient's needs, and includes a statement of the short- and long-term goals and the methods by which the goals will be pursued. When clinically indicated, the treatment plan provides inmates with access to a range of supportive and rehabilitative services such as individual or group counseling and/or self-help groups the physician deems appropriate.

Financial Responsibility

Financial Responsibility - NDCS

- Health care delivered to inmate for whom NDCS is responsible.
- Providing Durable Medical Equipment (DME).
- Inmates may require health services for which another county, state, Medicaid, VA or other entity is either contractually or otherwise legally obligated to assume financial responsibility.
- When care is contemplated, patient's NDCS Primary Care Practitioner maintains a professional obligation to assure referral for such health care is medically appropriate.
- Nothing in IHP shall obligate NDCS to assume financial responsibility for health care received by persons prior to **OR** following their status as an inmate; including care related to health problems they experienced **OR** other health care they received during their status as an inmate.

Financial Responsibility – Inmate Patients

- Elective Procedures:
  Defines circumstances under which inmates may have the right to purchase health care services not covered by IHP
- Replacement Durable Medical Equipment (DME):
  Inmate patients are personally responsible for properly operating and maintaining provided DME and exercising reasonable care to prevent loss or theft.
  Any willful or negligent damage, destruction, or loss of devices or equipment will be considered grounds for disciplinary action that may include payment for cost of repair or replacement costs which may include professional fees, testing, labor, travel and associated custody fees.

Levels of Emergency Medical Care

Medical staff conducting initial assessment divides patients into the following Triage categories:

1. EMERGENT – critical life threatening (risk to life, limb)
2. URGENT – Serious non-life threatening (less risk with delay in treatment)
3. NON-URGENT – lowest priority (minimal risk and may provide self-treatment)

Limitations

Note: Inmates generally may refuse treatment, but not sentence-related programming without consequences.

When an inmate is disruptive, unruly, abusive **OR** uncooperative to the extent the behavior seriously impairs NDCS ability to furnish services to the inmate **OR** when the behavior poses a threat to NDCS staff, authorized health services may be delayed.

In these cases, the Provider will counsel the patient explaining why treatment is necessary and ask about patient concerns. If concerns can be addressed, treatment may continue when the inmate's behavior is no longer a constraint.

Medication

Authorization procedures for medication use are described in
NDCS Pharmaceutical Management documents.

Special Circumstances or Exceptions

Care Provided during Hospitalization

- Community inpatient care, during day surgery or ER is usually under the direct care of non-NDCS Practitioner/Providers.
- Mechanics of delivering care in these settings may not always permit care to be delivered exactly as described in the IHP.
- Practitioners/Providers are encouraged to inform community colleagues about the IHP and participate in clinical decision making where possible.
- Hospitals will only be reimbursed for services authorized in the IHP and in accordance with any NDCS contracts.
    - Comfort items with additional charges are NOT authorized by the IHP.
    - NDCS is NOT financially responsible for medical or non-medical services, goods or supplies provided in response to a patient's request.

Role of Consultant(s) Recommendations

- During the course of health care, patients are sometimes referred to consultants. Such referrals often generate recommendations including instructions and orders.
- NDCS is not obligated to execute these recommendations, which are subject to the same criteria as any other NDCS provided care.
- It is the responsibility of the patient's NDCS primary care Practitioner to evaluate appropriateness and necessity of the recommendations in light of the patient's health while considering the IHP, NDCS policy and any other pertinent factor(s).
- When NDCS primary care Practitioners do not execute consultant recommendations, they are expected to explain their reasons to the patient and document the reasons in the health record.

Behavioral Health Services

Access to Care

Admissions to NDCS undergo a multidisciplinary screening and assessment process.

Receiving institutions:

- Diagnostic & Evaluation Center (DEC) for adult males.
- Nebraska Correctional Youth Facility (NCYF) for male youth/adolescents.
- Nebraska Correctional Center for Women (NCCW) for females of all ages.

- Mental Health Screenings - all newly admitted inmates to NDCS, as well as parole violators arriving directly from the community, will be screened for mental health needs upon admission.
- Mental Health Programming - Screenings will occur as determined by appropriate clinical teams. One example is the Clinical Violent Offender Review Team (CVORT).
- Intra-system inmates transferring between Department facilities will be screened.
- Inmates identified, during screening, as potentially needing mental health services, will undergo a Mental Health Appraisal.

Self-Referral:

- Any inmate can request mental health services by submitting a Health Services Inmate Interview Request (IIR).

Staff Referral:

- All facility staff receive Mental Health referral training while at Staff Training Academy. Referrals will be submitted to Mental Health staff **OR** by making immediate contact with mental health staff in the event of a mental health crisis.

Mental Health Screening (AR115.23)

I. Anger/Violence Programming:

Inmates convicted of a violent offense; have a history of violence; and/or violent Misconduct Reports will be screened and referred to the Clinical Violent Offender Review Team (CVORT), which makes treatment recommendations based on clinically-assessed risk and need. Inmates will receive recommendations in writing and will be provided the opportunity to accept or decline the recommendations.

1. **Anger Management:**
   - Treatment provides instruction and practice on basic anger control strategies.
2. **Aggression Replacement Training (ART):**
   - ART is a program available for juvenile offenders considered to be at high-risk for violent re-offense. In addition to targeting effective anger control, it attempts to promote pro-social thinking patterns (i.e. moral reasoning) and pro-social interpersonal behavior (social skills training).
3. **Domestic Violence (DV):**
   - Domestic violence intervention utilizing the Duluth Model to assist inmates in understanding patterns of abusive behavior. DV concentrates on providing group facilitated exercises that challenge a male's perception of entitlement to control and dominate his/her partner.
4. **Violence Reduction Program (VRP):**
   - VRP is a residential treatment program designed to provide inmates the opportunity to understand, manage, and reduce frequency and intensity of their violent offending.
   - VRP can also help inmates develop useful skills for achieving their short-term goals or long-term goals (i.e. successful re-entry into the community).

Covered Services

Mental Health Treatment

- Screening for mental health problems on intake as approved by the mental health professional.
- Outpatient services for the detection, diagnosis and treatment of mental illness.
- Crisis intervention and management of acute psychiatric episodes.
- Stabilization of the mentally ill and the prevention of psychiatric deterioration.
- Residential mental health services in general population and secure housing settings
- Provision for referral and admission to licensed mental health facilities for inmates whose psychiatric needs exceed the treatment capability of the facility.
- Procedures for obtaining and documenting informed consent.
- When mental health care services are rendered against an inmate's will, it is in accordance with state and federal laws and regulations. Otherwise, any inmate may refuse (in writing) mental health care services.
- Mental health care encounters, interviews, examinations and procedures should be conducted in a setting that respects the inmate's privacy.

Sex Offender Services

Healthy Lives Programs (HeLP): Inmates convicted of a sexual offense will be screened by Clinical Sex Offender Review Team (CSORT), which makes programming recommendations based on clinically assessed risk and need. Inmates who are not convicted of a sexual offense, but have a sexual component to their crime may be screened by CSORT for programming recommendations. Inmates will receive recommendations in writing and will be provided the opportunity to accept or refuse the recommendation. Inmates convicted of a sexual offense who refuse or do not satisfactorily complete the recommended sex inmate program may be subject to a mandatory psychological evaluation pursuant to the Sex Offender Commitment Act (LB1199). Inmates who accept the treatment recommendation will have their name added to the appropriate wait-list. Inmates with questions may submit Inmate Interview Requests to CSORT.

Social Work Services (AR 115.25)

MISSION

Provide comprehensive and integrated discharge and aftercare planning as part of the continuum of care provided by Behavioral Health Services. We seek to address needs of high-risk and high-need inmates with the goal of reducing recidivism by connecting inmates to community resources and supports that help them maintain stable lives in the communities in which they reside.

Social Workers priorities include, but are not limited to:

- Major Mental Illness
- Substance Abuse Issues
- Chronic Medical Needs

Social Workers also offer assistance in following areas:

- Community Support
- Education
- Employment
- Financial Resources
- Living Arrangements
- Medical & Mental Health Appointments
- Medication Management
- Parole
- Substance Abuse follow-up

Inmates can obtain social work assistance through:

- NDCS staff referral
- Outside referral (family member, outside agency, etc.)
- Inmate request

Whether referred by staff, outside party or self-referred, social workers will review the appropriateness of a referral and the time frame to discharge or parole. The inmate may be asked to contact Social Work again when closer to discharge/parole if they are more than 6 months from release.

Social Work Services and Reentry work together to provide discharge planning assistance. If it is determined an inmate does not meet criteria for Social Work assistance, the inmate will be encouraged to utilize the reentry specialist from their institution. Inmates are not required to meet with Social Work if they have been recommended by NDCS staff, but it is encouraged by parole board in an effort to address potential discharge concerns.

In addition to providing assistance with discharge planning, Social Work strives to integrate input from all areas of the institution to help identify and meet the needs of discharging/paroling high-needs inmates. Social Work Services provides consultation to other NDCS staff regarding resources and identifying support systems and supportive community agencies.

Substance Abuse Services (AR 115.09)

Updated assessments and level of care recommendations are performed throughout an inmate's sentence on a regular basis and/or special circumstances - e.g. changes in sentence structure, positive urinalysis for substance use and substance use treatment completion/termination/refusal.

Residential Substance Abuse Treatment:

- Education, recovery and relapse prevention treatment in conjunction with additional emphasis on criminal thinking/choices/behavior patterns. Residential programs rely on concrete rather than the abstract in working with substance use inmates.
- Treatment is evidence-based, holistic and includes a variety of disciplines to assist inmates with issues of substance use, criminal thinking/behavior, anger, stress, violence, lifestyle (work, leisure, health) and spirituality. Programs require inmates to take responsibility for their actions; to participate in all program components; and to accept the obligation to practice new attitudes, thoughts and behaviors.
- Individual treatment plans and progress are assessed by the primary counselor and the treatment team at regularly scheduled intervals and under special behavioral considerations based on individual need.
- Orientation/Initial Classification to residential treatment programs occur during the first weeks after arrival. This process determines the group, primary counselor, room/job assignment and assures inmates have received DCS Rules and Regulations and Treatment Program In-House Rules. Orientation also provides instruction on Program Agreement; Inmate Rights and Behavioral Expectations; Conditions of Participation; institution-specific procedures; and group process. Inmates become involved in a regular program of group and individual counseling; substance use education; recovery and relapse prevention classes/groups; cognitive restructuring classes/groups; random drug testing; life skills; leisure skills; parenting; physical fitness; health; and work.
- Group counseling addresses issues important to each group's members, including anger control, violence/domestic violence, parenting, human sexuality, relationships and communication. Since inmates are involved in group counseling from the outset, each has many opportunities to suggest focus areas for the group. Individual counseling addresses particular issues and works in conjunction with group counseling, providing individual instruction and progress assessments.

- Substance use recovery and relapse prevention classes/groups expect participation in the holistic program. Participants learn and practice recovery/relapse prevention designed specifically for correctional settings. Members identify their own warning signs of relapse; mentor others in the process; examine potential re-entry problems and expectations; and take the first steps to finding re-entry resources and sponsors.
- Cognitive restructuring is a systematic cognitive-behavioral approach to promote change in criminal thinking, criminal excitement and its related behaviors. Held in conjunction with substance use classes and group work, an inmate learns to see thinking errors; learns how to change criminal behavior; begins to practice new behavioral patterns and identifies patterns; and strategies to effectively cope with criminality relapse issues.
- Physical Fitness and Health are two essential components of successful substance use recovery. Substance Use staff and the Activities and Recreation staff provide numerous opportunities and growth experiences for inmates in residential treatment programs.
- Institutional work assignments focus on the application of demonstrated and learned work skills. Inmates learn to experience pride in their work and the responsibility associated with it. Subsequently, their work will enhance their physical surroundings and benefit their individual and group treatment.
- Residential Treatment Community groups of inmates have been involved in various community service projects including **Matt Talbot Kitchen** and **Lincoln Food Bank.**
- Women's programs provide gender-specific components for dealing with issues surrounding female substance use as well as addressing criminal thinking/choices/ behavior patterns.

Non-Residential Substance Abuse Treatment Services (NRTS)

- NRTS address needs of inmates who meet requirements and criteria for a less intense level of care or, due to other circumstances, including limited sentence structure, are not eligible for residential treatment services.
- NRTS programming consists of two levels:
    - Intensive Outpatient (IOP)
    - Outpatient (OP)
- Modeled after and similar to residential treatment programming, NRTS provides a cognitive-behavioral approach with emphasis on recovery, relapse prevention and criminal thinking/behavior which is delivered through classes, groups and individual sessions.

Services Not Medically Necessary/Not Authorized

- Abortion
- Caffeine-related Disorders
- Chiropractic Care, unless medically necessary
- Communication Disorders
- Dental Implants
- Elective Procedures
- Erectile Dysfunction
- Factitious Disorder
- Learning Disorders
- Motor Skills Disorder
- Nicotine-related Disorders
- Other conditions/disorders/issues/procedures
    - as determined by Deputy Director – Health Services
- Payment for newborn care

Appeals

Inmate Patients may appeal authorization decisions through the normal grievance process.

Medical Services

Access to Care

Inmates may access health care by:

- Going to Sick Call.
- Sending a written Inmate Interview Request (IIR) to Health Services.
- For emergencies, reporting to any NDCS staff.

Covered Medical Services:

1. **Dental Services**

NDCS provides medically necessary dental care. At any time during incarceration, an inmate may seek evaluation by a dental Provider and may receive treatment based on existing guidelines. Services at some facilities are limited and may include the use of Travel Orders.

Emergent and Urgent Dental Treatment

- Intractable pain.
- Severe pain and swelling with or without fever due to dental disease.
- Facial bone fractures and facial trauma shall be evaluated emergently or urgently referred to appropriate Emergency Room or Practitioner/Provider.

Non-emergent, Non Urgent Dental Treatment (NENUT)

- Dental examinations are provided at intake and before initiation of routine care.
- Treatment plans must be updated as necessary to remain current.
- Nature of services are determined by Providers, Chief of Dental Services in accordance with IHP, guidelines and protocols.
- Services are further prioritized based on patient acuity level and functional impairment.

2. **Chemotherapy**
3. **Dialysis**
4. **Durable Medical Equipment (DME)**
5. **Emergency Care**
6. **End of Life Medication and Care**

NDCS does not provide medication to a patient with a terminal illness for the purpose of self- administration to end his or her life.

7. Hearing Care

Hearing screening exams will be performed upon entry into NDCS.

Hearing assessments and one or two hearing aids are provided when medically necessary.

Any willful or negligent damage, destruction, or loss of hearing aids will be considered grounds for disciplinary action and may include payment for the cost of repair or replacement.

8. <u>Hospital Care</u> (in the Community)

Inpatient services will be provided either in a community hospital or in one of three (3) Skilled Nursing Facilities (SNF). The most appropriate setting will be determined by the authorized NDCS health care Practitioner according to the severity of illness or level of service required.

Any hospitalization must be authorized by NDCS.

When hospitalized in the community, the inmate's medical needs, custody level and community safety considerations will determine the type and location of hospital room assigned.

Medical and/or security needs may require an inmate be assigned to a private hospital room.

When ordered and medically necessary, the following will be provided:

Anesthesia	Labor and delivery room
Casts	Laboratory
Diagnostic services	Medical rehabilitation
Dressings	Nursing care
Drugs administered during the stay	Operating room and related Services
Equipment	Radiation
Hospital services	Radiology
Intensive care unit and services	Respiratory services

Additional charges for television are not authorized for stays in community hospitals. Personal comfort items such as hygiene items or slippers that cause additional charges will not be issued unless authorized by NDCS.

Reimbursement will only be made for services authorized by NDCS in accordance to this IHP per allowable charges between NDCS's third party Administrator and the hospital.

9. Maternity Services

Medically necessary maternity services are covered for inmates during their period of incarceration. These services are provided in the most appropriate setting (institution's clinic or a community facility) as determined by NDCS health care Practitioner in accordance with the level of service required. Services include diagnosis of pregnancy; prenatal care; delivery; postpartum care; care for complications; physician services; and hospital services.

10. Medical and Surgical Services

Medical and surgical services are limited to the following and are covered only when ordered or prescribed by an authorized NDCS health care Practitioner.

These services will be provided in NDCS clinics or three SNFs unless the necessary equipment or supplies are not available, or the health care Provider determines the severity of illness or level of service required indicates a community health care facility is the most appropriate setting for the care. Medically necessary non-emergent community care is subject to approval by Deputy Director - Health Services.

The following services are included in this provision:

- Anesthesia and oxygen services.
- Blood derivatives and related services.
- Chemotherapy.
- Community or Provider office and hospital visits and related services to include diagnostics, treatments, consultations or second opinions.
- Dialysis.
- Dressings, casts and related supplies.
- Health appraisals to determine programming or work restrictions.
- NDCS health care Provider clinic, SNF and hospital visits to include initial. evaluations, diagnostics, treatments, consults or second opinions.
- Medications as defined in "Pharmacy" section below.
- Physical therapy, occupational and speech therapy.
- Radiology, nuclear medicine, ultrasound, laboratory and other diagnostic services.
- Surgical and anesthesiology services.

11. Optometry - Optical Care

Vision screening exams will be performed upon entry into NDCS

New glasses will be provided when medically necessary due to change in visual acuity.

Any willful or negligent damage, destruction or loss of glasses will be considered grounds for disciplinary action and may include payment of the cost of repair or replacement.

12. Pharmacy

NDCS formulary lists drugs and supplies that will be provided when prescribed by NDCS heath care Practitioners:

- Generic equivalents will be provided in accordance with formulary.
- Over the counter medications will be available per NDCS policy.
- Non-formulary drugs and supplies will be provided only when authorized by Deputy Director - Health Services.

13. Preventive Care

The following preventive and screening services are available:

- Initial physical, mental health and dental exams, including diagnostic screening tests.
- Periodic health maintenance evaluations conducted when necessary and appropriate.
- Voluntary and court-ordered HIV testing and counseling.
- Immunizations, as deemed medically appropriate.
- Screening and diagnostic tests for sexually transmittable and blood-borne disease(s).

14. Skilled Nursing Facility (SNF)

Inmates may be placed in one of three (3) NDCS Skilled Nursing Facilities (SNF) to receive care and services that cannot be provided in outpatient clinics; or for health conditions that prevent them from living in general population safely:

- Diagnostic & Evaluation Center (DEC)
- Nebraska State Penitentiary (NSP)
- Tecumseh State Correctional Institution (TSCI)

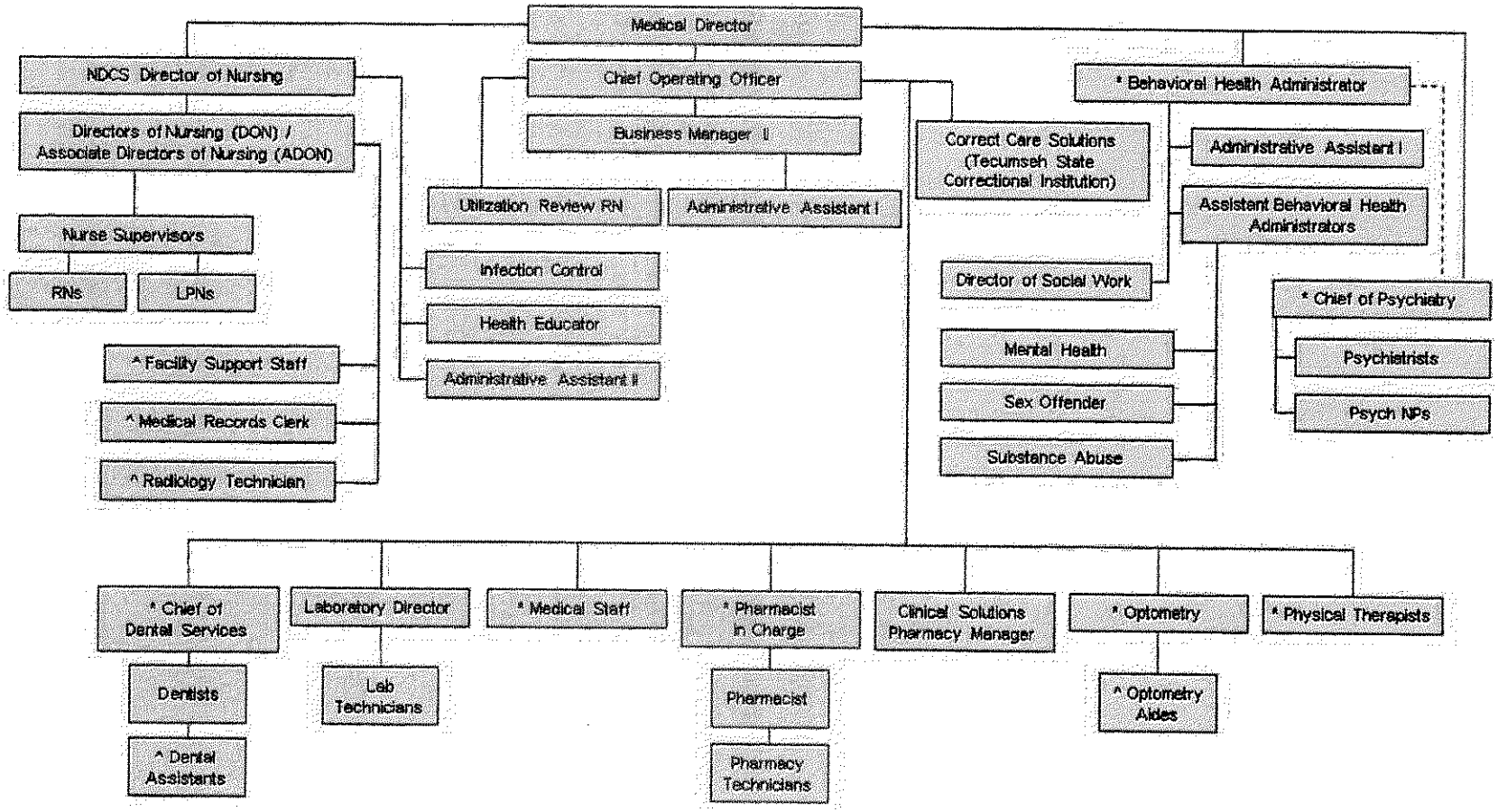
Hospice services are available for terminally-ill inmates who choose not to continue cure-oriented services. Hospice care shall emphasize palliative services for pain management and support.

ADMINISTRATIVE REGULATIONS

Blue links in Inmate Health Plan sections take you to A/R public location on NDCS Website http://www.corrections.nebraska.gov/policieshealth.html and are available in inmate libraries

A/R #	ADMINISTRATIVE REGULATION TITLE
115.01	Health Authority and Administration
115.02	Health Personnel Management
115.03	Health Care Records
115.04	Access to Health Services
115.05	Health Screenings, Examinations, Appraisals and Reviews
115.06	Emergency Medical Care
115.07	Dental Care
115.08	Pharmaceutical Services
115.09	Substance Abuse Treatment Programming, Detoxification, and Chemical Dependency
115.10	Pharmacy Medication Distribution, Access & Training
115.11	Health Education
115.12	Special Needs Inmate Programs
115.13	Serious Illness or Injury, Advance Directives and Death
115.15	Serious Infectious Diseases
115.16	Disposal of Infectious Waste
115.18	Management of Medical Control Items
115.23	Mental Health Services
115.24	Critical Incident Stress Management (CISM)
115.25	Social Work Services

NDCS Health Services Organizational Chart



* Clinical Supervision: Medical Director
Administrative Supervision: Chief Operating Officer

^ Auxiliary Staff Supervised by DON / ADON / Patient Flow Coordinator

..... Secondary Supervision

Revised June 7, 2016

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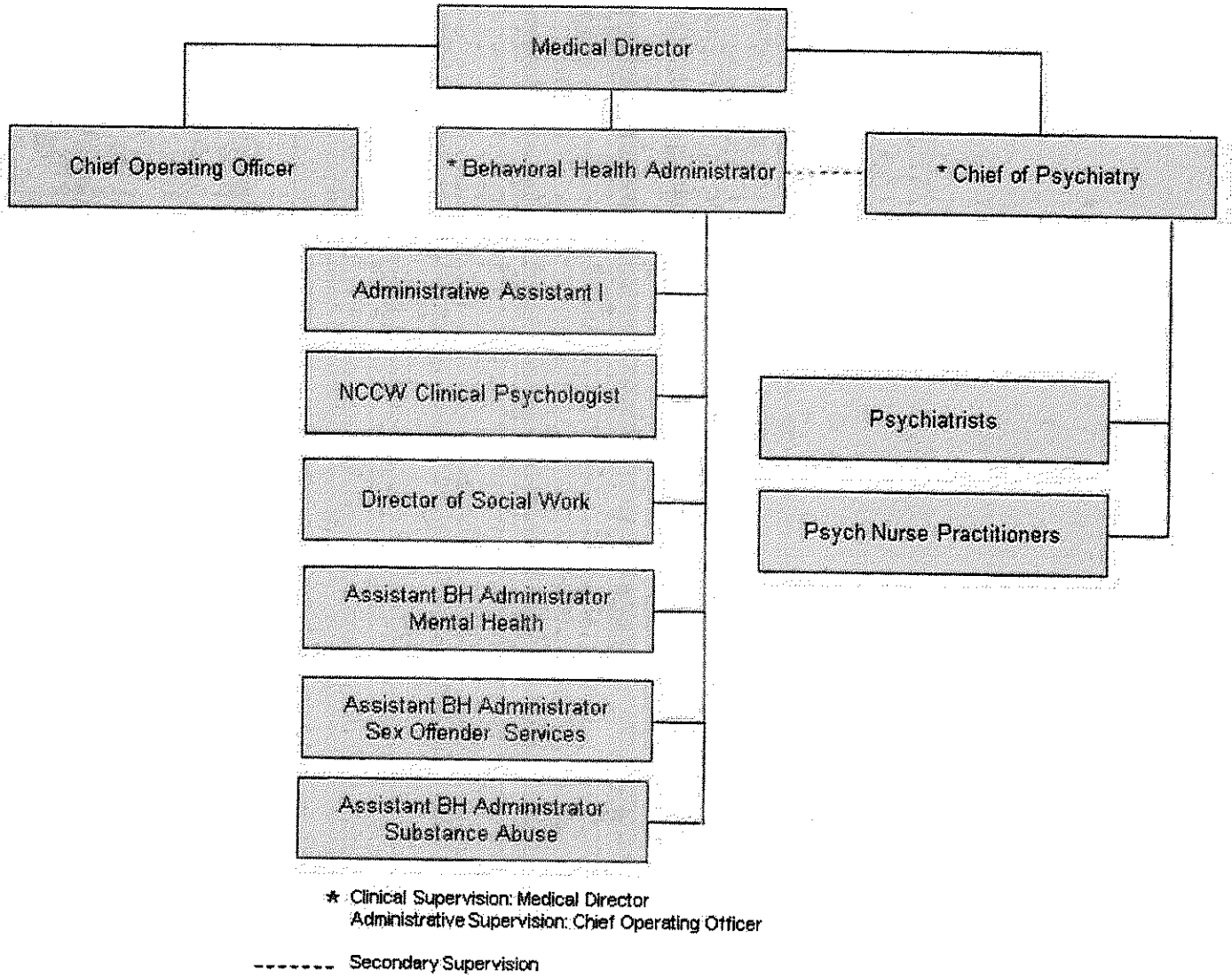
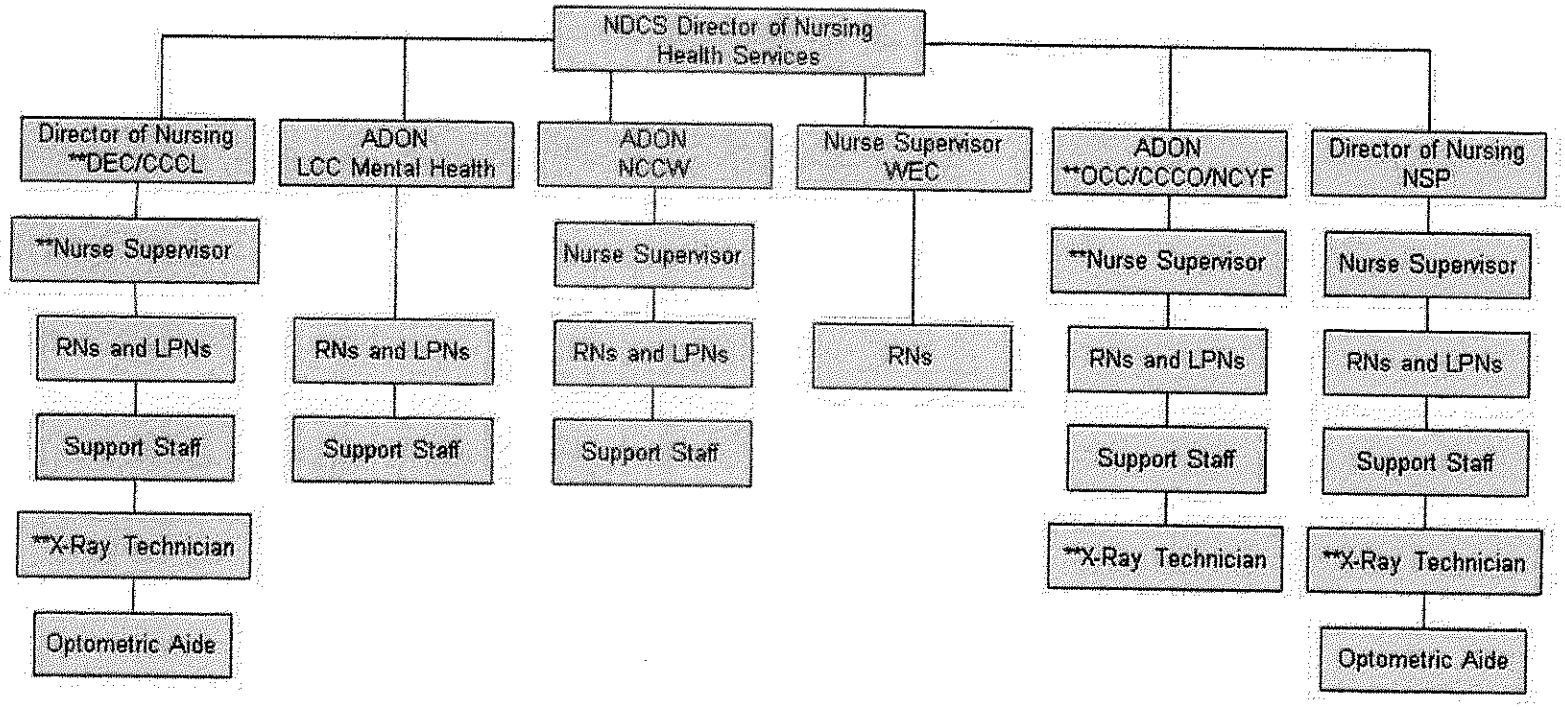
NDCS Behavioral Health Organizational Chart



Revised June 6, 2016

NDCS Nursing Organizational Chart



** Same Person Travels to Facilities

Revised September 24, 2015

Information for Senator Bolz 6-14-16

1. How many psychiatrists are currently on staff? There are currently 2 psychiatrists on staff: Dr. Martin Wetzel and Dr. Natalie Baker.

2. How many psychiatrists are working with the Department on a contract basis? There are currently 3 ARPN's or Psychiatric Nurse Practitioners currently working on a contract basis with the Department.

3. How many psychiatrists do you expect to have on staff in the next few months? In the next year? We are currently advertising for 1 psychiatrist position to fill a vacancy created by a retirement.

4. Inmate to behavioral health staff ratio by facility. The table below provides the number of inmates with a behavioral health diagnosis as well as the 2016 average daily population for each facility and the ratio of diagnosed inmates to treatment staff.

Facility	Female[1]	Male[1]	Diagnosed Pop[1]	2016 ADP[2]	Treatment Staff	Ratio
CCL[3]	67	282	**349**	385	7	55-1
CCO[4]	21	128	**149**	170	4	37.3-1
DEC		309	**309**	398	9	34.3-1
LCC		454	**454**	504	22	20.6 -1
NCW	262		**262**	343	14	18.7-1
NCY		56	**56**	65	3	18.7-1
NSP		1,176	**1,176**	1,353	37	31.8-1
OCC		706	**706**	764	17	41.5-1
TSC		882	**882**	1,034	8	110.2-1
WEC		166	**166**	175	6	27.7-1
Grand Total	**350**	**4,159**	**4,509**	**5,191**	**127**	**35.5 -1**

[1] Male, female and total number of inmates with a behavioral health diagnosis, including substance abuse

[2] 1/1/2016 – 6/14/2016 Inmate Average Daily Population

[3] Includes 6 substance abuse treatment staff located at Trabert Hall in Lincoln

[4] Includes 4 substance abuse staff at the Omaha State Office Building.

5. Status of VRP Positions at TSCI: The Department has filled the VRP psychologist position and is still in the process of advertising for the two LMHP positions.

6. Use of VRP Funds. The Department is in the process of scheduling a VRP training in October of 2016 with international experts in violence reduction programming from Canada.

7. Total # of positions by facility: Behavioral Health currently has 161 FTE. There are an additional 5 contracted behavioral staff currently. 1 psychiatrist, 3 psychiatric nurse practitioners and 1 mental health practitioner. See #8 below for a breakdown by facility.

8. Total # of staffing vacancies by facility: Out of a total of 161 positions within behavioral health, there are currently 34 total vacancies: 8 Psychologists, 1 Psychiatrist, 9 Mental Health Practitioners, 8 chemical dependency counselors, 2 Social Workers, 1 nurse practitioner, 1 registered nurse, 1 clinical program manager and 3 support staff. These include positions that have become vacant due to recent promotions to fill leadership positions within behavioral health and newly created positions from LB 598 that we have been unable to fill to date.

The table below provides the total number of employees, the number of vacancies by facility. The table below lists the vacancies by position and facility.

Facility	Total # of Positions	Vacancies
Diagnostic and Evaluation Center (DEC)	9	0
Lincoln Correctional Center (LCC)	31	9
Nebraska Correctional Center for Women (NCCW)	16	2
Nebraska Correctional Youth Facility (NCYF)	3	0
Nebraska State Penitentiary (NSP)	44	7
Omaha Correctional Center (OCC)	20	3
Tecumseh State Correctional Institution (TSCI)	14	6
Work Ethic Camp (WEC)	7	1
Community Corrections Lincoln (CCL)	7	0
Community Corrections Omaha (CCO)	4	0
Other*	6	6
Total	161	34

*Other includes Central Office and unfilled positions that have not yet been assigned to a facility.

9. Waiting List Information – The current waiting lists for substance abuse, sex offender and violence offender programs are provided below.

Substance Abuse Treatment:
OCC/SAU—96 beds, 96 in treatment (Waiting List = 56)
TSCI/SAU—72 beds, Just started new program 13 in treatment, 9 starting 4/18 (Waiting List = 78)
NSP/RTC-100 beds, 100 in treatment (Waiting List = 114)
NCCW/SAU-48 beds, 48 in treatment (Waiting List = 51)

Sex Offender Services:
bHeLP - 17 just beginning treatment (Waiting List = 33)
oHeLP – 50 in treatment (Waiting List = 67)
iHeLP – 52 in treatment (Waiting List = 28)

Violent Offender Services:
DV (Domestic Violence) – 62 in treatment (Waiting List for DV with CVORT Review=99)
AM (Anger Management)– 68 in treatment (Waiting List for AM with CVORT Review=91)
VRP(Violence Reduction Program) – 8 in treatment (Waiting List = 84)

*Waiting List for DV without CVORT Review is around 90 each.
*Waiting List for AM without CVORT Review is around 90 each.

FROM THE OFFICE OF THE DIRECTOR
SCOTT R. FRAKES

FOR IMMEDIATE RELEASE
August 28, 2015

FOR MORE INFORMATION CONTACT:
NEBRASKA DEPARTMENT OF CORRECTIONAL SERVICES
James Foster, PIO (402-479-5713)

NDCS Announces Behavioral Health Services Review Report

Report highlights recommended changes, successes

Lincoln - Today, Nebraska Department of Correctional Services (NDCS) Director Scott Frakes announced the release of the review conducted by Dr. Bruce Gage on behavioral health services in NDCS. The review provides suggested improvements and a vision of what the NDCS behavioral health services should strive to look like in the future.

"I appreciate the service Dr. Gage has provided to the Nebraska Department of Correctional Services," stated Director Frakes. "I am reviewing Dr. Gage's recommendations with the behavioral health team, looking for improvements that enhance our behavioral health system.

The report made findings and recommendations in a variety of areas including crisis response, staffing, suicide prevention, medication management, and information technology among many other areas. Highlights from the findings and recommendations include:

- VISION STATEMENT – NDCS' treatment practices lack an overarching mission statement. The author recommends that the department draft "a guiding vision of what values and principles are to govern the mental health system" (page 21).
- INITIAL ASSESSMENTS – An analysis of NDCS's initial assessment and mental health screening found that "NDCS is currently doing more than is necessary" and that the assessment should focus on identifying "high risk problems" (page 23).
- STAFFING VACANCIES – The report's author found the department's "mental health staff to be professional and knowledgeable" (page 13) but goes on to say "The most notable issue with regard to staffing is the number of vacant positions" (page 35).
- INFORMATION TECHNOLOGY – The report finds that "information technology systems at NDCS are limited and outdated" and that the department lacks "a data system capable of providing real reporting functionality" (page 17).

- TRAINEE PROGRAMMING – Interviews with participants in NDCS' programming for students in psychiatry residencies and physician assistance programs produced "positive reports about their experience and the quality of supervision" (page 16).

Director Frakes states he is actively working with the new leadership at NDCS to implement short term changes, while building a long term plan that will meet the needs of mentally ill offenders. "In addition to filling key leadership positions, we have added additional beds to the Secure Mental Health Unit at LCC and have created a Protective Management Unit at TSCI. In the months ahead we will continue to build a system of mission specific housing, providing inmates housing assignments that are consistent with their needs and custody level. " Frakes went on to say "Dr. Gage's report offers a broad range of recommendations specific to the issues he observed, as well as thoughts on building a more effective behavioral health system within NDCS." "Dr. Gage stated 'while the NDCS mental health system has room for growth, there is a lot of good work going on." "I appreciate the time and thought Dr. Gage put into this thorough review of the NDCS mental health system," stated Dr. Martin Wetzel, Chief of Psychiatry. "His recommendations add additional focus points as we build NDCS' mental health system for the future".

NDCS continues to review all areas of operations, and appreciates the assistance and cooperation it has received, not only from within the borders of Nebraska but also from resources outside of Nebraska. Our inmate population presents significant behavioral health needs. We are committed to providing services that meet the needs of the inmates, and ensures public safety.

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Department of Corrections
WASHINGTON STATE

Mental Health System Consultation

July 6, 2015

Bruce C. Gage, M.D.

I have completed this consultation regarding the mental health services in the Nebraska Department of Correctional Services (NDCS) at the request of Director Scott Frakes. While behavioral health encompasses mental health, sex offender, and chemical dependency services, the charge was to focus on the mental health component. In the interest of full disclosure, Mr. Frakes and I worked together during his tenure with the Washington Department of Corrections (WA DOC) and WA DOC has kindly afforded me the time to provide this consultation. I am not being compensated for this consultation other than receiving my normal salary.

NCDS leadership, notably Dr. Cameron White, was very helpful and accommodating, providing open access to facility staff, facilities, and inmates as well as a great deal of background information. Staff were uniformly professional and courteous, answered questions readily, and openly offered their thoughts and opinions.

I am aware that this consultation occurs in the context of concerns about the quality of mental health services in NDCS, among other concerns about the agency. I am further aware that some of this concern, especially with regard to mental health, was magnified by a released offender who committed several murders shortly after leaving NDCS.

At the time of my visit, the NDCS census is about 5225 and the system is running over capacity, specifically at 160% of designed capacity and 117% of official capacity.

My charge in conducting this consultation was to provide an objective and impartial opinion about mental health services in NDCS and to make recommendations for improvement.

ASSUMPTIONS AND BACKGROUND DATA

It is important to convey some assumptions underlying this report that are based on general research in the correctional arena. Specifically, the most reliable studies of prisons find that about 20-25% of male prisoners and 30-50% of female prisoners receive or need some form of mental health treatment. Most of these individuals do not require hospital or even residential level services; only 2-4% are so ill that they need this level of robust service. This excludes most personality disorders, intellectual disability, and dementia. These special populations are generally not served in residential mental health units as they require very different types of service.

DATABASE

The database for this evaluation consists of the following:

1. Three day site visit including LCC, DEC, NSP, and NCCW including:
    a. Interview of numerous staff and patients

   b. Review of patient records
   c. Visits to the male and female mental health residential units, restricted and secure housing units (mental health included), general population settings (various custody levels), medical facilities, and recreational facilities
2. NDCS policies
   a. AR 115.09
   b. AR 115.12
   c. AR 115.23
   d. AR 115.24
   e. AR 115.25
   f. AR 115.30
   g. AR 116.02
3. NCDS behavioral health positions (authorized and filled/vacant)
4. NCDS behavioral health organizational chart
5. 2013 NCDS statistics
6. Department of Correctional Services Special Investigative Committee (LR 424-2014) Report to the Legislature dated 12/15/14
7. Nebraska Department of Correctional Services: Disciplinary Process, Programs, and Commitment Processes by the Performance Audit Committee of the Nebraska Legislature dated 11/14
8. A list of all mental health contacts from the Nebraska Inmate Case Management System (NICaMS) from 2013-2014 (this does not include some contacts by psychiatric prescribers that are placed in the hard copy medical record)
9. Numbers of inmates on psychotropic medication
10. Average length of stay in residential mental health units
11. A list of all suicide attempts from 2013-2014
12. A summary of all mental health diagnoses in NDCS
13. Mental Illness Review Team (MIRT) procedures
14. Clinical Violent Offender Review Team (CVORT) procedures
15. LB1199 (civil commitment of sex offenders) assessment procedures
16. Manuals and program descriptions of the male (LCC) and female (NCCW) mental health residential programs in NDCS
17. Healthy Lives (sex offender treatment) program description
18. Violence Reduction Program (VRP) program description
19. The NDCS formulary
20. Medical Protocol 29 detailing the Peer Review Process
21. Medical Protocol 36 detailing the Audit Plan
22. Consultation reports by Dr. Thomas White dated 6/19/06 and 5/13/13
23. A compendium of groups and services provided by behavioral health staff
24. A listing of current groups and numbers of participants
25. A summary of social work contacts for 2014
26. Documents summarizing the peer review process
27. Various forms
   a. Special Needs Contact Documentation

b. Mental Health Programming Involvement
c. Mental Health Psychological Evaluation Request
d. Release of information

The following are salient observations and reviews of data. In the interest of readability, the notes and databases underlying these findings will not be recapitulated in detail but summarized. Interested parties are welcome to review all of the underlying information collected.

POPULATION

NDCS provided its population including total census, demographic information, mental illness diagnoses, the number of patients defined as having major mental illness (essentially those with psychotic disorders or other disorders with severe functional deficits), and numbers of patients on psychotropic medications. NDCS has a designed institutional capacity of 3275 and a census of 5225 (4/30/15). 2013 demographics reveal an average age of ca. 36, 7% female, and a racial mix that shows greater proportions of minority populations than in the general Nebraska population.

As in other correctional settings, NDCS has seen growth in the numbers of mentally ill and, along with that, serve more severely ill. The number of inmates with diagnosed mental illness is 4462 (82%) with the percentage of women having a diagnosis at 85% and males at 82%. The number of inmates with only a substance abuse diagnosis is 1621, leaving 2841 (52%) with some other mental illness diagnosis. About 25% of the male and 50% of the female population is on one or more psychotropic medications; these numbers are typical for prison settings.

In part following recommendations by Dr. Thomas White, NCDS has undertaken to identify and focus treatment on its most seriously mentally ill, designated as major mental illness (MMI). This includes patients with diagnoses of a psychotic disorder, bipolar disorder, and major depression. The prevalence of MMI in the system is reportedly 2-3% (100-150). This is lower than would be expected; most prevalence studies show rates of psychotic disorders alone in state prisons of 4-15% and depression is on the order of 10%. A conservative estimate is that 3-6% have a psychotic or schizophrenia-spectrum disorder and about 10% have significant depression or bipolar disorder. The remainder have less severe conditions, likely comprising the vast majority of those 25% of men and 50% of women on psychotropic medications.

LCC typically has about 85-90 in residential mental health and 350 being followed for mental health needs in general population.

NSP reports that 377 of their 1321 inmates are on psychotropic medications (28.5%). But they report only 12 identified as MMI.

NCCW report that they have 150 MMI by official tally but NCCW clinical staff believe the number is closer to 50. With a total census of about 325 and given that the agency wide estimate is only 100-150 MMI total, it is unclear what these numbers mean. Based on national figures, it is likely that at least 15% of the female population (50) have a major mental illness. Though typical of many correctional settings, the figure of 50% of the female population receiving psychotropic medication deserves careful review.

INITIAL ASSESSMENT

Initial assessment for males is conducted at the Diagnostic and Evaluation Center (DEC). Masters psychology associates (three) and doctoral psychologists (one, about .75 time) conduct thorough assessments on all inmates admitted to NDCS, about 2500 per year, or about 50 per week (about 13 per clinician per week). The month prior to my visit, there were 275, which is higher than normal. Assessments reviewed were fairly thorough and diagnoses consistent with the findings of the assessment. It is estimated that it takes up to two hours to complete an initial assessment, which is reasonable for a complete assessment. The expectation is that routine assessments are completed within 14 days; this has generally been possible but sometimes cannot be met when caseloads are high or any staff are out.

There is a psychiatric APRN stationed at DEC who sees all inmates on psychotropic medications and any others who ask to be seen. At the time of my visit, there were 160 patients on the APRNs case list, about 50 of whom had not yet been seen.

There is no defined benefit for treatment and no utilization review or utilization management mechanisms so the only determinants of who gets treated are inmate request and provider willingness to treat.

The DEC also houses a skilled nursing facility, which generally houses all those on suicide watches. There is some limited provision for watches elsewhere but this is not systematized. Sometimes those who are seriously decompensated are housed at DEC and, for a variety of reasons including lack of beds and denial of transfer due to concerns about dangerousness, may remain for extended periods of times. This also includes females having serious mental health conditions.

Two LMHP2 provide treatment services in DEC and also manage violators and county safe-keepers. There is also a limited amount of telepsychiatry time that is used to manage these patients; it has been difficult to get this operating in an organized fashion. The county safe-keepers are a challenge as they are high needs and reportedly cannot be place elsewhere, even on the mental health unit when their needs could be better managed there.

Female intake services are generally done at NCCW where they conduct about 40 intakes per month; these are done by the psychologist. They may sometime be done at DEC if the patient requires infirmary services or is on an extended watch.

The assessment includes a "level of care" determination with patients being identified as needing to be seen weekly, every two weeks, monthly, or every two months. This designation can be modified by clinicians at the receiving facility.

MENTAL HEALTH SERVICES

NDCS provides outpatient and residential services. It does not have access to licensed mental health beds; it neither has its own nor will any community hospitals take patients from the prisons. The sickest mentally ill are usually treated in the residential units or might occasionally be admitted to infirmary (skilled nursing level at NDCS) settings. This is almost always the case for those placed on suicide watch except for short duration or special cases where the decision has been made to retain those who are engaging in self-injurious behavior for secondary gain.

One issue that deserves sharp clarification has to do with a Nebraska law governing the standard of care in the prison system. The law reportedly speaks to the standard of care being the same as in the community. At this point, it is being interpreted very broadly. Many inmates are receiving mental health services for conditions that most systems would not treat unless compelled by law.

Crisis Response

Crisis response is a substantial element of the mental health workload and the predominant task for non-prescribers working outside of residential mental health settings. During normal working hours, local mental health staff cover crisis response. This is typically initiated by a custody telephone call to local mental health; there is an informal call network rather than a structured approach. The nature of the approach to crisis response varies from setting to setting. At NSP, one MHP is assigned to crisis response for a week at a time on a rotating basis. The psychologist on staff at NCCW provides crisis coverage during working hours.

After hours, when no mental health staff are on site, crisis calls go to nursing staff who conduct an evaluation and then call the Mental Health Officer of the Day (MHOD) for the facility. Management decisions are made in conjunction with medical and correctional staff when needed. There is no psychiatric prescriber on call but the one full time psychiatrist in NDCS is often available for consultation.

Referral

Any staff can make a routine referral through a standardized form. Mental health staff are expected to see routine referrals within 14 days. The clinician then determines whether or not additional services are needed but there is no formal guidance about who should receive services and of what type.

Inmates can complete kites to request. Kites are answered within three days (this was not formally evaluated) and prioritized. In general, staff are obligated to see those who submit kites.

Outpatient (General Population) Services

NDCS mental health treatment staff (again, largely excluding those providing sex offender and chemical dependency treatment) are conducting about 1500 individual sessions per month (this includes residential settings). The nature or model of treatment is not indicated and individual outpatient treatment is not done under the guidance of a treatment plan. Much of the individual contact time is response to crises and other unstructured interventions in response to staff and offender requests; this primarily serves the cause of institutional management rather than a directed course of treatment. Those identified as MMI are assigned a MHP who sees them at least every two months.

NSP assigns mental health clinicians to residential settings in PC, restrictive housing, and the Violence Reduction Program. Others are assigned institution-wide and serve the general population; cases are assigned on a rotating basis.

I interviewed an MHP providing services to GP at LCC. There, a GP population of 400-500 yields a case load of up to 220-240 on medications and another 25 getting services but no medications. In addition, the position is responsible for conducting a mental status examination on 120 plus in Protective Custody every 3 months (some help has been provided recently). Until recently, about 20 hours were left for providing direct treatment and case management but this had been eroded because of having to spend 1 day each week supporting telepsychiatry visits and another half-day each week scheduling and

assisting contract psychiatrists (setting up the calendar, getting patient passes, processing kites, and prioritizing follow-ups). This has left about 15 hours per week for structured treatment and about 5 hours per week responding to crises in GP; groups had to be cancelled in response to this work addition. No groups are being run in GP. This MHP noted that there is no formal guidance or plan that designates who should receive what types of services. Services vary from short term treatment for anxiety and acute (usually situational) problems (3-5 sessions) to monthly check-ins primarily for those with MMI and trauma. Others get little or no service.

There is more individual outpatient work being done at NCCW, though the amount is not tracked. An informal survey of staff at NCCW indicated that one Mental Health Professional was seeing about 20 patients weekly, another was seeing 5 weekly, and a psychologist (with a limited 8 person case load owing to other duties) was seeing one person weekly. Again, treatment is not guided by a treatment plan. Most treatment is CBT in orientation; DBT is not available. The staff note a good deal of unmet need in the GP, primarily related to issues associated with childhood trauma.

Mental health group work is dominated not by provision of mental health treatment groups but by what I will refer to as correctional programming. Correctional programming includes groups that may be run by non-clinicians and primarily serve the correctional mission, such as addressing criminogenic attitudes and anger dyscontrol. Most of these inmates do not require mental health treatment services. At the time of my visit, this included the following violent offender groups:

- NSP
  - Violence Reduction Program group – 12 participants
    - Four groups per week
  - Anger Management groups (2) – 20 participants
    - Two groups per week
  - Domestic Violence (unknown participation)
- CCCL
  - Anger Management groups (2) – 20 participants
- OCC
  - Anger Management groups (2) – 16 participants
- NCYF
  - Aggression Reduction Therapy groups (2) – 16 participants
  - Anger Management group – 6 participants
- TSCI
  - Anger Management groups (2) – 11 participants
- LCC, NCCW, WEC – none
  - Moral Reconation Therapy (MRT) is offered as "elective"

Restricted Housing Services

In most facilities, mental health staff are not specifically assigned to restricted housing though at NSP, 0.6 FTE of a MHP is assigned.

On restricted housing units, mental health does monthly mental status examinations of all inmates identified as mental health and every 90 days for others but does not do an assessment at the time of admission. A nurse reviews the chart of those newly admitted; if there is a medical problem at

admission a nurse does an evaluation and if there is a question of mental health concerns, the nurse contacts mental health. Nursing also does daily health check rounds.

Those placed in restricted housing have all medications converted to staff administration except for rescue medications. The number of rescue medications the inmate may possess can be limited if necessary.

Custody staff does suicide screening on all entering restricted housing using a standard set of questions to which any yes answers necessitates a call to mental health and initiation of 15 minute checks in a camera room or if unavailable, placement in a suicide room in a skilled nursing facility. They remain on checks until seen by mental health, which may be the next working day.

Mental health also works in conjunction with custody in Multi-Disciplinary Teams where behavioral plans, usually drafted by mental health, are forged. These plans are generally not posted at inmate doors and fidelity to these plans has been mixed. Plans are rarely carried through to GP. According to mental health staff, these are used primarily at TSCI.

The restricted units at NSP, TSCI, and LCC are using the METEOR and ExPLORE programs to address behavioral problems. Mental health is running these groups.

At LCC, some mentally ill are housed in the 16-bed control unit, unit A. There is no programming here except for some in-cell, self-paced, workbook-based modules. They have some access to educational services.

Residential Mental Health Units

LCC

LCC D unit has a maximum capacity of 77, with a census of 72 during my visit. The average length of stay is about 80 days. The unit is run at a lower custody level than the physical plant provides for. Patients are allowed out after breakfast other than being locked down at lunch and at 1600, and then go down for the night at 2030. They are out of cell close to 10 hours per day. They get about one group per day and variable individual contacts. There is no transitional program from D unit and no "step-down" residential setting available. A GP MHP provides follow-up, generally regular initial visits but quickly transitioning to monthly check-ins.

Those who leave to GP, which is usually locally to LCC (which does not have minimum custody), generally have a dramatic reduction in their privileges owing to the unit being run at an effectively lower custody level, for example they generally do not have the same degree of access to courtyards and/or dayrooms. Staffing shortages also interfere more with GP units than the residential mental health unit, which LCC tries to maintain full staffing for custody.

Treatment consists in groups, individual sessions, and medications. Treatment groups include "Core Groups" (which are described as on-going process groups), social skills, Dialectical Behavior Therapy (DBT) – both basic and advanced, some psychoeducational groups, and socialization groups such as Current Events.

There are 14 beds of restricted housing on LCC C unit, run at a higher custody level. The average length of stay is about 30 days. Patients get up to 12 hours out of cell per week (policy mandates 10 hours per

week) and may take meals, showers, and yard time on D unit as a transition step. They receive a minimum of 2 hours and up to 3 hours of structured programming per week. This consists primarily of "Core Groups". There is a list of other more structured groups, similar to those on C, that is expanding but few are being run.

On both D and C units, staff monitor patient behavior daily using a tool referred to as a "Baseline" that tracks basic behaviors including acting out, program participation, and medication taking. On the basis of patient performance, they receive privileges. The privilege system is limited to essentially two levels with no clearly structured criteria and minimal privileges can be earned outside of additional commissary.

Privileges are limited. Patients either receive "A-Card" of "B-Card" privileges. The former provides for full canteen access and full access to the communal day areas whereas the form restricts canteen access and during day area privileges, they have to stay in the local day area. Their privileges for meals, showers, and yard are otherwise the same.

The population is very diverse with serious mentally ill, intellectual disabled, demented, and personality disordered patients mixed on these units (consistent with my observations and reviews). This has made development of a coherent program difficult. There has been a recent increase in the number of personality disordered patients referred by MIRT.

The Multi-Disciplinary Team (MDT), consisting of mental health and custody staff, meets every morning to review the behavior of each patient and to reinforce plans. The clinical treatment team also meets weekly to discuss the clinical treatment planning. Treatment plans are updated at least every three months. Treatment plans are very basic. I attended a team meeting where the plans for three patients were reviewed. The team reviewed progress, medications, behavior, program participation, and plans (treatment and/or release).

Chemical dependency, anger management, and social work services and groups are also provided on the units. Sex offender services not available on the residential mental health units.

There are a limited number of jobs available to the mentally ill ($1.21/hour). Those that cannot get jobs get paid $0.60/hour for treatment participation. They are paid monthly.

The mental health program utilizes special porters who are licensed as CNAs and provide assistance to particularly limited, often cognitively impaired, patients. They are generally made cellmates and assist in activities of daily living and helping their charges meet their programmatic obligations.

NCCW

NCCW has female residential beds, referred to as the Strategic Treatment and Reintegration (STAR) Unit, that are co-housed with protective custody. The two populations are not permitted to mix, which has limited out of cell time and programming opportunities for the STAR Unit women to some degree. The unit is run at essentially a medium custody level. Patients receive one hour of individual therapy per week, one group per working day (1-1.5 hours) and 3-4 hours of unstructured out of cell time per day (less lately due to problems coordinating the PC inmates' time out). They also get about 3.5 hours at the gym each week and take meals off the unit. Thus there is a total of about 40 hours out of cell time each week. The STAR program incorporates a phase system, which is a rudimentary level system with

advancing privileges but with no formal criteria for advancement – individual therapists decide who advances. There is no formal transitional program but patients typically engage in off-unit activities such as a job prior to moving to GP.

The average length of stay is about 10 days and there were 9 patients at the time of my visit. The patients have varied diagnoses including schizophrenia, mood disorders, traumatic brain injury, and personality disorders.

There are two mental health professionals assigned to this unit. They are sometimes called to do other duties.

DEC

There are 31 beds licensed as skilled nursing beds in the DEC infirmary. Sometimes those with severe mental health problems are housed in the infirmary, though there is no formal mental health program here. It is primarily for those patients who need restraint and active medication management.

Mental health staff report that patients can get "stuck" in the DEC skilled nursing beds owing to limited opportunities for placement elsewhere.

This area is also where the suicide monitoring cells are located. If they are filled, those needing a watch may be transferred to another facility, e.g. NSP.

TSCI

There is a long-term plan to open residential mental health beds in a high level custody setting at TSCI but difficulty covering current staffing needs has slowed this plan.

Medication Management

NDCS has a formulary, which is the only real restriction placed on prescribing. The formulary is moderately restrictive with regard to psychotropics but non-formulary medications are obtained fairly readily and regularly, often for good reasons (such as clozapine).

Psychiatric prescribers spend virtually all of their time conducting assessments and follow-ups for the purpose of prescribing psychotropic medications. Psychiatric prescribers are following about 1300 patients on psychotropic medications (about 100 in residential beds).

The psychiatric APRN stationed at DEC is doing the vast majority of initial psychiatric assessments. These are done for all patients on psychotropics at admission, any patient referred by mental health (emergently or routinely), and any patient who requests to be seen for medication.

Patients who come in on psychotropic medications have initial orders written either by medical staff (for up to 30 days) or a psychiatric prescriber, usually the psychiatric APRN.

A weekly report of expiring medications is generated from the pharmacy software. Mental health receives a copy. Medical will sometimes write bridging orders for up to one month if a psychiatric prescriber is unavailable.

Long-term use of benzodiazepines is fairly common in NDCS. I also saw some examples of polypharmacy, such as three or more antipsychotics or antidepressants ordered for a patient (there is

no good evidence for use of three agents like this but occasionally in refractory patients it is reasonable to try such combinations). Virtually no stimulants or atomoxetine are used for ADD/ADHD but some receive clonidine or guanfacine. But in general, other than the substantial benzodiazepine use, prescribing practices are conventional and appropriate for the correctional setting. Laboratory (e.g., drug levels, metabolic studies) and AIMS monitoring was present in a number of charts though I did not do a systematic review of medication monitoring.

The rate of provision of involuntary medications is reasonable for the population. I did not see evidence of over- or under-use. All those on involuntary medications are on a residential mental health unit. While appropriate in most cases, it is reasonable to house those who are stable on involuntary medications in general population, assuming they can be well-monitored. Currently, NDCS mental health staff estimate that 15 patients in the residential units are on involuntary medications, many of whom are stable enough for general population but remain because of their involuntary order.

During normal work hours, emergency medications are obtained by whatever psychiatric prescriber can be located. This may not be a prescriber assigned to the institution. For instance, NCCW first calls the APRN at DEC to get emergency order and if that fails will usually try to contact a medical provider.

There is no formal on-call provision for psychiatry. Emergent medication orders after hours are generally given by medical providers in consultation with the MHOD and nursing staff. The one full time NDCS psychiatrist is often available informally after hours and will sometimes provide orders.

Facility Transfer

Mental health does a 5-10 minute intake screening when inmates transfer from other facilities. Nursing and custody also screen incoming transfers. This is sufficient.

Staff report that medications occasionally do not accompany inmates when they transfer, causing disruption in treatment as it can take several days to get a new supply from the pharmacy. The magnitude of this problems is unclear.

Re-Entry

Social workers focus on re-entry planning, including some limited transition group work. Each tends to specialize on different populations because of the different needs and community services they require. They provided services to 612 inmates during 2014. This is about 25% of those releasing. The social worker creates a 2-4 page release plan specifying aftercare details.

Staff and patients both report that the two week supply of medications NDCS provides at release is rarely enough to bridge the gap until their first appointment with a community psychiatric prescriber.

Social workers are assigned to residential mental health units and to serve those in GP with high needs. Homeless releases for those receiving social work services are uncommon (except for those with sex offenses). Most mentally ill are placed in group homes, halfway houses, clean and sober housing, or occasionally with family.

As noted below, offenders get two weeks of medications at release. The social worker on LCC reported that the majority of patients can get new medication orders within that time but a substantial number cannot.

SUICIDE AND SELF-HARM

Custody staff can place any inmate on 15 minute checks in a camera cell or, if such a cell is unavailable, can place the inmate directly into a suicide cell in the Skilled Nursing Facility (SNF). The SNF at DEC has safety cells that are suicide proof and have cameras that provide good coverage.

Custody does routine suicide checklists for those brought into restricted housing and if positive any of the items are positive, the inmate is similarly placed and the mental health must be contacted (the form is also routinely forwarded to mental health for review and follow-up as necessary). The inmate stays on this level of watch until seen by mental health, which may be the next working day. Mental health then determines whether to be placed on Plan A (full suicide precautions with smock, safety trays, and constant monitoring) or Plan B (step-down precautions). While these involve standard conditions, mental health can modify these as needed. Mental health staff of course can also place inmates on watch themselves.

I noted that some of the suicide smocks are deteriorating. And they are of a type that can be taken apart and used to create ligatures, especially as they age and are repeatedly washed.

NCCW estimates that 1-2 females are placed on watch each week (primarily for suicidality and mostly from intake). Most stay at NCCW in the suicide cells located in the secure unit of NCCW. They report few who engage in self-injurious behavior such as cutting, but mental health staff wonder whether this is under-reported. There has not been a suicide at NCCW for about 20 years.

RESTRAINT

Restraint decisions are made, as specified by policy, by a triumvirate of custody, medical, and mental health staff. If there is no agreement, the final decision falls to the medical director. Staff report that mental health recommendations are generally followed and none saw the process as problematic, though somewhat cumbersome.

While behavioral restraint of males occurs regularly, it is rare for females, the last being in 11/13.

Mental health staff see all patients in behavioral restraint every 12 hours, including on weekends. Cursory review of charts indicated that this was being adhered to.

I saw one inmate restrained on a hard bed with no mattress. This is reasonable only for very short term placement.

FACILITIES

Facilities are highly variable. There is limited programming space on both the male and female residential mental health units. Minor physical plant modifications could improve the usability of some spaces.

LCC

The mental health residential units have been spared the degree of double-bunking and other measures necessary in general population to house the committed population. The D unit LCC residential mental health unit can house up to 77 in 53 cells. The C unit restricted mental health housing is currently 14 beds with 16 to be added. This is an older facility and is not suicide-proof, having second floor tiers from

which jumping is possible. There have been attempts to jump and hang, but none successful in the memories of staff or in provided data sets. The cells themselves are reasonably suicide-proof for this setting but still provide anchor points for hanging. Yard space is adequate but with limited facilities. There is a plan to post video monitors in D unit hallways so that patients in cells can have passive access to some programming and entertainment.

There is no provision for those in residential mental health to eat separately from GP though staff monitor them and they are somewhat physically separated from GP.

The secure mental health unit (A unit) in LCC is archaic and austere. The 16 cells are marginally suicide-proof for this setting with breakable fixtures accessible; there are only low anchor points. There are four cells with cameras, though they are easily covered. There is no programming space on this unit. This setting is not adequate for the delivery of mental health services and provides only a secure setting. Many mentally ill transition through this unit into the residential mental health housing. Yard space is limited and there are no facilities.

There are four ADA cells in the medical area (two with cameras and two being used for storage) but they are not set up in an easily monitored fashion and are in disuse. But the facility in general (including the mental health residential settings) is not ADA compliant.

NCCW

The NCCW residential housing or Strategic Treatment and Reintegration (STAR) unit is co-housed with Protective Custody and does not have a fixed number of beds but is generally considered to be 19 rooms with a maximum census of 30; the census at the time of my visit was 9. NCCW is more modern but the STAR unit is also not suicide proof, again having second floor tiers from which jumping is possible. The cells are reasonably suicide-proof for this level of care.

There is one small group room on the unit.

NCCW has two cells in their secure housing area that are reasonably suicide proof and provide adequate video-monitoring capability. The low anchor points seen at LCC have been mitigated to some degree at NCCW (e.g., the desks have been modified). Those needing more extended suicide watch are transferred to DEC.

TCSI

While facilities at Tecumseh are reportedly much better (I did not visit), as noted above it has been possible to maintain only enough mental health staff to provide basic mental health surveillance and limited service.

There is a mental health secure placement and suicide watch cells but, owing to the staffing shortages, they are generally only used temporarily prior to transfer to LCC.

DEC

There is a skilled nursing facility in the DEC that includes four cells set up for suicide watches. In general, any patients requiring suicide watch are moved to this facility though there are two similar watch cells in the skilled nursing facility at NSP. The DEC suicide watch cells are highly suicide proof and have good quality video-monitoring capability.

NSP

NSP is an older facility. It does not have residential mental health. The mental health building houses only offices but no patients can be there as it is in an area not monitored by custody. This means that mental health has had to find and share spaces for running groups and seeing patients, which interferes to some degree with scheduling and productivity.

The control unit here is archaic with linear cell blocks having barred cells. The cells are minimally suicide proof; they have breakable fixtures, available anchor points, and cameras that are easily covered. There is a marginally adequate programming space with eyelets in the floor to restrain a small number of prisoners while they participate in groups. There are eight individual yards which are adequate size but without any facilities.

NSP has 12 Skilled Nursing Facility beds almost exclusively used for medical treatment. There are 26 ADA beds (primarily for those with mobility problems but occasionally manages the demented) that is full; there is no special program here and no additional staff – use of this is determined by medical staff. There is also a 100 bed substance abuse program at NSP with 15 dedicated clinical staff.

The two suicide cells in the Skilled Nursing Facility area at NSP are reasonably suicide proof and provide adequate video-monitoring capability.

STAFFING AND ORGANIZATION

Organizational Structure

In 2004, mental health was consolidated under NDCS health services, which itself had been created to provide general oversight for health care in 2001. The Behavioral Health Administrator reports to the Medical Director and Chief Operating Officer. The Behavioral Health Administrator oversees psychiatric prescribers directly as well as the Behavioral Health Assistant Administrators for Substance Abuse, Sex Offender Services, and Mental Health and the Director of Social Work.

Mental Health Staffing

I found the mental health staff to be professional and knowledgeable. They knew their patients and most demonstrated sound understanding of the functioning of the system. They reported generally collegial relationships with custody and other health services staff.

The numbers below are not crystal clear to me but reflect the information provided. I note that in many instances, positions are reported full but there are spreadsheets that indicate that positions are marked "leave vacant for cost savings" but are then not marked as vacant (e.g. at NCCW). There are also position numbers rendered but with no information about what types of positions though may indicate they are designated for "MH", "SOS", "SW", or "SA".

Of the 181 positions in all of behavioral health, the positions are assigned as follows

- Designated "907" – 18
  - 2 vacant (one NSP, one OCC)
  - This includes MHP II, mental health security specialists, master social worker, and nurse practitioner positions, many (or all) of which are assigned to MH
- Designated "Dual" (meaning work for more than one section of behavioral health) – 2

  - None vacant
- Designated "MH" – 53
  - 8 vacant (one DEC [administrative], two LCC [clinical], two NSP [administrative], three TSCI [clinical])
- Designated "Psychiatry" – 4
  - Two vacant (but note that one of them is actually filled by a medical mid-level)
- Designated "SA" – 65
  - 12 vacant
- Designated "SOS" – 11
  - 2 vacant
- Designated "SW" – 9
  - One vacant
- Undesignated – 19
  - Most are marked as "leave vacant for cost savings", "gone from budget 2010", or have been reclassified.

Central Office

Dr. Cameron White (1.0 FTE) and 0.5 administrative time (it is designated as full time but only filled part time) constitute the mental health presence at the Central Office. Dr. White is functioning as the Behavioral Health Administrator. The 0.5 FTE Mental Health Director position is vacant. In addition to mental health, Dr. White also oversees the sex offender and substance abuse programs.

Psychiatric Prescribers

The information provided gives different information regarding psychiatric positions. The organization chart indicates 5 FTE whereas the position listings show different numbers of mid-levels and psychiatrists, some of which are medical providers. Regardless, the actual psychiatric presence consists of one psychiatrist, one psychiatric APRN, and there has been a recent addition of contract psychiatric services. The contract services consist of telepsychiatry and on-site visits totaling about 0.7 FTE at NCCW, 0.6 FTE at NSP, and 0.2 FTE at LCC.

There is no provision for psychiatric on-call services but the psychiatrist is informally available most of the time. Medical providers do order emergent medications after hours in consultation with the MHOD and on site nursing staff.

Mental Health Service Providers

There are 82 FTE facility clinicians assigned to mental health, 12 of which are vacant:

- 17 Clinical Program Managers and Clinical Psychologists (the clinical leadership for mental health, 4 vacant
- Three Mental Health Security Specialists (a hybrid custody and mental health position), one of which is vacant
  - Three additional positions are reportedly being added to add the additional C unit residential mental health beds at LCC
- One Mental Health Practitioner II

- Two Mental Health Nurses, one vacant
- Two Mental Health Professional I, one vacant
- 34 Mental Health Professional II, two vacant
- 6 Mental Health Professional Supervisors, one vacant
- 12 Social Workers (including the Director), two vacant
- 5 Psychologist I

Staffing has been a substantial problem at TCSI. DEC, NCCW and NSP clinical positions are filled (other than psychiatry). LCC is intermediate.

Psychiatric coverage at LCC consists of the one full time psychiatrist and additional contract hours that amount to about one position.

LCC general population is served by two MHP. One MHP is also assigned to restricted housing.

LCC residential is staffed by one Clinical Program Manager, one psychologist, one psychiatric nurse, 4 MHP, and one social worker.

Custody staffing on LCC D Unit consists of one Mental Health Security Specialist (an additional is being added – they work 1200-2000), who serve the custody officer function but also have training in mental health, though they are paid less than officers. They run some groups (1-2 per day) in addition to managing the floor along with two Case Workers, one Case Manager, and a 0.5 FTE Unit Manager.

Mental health staffing on LCC C Unit consists of one MHP and one Mental Health Security Specialist II (MHSS-II). The custody staffing on C Unit is similar to D Unit; there is a plan to add 3 MHSS-II and one MHP when the beds are increased from 14 to 30 in the near future. Officers cover the remaining security functions, primarily external security.

NSP has one psychologist, one MHP Supervisor, 5.5 MHP, and three days of contract psychiatric time per week. All mental health positions are filled.

NCCW has one Mental Health Services Supervisor (15% clinical), 2 MHP on the STAR Unit, one psychologist who conducts intake and does crisis response (and a small treatment load), one MHP who responds to kites and does routine appraisals (other than intake) and some treatment, and one secretary. All mental health positions are filled. Psychiatric coverage is fragmented with one psychiatrist providing a day per week on site and another 2.5 days per week is provided by various telepsychiatry practitioners.

There is a mental health officer of the day (MHOD) available by telephone at off hours. Nursing staff conduct evaluations and consult with the MHOD on crises and other concerns.

Other Behavioral Health Staffing

I also note that there are about 70 positions assigned to chemical dependency treatment and 11 to sex offender treatment.

Trainees

NDCS provides training for medical students and trainees in psychiatry residencies, physician assistant programs, and APRN programs. Trainees had positive reports about their experience and the quality of supervision.

POLICIES AND PROCEDURES, INFRASTRUCTURE AND SUPPORT

Policies and Procedures

In general, policies and procedures are in place for important mental health functions. Some salient policies deserve mention here but I will not comment on their general content and instead address issues in my opinions and recommendations.

Placement

The Mental Illness Review Team (MIRT) is the body that determines whether an inmate is designated as having a Major Mental Illness (MMI). MIRT also makes decisions about who utilizes residential beds and whether those with MMI are placed in designated Secure Mental Health Unit (SMHU) beds in restricted settings, though the warden may overrule MIRT placement decisions (and sometimes does).

MIRT meets monthly but there is provision for handling emergent cases electronically. Movement out of the residential units can be difficult to effect owing to overcrowding in general population. One patient on the unit had been cleared for GP placement 3 weeks previously and staff report it typically takes a month. As a result, the unit is almost always full (especially given limits on those who can have cellmates) also making it difficult to get people into the unit when needed. While MIRT makes decisions about who can use the beds, custody will sometimes block placement if there is a concern about safety/security, including when staff have a history of being assaulted or threatened by a mentally ill inmate; there is no alternative placement in such situations.

The Clinical Violent Offender Review Team (CVORT) similarly assesses inmates but in this case not for treatment but for the need for correctional programming directed at violence reduction. The Violence Reduction Program (VRP) at NSP, to which CVORT can refer, was developed as part of a PREA grant in 2007 and has continued on after the grant, staffed by mental health.

The Sexually Violent Offender Review Team (SVORT) serves the same function for inmates with sex offenses. Note that while Nebraska has a civil commitment law for sexually violent predators, it does not have mandatory prison sex offender treatment related to particular crimes.

The Clinical Substance Abuse Review Team (CSART) serves this function for those with substance abuse disorders. There are 313 substance abuse beds in the system as well as some outpatient level treatment in GP and out of custody. Nebraska law does not have statutorily mandated substance abuse treatment as a sentencing alternative.

It is important to note that there is presently no centralized bed control for the whole NDCS system.

Discharge Review Team

This team reviews inmates who might represent a danger to the community when released. The primary charge of this team is to review cases for whether or not civil commitment is indicated.

Peer Review Process

The internal and external peer review process is not intended to be a robust peer review process for the purposes of monitoring the general practice of clinicians. It is more consistent with morbidity and mortality committee function in that it is driven by events or complaints rather than routine assessment of practice by their peers. It appears that this function is done through the supervisory function rather than peer review. This is reasonable and typical in correctional settings.

Audit Plan

The Audit Plan (MP36) is generic but sufficient. However, review of the audit forms shows them to be very rudimentary and to consist primarily in a chart review to determine whether the correct elements are present. I did not review any audit results.

Medication Administration

It is my understanding that nursing staff administer medications at OCC, NCYF, TSCI, and in Skilled Nursing Facilities while custody gives medications to patients in other settings from a tackle box that is charged by the pharmacy. While policy provides that the staff member will write down the number of pills that the patient took, in fact the patient wrote this themselves. During my visit, tackle boxes were stolen by a porter when a door was not properly secured. The medications were replaced from the local pharmacy and there were reports of GP inmates exchanging pills; the medications were not recovered.

Diversion of medications is identified as a growing problem at NCCW with Wellbutrin and opiates leading the way. The magnitude of the problem is unknown and staff do not know how big the issue is in the male prisons.

Information Technology

Information technology systems at NDCS are limited and outdated. The mental health data system (NICaMS) was created by NDCS in order to track mental health information and provide a limited records function. Its functionality is limited to free text entry and a few drop-down boxes to characterize the nature of patient encounters and enter diagnoses. It does provide the ability to search and aggregate the data. Mental health is the only clinical group that uses this system. Medical providers use a paper record. Psychiatric providers use both systems. The pharmacy uses the CIPS system.

Routine reports for mental health are limited. There are reports for some clinical purposes such as detecting those whose prescriptions are expiring. In general, this functionality is not readily available. The existing systems are fragmented, archaic, and the data is not aggregated in a data system capable of providing real reporting functionality.

The most notable feature of medication management is that there are no nurse-administered medications except in the skilled nursing areas. Some offenders keep and administer their own medications, typically delivered on a standard pill card. The rest have their medications delivered from pharmacy in unit doses to custody staff (no nursing staff involved) in a tackle box who then give the medications to the inmates. It was said that the custody staff write down the number of pills given to the inmate who then writes down the number taken. What I saw was that the inmates wrote down the number they were ordered and also wrote down the number taken. The custody staff generally

required that the inmate show their identification and then got the medications out of the packages and gave them to the inmate. The custody staff floated some medications (they came crushed); they did not use gloves or wash hands. Sometimes a cursory mouth check was done. While I was visiting, a tackle box being delivered by an inmate went missing and medications were reportedly being given or sold to other inmates. There was reportedly a breakdown in the procedure for obtaining and checking in the tackle boxes of medications. These boxes were seen unsecured several times throughout the visit.

There has been a substantial problem with diversion and overdose (some requiring hospitalization) at NCCW, primarily Wellbutrin and opiates.

Laboratory and Ancillary Services

Laboratory studies and specialized studies such as MRI are available though access to specialized studies is limited and may take a long period of time to obtain other than in emergencies.

Training

There is no regular gathering of mental health staff. There are periodic –in-service offerings, including from outside experts brought in by NDCS.

RECOMMENDATIONS

Before going into detail, I enumerate my primary recommendations. They are put in the general order in which they should be addressed; this is especially true for the first few.

- Develop a clear sense of vision for the mental health system
- Establish a "mental health benefit" for the system
    - Develop utilization review and utilization management processes over time
- Develop more robust informatics
    - This will be necessary to provide the QI, audit, and utilization processes with the information needed to implement, manage, and monitor the system – without sufficient informatics, an effective system cannot be created or maintained
- Review organizational structure in light of vision
- Focus initial assessment
    - Not every admission needs a complete mental health assessment
        - Admission is not a good time for comprehensive assessment owing to the distorting effects of the early period of incarceration
        - A brief face-to face assessment by mental health ASAP following admission is optimal
            - 5-10 minute screening to detect suicidality, risk of self-harm, acute mental illness and the potential for mental health needs
                - Prioritize based on screening
                    - Emergent – see immediately
                    - Urgent – see next working day
                    - Routine – assess within two weeks
                    - No further assessment required at this time
            - In my view, this meets NCCHC standards (which are not clear on what such an assessment consists of)

- Full assessment for those entering on psychotropic medication or who are detected on the initial screening
    - Only refer those on psychotropic medications or who meet medical necessity criteria for treatment to a psychiatric prescriber

- Assure robust detection and referral mechanisms
    - Staff referral (custody or medical)
        - Emergency – staff must be able to declare emergencies
        - Routine requests
            - Must include a reason for referral
            - Triaged within one working day
                - Emergent – see immediately
                - Urgent – see next working day
                - Routine – see within two weeks
    - Inmate self-referral
        - Emergency – inmates must be able to declare emergencies and be appropriately evaluated, which may initially be by nursing staff
        - Routine ("kite") requests
            - Must be confidential or done through clinical staff
            - Triaged within one working day
                - Emergent – see immediately
                - Urgent – see next working day
                - Routine – see within two weeks
- Structure mental health outpatient mental health services
    - Distinguish treatment and programming
        - "Treatment" is done for the purpose of benefitting a patient; "programming" is done with the correctional mission in mind, primarily reduction of recidivism
            - Mental health staff should focus on treatment
    - Provide for dedicated crisis response (rather than asking primary therapist to respond
    - Clarify and sharpen the mental health role in restrictive housing
        - Effective mechanisms for diversion from restrictive housing are necessary for this function to achieve its full value
    - Develop/endorse treatment protocols, modules, and/or manualized treatment for common conditions treated in GP
        - Emphasize group over individual to the extent possible
- Develop a more diverse residential mental health service and special housing settings
    - Differentiate housing settings by type of disorder to the maximum extent possible (owing to the variability of the symptoms and behaviors some patients with disorders of another category may fit better with a different group of patients, for example some TBI patients will be better treated in residential mental health than with other cognitively impaired)
        - Major mental illness (psychotic disorders, bipolar disorder, major depression – moderate or more severe, other mental illnesses with severe functional deficits)
        - The cognitively impaired
            - Traumatic brain injury (TBI)

        - Dementia
        - Intellectually disabled (best if have their own special housing unit)
      - Personality disordered, behaviorally disruptive
        - Including most self-injurious behavior
    - Develop mental health residential at various levels of custody
      - Restrictive (the following are emerging standards or recommendations being promulgated by experts in the field)
        - 10 hours of structured out of cell programming per week
          - Treatment
            - Structured recreation
            - Formal groups
          - Education
          - Work
          - Correctional programs
        - 10 hours of unstructured out of cell programming per week
          - Free recreation
          - Meals
          - Showers
          - Yard
      - Intermediate
        - 12-20 hours of structured out of cell programming per week
        - 10 hours of unstructured out of cell programming per week
      - Minimum
        - Highly variable needs. Typically need less structured treatment and more work/education/correctional programming and more unstructured time.
- Strengthen systems for bed control
  - Nobody placed in a residential mental health unit without mental health assent
  - Nobody removed from a residential mental health unit without mental health assent
  - Safety/security needs may trump a particular placement but some placement must be found
- Develop structured approaches to psychotropic prescribing
- Do away with tackle boxes for medication administration
- Support Discharge Review Team
- Sharpen peer review
- Expand quality processes
  - Build out audits
  - Develop QI processes
- Simplify restraint process
- Expand options for suicide monitoring and put decision-making in hands of mental health
- Develop staffing to serve the preceding
- Improve facilities
- Provide access to licensed level of care

Vision

Vision statements can be worthless or enlivening and guiding. What I suggest here is not a simple statement of purpose or mission such as taking care of the mentally ill but rather a guiding vision of what values and principles are to govern the mental health system.

A caveat emptor is in order here. In many of the recommendations that follow this "vision" section, the reader will be aware that they imply particular answers to some of these questions. I will try to point out different directions where reasonable but doubtless my personal bias will creep in.

Questions that you can use to develop the vision might include:

- How are we to prioritize our resources for mental health, substance abuse, and sex offender treatment?
    - Most of the below questions should be posed regarding all three services but I posit them for mental health
- How and to what degree does mental health participate in institutional management and control and how is this balanced with patient care?
- Should mental health have a role in offender programs and if so, what is it?
- Do we want to do the constitutional or statutory minimum and if not, how much more?
- Do we focus on doing a good job of treating the sickest or do we try to expand and stretch our resources to serve as many as possible?
- Is our primary treatment goal symptom reduction or functional improvement?
- What correctional interests do we serve?
    - Reduced recidivism
    - Reduced infractions and behavioral disruption within the prisons
    - Restoring function sufficiently to allow prison program participation
- Do we want to emphasize crisis management or structured treatment?
- Should the focus of treatment be on psychotropic medications or are other forms of treatment important to establish and develop?
    - If so, what kinds of treatment?

Mental Health Benefit

Answers to the above questions will guide you to establishing what I am calling your mental health benefit. But it is essential for NDCS to have a clear understanding of the Nebraska law that is said to mandate that NDCS provides the same standard of care as the community. NRS 83-4, 154 states that NDCS must provide "...the type, quality, and amount" of medical care that a person in the community "...could expect to receive in that community." But it also speaks to the "community in question", raising the possibility that it is a local (not state) standard. It cannot be the case that NDCS is required to treat anyone who asks to be treated. Any health care system or insurer will have defined benefits.

NDCS should establish a defined benefit for mental health care. As it is difficult to do this purely on the basis of diagnosis for mental illness, it will almost certainly be necessary to include a functional component to determinations of medical necessity unless barred by law.

In order to implement a defined benefit, some form of utilization review and utilization management is necessary. It need not start as a robust system and can even begin simply by publishing the benefit with

the expectation that individual practitioners will adhere to the benefit under ordinary supervision. You will find this a relatively ineffective system but it introduces the concept and can help you refine the benefit (an on-going process). Staying within this approach, the role of the supervisor can be strengthened and expanded to allow for formal authorization for treatment (in at least some cases) to be required for treatment to begin. This changes the role and workload of supervisors but this is not a real barrier. They do less direct care but structure services in general so that it is more effective and the overall efficiency of your system improves.

A more robust system that provides for independent utilization determinations can also be developed but may not be necessary. This could be done by committees (including of practitioners themselves), a utilization office, or any of a number of models.

Note that utilization mechanisms demand accurate assessment and thereby indirectly feeds back on your peer review, audit, and QA/QI processes.

But most importantly, you will need mechanisms for tracking utilization.

Informatics

It is not possible to create and maintain utilization processes without a better system of information management. Reliable data and the capacity for robust analysis of that data are essential for a variety of other functions (notably QA/QI, budgeting, and resource allocation).

NDCS has serious shortcomings with regard to informatics in mental health and health services in general. While a number of staff have, out of necessity, created workarounds to try to address these limitations, they are poorly integrated and inflexible. It is not currently possible to get a clear picture of the services delivered to an individual, by a staff member, or in the aggregate. A tremendous amount of work had to be done by hand in preparation for my visit; much of this was information that should be considered "dashboard" level information available at any time, such as the ability to characterize the current mental health population, to track service delivery and service utilization, to monitor medication trends and costs, to manage bed utilization, to track critical incidents, etc.

This is an area for substantial development with large potential pay-offs in terms of developing real systems for utilization review and management, ability to report efficiently both inside and outside the organization, and audits and quality improvement. In short, without better informatics, it will be very difficult to maximize the efficiency and effectiveness of services.

Organizational Structure

In general, the administrative organizational structure is typical of correctional mental health systems. The system has chosen to break behavioral health up into mental health, substance abuse, sex offender, and social work services. The only unusual structure is that facility psychiatrists report directly to the behavioral health administrator; they would typically report to the local mental health administrator but I do not see this as problematic as long as there is sufficient clinical oversight through peer review or other structured clinical oversight. At this point, the Medical Director provides clinical oversight to the psychiatric prescribers. It would be preferable for psychiatric prescribers have clinical oversight by a psychiatrist, which could be done by a chief psychiatrist (discussed below under **Staffing**) or by peer

review (which would need to be restructured if it were to serve this purpose, also as noted below under **Peer Review**).

The decision to split behavioral health up is reasonable and allows clarity and division of mission. It can create problems of silos and challenges to fluid restructuring of clinical services but I do not see it as a fundamental barrier. In some ways, it forces a careful evaluation of how your services are arrayed in light of the priorities that are established by your vision. In my view such a careful analysis is critical. For instance it is noteworthy that your staffing for substance abuse treatment is more robust than for mental health. Is this in line with the department's vision and meeting its legal obligations?

These sorts of questions must be answered not in the sense of winners and losers but from the perspective of achieving the goals of behavioral health in the context of the NDCS prison system and its larger mission and vision.

Behavioral health cannot function in a vacuum and has some responsibility to the overall correctional system. It is for this reason that I support your system's approach of not privatizing mental health. When the focus is on profits and the delivery of contracted clinical services, the system loses the sometimes unrecognized benefits of an embedded mental health system. An embedded system can add a great deal of value by providing forensic functions, training, program development (not just for mental health), risk assessment, risk reduction, connections to training programs, leadership, and so on. A privatized system can provide sound clinical care (with a properly crafted and monitored contract) but in my opinion a degree of flexibility and ineffable added value is likely to be lost.

Initial Assessment

The nature of the initial assessment must be driven by a variety of factors including: standards, volume, resource management, and the mental health benefit. In general, there must be some form of mental health screening of every inmate. But what NDCS is currently doing is more than is necessary. The primary goal at this point is to not miss high risk problems: suicide risk, psychosis, severe mood disorders, and significant cognitive deficits.

A reception screening can be conducted by a trained officer or nursing staff (in prisons, this is almost always done by nursing staff and is the most prudent approach). This should include a mental health component (typically a checklist) that addresses: suicide (current ideation and past attempts and ideation), psychotropic medications (whether currently ordered, currently taking, any past use), past psychiatric hospitalizations, current and past outpatient treatment, past correctional treatment, any mental health complaints, history of special education, and observations of unusual behavior, orientation, and general demeanor (agitation, tearful, etc.).

Currently, a full assessment is being done on all admissions to NDCS; this is unnecessary. An intake mental health screen should be done on all admissions by mental health staff ASAP (but within two weeks in all instances). But this need only be a 5-15 minute, semi-structured interview that covers most of the elements of the reception screening and adds additional information such as what specific medications are being taken or have been taken, reasons for past hospitalizations, details of current complaints, and more robust inquiry into suicide risk and significant signs and symptoms of major mental illness.

An assessment need be done only on those for which either screening is positive. And even at this stage, it need not be a full assessment but a brief assessment sufficient to make a determination about whether the inmate is likely to meet medical necessity criteria for treatment (the exception to this is that a full assessment will be necessary for anybody admitted on psychotropic medication). One way to handle this is by designing a progressive assessment that can be halted at several points along the way to a complete assessment.

Referral

Initial screening will always miss some cases and of course many inmates will decompensate after admission. There must be robust detection mechanisms. This requires that both staff and offenders can initiate an emergency to which there will be an immediate response either by mental health staff or by nursing (who then consults with mental health). Note that mechanisms to curb inmate abuse may be necessary, which may include infraction for misuse of emergency declarations, co-pays for emergencies, or other behavioral approaches.

Both inmates and staff (custody and medical) must also be able to generate a routine referral. It must include a reason for the referral. The inmate must be able to submit the referral confidentially (NDCS has taken officers out of this process to insure confidentiality).

Referrals then have to be triaged, usually by the next working day is sufficient (since there are other mechanisms for emergencies). The referrals are categorized into emergent (to be seen ASAP), urgent (to be seen by the next working day), and routine (to be seen within two weeks).

Urgent and emergent responses should not entail a full assessment but crisis management and a referral for full assessment if indicated. Routine referrals also need not entail a full assessment but a brief assessment to determine whether a condition meeting medical necessity is likely present.

It is important to track referrals as this is an essential detection function and a place where systems often struggle to meet their own internal standards.

Outpatient Services

Another area where substantial clarification and some potential savings can be accrued is in minimizing the use of mental health staff for correctional programming. Licensed mental health staff should generally be reserved for treating those whose conditions meet medical necessity criteria. This not only brings structure and savings but also prevents NDCS from running afoul of informed consent. One way to look at the distinction between treatment and programming is that treatment can be refused without fear of sanction (inmates have a right to refuse all but legally mandated involuntary treatment) while inmates who refuse programming may be sanctioned.

But it is also reasonable to ask mental health to assist in establishing some of these programs both in terms of using their expertise in identifying evidence-based programs but also in terms of providing training and initial direct service while non-licensed staff develop the expertise to conduct the program with fidelity.

With regard to general outpatient services, it is important to move from a crisis-driven system to a proactive and preventive system to the maximum possible. When crises are the only way to assure contact with mental health, crises are reinforced and it creates a negative spiral. Delivery of structured services to those in need is the best antidote for this. Other than medications, this should primarily focus on short courses of treatment (8-12 weeks) in groups and limited individual therapy using evidence-based approaches to the most common serious problems faced in GP: PTSD, depression, and severe anxiety disorders. Most of this will be CBT-based treatment but the most important initiative is to bring structured courses of evidence-based (often manualized) treatment to GP.

Those with major mental illness in GP will primarily need medications and case management services (assistance in developing programs and navigating the system, supportive contact, and psychoeducation). This too needs to be structured with scheduled contacts and formal expectations.

The most effective structure for providing this is to assign primary therapist to active patients, i.e. those receiving case management services or more. This provides continuity of care, confers clear clinical responsibility, and simplifies coordination with custody, medical, and other behavioral health services. They become the point of contact and coordinator for their patient much like a primary care doctor.

It is also important to strengthen the mental health presence in restrictive housing. Placement in restrictive housing is a high risk time. I recommend that mental health be assigned to all restrictive housing units in sufficient number to allow initial screening of all new entries by the next working day. The custody and nursing screenings are adequate to detect emergent problems but more careful assessment is prudent. Weekly rounds are also a sound practice being adopted in many systems and I recommend this occur as well. While rounds can be conducted at cell front, screenings and assessments should be done in private, even if that is with a restrained patient or in a non-contact booth.

Unless these initiatives are accompanied by real mechanisms for transferring those with serious mental health conditions out of restricted to a residential setting with meaningful access to care (even if high security), this function is almost useless. The mental health treatment that can be offered in traditional restrictive housing units is extremely minimal and limited in efficacy.

Residential Mental Health Services

It can be expected that about 2-4% of the correctional population will need residential or hospital level mental health services, depending on the efficiency and effectiveness of outpatient services and the conditions in general population. The worse these are, the more it can be expected that those with mental illness will fare poorly. Conditions such as crowding, violence, and limited direct oversight by correctional staff are particularly notable in terms of the likelihood of leading to mental health decompensation. Lack of structured outpatient services and access to psychiatric services are of course contributory as well.

The array of residential services in NDCS is limited. At the present time, the residential mental health units house patients with very diverse disorders including dementia, traumatic brain injury, intellectual disability, personality disorder, and major mental illness. It is not possible to run an effective program with such diversity both because the services they require are so disparate and because these populations often do not mix well together.

This problem is not easily remedied at NCCW as the numbers are too low to efficiently create special housing settings for the different populations. This means that mental health staff in the STAR program must be able to provide flexible programming targeted at the different populations. The one point I will mention is that NDCS would do well not to mix the PC and mentally ill as this is resulting in a situation in which, by virtue of being mentally ill, these inmates get reduced access programs and out of cell time, which is likely an ADA issue. If there are logistical strategies that can remedy this issue, that is sufficient as there is no inherent reason the populations cannot be in the same living area. Beyond this, I have no helpful recommendations for the STAR program (except see my comments below on a level system) other than to develop diverse interventions to match the diverse population. The small numbers and diversity make group treatments less attractive though they should be used to the maximum extent possible.

The male prisons have the numbers to make some progress on these issues. In order to frame the issue better, I will offer some prevalence information as background. The prevalence of dementia in those over age 70 is 14% (and very low below age 65), higher in correctional settings. The prevalence of intellectual disability in correctional settings is 4-10%. The prevalence of TBI has been estimated as high as 60% in corrections. In the general population, the prevalence of disability following hospitalization for TBI is 1%. Thus at a minimum, about 6% of the NDCS population (over 300 inmates) likely has a readily demonstrable cognitive deficit. This population should not be admixed with the mentally ill, though some with these conditions may have concomitant mental illness that necessitates their placement in mental health residential settings. They have very different service needs, often have physical limitations (requiring appropriate physical plants), and need a different living unit structure (privilege system, activities, incentives, etc.). 3

There is currently no good option for any of those with cognitive impairment and this is clearly an area that will need to be developed. Unfortunately, those with dementia, traumatic brain injury, and intellectual disability can also have very different needs. Typically, systems address this by having special housing for the demented and the intellectually disabled and those with traumatic brain injury may be housed in either of those units or on a mental health unit, depending on the nature of their symptoms and behavior. Those with dementia should be preferentially directed to the ADA beds at NSP, as long as reasonable separation can be maintained between this population and those with mobility problems. The most essential intervention is to keep them busy with structured, non-stressful activities. This leaves the intellectually disabled and TBI; many with TBI can be treated successfully in habilitative programs alongside the intellectually disabled. Those TBI patients with profound deficits can also be directed at the ADA beds at NSP and those with symptoms more consistent with mental illness can be in residential mental health. Those with significant behavioral disorders will remain a challenge and various placements may be tried.

The needs of the personality disordered population (the majority of inmates have a personality disorder of varying severity) are also quite distinct from the mentally ill and the cognitively impaired. In general, they should not be placed in the same units, though again sometimes must be placed (preferably for short periods) in mental health settings. This population is especially challenging to treat. The VRP provides the right kinds of services for some of this population but does not address the needs of those who engage in self-harm and non-violent behavioral problems such as feces smearing, throwing, spitting, name calling, and other distasteful but non-dangerous actions.

Further, the VRP is set up as a voluntary program so some of the most behaviorally disruptive with severe personality disorders will not qualify. Note that were the VRP run as a program rather than as treatment, offenders could be assigned rather than render consent. While it is a good idea to have a voluntary program like the VRP, it may also be prudent to consider developing a residential program (likely in restricted housing) that uses the same basic principles as the VRP but does not require voluntary placement. The primary target population would be those with behavioral problems not due to a major mental illness or cognitive impairment, most of whom would have primary diagnoses of personality disorders. Some would have mental health treatment needs, but they would be secondary issues.

Recall that 2-4% of the population is likely to need residential or licensed care (about 100-200 in NDCS). Were special populations such as the cognitively impaired and behaviorally challenging personality disorders to be removed from the residential setting, the current number of beds (77 D, 30 C [including 16 planned beds], 10 NCCW, limited DEC beds) is marginally adequate for those with major mental illness such as schizophrenia and severe mood disorders.

The major question is how to move from the current situation of having a broad range of disorders placed in a limited program to a more differentiated program with varied services targeted at different populations. In the simplest terms, the question amounts to what type of special housing unit to develop first. The two obvious choices are a unit for the cognitively impaired (likely emphasizing the intellectually disabled) or a step-down unit for the mentally ill. In order to answer this question, the first task is to determine how many cognitively impaired that could be housed together are in the existing male residential mental health beds and in restricted housing (recognizing that the system may not be well identifying this population, an initiative to identify this population may be necessary). If the number identified is sufficient to create a housing unit, this would be a reasonable first step that would also open beds for the mentally ill.

But the NDCS mental health team has identified a need for a "step-down unit", essentially a lower custody and less acute setting to transition patients towards general population. It also allows separation of those who must be kept apart. This type of unit will likely be necessary at some point but if sufficient beds can be opened by removing those with cognitive deficits, it may not be necessary to open such a unit immediately. The expansion of C unit beds will assist in this. And since the D unit is being run at an effectively lower custody level than the physical plant provides, NCDS would at least have residential beds at restrictive and medium custody levels. This allows some capacity to manage separtees. But in order to do this, the mental health programs at both C and D will need to be strengthened, especially C unit. D unit is likely just meeting the recommended hours of structured and unstructured time out of cell. The types of groups should be expanded to allow flexibility in offerings to meet the needs of a varying population. In general, D unit is providing sound care but will be aided tremendously by placing only those with major mental illness on the unit.

It will take substantial expansion of services on C unit to meet the 10 hours of unstructured and 10 hours of structured out of cell time. Assuming NDCS is able to preferentially house those with major mental illness on this unit, groups should be targeted primarily at low-demand, highly structured groups focusing more on rehabilitation (or habilitation) and recovery. Unstructured, on-going groups are generally of limited value with those having major mental illness.

In addition to the above comments on the content of treatment in the residential units, I recommend that NDCS develop a more robust level or privilege system on its units. The current systems are very minimal and are not altogether behaviorally sound.

This will be most effective once the populations have been separated as each will be different. What I am recommending is a progressive system of 3-5 levels that starts (for all those admitted) with minimal privileges and provides for progressive privileges that are explicit and largely invariant. To promote to the next level, patients must achieve specific behavioral criteria for specified periods of time. The criteria should be developed in conjunction with the privilege to be earned. As a simple example, access to groups (unrestrained) might be made contingent on no staff assaults, not making threats to others, and being able to participate in the give and take of conversation for, say, two weeks. Domains of criteria might include: aggression/violence, treatment participation, medication taking behavior, social interaction, anger management, and self-care. These domains and the specific expectations within them would vary depending on the population of the unit.

Bed Control

The mechanisms put in place to identify specialty population (MIRT, CVORT, SVORT) are reasonable for identifying and prioritizing use of beds. However, it has proven challenging to move inmates to make space for those who have greater need services. It is often not possible to readily find a bed in general population for a lower acuity inmate. This has not been as big a problem for those who need a more secure setting and the female population as there are generally openings available for these populations. But it is a substantial problem for the D unit residential setting. Being able to promptly open space for those with more acute needs, without having to place them in highly secure settings when unneeded, is a critical need.

There are two obvious drivers for this problem: overcrowding in general population and the lack of centralized bed control for NDCS as a whole. Overcrowding makes it very difficult to have the flexibility that is needed to move inmates promptly, preventing efficient use of beds. Lack of centralized bed control precludes the use of automated processes in bed assignment which both improves accuracy and speeds the process. It also makes the operation of a mental health system within a correctional system very difficult as dynamic placement is important to efficient utilization.

Another issue that needs to be addressed is what to do when an inmate needing residential services is denied placement because of security concerns or other issues that a warden may identify. Right now, these inmates simply do not get the level of service needed. The problem is that there is only one location where certain services are available (e.g. LCC D unit) and if there is a keep separate situation, no alternatives exist. A formal solution needs to be developed for these situations. This could include developing special conditions for mentally individuals in a GP setting (probably on a case-by-case basis) or developing residential services at other locations.

Psychotropic Medications

My main recommendations with regard to psychotropic medications are to develop protocols and guidelines directed at common disorders where such guidelines are reliable and fairly prevalent in corrections, e.g. PTSD, ADHD, OCD, Panic, and Generalized Anxiety Disorder. For other conditions where guidelines have been less successful, such as mood disorders and to some extent schizophrenia-

spectrum disorders, general formulary limitations such as allowing no more than two antipsychotics or two antidepressants absent review by the chief psychiatrist or other body are prudent.

Though non-formulary medications can be obtained, consider opening up the formulary. One way to do this without incurring undue cost is to provide for formulary and restricted formulary designations. Most often, generics are formulary and brand name drugs, high risk drugs, and other expensive drugs are made restricted, only to be accessed after demonstrated failure of formulary drugs.

These sorts of guidelines and formulary limitations should be done so as to dovetail with the mental health benefit. The benefit determines who gets treated and the guidelines determine how they get treated.

By developing such guidelines and a structured formulary, it provides the agency with a way to demonstrate diligence to outside interests both in terms of attention to appropriate clinical standards and in terms of fiscal accountability. It is important the NDCS be able to present a rational and consistent approach to all patients. The agency is not required to provide all treatments or even the best treatments but adequate treatment. It is entirely reasonable, and in fact necessary, for the agency to place limits on the scope of practice of individual practitioners. But it must be done in a manner consistent with the clinical and scientific literature.

Medication Administration

The use of tackle boxes as is being done in NDCS is highly problematic. Even if it is totally legal, it is very unwise. In my opinion, the current practice of custody delivering medications from a tackle box must be stopped. While it is possible for custody to provide this function, there are many problems in allowing this and in how it is being done presently. There is a lack of security around the tackle boxes, a lack of attention to cleanliness (gloves not used; no hand-washing), poor tracking of medications from pharmacy to patient (identification was not uniformly checked), inability to closely monitor for adverse effects, lack of privacy, and a lost opportunity to provide teaching and coaching about mental illness and medications by clinical staff.

As I noted above, medications are not being properly handled in terms of cleanliness and proper tracking and security. Custody should also not be permitted to directly handle medication, such as taking out pills or floating crushed medications, which they do. Further, custody is not following the policy as it is written, including not tracking the medications as specified and not properly identifying patients. But even if it were done well (which would entail custody providing unopened, packaged medication from a secure container to patients who take them and then return the package to custody, documenting what they took) this system presumes that the patients are capable of medication self-administration because that is truly what this is or should be; custody is, in essence, just storing medication that patients are taking on their own. It is unreasonable for NDCS to assume all patients are capable of serving this function competently.

By having nursing staff provide medications for the most ill, it also provides a chance for monitoring efficacy, identifying adverse reactions and side effects promptly, and patient education. It also takes custody staff out of a precarious position.

Conversely, it is also important to have a clear pathway to self-administered medications. Self-management of mental illness is both an important skill and, if beyond the capacity of the patient, an

important consideration with regard to re-entry planning. A structured approach to self-medication, at least in the residential mental health units, is prudent, especially if transferring to general population where self-management is essential. But this should be reserved for those who have demonstrated the ability to properly take and self-monitor their medications. For the mentally ill, a self-medication program could readily be developed where patients would demonstrate their readiness in a system that progresses to full self-administration.

I recognize that there are safety and security concerns with self-medication. These are valid and must be carefully considered. If properly managed, self-medications can be done safely. It cannot be seen primarily as a cost-cutting measure, though it will reduce costs compared to staff-administered medications. The risks of diversion and overdose must be weighed against reasonable cost savings and the development of patient self-management skills. But in no cases should patients on suicide watch or, in my opinion, in restricted housing be self-administering medications (except necessary rescue medications).

Discharge Review Team

The Discharge Review Team is charged with providing risk assessments and civil commitment recommendations regarding pending releases who may be at high risk of violence. This team needs to be supported in conducting its work and assured that it is not the outcome that determines their effectiveness and value but the quality of their work.

It is important to be very clear in policy about how referrals to this team are made and for what purpose. Formal criteria are preferable though must allow for some clinical judgment. If the primary task is to assure that those who might qualify for civil commitment are detected and carefully evaluated, it makes sense for mental health (in conjunction with your legal team) to set the criteria for who should be referred and how they should be evaluated. In general, a formal actuarial risk assessment is not indicated for this purpose. In fact, testing is of little value as the question is whether they have a qualifying condition (mental illness as defined in statute and/or case law) and whether they meet the dangerousness criteria, which in do not map onto formal actuarial risk assessments. Dynamic risk assessment is pertinent and can be done using semi-structured tools but there is no formal test that can be used to determine whether someone is committable.

If a more general risk assessment is desired, then broader criteria for inclusion is indicated. But the product needs to be clearly specified. If it is to conduct an actuarial risk assessment, that leads in one direction – but it only gives a sense of who to be concerned about and does nothing to manage the risk. A risk reduction approach leads in yet a different direction, likely an actuarial risk assessment that determines who needs to have a risk reduction plan. The risk reduction plan would then need to be based on a dynamic risk assessment.

The team could serve both functions, but each would need to be spelled out explicitly.

Peer Review

It is important to have the function that this process serves, that is, a systematic review of sentinel events and other occurrences that the health care team wants to track for the purposes of risk reduction and quality control and improvement. It is appropriately viewed as coming under laws that provide some protection from public disclosure.

But this is not a typical peer review process, which contemplates review of routine clinical practice by peers. As long as regular evaluation of the practice of clinicians by clinicians is undertaken in some fashion, such as annually by a supervisor with the clinical credentials to evaluate the practice of the supervisee, then all is well. If this is not provided for, it is essential that some form of clinical supervision or clinical oversight (as distinguished from administrative supervision) be put in place.

Quality Processes

Quality improvement is of course essential. One way of distinguishing quality assurance from quality improvement is that the former focuses on "counting widgets" whereas the later focuses on making the widgets better. Quality assurance is thus a first step in QI as you thereby "assure" that you are doing what you say you intend to do. The next step is to improve the processes and the content. In the world of mental health, this means first being able to assure that you are rendering the services that your policies and your mental health benefit demand. Essential elements include:

- Diagnostic distribution of the patient population
  - In general population
  - In each residential unit
- Encounter tracking
  - Number of each type of encounter, at a minimum
    - Initial screening
    - Mental health assessment
    - Crisis response
    - Group treatment sessions (with growing sophistication, you can track type of group – e.g. CBT, psychoeducational, rehabilitative)
    - Individual treatment sessions (also can track type of treatment)
    - Psychiatric assessment
    - Medication management
    - Consider: re-entry planning, evaluation of those in restraints or on suicide watch, rounds, required periodic assessments such as PC or maximum custody)
  - Types of encounters by clinician and location
- Numbers on suicide watch
- Numbers in restraint
- Suicide and suicide attempts
  - Also requires formal assessment, usually in line with sentinel event policies and procedures and/or morbidity and mortality committee (or similar function
- Referrals and outcomes for civil commitment
  - Mental health
  - Sex offender
- Psychotropic medication monitoring
  - Numbers and percentages of patients on psychotropic medications
    - At admission
    - In the population
      - Preferably by GP and residential settings as well

        - By different categories of medication: antipsychotics, antidepressants, antianxiety agents, mood stabilizers (as a starting point)
    - Tracking those on involuntary medications
    - Medication costs
    - Important patterns (may vary with time)
        - Polypharmacy
        - Use of particular medications (e.g. controlled substances)
- Response to referrals
- Response to kites

These elements will allow you to both respond to common requests for information and will also give you a pretty clear picture of how your resources are actually being used and what kind of service the patients are receiving. In addition, it can give a clear sense of access both by giving raw numbers of those being treated and the timeliness of response.

The audit function, a quality assurance function, is essential and should be carefully tied to reports and informatics. Put differently, findings of audits should drive the creation of reports or "dashboards" that track problems identified during audits, especially those that are systematic in nature and represent either recurrent problems of systems changes.

As noted previously, the current audit forms ask for very rudimentary information. While a reasonable place to start, the intention must be to move from only looking at the content of an individual medical record (which is certainly important) to provision of services at a system level. Tracking things like timeliness of assessments, access to care, response to kites, and provision of services on a system level is essential to running a system. While not all of these would necessarily be part of an audit process, certainly many can (and should) be included; others can be addressed through the QI process.

As mentioned in the section on informatics, NDCS also needs more robust report capacity, which can supplant staff-intensive audits in many instances. High level dashboards, detailed standing reports, and ad hoc reports targeted at specific problems or initiatives are all essential to quality improvement and quality assurance. But they require infrastructure and carefully designed data systems and data calls.

Measurement is often a missing piece in correctional health systems due to challenges with informatics and staffing limitations. But without measurement, audits, corrective action plans, and quality improvement initiatives have very limited value.

Restraint

I did not see any major problems with restraint usage or over-usage. I would raise caution about restraining on a hard bed, which should not occur for any more than a few hours.

The main question I have is around the ordering of restraint. Presently, you provide for a triumvirate of custody, mental health, and medical to use behavioral restraint. Final authority for behavioral restraint resides with the Medical Director. This is consistent with the emerging trend for any medical and mental (behavioral) health restraint to be ordered by clinicians. But to demand this triumvirate make a joint decision in all cases is unduly cumbersome and does not put the person with the expertise in the position of making the decision. In short, for behavioral restraint mental health staff should have the

ultimate authority, for medical restraint medical staff should have the ultimate authority, and for safety and security custody staff should have the ultimate authority.

I should add that, in my view, custody should have the authority to initiate behavioral restraint but evaluation and a formal order by a clinician should directly ensue.

I would also note (though did not have a chance to review this so it may not be a problem) that monitoring in restraint should consist of:

- Appropriate clinical restraints (restraint chair OK for up to four hours)
- Constant, direct observation
- Initial assessment by nursing
- Every 15 minute circulation checks by nursing for the first hour and then every two hours
- Nursing assessment every 4-8 hours
- Range of motion of all extremities every two hours (if safe to do)
- Ambulation daily (if safe to do)
- Offer water every two hours – track intake to the extent possible
- Offer food at usual times
- Initial order by clinician to initiate restraint or to continue custody-initiated restraint
    - Ordering clinician to see within 4 hours to evaluate need to continue
- New order for restraint every 4 hours for the first 24 hours, then every 12 hours (varying standards exist, including on-going every 4 hours in line with CMS standards, but this is reasonable in my view)
    - Ordering clinician sees patient and/or formal mental health assessment and consultation with ordering clinician daily
- Formal mental health assessment within 24 hours if not done in previous step
- Consider measures to reduce deep venous thrombosis if restraint continues past 48 hours
    - Heparin
    - Compression stockings

Suicide Monitoring

I did not find major problems with suicide monitoring practices, though I think it could be structured somewhat more clearly and, at the same time, provide for more flexibility. But I think the policy itself has some problems.

One thing I recommend be changed is the provision for custody, medical, and mental health to make joint decisions about degree and nature of suicide monitoring and conditions of confinement. Mental health staff are the experts in this area and are the ones that should have the responsibility and authority to make these decisions. This is the same point made with regard to restraint.

Similarly, policy provides that "The discharge of the suicidal inmate from the hospital or other segregated areas will be a joint decision among Medical, Security, and Mental Health Staff." If the purpose of this is to provide for placing suicidal inmates who are also dangerous in more secure settings, that is reasonable, assuming that full suicide precautions can be applied. But in general, if this effectively allows staff other than mental health to limit suicide precautions, this is unreasonable. A comparison with a medical condition can be instructive. It is legitimate for custody to remove a patient

with chest pain and possible heart attack from a hospital emergency room if the safety and security conditions warrant – but the agency and the officer must be prepared to defend their decision in the face of a death from heart attack. It is no different for the suicidal. Put differently, custody considerations can trump medical and mental health considerations and medical and mental health are obligated to do the best they can under whatever circumstances emerge, but this should be viewed as trumping the recommendation of the experts in their field rather than a joint decision. Where the body is placed is ultimately a decision custody must make and all will need to coordinate their efforts and do their best to render services regardless of setting. But the decision should lie with the expert, subject to being overruled on other grounds, which is not the same as making the decision jointly.

While policy provides for "constant or intermittent supervision (15 minute staggered checks)", it is not crystal clear that this provides for constant, unbroken, direct monitoring. It is necessary to have explicit provision for such monitoring unless that is to be provided in a licensed setting (see below), though even then it is necessary to have this provision while awaiting and during transport. Camera observation is not a substitute for constant, unbroken, direct monitoring. This is typically one-to-one. While opinions vary on this, I believe that one staff can monitor more than one person, depending on the physical layout. The staff needs to be able to see all those being monitored at any time; this can typically be done for no more than 2 or 3 at a time.

The next step is usually 15 minute staggered checks, with or without camera monitoring (without sometimes considered an additional step). After this, some systems provide for 30 minute checks, depending on what the routine monitoring is on the unit where the inmate is housed. Many systems are also moving to a formal step of housing with a cellmate, as appropriate on a case-by-case basis.

Mental health staff should also determine the conditions of confinement, that is, what items the patient may possess. As noted, it is reasonable to have standard conditions (such as Plan A and Plan B) as long as they can be modified as needed. They also should not be tied to the degree of monitoring, which contemplates different aspects of risk.

Lastly, the location of monitoring should be considered. Policy provides for this to occur in an infirmary or a segregation observation room. If these are the only locations with suicide-resistant cells, then this may be your only choice for the highest levels of suicide monitoring. It is preferable to have cells outside of segregation, usually near or in a clinic or infirmary; being placed on suicide monitoring should not be seen in any way as similar to or a form of punishment – it is already restrictive enough. Absent the need for placement in licensed care or residential housing, those on monitoring should remain at the institution if at all possible, in part to reduce incentives to claim suicidal ideation and, more importantly, because that is where the clinicians familiar with the case are. So providing flexibility of location, assuming other suicide-resistant cells are available, would be a benefit. Note that suicide-resistant does not mean no toilet, no shower and no bed. It only means that there are no ready anchor points. Here I note that the suicide cells at NCCW are adequate but not as good as DEC. Expanding suicide-resistant cells may be a benefit to the system by reducing transport and not overburdening DEC with high acuity patients that they do not know.

Staffing

For a system this size, the minimal mental health staffing in the central office is likely only to be able to provide for basic oversight and monitoring of staff and mental health operations. In order to do the

staff work necessary for real system construction, Quality Improvement, and utilization management, at least an additional FTE would be necessary, preferably a person with both clinical and administrative experience. It is also important to have at least a small amount of a psychiatrist's time to oversee psychotropic prescribing and provide clinical oversight of psychiatric prescribers as discussed above (one day a week would be sufficient).

The most notable issue with regard to staffing is the number of vacant positions.

It is beyond the scope of this report to recommend any formal staffing model. But a few points can be made. First, a comment about staff productivity is in order. In general, clinical hourly production (that is, the amount of time delivering direct care or documenting direct care) rarely surpasses 70%.

I offer the following assumptions to use when evaluating your own staffing and then offer an analysis of psychiatric positions to give a sense of how to think through your staffing needs.

In terms of staffing, positions are reported as full time equivalents (FTE). In general, it is prudent to have a staffing model based on patient population and general expectations of productivity in light of the types of services intended to be rendered by the mental health system. As the service model is not yet well-defined at NCDS, it may be difficult to have clarity about this, but I provide some rough estimates. This project is also made more difficult by virtue of inherent inefficiencies in delivering healthcare in correctional settings caused by limited movement in general (patients and staff), periodic curtailment of movement, escort requirements, and a variety of other conditions intrinsic to corrections. As such, it is unreasonable to expect clinical productivity much higher than 60% (60% of clinicians' time providing direct care). When custody staffing is limited or there are high levels of security restriction, productivity is further reduced. It is important to emphasize that what follows does not represent rich staffing, but minimally adequate staffing.

A For psychiatric prescribers, it is reasonable for one FTE to have a case load of about 100 in a residential (non-licensed) mental health setting such as D unit at LCC or STAR at NCCW. As above, NDCS needs 100-200 residential beds. At a minimum, this calls for one FTE psychiatrist.

For outpatient services, covering a caseload of 400 is reasonable and 500 is generally a maximum in this setting. This allows outpatients to be seen at least every 90 days. In part, this depends on how often patients move between facilities, which requires additional time to review new patients. If we assume a stable load of 500 outpatients, this requires 250 clinician services hours (patient visit, charting, orders, etc.) every 90 days or 1000 hours/year. At 60% efficiency, one FTE provides 1200 hours/year; the additional time is necessary for new patients. Since about 25% of GP inmates are on medications in male prisons, there should be about 0.25 X 4900 = 1225 patients on medications, requiring about 2.5 FTE psychiatrist.

At NCCW, with a population of 325 and 50% on medications, about 160 are on medications. There are 10 in the residential setting. This amounts to just short of 0.5 FTE.

Given that about 25% of entering inmates will be on or need psychotropic medications and there are about 50 intakes per week, this means there are at least 12 new cases each week for the psychiatric prescriber at DEC. This is about 0.5 FTE. As this is also a population that is likely to need frequent visits initially, the remaining 0.5 FTE will only be adequate if stays at DEC are short, on the order of 2 months. Further, coverage of the suicide rooms and SNF are also potentially substantial work drivers, though

variable. It should be expected that management of these cases is about 0.25 FTE. The APRN has a current case load of 160. Assuming this is typical and assuming a monthly average follow-up, this represents an additional 80 hours per month or 0.5 FTE. This results in an estimated need of 1.25 FTE at DEC.

This totals up to 5.25 FTE of psychiatric time at a bare minimum. In my opinion, the residential need is more likely to be closer to 200 than 100. I recommend that NDCS provide a minimum of 6 FTE psychiatrist. In addition, at least 0.2 FTE should be dedicated to central office functions such as monitoring prescribing practices, committees (e.g. pharmacy and therapeutics), developing protocols, and assisting in program development.

B It is more difficult to assess the need for primary therapists as it depends entirely on the type of services they are expected to provide. A rough estimate is that a residential case load of 30 is a maximum which allows for individual meetings about every other week, one daily group (10 hours with preparation and charting), and administrative duties. The addition of a recreation and/or occupational therapist would allow more individual meetings by primary therapists and provide a type of service that psychologists are not trained in but is needed for those with major mental illness.

For outpatients, it is more highly variable but a case load of about 100, the majority of whom are getting only case management services, is a minimal starting point.

In addition, the following mental health services need to be accounted for:

- Clinical oversight and supervision
- Quality improvement
- Transfer and placement (e.g. MIRT)
- Intake screening
- Intake assessment
- Transfer screening
- Crisis response
- Restrictive housing
- Forensic functions
- Re-entry planning
- Any offender change groups being run by mental health

Nursing must also be provided around the clock. While it is preferable to have a psychiatric nurse around the clock, this is probably not feasible. Nursing coverage for the residential beds at LCC can be provided by a dedicated nurse (preferably psychiatric) who can provide day shift coverage five days per week and facility nurses would then have to provide off hours coverage. But see below my recommendations regarding medication administration, which would have a more substantial impact on nursing staffing. Given the size of the STAR program, nursing coverage would have to be shared with other services but it is important that there be a dedicated nursing function to check vitals, monitor side effects, respond to and screen medical complaints, and provide basic medication psychoeducation.

Social work services for re-entry are also essential. The current staffing seems sufficient.

Given the extent of reorganization I recommend, it will be very challenging to make a clear recommendation about staffing as it depends a good deal on what recommendations are undertaken. For instance, if mental health will continue to run offender change groups, this is a large amount of mental health staff time that is not directed at the mentally ill and their numbers should not be considered part of the mental health treatment numbers.

General sense front line

My general sense is that were NDCS positions filled and a more structured system developed, that the front line resources would be only slightly on the low side, assuming mental health staff are focused on mental health treatment rather than correctional programming per my discussion above. Where more resources are needed is oversight and, as noted above, central office as these functions are necessary to bring the kind of structure to the system that allows the frontline staff to function more efficiently and stretch their resources further.

Supervising clinicians

But I do recommend that each of the five major facilities have a general population supervising clinician with substantial training and experience, typically a doctoral psychologist, whose primary responsibilities are overseeing the clinical work of supervisees and assuring implementation of the system structure, including serving the frontline utilization review function. In short, this position is charged with making determinations (at least in marginal or unclear cases) about who gets treatment, providing clinical oversight of practitioners, and participating in system functions such as MIRT. They provide some direct service, but probably no more than half time in prisons of around 1000 (as they will not have large numbers to oversee).

Residential Director

I also recommend that you have a residential director for each residential unit. Given the current array, one for LCC D and a 0.5 position for LCC C would be sufficient. Given the limited residential beds at NCCW, the STAR program can be overseen by the NCCS mental health director.

Facilities

Other than my comments above about suicide cells, I will withhold any recommendations about physical plant modifications as that is beyond the scope of this report. The one exception is that it is my understanding that the LCC mental health residential setting is not ADA compliant; a solution needs to be found as the physically disabled must have access to these services.

But I will recommend that NDCS continue to explore using monitors in various settings to provide passive programming and also that the environment be generally enriched, especially in control units and special housing units. Lack of varied sensory stimulation is neurologically damaging.

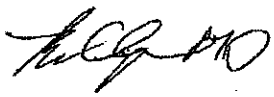
Licensed Level of Care

All systems need to have access to licensed services for the most seriously ill. Systems can either create these themselves (usually only realistic in very large systems), coordinate with public sector hospitals, or enter into contracts with private hospitals. While the need for these beds should be sporadic when the prison mental health system is well-designed and fully implemented, there are always cases beyond the reach of the level of services that prisons should reasonably be expected to provide.

DEC is not a reasonable substitute for licensed level of care. It is a poor facility for providing mental health treatment as it has no programming space, limited access to meaningful privileges, and is not staffed to serve this function. As it will continue to need to serve medical purposes, modifications are not feasible. Most importantly, it is highly unlikely that any reasonably possible set of modifications and staffing increases would bring it into licensure.

This concludes my report. But before closing, I wanted to say that while the NDCS mental health system has room for growth, there is a lot of good work going on. Again, the focus on those with major mental illness and the services provided at LCC D unit are moving in the right direction and were the correct places to start. You also have high quality, professional, and dedicated staff. It is important for them to experience positive change and to know that their work is valued.

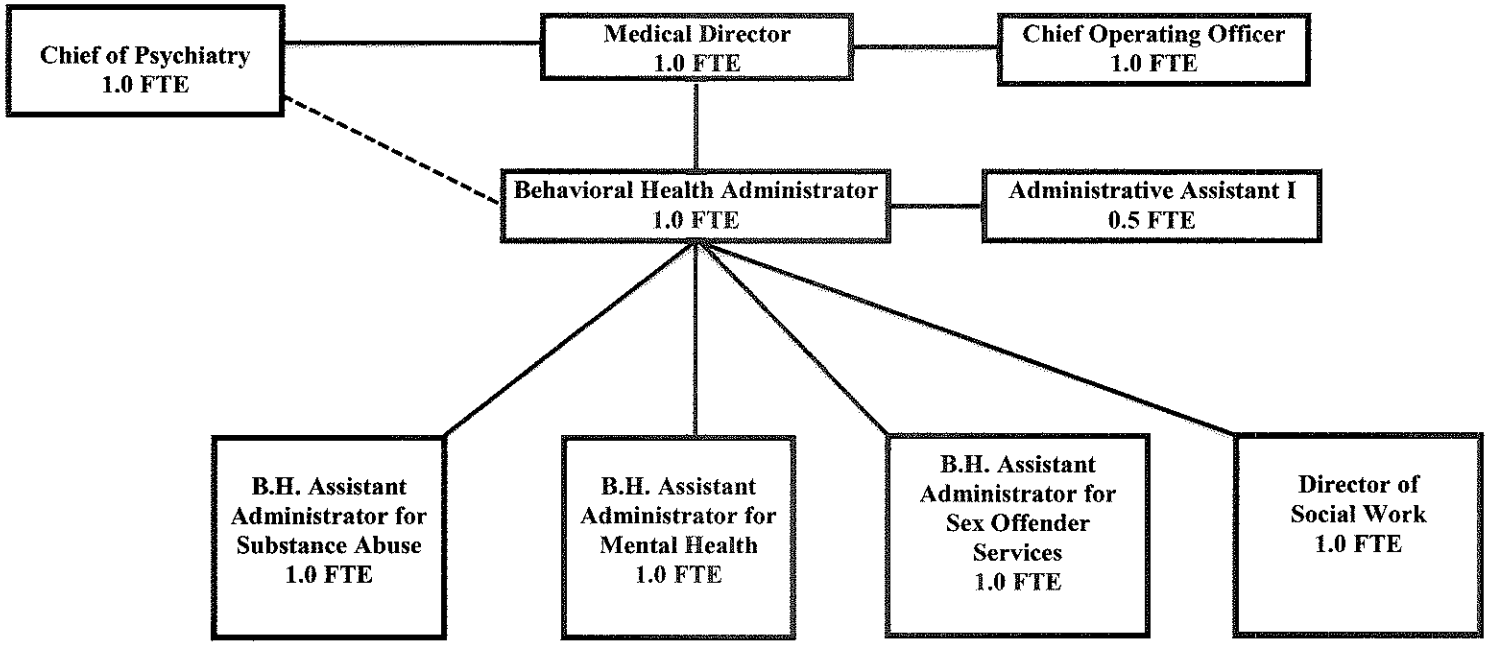
Respectfully submitted,



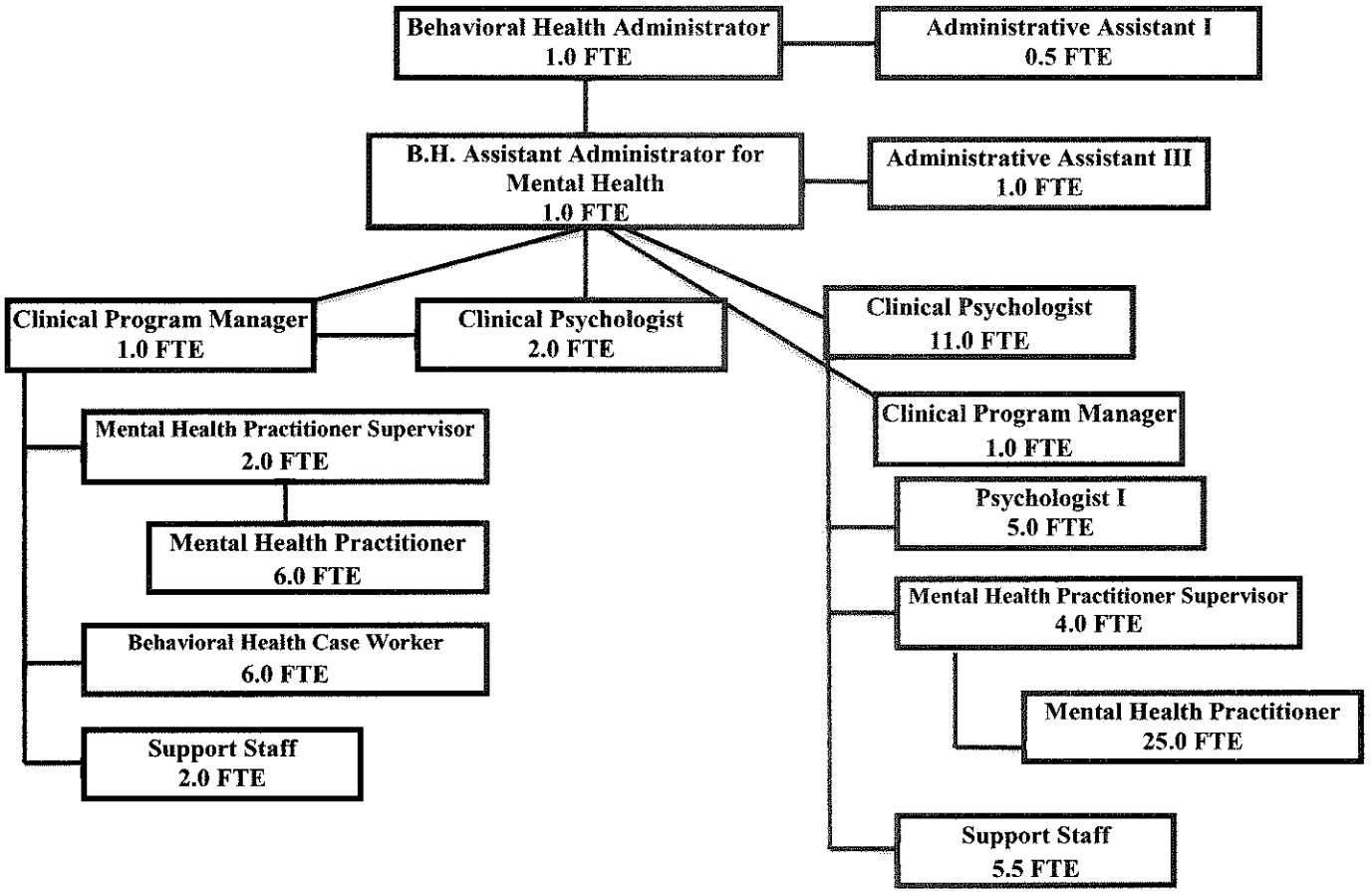
Bruce C. Gage, M.D.

Chief of Psychiatry, Washington Department of Corrections
Clinical Associate Professor, University of Washington

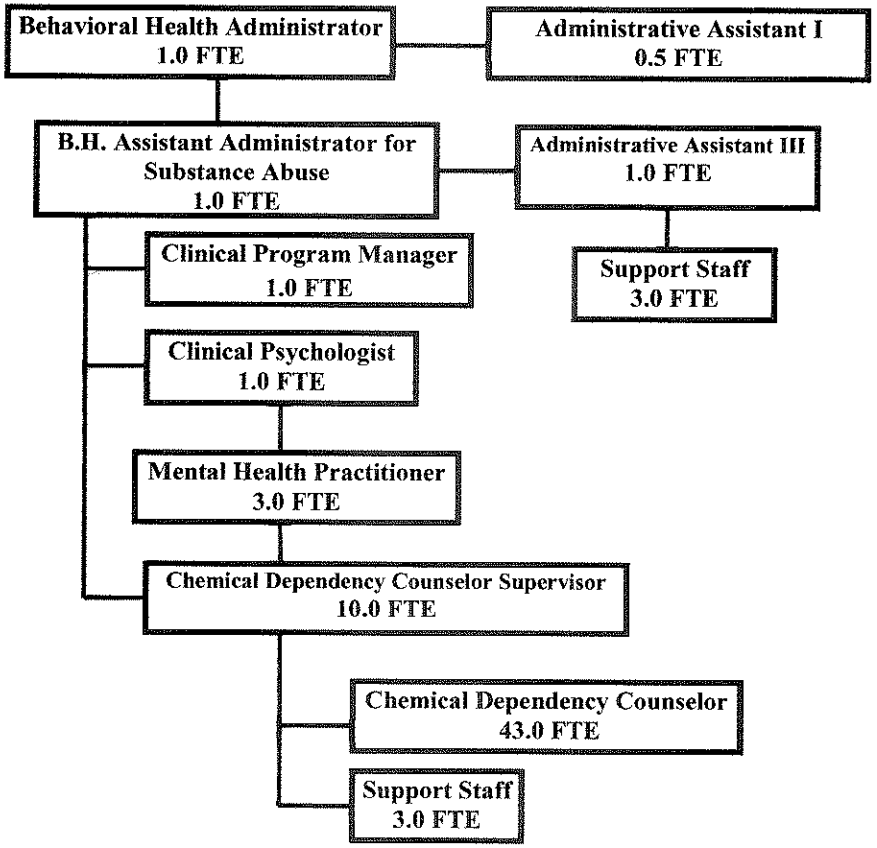
Nebraska Department of Correctional Services
Behavioral Health (B.H.) Section
Organizational Chart



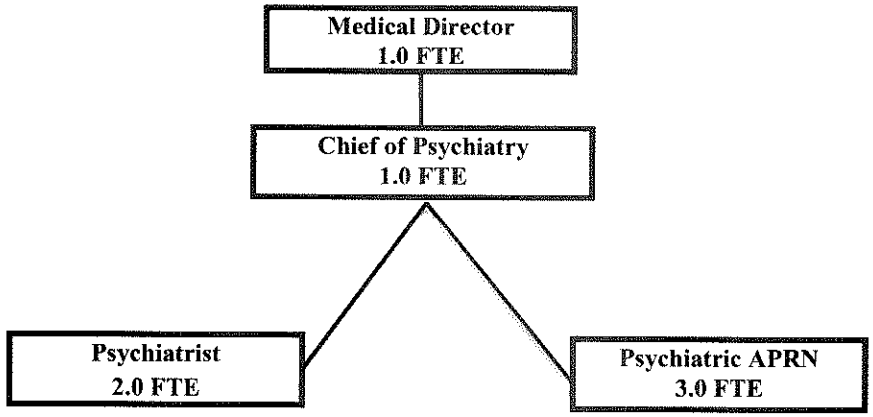
Nebraska Department of Correctional Services
Behavioral Health (B.H.) Section
Organizational Chart – Mental Health



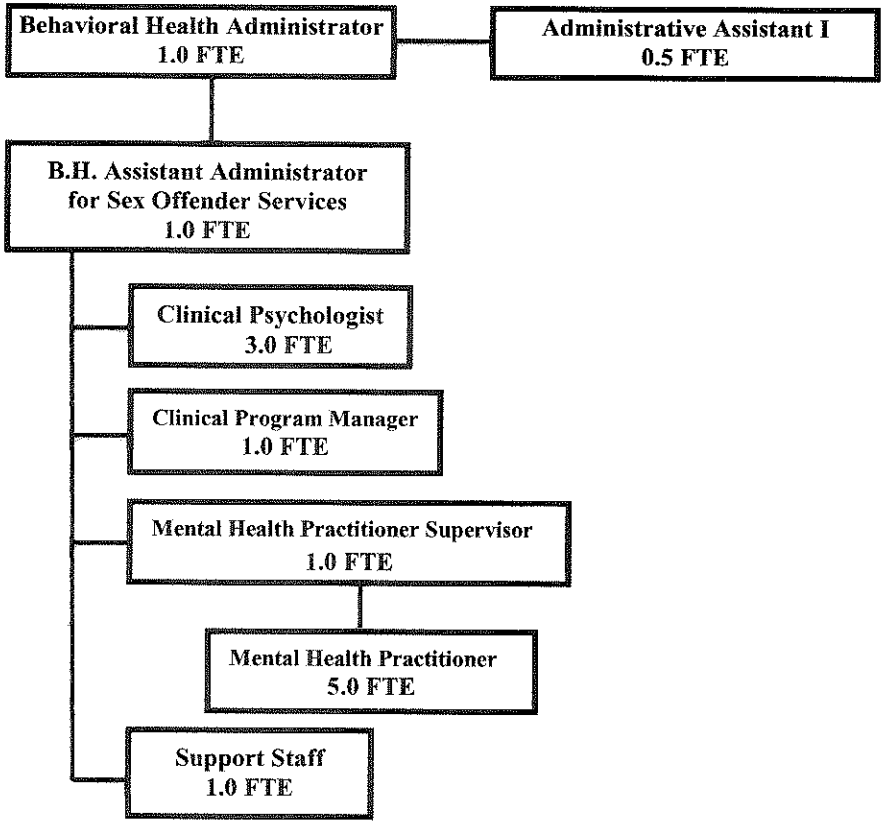
Nebraska Department of Correctional Services
Behavioral Health (B.H.) Section
Organizational Chart – Substance Abuse



Nebraska Department of Correctional Services
Behavioral Health (B.H.) Section
Organizational Chart – Psychiatry



Nebraska Department of Correctional Services
Behavioral Health (B.H.) Section
Organizational Chart – Sex Offender Services



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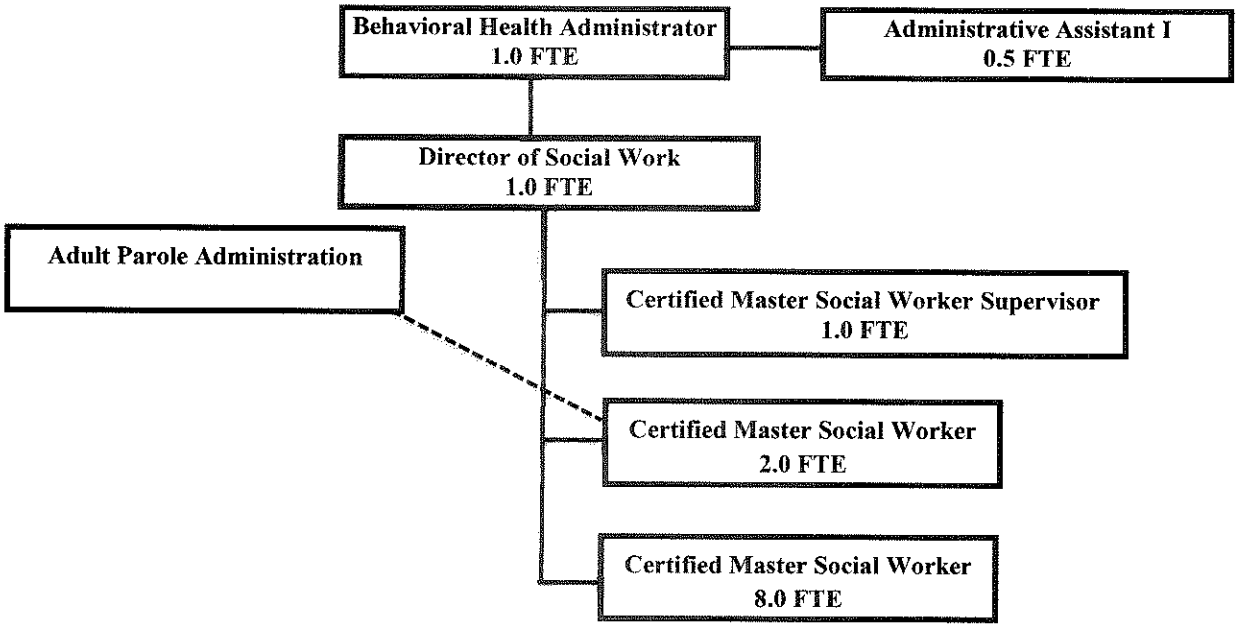
Nebraska Department of Correctional Services
Behavioral Health (B.H.) Section
Organizational Chart - Social Work



Health Services Staffing By Facilty and FTE

CCCL	1st Shift	2nd Shift	3rd Shift	Rotates Weekend
Chem Dependency Counselor	1			
Physician Assistant	1			
Registered Nurse	1			

Central Office	1st Shift	2nd Shift	3rd Shift	Rotates Weekend
Administrative Assistants	3			
Behavioral Health Admin	1			
Business Manager II	1			
Community Health Educator	1			
DHHS Program Specialist/RN	1			
Discretionary Non-classified	1			
Infec Control/risk Mgmt Nurse	1			
Medical Records Clerk	1			
Medical Services Director	1			
Nursing Director	1			

DEC	1st Shift	2nd Shift	3rd Shift	Rotates Weekend
Chem Dependency Counselor	1			
Dental Assistant	1			
Dentist	2			
Laboratory Scientist II	1			
Licensed Practical Nurse	2	1	1	3
Medical Radiographer	1			
Mental Health Practitioner II	2			
NP/PA	3			
Optometric Aide	1			
Psychologist/Associate	3			
Registered Nurse	8	3	1	5
Secretary II	2			

LCC	1st Shift	2nd Shift	3rd Shift	Rotates Weekend
Certified Master Social Worker	1			
Chem Dependency Counselor	1			
Clinical Program Manager	1			
CMSW Supervisor	1			
Corrections Unit Caseworker	5			
Dental Assistant	1			

Health Services Staffing By Facilty and FTE

NSP cont.	1st Shift	2nd Shift	3rd Shift	Rotates Weekend
Optometric Aide	1			
Psychologist	9			
Psychology Director	1			
Registered Nurse	8	3	3	8

OCC	1st Shift	2nd Shift	3rd Shift	Rotates Weekend
Certified Master Social Worker	2			
Chem Dependency Counser/Spvr	8			
Clinical Program Manager	1			
Licensed Practical Nurse	2	1	1	2
Mental Health Practitioner II	4			
Physician/PA	2			
Psychiatrist/clinical	1			
Psychologist	2			
Registered Nurse	6	3	2	3
Admin Assistants	3			

Pharmacy	1st Shift	2nd Shift	3rd Shift	Rotates Weekend
Pharmacist	2			
Pharmacy Inventory Technician	1			
Pharmacy Manager	1			
Pharmacy Technician	6			

Trabert Hall	1st Shift	2nd Shift	3rd Shift	Rotates Weekend
Chem Dependency Couns/Spvr	5			
Mental Health Practitioner II	1			

TSCI	1st Shift	2nd Shift	3rd Shift	Rotates Weekend
Administrative Staff	3			
Chem Dependency Couns Supv	1			
Chem Dependency Counselor	5			
Certified Med Aides	7			
Dentist	1			
Dental Assistant	1			
Health Service Administrator	1			
Licensed Practical Nurse	4	2		6
Medical Director	1			

State of Nebraska 2014 Nebraska Employers Salary Survey

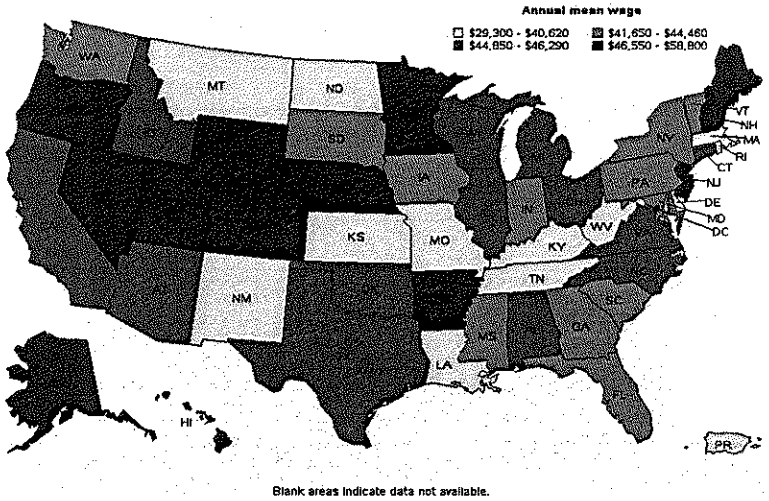
Position	Survey Respondents				State	
	# Employers	# Employees	Average Hourly Salary	Average Hourly Range Minimum	Average Hourly State Salary	Average Hourly Range Minimum
Chemical Dep. Counselor	4	16	$23.89	$18.44	$18.89	$17.08
Mental Health Practitioner II	9	51	$26.80	$22.05	$21.15	$19.73

Respondents: Madonna, Brian Health, UNL, UNO, Concordia, Children's Hospital Omaha, St. Francis Grand Island, Boys Town, Douglas Co., Faith Regional Norfolk.

Other Counselor Information

Source	Position	# Employees	Average Hourly Salary	Average Hourly Range Minimum
Supreme Co	Treatment Probation Officers	19	$24.92	$23.46
BLS	NE Mental Health Counselors-Median	-	$21.38	-
BLS	NE Mental Health Counselors-Experienced	-	$26.88	-

Annual mean wage of mental health counselors, by state, May 2014



Blank areas indicate data not available.

Top paying States for this occupation:

State	Employment (1)	Employment per thousand jobs	Location quotient (9)	Hourly mean wage	Annual mean wage (2)
Alaska	650	1.99	2.24	$28.27	$58,800
Oregon	2,370	1.41	1.58	$25.64	$53,330
Wyoming	320	1.14	1.28	$25.40	$52,840
Hawaii	240	0.39	0.44	$24.34	$50,630
New Jersey	4,320	1.12	1.26	$23.88	$49,670

Source: Occupational Employment Statistics; BLS

Behavioral Health Practitioner Series

Proposed Classifications:

BHP Series Level	Current Classifications
Behavioral Health Practitioner I (provisional License)	➢ Mental health Practitioner I ➢ Chemical Dependency Treatment Specialist
Behavioral Health Practitioner II (Full licensure)	➢ Mental health Practitioner II ➢ Chemical Dependency Counselor
Behavioral Health Practitioner III (Full licensure + Provisional)	➢ Mental health Practitioner II ➢ Chemical Dependency Counselor
Behavioral Health Practitioner IV (2 Full licensures)	

Pay Line:

Because the Chemical Dependency and Mental Health Practitioners will be converted to the Behavioral Health Practitioner series we will build the pay-line on the higher paid Mental Health Practitioner II, with a July 1 pay range of $20.178 - $29.224.

The 12/3/2012 agency request included a 15% differential between the BHP I and the BHP II, and the BHPII and BHP III, and a 7.5% differential between the BHP III and BHP IV. If these differentials are used the July 1 pay-lines will be:

	Minimum	Maximum
BHP I	$17.546	$25.412
BHP II	$20.178	$29.224
BHP III	$23.205	$33.608
BHP IV	$24.945	$36.128

6/9/2015

TESTIMONY REGARDING LR34 SPECIAL INVESTIGATIVE COMMITTEE

Good Morning, My name is Jerall Moreland (J-E-R-A-L-L) (M-O-R-E-L-A-N-D). I am here today representing the State Ombudsman's Office, in the capacity as Deputy Ombudsman for institutions. I would like to thank Senator Pansing Brooks and all other members of the LR 34 Committee for the invitation to offer our views on the department's mental health and segregation systems.

Summary

Legislation passed last year required the Department of Corrections to implement a needs assessment regarding behavioral and mental health treatment and staffing. It also required the Department to issue a report concerning the assessment by January 1, 2016. To meet these requirements, the Department sought the services of Dr. Bruce Gage, the Chief of Psychiatry for the Washington Department of Corrections, to assess the Nebraska system's behavioral health services and make recommendations on the system.

The Ombudsman's Office has reviewed the assessment presented to the Legislature. We believe the document to provide a fairly comprehensive look at the NDCS behavioral health system that addresses many of the concerns of our office. We have seen many initiatives implemented since this report under the leadership of Director Frakes and his staff. The report identifies strategies for the Department to become more robust in the services offered to its inmate population, including strategies that would ultimately improve for public safety. However, we do want to caution that, in our opinion, there are points where we see that more work needs to be done to assure that the vision set forth for behavioral health in Nebraska's system can be truly realized and measured. In other words, whereas we do see reform efforts being built within the system, we also believe there to be crucial roadblocks that need to be addressed and expanded on.

For example, overcrowding and staffing vacancy issues are serious deficiencies that we see impacting the ability of the Department to execute those strategies and initiatives set in the Gage report. Also, we still see problems with how an inmate taps into the Department's mental health system and, if they do get in, with how robust the system is to ensure that there will be continuity or continuation of care during their incarceration time.

In his report, Dr. Gage appropriately discussed the prevalence of major mental illness (MMI) in the corrections system. He indicated that most prevalence studies show rates of psychotic disorders alone in state prisons of 4% to 15%, and depression on the order of 10%. He goes on to estimate that the prevalence of MMI in the system is conservatively closer to 3% to 6% with a psychotic or schizophrenia-spectrum disorder, and about 10% with significant depression or bipolar disorder. We tend to always discuss the system's male population on this issue, but we must not forget the female population. For example, recent reported statistics indicate that as of this August there were 430 female inmates incarcerated within NDCS. Of these women, 344 or 80.0% were identified to have behavioral health needs. Also, 208 or 48.4% have a co-occurring mental health and substance use diagnoses. Of interest in this area is the differences of reported MMI within the system. As of August 5, the Department reports 47 or 10.9% of its female population is identified to have a MMI. However, based on national figures as represented in the Gage report, it is likely that at least 15% of the female population has a MMI.

There were many recommendations made in the Gage report. We would suggest that, since the recommendations were made July of 2015, a follow up assessment of the Department's mental health system be started July of 2017, with a report due to the Legislature in January of 2018. We support the Department's continuing efforts to explore options to best meet the needs of its mentally ill inmate population, through strategies such as mission based housing, which would target special treatment approaches for the varied Mental Health diagnosis of its inmates.

I would also like to make a few comments about the Department's segregation system, which is another area that LR 34 asked the Committee to study. Neb. Rev. Stat. section 83-173.03 requires that the Department adopt and promulgate rules and regulations pursuant to the Administrative Procedure Act establishing such levels of restrictive housing as may be necessary to administer the correctional system. Those rules and regulations were to address behavior, conditions, and mental health status under which an inmate may be placed in each confinement level, as well as providing for procedures for making such determinations. These rules and regulations were also to provide for individualized transition plans, for inmates on each confinement level to facilitate transition back to the general population, or to society. These individualized transition plans were supposed to be developed with the active participation of the committed offender.

As you may already know, the Department of Correctional Services recently promulgated their rules and regulations on "restrictive housing." During this process, the Ombudsman's Office provided several comments concerning regulatory standards and principles that we believed needed to be added to the restrictive housing rules and regulations. We would be acknowledge that the Department did make progress on many of the matters of concern to this office, and we feel that these changes could result in good outcomes, once the policies are fully implemented. However, considering the overcrowding and staff level challenges currently plaguing the Department, there is some concern that the full effect of the changes may not be recognized until the program is thoroughly implemented.

On October 7, 2016, Marshall Lux, the Nebraska State Ombudsman, provided each LR 34 committee member a memo detailing our remaining concerns regarding the Department's segregated housing regulations. As mentioned in Mr. Lux's memo, their remains two outstanding issues needing to be addressed by the new DCS "restrictive housing" regulations, namely how an inmate is selected to be placed on segregation, and what due process protections are provided relating to that placement. In addition, I am submitting to the Committee a document entitled *Details on the Behavioral Health and Segregation System within the Nebraska Department of Correctional Services*, which discuses a number of mental health and segregation related issues in further depth.

I want to thank to the Committee for the opportunity to share our perspectives regarding the subjects of mental health and segregation.

I can take any questions that you have.

Details on the Behavioral Health and Segregation System within the Nebraska Department of Correctional Services

By Jerall Moreland, Deputy Ombudsman for Institutions

Mental Health System

One of the LR 34 Committee's specific tasks was to study the "availability of mental health care and procedures in place, to ensure that inmates receive appropriate mental health care." According to the LR 424 Committee, it was concluded that "the resources available to inmates within the Nebraska Department of Correctional Services (NDCS) are wholly inadequate. While we have seen progress in directing resources to mental health services, the REALITY is, that the Nebraska correctional system continues to be stressed from an overcrowding situation that not only impacts the mental health care provided to those inmates incarcerated, but that also limits available programming options and creates a potential safety risk to the community. In essence, the Department's mental health system is still not robust enough to meet the many needs of its population on a consistent steady manner. While cost may be a barrier in some respects, access to the mental health services and a lack of diverse target treatment approaches are prevalent as well.

When taking considering the mental health treatment system in the State of Nebraska, you don't need to look very far for the system's two major mental health service providers, those being the Nebraska Department of Correctional Services and the Lincoln Regional Center. When looking at the question of what the Department's mental health system should look like, we would suggest that it would be useful to consider whether both of these entities still need to have significant improvements, to ensure quality and continuity in providing the needed services. Included in the examination should be an in-depth look at the complexities of the mental health system, and the bed-allocation system at the Regional Center, and in the Department of Corrections. What this adds up to is the need for Nebraska's policy-makers to consider the fundamental question of how it wants to deal with the state's institutionalized mentally ill, including both those who are incarcerated in the State's correctional system, and those who are civilly committed, with the goal being to develop an improved system that ensures programming and services, and provides humane treatment, stability, and structure, to the State's mentally ill, mentally disabled, and behaviorally disorder individuals. From chronic behavioral issues, to mental illness, to anti-social norms, we are faced with a problem not only in the Nebraska Correctional System, but throughout the State's system for providing mental health services. However, as far as this document is concerned, I am going to focus on the Department's mental health system.

How does an inmate gain introduction into the corrections mental health system?

Upon intake to corrections, all inmates are to be diagnosed for any signs of mental health issues. At this point, an initial determination should be made as to the mental health status of an inmate, to include the identification of needed programming, medical care, behavioral health, and psychiatric services. As should be expected, this process may continue on and off during an inmate's incarceration. For the majority of the corrections inmates who are designated as mental health cases, they will be seen by a

mental health practitioner and a determination will be made on needed medication while housed at the Diagnostic and Evaluation unit. This however, is not a place where extensive therapy or services is provided, since the whole point is for these individuals move steadily to eventually be classified and transferred to the appropriate facility.

In practice, what we see are about four paths for these individuals upon intake at D&E. One path is that where the inmate in question may have behavioral health needs and it has been determined that they can function in general population. Hence, there is a classification and transfer of the inmate to another facility's general population. A second path is that where the inmate, while housed at D&E, is disruptive and displays problematic behaviors. In these cases the D&E custody staff is tasked with identifying these behaviors, and reporting them to case managers for possible mental health intervention and action. In general, this route also produces a misconduct report written by staff on those inmates who have been suspected of violating the DCS code of offenses. Eventually, due to the frequency, or the nature, of the misconduct report attention to this individual is given which may lead to his being placed on restrictive housing (located at the Lincoln Correctional Center). Here the inmate could undergo a mental health review by the Mental Illness Review Team (MIRT) to determine appropriateness to remain on restrictive housing, or placement in the mental health unit (inpatient treatment unit at LCC), or placement in the secure mental health unit (also at LCC). If the behaviors displayed appear to be less a matter of mental illness, and more behavioral in nature, then we generally see the inmate remain on restrictive housing for a period of time, before being returned to D&E for completion of their evaluation, or being sent to their next facility placement. Once an inmate is classified from D&E to another Department facility, staff are tasked with reporting potential Mental Health behaviors, or the inmate can request Mental Health services, or self-report themselves for a Mental Health evaluation. A third path is for the inmate to go directly to the Lincoln Correctional Center control unit or as the inmate population refers to it, the "dungeon or hell hole." As you may recall, the Department has indicated that they will be closing this unit. We support this action by the Department, as we believe there are great difficulties in assuring humane care to the inmate population in this housing unit. For the County safe keepers who have identifiable mental illness or disorders, we are seeing that they are housed on restrictive housing, albeit they appear in some cases to be provided more treatment attention than others on restrictive housing, but are still not getting the therapeutic environment that may be needed in these cases. It should also be noted that we are aware of several County Safe keeper cases in which the Department has sought an Immediate Medication Order (IMO). Also, several of these cases have been recently transferred to the Lincoln Regional Center for restoration of competency. We believe it positive that these transfers are occurring, especially considering that the Department is not providing this group with the option of placement in LCC in the secure mental health unit, or the inpatient mental health unit.

What to do when an inmate not able to gain introduction into the Department mental health system?

There are inmates in segregation units who have identifiable "mental illness or disorders", but who cannot be sent to the Department's Secure Mental Health Unit because they do not have a "serious mental illness," or because they are County safe keepers. For those inmates in segregation who do not have a Serious Mental Illness, as defined by the Department, it is the Ombudsman's Office has urged the Department to take action to develop a therapeutic environment for those inmates, in order that their mental health issues and/or challenging behaviors or needs can be addressed through some form of meaningful professional intervention. What this would look like is mission specific housing units for the diverse set of needs this population of inmates who have mental health issues, but cannot be admitted

to the Department's inpatient Mental Health treatment unit at LCC. For those suffering from dementia to personality disorders, these units would target programming for inmates with these types of issues, by segregating the inmates according to their treatment needs. The point here would be to have units that would offer a therapeutic environment for those inmates who have different mental disorders, to include those with significant behavioral issues, but who do not qualify for the secure mental health unit at LCC.

The issue concerning handling of the County safe keepers should also be explored. Currently, the Department's involvement with County safe keepers can best be described as follows: In most cases, County jails are transferring those individuals awaiting adjudication because they cannot properly manage or offer appropriate mental health services to these individuals in the county jail. These are individuals who are likely to disrupt jail operations and stress the jail's system. The Department receives these individuals usually two ways. In general, either they are processed through intake at the D&E, or they are immediately taken to restrictive housing. In some cases, these inmates may well remain in restrictive housing for the bulk of their stay, until they go back to the county or are committed to LRC for an evaluation of their competency. In practice, we are seeing in some cases where the individual will remain in the Department's custody for an extended period of time, without the full array of mental health services provided to them.

What will the behavioral health and mental health system look like in the future?

In December of 2015, the Department submitted to the Committee a document concerning Director Frakes' hiring of new leadership for the Department's behavioral and mental health systems. We were, frankly, pleased and encouraged with the hiring of Dr. Lisa Jones, as the Department's Behavioral Health Administrator, and Dr. Martin Wetzel as the DCS Director of Psychiatry. We also supported many of the initiatives that they were implementing. Unfortunately, Dr. Jones is no longer with the Department, and recently we were informed that Dr. Wetzel has tendered his resignation. Also, to put some perspective on these losses, Dr. Kohl, the longtime DCS Deputy Director for Health Services, who supervises these programs has recently retired. It goes without saying that the turnover of leadership in this area needs to be resolved in a most expeditious way, to hopefully minimize the impact on the initiatives started under these people who are leaving the Department.

Additionally, we recently reviewed the Department's staffing levels in the behavioral health and medical care areas. In the behavioral health area the picture is not good. In that area, we found that there were approximately 30 vacancies, with some positions that have not been filled since 2014. We are also very concerned with the implications that this situation might well have for the Department's plans relating to mission specific housing, and reform work efforts on restrictive housing, which clearly contemplate the use of mental health professional in these areas. We are also very concerned that this shortage of staffing may already be impacting the Department's ability to perform more reviews on mission specific housing, tighten timeframes for decision making, and improve structured plans for transitioning people out to the least restrictive area, in particular, those who are currently in longer-term restrictive housing.

We continue to support the Mental Health Unit at LCC, and many of the new initiative strived for, as set out in Dr. Gage's report on the Department's mental health system. However, this does not mean that everything is fine. There may still be several serious areas of concern in the DCS mental health services system. One of the most pressing concerns for the DCS mental health system is the recent news about Dr. Wetzel's resignation. We are concerned that Dr. Wetzel's departure will not only impact the current

provision of psychiatric services offered by the Department, but may also slowdown the Department's progress with the recent mental health bed expansion project and other developments.

In light of all of this, we would suggest the following areas of inquiry for the Committee, as it considers the subject of mental health services in the Department:

1. Taken into consideration that there are too many inmates in the Nebraska system, and that it has been reported that 82% of the inmate population is diagnosed as having some sort of mental disorder, there must be a concern about whether the mental health system within the Department is robust enough to meet the many needs of the diverse inmate population.

2. While some of those diagnosed mental disorders may be able to live in general population, we are finding that some with the more acute or chronic disorders find it very difficult to function adequately within the rules and regulations of correctional confinement, which in many cases results in their placement into a segregation status. In this setting, their symptoms get worse, meaningful treatment is unavailable, and because they "act-out" they lose good time and linger in segregation for a significant period of time.

3. The system appears to have inmates with a Major Mental Illness housed in the secure mental health unit at LCC who are too chronic to house in the inpatient mental health unit, let alone in the general population. The Department needs to consider alternative placements for these individuals that does not rely upon restrictive out-of-cell times as the only solution. We believe alternative housing or institutional transfer to the Lincoln Regional Center should be considered for these chronic cases.

4. Currently, mental ill inmates are placed in segregation/restrictive housing or Department control units for rules infractions, bizarre behavior or instability. If stability is gained in these case, then we generally see some inmate movement from segregation to secure mental health unit. If stabilization is not gained, we generally still see difficulties in management and no movement.

5. Although, the Department recently promulgated restrictive housing rules that went into effect on July of 2016, the definition for "Serious Mental Illness" is still probably too restrictive. What we found in a recent visit to the facilities is that in some cases an inmate may have participated in programming on the inpatient and/or secure mental health unit several times, but because they were currently placed in restrictive housing, they were not now formally designated as having a "Serious Mental Illness," as defined by the Department. However, these same inmates still appear to be vulnerable to the harms that are normally associated with extended restrictive housing/confinement. We found a number of inmates with at least a "Mental Disorder" who are being retained in long-term restrictive housing in Nebraska's system. The fact that some inmates with a mental illness can receive treatment by being transferred to a secure mental health unit is obviously a positive thing. However, we believe that there are still a number of inmates with significant mental disorders who are being held in segregation cells in our system. We also note that some of these cases tend to be the inmates who are the most difficult cases to handle.

6. Co-occurring disorders are prevalent among inmates in the corrections system. We are finding cases of inmates with substance abuse disorders and mental health disorders. It is important that the State know if co-occurring disorders exist, because each disorder can cause symptoms of the other disorder, leading to slow recovery. The Committee needs to consider whether the Department's current treatment approach reflects best practices in this area.

7. There is a lack of concrete therapeutic requirements and minimum out-of-cell time for those inmates in the secure mental health housing units, and in restrictive housing. Hence, it is no surprise that what we are actually seeing in the secure mental health housing unit are elements of long-term restrictive housing.

8. There will be cases in which some mentally ill inmates will be placed into segregation of some form, due to behavioral and/or security issues. If this does occur, then we would suggest that it is crucial that any such placement be accompanied by adequate structured programming along with other unstructured activities that include exercise and/or recreation time.

9. Experts have concluded that the segregation/isolation of juveniles is psychologically damaging, and can result in long-term mental health and/or behavioral health issues. There is a provision in the Department's new regulations that addresses the subject of juvenile inmates directly (72 NAC section 004.04B1). That regulation states that, "The use of restrictive housing for...inmates under the age of 19 requires approval of the Warden within eight hours of placement." Our office has found that this provision is being followed.

10. As it now stands, the Department seems to be struggling to handle a population which they report consists of only 2% to 3% who have a Major Mental Illness. However, if these numbers are accurate, then we could boast that we are well under the national average in this regard. The national average suggests that from 14% to 16% of the population in corrections and jails across the country have a Major Mental Illness. Based on this disparity, it is difficult to design an effective, comprehensive, and humane mental health system that could serve the needs of the corrections population in Nebraska. There is quite a separation between 2% and 16%, and given this disparity, the Committee may want to ask for expert assistance on identifying the correct number of inmates with a Major Mental Illness in Nebraska's system. Without that, it will be difficult to truly determine how robust the Department's mental health system needs to be.

11. The Department needs access to an adequate level of mental health beds for its population. The restrictive housing setting, the control unit, and the skilled nursing facility are not suitable placements. The Committee needs to consider whether the Lincoln Regional Center should have beds accessible to the Department for the chronic difficult cases. We believe that the Committee should consider recommending enactment of a law that designates a given number of beds at the Lincoln Regional Center for use by DCS inmates.

Segregation System

Another issue raised in LR 34 was concerned with the use of "segregation within the department." **Neb. Rev. Stat.** §83-173.03 required the Department to adopt and promulgate rules and regulations pursuant to the Administrative Procedure Act that established levels of restrictive housing as may be necessary to administer the correctional system. Those rules and regulations were to establish behavior, conditions, and mental health status under which an inmate may be placed in each confinement level, as well as procedures for making such determinations. These rules and regulations were also supposed to provide for individualized transition plans, developed with the active participation of the committed offender, for each confinement level back to the general population or to society. In fact, the Department of Correctional Services did recently promulgated their regulations on the subject of "restrictive housing." During this process, the Ombudsman's Office offered several comments concerning the standards and principles that we believed needed to be included in the restrictive housing rules and regulations. It should be acknowledged that the Department did make progress on many of the matters of concern to our office, and we believe that these changes could result in positive outcomes, once the policy is fully implemented. However, considering the overcrowding and staff level challenges currently plaguing the Department, there is some concern that the full effect of the changes may not be realized, until the Department is adequately staffed to make the system work.

Also provided for under §83-173.03 was a requirement that the Department to adopt and promulgate rules and regulations to define the term "flagrant or serious misconduct." Attached, I have included a document titled *Public Comments - Proposed Regulatory Changes regarding "Title 68, Chapter 6 of the Nebraska Administrative Code on "Inmate disciplinary Procedures."* We are submitting this to the Committee since it relates to restrictive housing/segregation. In that document, we recommended that,

> When a serious mentally ill inmate is being investigated for a disciplinary offense, the treatment team or treatment leader should make a report as to; (1) Whether the inmate's current mental illness precludes participation in the disciplinary process; (2) Whether the inmates' mental illness contributed significantly to the alleged disciplinary offense; and/or (3) whether the inmate's mental status contraindicates any particular form of punishment. The evaluation's findings and recommendations of the mental health staff shall be forwarded to the investigating officer, be filed as a part of the disciplinary record, and be filed in the inmates' inpatient mental health records. The treatment team leader/designee shall sign the report.

We pointed out that since the seriously mentally ill are really not capable of collecting and presenting evidence effectively on their own behalf, the agency should provide staff assistance at all disciplinary hearings for those inmates who are seriously mentally ill.

In Dr. Gage's report, he recommended the use of emerging standards that were being advocated by experts in the field of mental health residential units. Essentially, Dr. Gage has recommended that the Department develop various levels of custody, with the custody levels being Restrictive, Intermediate and Minimum. The goal appears to be to accomplish more out-of-cell time for each progressively lower custody level. It should be noted that the most restrictive level allows ten hours of structured, and ten hours of unstructured, out-of-cell programming time, and intermediate levels allow 12 to 20 hours, and ten hours respectively. To put this in prospective our secure mental health unit, appears to allow an average ten hours a week out of cell time only. It also appears that these emerging standards allow

incentives for movement within the residential units. This is an area that we believe the Department needs to improve on.

Also, §83-173.03 established a long-term restrictive housing work group. The group was supposed to advise the Department on policies and procedures that were related to the proper treatment and care of offenders in long-term restrictive housing. Additionally, the Department was to provide the work group with quarterly updates on the Department's policies related to the work group's subject matter. We see value in this work group, and would suggest that Departmental data surrounding the conditions, complaints, and any other materials on who is held in restrictive housing need to be made available to this group on a quarterly basis as well.

Finally, the members of the Committee may recall that Director Frakes shared with the Committee some time ago that at his request the Vera Institute of Justice had agreed to assess the Department's use of segregation. The Vera group works closely with government to build and improve justice systems that ensure fairness, promote safety, and strengthen communities. We have been waiting for this report in hopes of learning from its analysis of the Department's use of segregation though the eyes of Vera. We would suggest that the Committee determine when this report could be made available to our office, and to the LR34 Committee as well.

Other observations from this office regarding this matter consist of the following:

a. We agree with Dr. Gage's assessment concerning needed physical plant modifications in the control units and restrictive housing units.

b. We recognize that the Department has implemented several different initiatives to try to reduce the number of inmates placed in segregation. The Committee members may recall that there was a Departmental "repurposing plan" relating in part to the use of segregation. We would suggest that it would be beneficial for the Department to present this Committee an update on the repurposing plan and on how the Department intends to reduce its segregation population.

c. There may need to be a study to see if there is a disproportionate number of minorities in restrictive housing/segregation

Steve Lathrop

From: Jerall Moreland <jmoreland@leg.ne.gov>
Sent: Tuesday, October 11, 2016 4:43 PM
To: Steve Lathrop
Subject: Testimony regarding LR34 Special Investigative Committee
Attachments: testimony for LR34 Committee.docx

Here is a copy of the testimony for tomorrow. Feel free to call me on my cell phone if you have any questions. My number is 402-730-0585.

We will see you tomorrow.

--
Jerall Moreland, Deputy Ombudsman for Institutions
Nebraska Legislature- Ombudsman's Office
402-471-2035
Jmoreland@leg.ne.gov

October 7, 2016

MEMORANDUM

To: Members - LR 34 Committee

From: Marshall Lux, Ombudsman

Re: DCS - Segregated Housing Regulations

As I am sure that the members of the Committee know, the Department of Correctional Services recently promulgated their new regulations on the subject of "restrictive housing," a category that includes administrative segregation. LB 598 of 2015 (now **Neb. Rev. Stat.** §83-173.03) was concerned with "restrictive housing," and required DCS to promulgate these new standards. The crucial provision is §83-173.03(2), which provides:

> The department shall adopt and promulgate rules and regulations pursuant to the Administrative Procedure Act establishing levels of restrictive housing as may be necessary to administer the correctional system. Rules and regulations shall establish behavior, conditions, and mental health status under which an inmate may be placed in each confinement level as well as procedures for making such determinations. Rules and regulations shall also provide for individualized transition plans, developed with the active participation of the committed offender, for each confinement level back to the general population or to society.

The Department's new regulations include a number of features that will definitely help to make the use of segregation in Nebraska's system more rational, and more humane. These features include:

- A requirement that the Department use a risk assessment instrument when making the decision on which inmates should be placed in segregation;

- A requirement that the Department of Corrections provide individualized planning and targeted programming for the inmates placed in segregation;

- The requirement that staff engage in "discharge planning," in order to get the segregated inmates out of segregation before they are discharged into society; and

- The development of "mission-specific housing" for inmates with special needs, as an alternative to placing those inmates in segregation.

The Department deserves credit for these improvements, although it is still early, and we will need to see how well these general ideas and principles can be implemented in the "real world."

For those of us in the Ombudsman's Office who have been addressing complaints having to do with the use of administrative segregation by the Department, there still remain two "big issues" that the new DCS regulations on restrictive housing have not adequately resolved. Those two issues are as follows:

1. **The Need for Strict Criteria for Placement of Inmates in Segregation**

   It has long been my opinion that the single most important reform that is needed in this area is to include in the promulgated regulations strict criteria for making the decisions to place inmates in segregation. Historically, DCS has had no guidelines for making such decisions other than very general reference to the "risk" that would supposedly exist, if the inmate in question were allowed to remain in general population. Predictably, the absence of any strict criteria has, in practice, produced segregation decisions that tended to be arbitrary, and/or inconsistent from case to case, because there were no strict criteria to assure that those decisions would not be made arbitrarily by the DCS decision-makers. Standard 23-2.7(b) of the ABA Standards on the Treatment of Prisoners addressed this issue by limiting assignment to administrative segregation to those cases involving: (1) a "history of serious violent behavior in correctional facilities;" (2) instances of "escapes or attempted escapes from secure correctional settings;" (3) involvement in "acts or threats of violence likely to destabilize the institutional environment to such a degree that the order and security of the facility is threatened;" (4) "membership in a security threat group (i.e., "gang") accompanied by a finding based on specific and reliable information that the prisoner either has engaged in dangerous or threatening behavior directed by the group or directs the dangerous or threatening behavior of others;" or (5) the incitement of "group disturbances" in the facility. The new DCS regulations on restrictive housing have all of these criteria (please see Title 72 NAC Chapter 1, section 003.02), and if the Department's criteria had stopped there, then the problem of arbitrary decision-making would have been addressed. However, the Department's new regulations have added one more criterion authorizing placement of inmates in segregation, namely those inmates "whose presence in the general population would create a significant risk of physical harm to staff, themselves and/or other inmates." Unfortunately, this last provision, which is certainly not found in the ABA Standards, is so broad and speculative in nature that it will reintroduce arbitrariness into the decision-making process. In effect, under this last criterion just about any inmate could be placed in segregation, if staff believed that his or her "presence in the general population would create a significant risk of physical harm."

2. **Due Process**

Standard 23-2.9 of the ABA Standards on Treatment of Prisoners states that a "prisoner should be placed or retained in long-term segregated housing only after an individualized determination, by a preponderance of the evidence, that the substantive (criteria) for such placement are met." What this basically contemplates is that decisions that are made to place inmates in long-term segregation must be based on a set of facts that indicates that the inmate needs to be segregated under the relevant criteria. The ABA standards then outline procedural protections as a means of testing those alleged facts, and of making a more reliable record reflecting why the decision to place the inmate in segregation has been made. Standard 23-2.9 of the ABA Standards provides for "*effective notice*," which is then to be followed by an *administrative hearing* where the inmate in question "may be heard in person," and may "*confront and cross-examine any witnesses*" whose testimony is relevant to the case. The ABA Standards further indicate that, after the administrative hearing, the decision to place the inmate on long-term segregation must be based upon an "*individualized determination, by a preponderance of the evidence*" which supports the conclusion that the inmate meets the criteria for such a placement. Unfortunately, the new Department of Corrections regulations on restrictive housing have nothing along the lines of providing segregated inmates with Due Process, as is contemplated in the ABA Standards. In requiring such administrative hearings, and in providing at least a minimal form of Due Process, the ABA Standards have two advantages that are worth noting: (1) it would help to guarantee that the decisions to place inmates on long-term segregation status would be based on the strict criteria that I described above, that is, it would validate that criteria by testing each case against those criteria; and (2) since administrators would now understand that they would need to prove the validity of their decisions assigning an inmate to segregation, it is likely that there would be fewer of those decisions, since the administrators would necessarily be more cautious in making those decisions. While the Department's regulations on restrictive housing provide for periodic paper reviews of the cases of inmates on long-term segregation, as things stand there is nothing whatsoever in the DCS regulations about providing Due Process in these cases, as outlined in the ABA Standards.

Recommendation

At this point, we believe that the LR 34 Committee should seriously consider resolving these two important issues by proposing legislation that would enact both ABA Standard 23-2.7(b) and ABA Standard 23-2.9 into law. However, in light of the Department's serious staffing concerns, we would also suggest that it would be desirable to make the changes enacting the Standards effective in 2018, so that the Department will have time to prepare itself to implement these changes in a manner that would not be disruptive to the good order of the State's correctional facilities. A copy of ABA Standards 23-2.7 and 23-2.9 is attached.

cc. Mr. Scott Frakes

ABA Treatment of Prisoners Standards

Approved by the ABA House of Delegates, February 2010

Standard 23-2.7 Rationales for long-term segregated housing

(a) Correctional authorities should use long-term segregated housing sparingly and should not place or retain prisoners in such housing except for reasons relating to:

(i) discipline after a finding that the prisoner has committed a very severe disciplinary infraction, in which safety or security was seriously threatened;

(ii) a credible continuing and serious threat to the security of others or to the prisoner's own safety; or

(iii) prevention of airborne contagion.

(b) Correctional authorities should not place a prisoner in long-term segregated housing based on the security risk the prisoner poses to others unless less restrictive alternatives are unsuitable in light of a continuing and serious threat to the security of the facility, staff, other prisoners, or the public as a result of the prisoner's:

(i) history of serious violent behavior in correctional facilities;

(ii) acts such as escapes or attempted escapes from secure correctional settings;

(iii) acts or threats of violence likely to destabilize the institutional environment to such a degree that the order and security of the facility is threatened;

(iv) membership in a security threat group accompanied by a finding based on specific and reliable information that the prisoner either has engaged in dangerous or threatening behavior directed by the group or directs the dangerous or threatening behavior of others; or

(v) incitement or threats to incite group disturbances in a correctional facility.

Standard 23-2.9 Procedures for placement and retention in long-term segregated housing

(a) A prisoner should be placed or retained in long-term segregated housing only after an individualized determination, by a preponderance of the evidence, that the substantive prerequisites set out in Standards 23-2.7 and 23-5.5 for such placement are met. In addition, if

long-term segregation is being considered either because the prisoner poses a credible continuing and serious threat to the security of others or to the prisoner's own safety, the prisoner should be afforded, at a minimum, the following procedural protections:

(i) timely, written, and effective notice that such a placement is being considered, the facts upon which consideration is based, and the prisoner's rights under this Standard;

(ii) decision-making by a specialized classification committee that includes a qualified mental health care professional;

(iii) a hearing at which the prisoner may be heard in person and, absent an individualized determination of good cause, has a reasonable opportunity to present available witnesses and information;

(iv) absent an individualized determination of good cause, opportunity for the prisoner to confront and cross-examine any witnesses or, if good cause to limit such confrontation is found, to propound questions to be relayed to the witnesses;

(v) an interpreter, if necessary for the prisoner to understand or participate in the proceedings;

(vi) if the classification committee determines that a prisoner is unable to prepare and present evidence and arguments effectively on his or her own behalf, counsel or some other appropriate advocate for the prisoner;

(vii) an independent determination by the classification committee of the reliability and credibility of confidential informants if material allowing such determination is available to the correctional agency;

(viii) a written statement setting forth the evidence relied on and the reasons for placement; and

(ix) prompt review of the classification committee's decision by correctional administrators.

(b) Within [30 days] of a prisoner's placement in long-term segregated housing based on a finding that the prisoner presents a continuing and serious threat to the security of others, correctional authorities should develop an individualized plan for the prisoner. The plan should include an assessment of the prisoner's needs, a strategy for correctional authorities to assist the prisoner in meeting those needs, and a statement of the expectations for the prisoner to progress toward fewer restrictions and lower levels of custody based on the prisoner's behavior. Correctional authorities should provide the plan or a summary of it to the prisoner, and explain it, so that the prisoner can understand such expectations.

(c) At intervals not to exceed [30 days], correctional authorities should conduct and document an evaluation of each prisoner's progress under the individualized plan required by subdivision (b) of this Standard. The evaluation should also consider the state of the prisoner's mental health; address the extent to which the individual's behavior, measured against the plan, justifies the need to maintain, increase, or decrease the level of controls and restrictions in place at the time of the evaluation; and recommend a full classification review as described in subdivision (d) of this Standard when appropriate.

(d) At intervals not to exceed [90 days], a full classification review involving a meeting of the prisoner and the specialized classification committee should occur to determine whether the prisoner's progress toward compliance with the individual plan required by subdivision (b) of this Standard or other circumstances warrant a reduction of restrictions, increased programming, or a return to a lower level of custody. If a prisoner has met the terms of the individual plan, there should be a presumption in favor of releasing the prisoner from segregated housing. A decision to retain a prisoner in segregated housing following consideration by the classification review committee should be reviewed by a correctional administrator, and approved, rejected, or modified as appropriate.

(e) Consistent with such confidentiality as is required to prevent a significant risk of harm to other persons, a prisoner being evaluated for placement in long-term segregated housing for any reason should be permitted reasonable access to materials considered at both the initial and the periodic reviews, and should be allowed to meet with and submit written statements to persons reviewing the prisoner's classification.

(f) Correctional officials should implement a system to facilitate the return to lower levels of custody of prisoners housed in long-term segregated housing. Except in compelling circumstances, a prisoner serving a sentence who would otherwise be released directly to the community from long-term segregated housing should be placed in a less restrictive setting for the final months of confinement.

2016 RESTRICTIVE HOUSING ANNUAL REPORT

NEBRASKA DEPARTMENT OF CORRECTIONAL SERVICES

September 15, 2016

Prepared by NDCS Policy and Research Division

Introduction

One of the keys to success in any reform process in a large organization is monitoring of implementation so that the question "Where are we now and what is the next step?" can be answered and necessary adjustments made. Successful implementation also takes time and data collection and reporting can initially be a struggle. Tracking progress helps to engage staff in the process and provides stakeholders the confidence that reform is moving forward. This report documents the use of restrictive housing within the Nebraska Department of Correctional Services (NDCS) for FY 2016. This is the first restrictive housing annual report from the Nebraska Department of Correctional Services (NDCS) pursuant to Nebraska Revised Statute §83-4,114, which states:

> The director shall issue an annual report on or before September 15 to the Governor and the Clerk of the Legislature. The report to the Clerk of the Legislature shall be issued electronically. For all inmates who were held in restrictive housing during the prior year, the report shall contain the race, gender, age, and length of time each inmate has continuously been held in restrictive housing. The report shall also contain:
>
> (a) The number of inmates held in restrictive housing;
>
> (b) The reason or reasons each inmate was held in restrictive housing;
>
> (c) The number of inmates held in restrictive housing who have been diagnosed with a mental illness or behavioral disorder and the type of mental illness or behavioral disorder by inmate;
>
> (d) The number of inmates who were released from restrictive housing directly to parole or into the general public and the reason for such release;
>
> (e) The number of inmates who were placed in restrictive housing for his or her own safety and the underlying circumstances for each placement;
>
> (f) To the extent reasonably ascertainable, comparable statistics for the nation and each of the states that border Nebraska pertaining to subdivisions (4)(a) through (e) of this section; and
>
> (g) The mean and median length of time for all inmates held in restrictive housing.

In addition to the statistical information regarding the use of restrictive housing, this report will also provide a summary of the restrictive housing reforms currently underway, including the new Title 72, Chapter 1 regulations, which went into effect on July 1, 2016, and the elimination of disciplinary segregation as punishment for violation of department rules.

Background: Restrictive Housing within NDCS

It is a reality that incarcerated individuals commit violent or disruptive acts in prison which require them to be separated from the general population for the safety of the inmate, others, and the security of the

institution. Restrictive housing serves a legitimate purpose when utilized appropriately for risk assessment and mitigation with the goal of returning individuals to general population as soon as it is safe to do so. Historically restrictive housing has been used as both punishment and a means to remove individuals from the general population due to threats to safety and security. There have been efforts in the last several years to reduce the time spent in restrictive housing, but it has not been enough. We have held people in restrictive housing as punishment in response to their behavior as opposed to utilizing it solely as a risk management tool.

The issue of restrictive housing reform has become a topic of national discussion in recent years. The focus of this discussion has been on the impacts of restrictive housing, available alternatives and the need to limit the duration and frequency of its use. The appointment of Scott Frakes as director of corrections in February 2015 coincided with an increased interest in restrictive housing reform in the Nebraska Legislature resulting in the adoption of LB 598 during the 2015 session. LB 598 required the Department to adopt restrictive housing rules and regulations and implement a 'least restrictive environment' standard for restrictive housing placements.

The reforms currently underway in NDCS fundamentally change the way restrictive housing operates and embody the concept that restrictive housing should be used to manage risk and not as punishment. Prior to the enactment of recent reforms, there were five categories of restrictive housing within NDCS:

1. Immediate Segregation (IS)- Short term placement as immediate response to disruptive act or security threat;

2. Disciplinary segregation (DS) - Punishment for violation of department rules, limited to 60 days per violation for Class I offense, 45 days for Class II offense; and 30 days for Class III offense. A maximum of 60 days of disciplinary segregation can be imposed for acts arising out of a single incident;

3. Administrative Confinement (AC) – Classification-based restrictive housing assignment of indefinite duration based on behavior and risk to safety and security of the institution;

4. Intensive Management (IM) – The most secure restrictive housing assignment. Similar to AC in that it was classification based and indefinite in duration . Intensive management was utilized sparingly during 2015 and was eliminated in the new restrictive housing rules and regulations; and

5. Protective custody (PC) - Restrictive housing assignment for protection of the inmate.

As required by LB 598, NDCS formally promulgated its restrictive housing rules and regulations, effective July 1, 2016, to establish the 'least restrictive environment' standard for all restrictive housing placements. The restrictive housing rules and regulations are located in Title 72, Chapter 1 of the Nebraska Administrative Code and can be found on the NDCS website. This standard requires that inmates in restrictive housing be housed in the least restrictive environment compatible with the safety of the inmate, others, and institutional security. These reforms also eliminated disciplinary segregation as punishment for violation of institutional rules and introduced the concept of mission specific housing.

An example of mission specific housing is the protective management unit at the Tecumseh State Correctional Institution which now houses over 340 protective custody inmates in a setting consistent with general population conditions. Very few protective custody inmates are being managed in restrictive housing, and only until bed space is available in the appropriate housing unit.

Pursuant to the new restrictive housing rules and regulations, after July 1, 2016 there are two categories of restrictive housing:

1. Immediate Segregation (IS)– A short-term restrictive housing assignment of not more than 30 days in response to behavior that creates a risk to the inmate, others, or the security of the institution. Immediate Segregation is used to maintain safety and security while investigation are completed, risk and needs assessments are conducted, and appropriate housing is identified.

2. Longer Term Restrictive Housing (LT)- A classification-based restrictive housing assignment of over 30 days. Longer-term Restrictive Housing is used as a behavior management intervention for inmates whose behavior continues to pose a risk to the safety of themselves or others and includes inmate participation in the development of a plan for transition back to general population or mission based housing.

The restrictive housing rules also establish a new process for reviewing and authorizing the continuation of restrictive housing placement. The Central Office multidisciplinary review team (MDRT) reviews and authorizes all placements into longer-term restrictive housing. The MDRT is a five member team led by the Deputy Director of Operations with representatives from behavioral health, classification, research and the intelligence unit. The MDRT also reviews each inmate on restrictive housing at least every 90 days to assess compliance with behavioral and programming plans and to determine if promotion to a less restrictive setting is compatible with the safety of the inmate, others and security of the facility. Wardens at each facility must approve placements to immediate segregation within 24 hours (8 hours for juveniles and pregnant inmates) and must also authorize retaining inmates in immediate segregation past 15 days. For a more detailed description of the current reform efforts, the NDCS Long Term Plan for Restrictive Housing Reform can be found here.

Restrictive Housing Placements

The race and sex of individuals placed in restrictive housing during FY 2016 are included in Table 1a. The same data for the entire population is listed in Table 1b. The age distribution of inmates placed in restrictive housing during FY 2016 can be found in Table 2. The total number of inmates in a restrictive housing classification as of July 1, 2016 was 304 and is found in Table 3. This represents 5.7% of the total population of 5,288 inmates. During FY2016, a total of 2,215 unique inmates spent time in restrictive housing, of which the largest percentage was white males between the ages of 22-36. 41%

Table 1a - Restrictive Housing Demographics, FY 2015					Table 1b - NDCS Demographics August 2016				
Race	Male		Female		Race	Male		Female	
	Count	Percentage	Count	Percentage		Count	Percentage	Count	Percentage
White	956	43.16%	76	3.43%	White	2564	49.74%	272	5.28%
Black	627	28.31%	46	2.08%	Black	1305	25.32%	82	1.59%
Hispanic	339	15.30%	16	0.72%	Hispanic	595	11.54%	36	0.70%
Native American	105	4.74%	13	0.59%	Native American	189	3.67%	28	0.54%
Asian	13	0.59%	0	0.00%	Asian	38	0.74%	2	0.04%
Unknown	9	0.41%	0	0.00%	Unknown	19	0.37%	0	0.00%
Other	6	0.27%	8	0.36%	Other	11	0.21%	9	0.17%
Pacific Islander	1	0.05%	0	0.00%	Pacific Islander	5	0.10%	0	0.00%
Grand Total	**2056**	**92.82%**	**159**	**7.18%**	**Grand Total**	**4726**	**91.68%**	**429**	**8.32%**

Table 2 – Age of Restrictive Housing Inmates FY 2015				
Current Age	Male		Female	
	Count	Percentage	Count	Percentage
17 - 21	178	8.04%	12	0.54%
22 - 26	467	21.08%	39	1.76%
27 - 31	410	18.51%	28	1.26%
32 - 36	327	14.76%	37	1.67%
37 - 41	225	10.16%	16	0.72%
42 - 46	166	7.49%	8	0.36%
47 - 51	107	4.83%	11	0.50%
52 - 56	85	3.84%	3	0.14%
57 - 61	50	2.26%	4	0.18%
62+	41	1.85%	1	0.05%
Grand Total	**2056**	92.82%	**159**	7.18%

Table 3 RH Population July 1, 2016		
Facility	Type	# of Classifications
DEC	IS	2
DEC Total		**2**
LCC	AC	32
	DS	19
	IS	36
	PC	16
LCC Total		**103**
NCW	DS	2
	IS	2
NCW Total		**4**
NCY	DS	4
	IS	1
	PC	3
NCY Total		**8**
NSP	AC	21
	DS	25
	IS	22
	PC	16
NSP Total		**84**
OCC	IS	15
OCC Total		**15**
TSC	AC	67
	DS	47
	IS	22
	PC	15
TSC Total		**151**
Total Classifications		**367**
# of Unique Inmates		**310**

Reasons for placement

Many inmates spend time in more than one restrictive housing status because under the old policy, individuals always started in immediate segregation and then, if there was a need for continued placement, transitioned to disciplinary segregation, administrative confinement or protective custody. Additionally, individuals could receive disciplinary segregation while in restrictive housing resulting in

some inmates having multiple restrictive housing statuses simultaneously (i.e. an inmate may have been on administrative confinement and disciplinary segregation simultaneously)

Table 4 provides a breakdown of the total number of restrictive housing placements during FY 2015 by restrictive housing category. There were a total of 6,264 assignments to restrictive housing during FY 2015 distributed across 2,215 unique individuals with immediate segregation and disciplinary segregation being the two largest categories. Some individuals had multiple stays in restrictive housing as indicated by the number of IS placements and many were in multiple restrictive housing categories simultaneously.

Table 4 - Restrictive Housing Assignments FY 2015

Seg Conf CD	Male	Female	Grand Total
AC	592	11	**603**
DS	1600	96	**1696**
IM	13		**13**
IS	2872	270	**3142**
PC	802	8	**810**
Grand Total	**5879**	**385**	**6264**

The department's data system does not allow for the aggregation of the specific reasons why individuals were placed into each category of restrictive housing for FY 2015. Changing this practice is part of the current reform effort. The new rules and regulations require all restrictive housing placements to be based one of the six categories:

1. A serious act of violent behavior (i.e., assaults or attempted assaults) directed at correctional staff and/or at other inmates;

2. A recent escape or attempted escape from secure custody;

3. Threats or actions of violence that are likely to destabilize the institutional environment to such a degree that the order and security of the facility is significantly threatened;

4. Active membership in a "security threat group" (prison gang), accompanied by a finding, based on specific and reliable information, that the inmate either has engaged in dangerous or threatening behavior directed by the security threat group, or directs the dangerous or threatening behavior of others;

5. The incitement or threats to incite group disturbances in a correctional facility; and

6. Inmates whose presence in the general population would create a significant risk of physical harm to staff, themselves and/or other inmates.

Table 5 provides a summary of the number of immediate segregation placements since July 1, 2016 and the rationale for each placement from the six reasons outlined above as an example of what our current system is tracking. The data indicates that a significant number of individuals who were placed in immediate segregation since July 1 have been transitioned back to general population within 30 days and never reach the next step of review by the MDRT. Table 6 provides the number of individuals the Central Office MDRT has reviewed for placement onto or continuation on Longer-Term Restrictive Housing between July 1 and September 1, 2016. Of the 254 individuals reviewed by the MDRT, 90 were

removed from restrictive housing and returned to general population or another housing unit. 154 were placed in longer-term restrictive housing and 10 were continued on longer-term restrictive housing.

Table 5 Placements on Immediate Segregation July 1 – August 31, 2016*							
Facility	Serious Act of Violence	Escape/Attempted	Threatened Violence	Active STG	Group Disturbances	Significant Risk of Physical Harm	Totals
DEC	30	0	9	3	6	13	**61**
LCC	35	0	4	0	0	22	**61**
NCCW	22	0	5	0	0	2	**29**
NCYF	2	0	2	1	0	0	**5**
NSP	54	1	10	0	24	54	**143**
OCC	3	0	0	5	0	11	**19**
TSCI	64	0	17	1	13	127	**222**
Totals	210	1	47	10	43	229	**540**
Percent	38.9%	0.1%	8.7%	1.9%	8.0%	42.4%	100%

*This table represents the # of RH placements and not individuals.

Additional automation of the restrictive housing data entry and tracking are scheduled to be implemented once the department's sentence calculation project is completed this fall. Future editions of this report and NDCS restrictive housing information moving forward will include documentation of the reason the individual was placed into restrictive housing. A sample of the new tracking format is provided below.

Table 6 MDRT Reviews July-Sept. 2016		
Decision	**Number**	**Percentage**
Place	154	60.63%
Remove	90	35.43%
Continue	10	3.94%
Totals	**254**	**100%**

Name	ID #	Facility	Status IS, LTRH	Date Assigned	SMI Yes or No	Reason for Placement	180th Day	Days in RH
John Doe	XXXXX	TSCI	LTRH	9/4/2015	NO	Assault on another Inmate with a weapon causing serious bodily injury. LTRH Review scheduled: 08/02/2016	3/1/16	363

Mental illness and Behavioral Health

One of the primary areas of concern in the restrictive housing discussion nationally is how to address the needs of mentally ill individuals whose behavior presents a risk to themselves, others and/or the safety and security of the institution. Untreated seriously mentally ill individuals that present a high risk need secure residential mental health treatment rather than restrictive housing. To accomplish this goal, NDCS has expanded the secure mental health unit at the Lincoln Correctional Center and transferred seriously mentally ill individuals who had been held in restrictive housing in other facilities to this new unit. While the secure mental health unit currently meets the statutory definition of restrictive housing in terms of out of cell time, mental health staff are assigned to this unit to provide a higher level of care for these high risk inmates. The department's goal is to continue to develop additional programming options for the secure mental health unit with the objective of operating this unit in the least restrictive

manner possible. Tables 7 and 8 provide a breakdown of the behavioral health diagnoses of individuals assigned to restrictive housing during FY 2015. Table 7 includes all individuals diagnosed with a serious mental illness, while Table 8 provides a similar breakdown of all behavioral health diagnoses, including substance abuse.

Table 7 - Restrictive Housing Serious Mental Illness Diagnoses FY 2015

Diagnosis	# of inmates
Bipolar Disorder NOS	198
Bipolar I Disorder - Most Recent Episode Depressed	18
Bipolar I Disorder - Most Recent Episode Hypomanic	15
Bipolar I Disorder - Most Recent Episode Manic	19
Bipolar I Disorder - Most Recent Episode Mixed	39
Bipolar I Disorder - Most Recent Episode Unspecified	36
Bipolar II Disorder	61
Delusional Disorder	14
Major Depressive Disorder	101
Major Depressive Disorder, Recurrent	159
Major Depressive Disorder, Single Episode	21
Major Depressive Disorder, Single Episode, Severe w/ Psychotic Features	3
Obessive-Compulsive Disorder	51
Obessive-Compulsive Personality Disorder	3
Schizoaffective Disorder	89
Schizophrenia, Catatonic Type	1
Schizophrenia, Disorganized Type	4
Schizophrenia, Paranoid Type	44
Schizophrenia, Residual Type	1
Schizophrenia, Undifferentiated Type	77
Grand Total	**954**

Table 8 - Restricted Housing Behavioral Health Diagnoses FY 2015

Diagnosis	# of Inmates	Diagnosis	# of Inmates
Acculturation Problem	3	Hallucinogen-Related Disorder NOS	3
Acute Stress Disorder	9	Histrionic Personality Disorder	4
Adjustment Disorder Unspecified	286	Impulse-Control Disorder NOS	54
Adjustment Disorder w/ Anxiety	66	Inhalant Abuse	7
Adjustment Disorder w/ Depressed Mood	74	Inhalant Dependence	2
Adjustment Disorder w/ Disturbance of Conduct	3	Insomnia	35
Adjustment Disorder w/ Mixed Anxiety and Depressed Mood	266	Intermittent Explosive Disorder	35
Adjustment Disorder w/ Mixed Disturbance of Emotions & Conduct	52	Learning Disorder NOS	1
Adult Antisocial Behavior	27	Major Depressive Disorder	101
Agoraphobia without History of Panic Disorder	3	Major Depressive Disorder, Recurrent	159
Alcohol Abuse	415	Major Depressive Disorder, Single Episode	21
Alcohol Dependence	586	Major Depressive Disorder, Single Episode, Severe w/ Psychotic Features	3
Alcohol Intoxication Delirium	1	Malingering	10

Diagnosis	# of Inmates	Diagnosis	# of Inmates
Alcohol Withdrawal	1	Mental Disorder NOS	7
Alcohol-Induced Anxiety Disorder	1	Mental Retardation, Severity Unspecified	4
Alcohol-Related Disorder NOS	33	Mild Mental Retardation	9
Amnestic Disorder NOS	3	Moderate Mental Retardation	3
Amphetamine Abuse	196	Mood Disorder Due to General Medical Condition	4
Amphetamine Dependence	570	Mood Disorder NOS	538
Amphetamine-Induced Anxiety Disorder	2	Narcissistic Personality Disorder	23
Amphetamine-Induced Mood Disorder	2	Nicotine Dependence	5
Amphetamine-Induced Psychotic Disorder w/ Delusions	2	No Diagnosis on Axis II	68
Amphetamine-Induced Psychotic Disorder w/ Hallucinations	2	No Diagnosis or Condition on Axis I	52
Amphetamine-Related Disorder NOS	36	Obessive-Compulsive Disorder	51
Antisocial Personality Disorder	361	Obessive-Compulsive Personality Disorder	3
Anxiety Disorder Due to General Medical Condition	1	Opioid Abuse	68
Anxiety Disorder NOS	475	Opioid Dependence	99
Anxiolytic Abuse	5	Opioid-Induced Mood Disorder	1
Anxiolytic Dependence	3	Opioid-Related Disorder NOS	3
Anxiolytic-Related Disorder NOS	1	Oppositional Defiant Disorder	11
Asperger's Disorder	1	Other Conduct Disorder	2
Attention-Deficit/Hyperactivity Disorder NOS	77	Other Substance Abuse	28
Attention-Deficit/Hyperactivity Disorder, Combined Type	50	Other Substance Dependence	36
Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Implusive Type	10	Other Substance-Induced Anxiety Disorder	3
Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	15	Other Substance-Induced Mood Disorder	16
Autistic Disorder	2	Other Substance-Induced Psychotic Disorder w/ Delusions	3
Bereavement	56	Other Substance-Induced Psychotic Disorder w/ Hallucinations	1
Bipolar Disorder NOS	198	Other Substance-Related Disorder NOS	7
Bipolar I Disorder - Most Recent Episode Depressed	18	Pain Disorder Associated w/ Both Psychological Factors & General Medical Condition	1
Bipolar I Disorder - Most Recent Episode Hypomanic	15	Panic Disorder with Agoraphobia	17
Bipolar I Disorder - Most Recent Episode Manic	19	Panic Disorder without Agoraphobia	51
Bipolar I Disorder - Most Recent Episode Mixed	39	Paranoid Personality Disorder	13
Bipolar I Disorder - Most Recent Episode Unspecified	36	Paraphilia NOS	14
Bipolar II Disorder	61	Partner Relational Problem	7
Borderline Intellectual Functioning	35	Pathological Gambling	6
Borderline Personality Disorder	70	Pedophilia	24
Brief Psychotic Disorder	3	Personality Change Due to Medical Condition	1
Bulimia Nervosa	2	Personality Disorder NOS	89
Cannabis Abuse	498	Phase of Life Problem	1
Cannabis Dependence	801	Phencyclidine Abuse	7
Cannabis Intoxication	1	Phencyclidine Dependence	2
Cannabis-Induced Psychotic Disorder w/ Delusions	2	Phencyclidine-Induced Psychotic Disorder w/ Hallucinations	1
Cannabis-Related Disorder NOS	44	Physical Abuse of Adult	99
Catatonic Disorder Due to - General Medical Condition	1	Physical Abuse of Child	13
Cocaine Abuse	120	Polysubstance Dependence	288

Diagnosis	# of Inmates	Diagnosis	# of Inmates
Cocaine Dependence	168	Posttraumatic Stress Disorder	313
Cocaine-Related Disorder NOS	7	Psychotic Disorder Due to - w/ Delusions	6
Cognitive Disorder NOS	4	Psychotic Disorder Due to - w/ Hallucinations	5
Conduct Disorder, Adolescent-Onset Type	12	Psychotic Disorder NOS	176
Conduct Disorder, Childhood-Onset Type	4	Relational Problem NOS	58
Cyclothymic Disorder	11	Religious or Spiritual Problem	1
Delusional Disorder	14	Schizoaffective Disorder	89
Dependent Personality Disorder	7	Schizoid Personality Disorder	9
Depersonalization Disorder	2	Schizophrenia, Catatonic Type	1
Depressive Disorder NOS	253	Schizophrenia, Disorganized Type	4
Diagnosis Deferred	377	Schizophrenia, Paranoid Type	44
Diagnosis Left Blank	32	Schizophrenia, Residual Type	1
Disruptive Behavior Disorder NOS	4	Schizophrenia, Undifferentiated Type	77
Dissociative Disorder NOS	2	Schizophreniform Disorder	5
Dyssomnia NOS	6	Schizotypal Personality Disorder	13
Dysthymic Disorder	29	Sexual Abuse of Adult	17
Eating Disorder NOS	2	Sexual Abuse of Child	186
Exhibitionism	2	Sexual Sadism	1
Factitious Disorder NOS	2	Sleep Disorder Due to General Medical Condition, Insomnia Type	1
Factitious Disorder w/ Predominantly Psychological Signs & Symptoms	1	Social Phobia	31
Fetishism	1	Somatization Disorder	4
Gender Identity Disorder NOS	4	Somatoform Disorder NOS	1
Gender Identity Disorder in Adolescents or Adults	4	Specific Phobia	2
Generalized Anxiety Disorder	324	Tourette's Disorder	1
Hallucinogen Abuse	50	Trichotillomania	1
Hallucinogen Dependence	30	Unspecified Mental Disorder (nonpsychotic)	2
Hallucinogen Persisting Perception Disorder	1	Voyeurism	1
		Grand Total	**10176**

Over 90 percent of individuals (2034 inmates) who spent time in restrictive housing during FY 2016 had at least one behavioral health diagnosis, while 28%, or 698 individuals, held in restrictive housing during FY 2016 were diagnosed as having a serious mental illness. These numbers are significant and the goal is to reduce the assignment of individuals with mental illness to restrictive housing whenever possible and to limit the time spent in restrictive housing as much as possible by providing mental health treatment to individuals in restrictive housing and developing behavior and programming plans which will allow individuals to demonstrate that they can safely be housed in a less restrictive environment and transition to the mental health unit or general population.

Length of Stay

How long individuals spend in restrictive housing, referred to as the length of stay, is one of the primary areas of discussion in the area of restrictive housing reform. There is no one rule or a set number of days that can address every situation where an inmate's behavior poses an ongoing risk to the safety of themselves or others. This standard allows for an individualized examination of the risk presented in

each case while keeping the focus on the goal of transitioning people out of restrictive housing to the least restrictive environment as quickly as possible.

As noted above, prior to the recent reforms, our restrictive housing data system allowed for individuals to be entered on multiple statuses simultaneously, which significantly complicates calculating the average length of stay for each type of restrictive housing status as the time periods often overlap. Table 9 provides the average and median length of stay for individuals in restrictive housing for FY 2016 and also provides the average for individuals who spent less than 1 year in restrictive housing. Similar information for immediate and longer-term segregation will be reported in future reports.

Table 9 - Restrictive Housing Length of Stay (LOS) FY 2016

	All RH Placements	RH Stays less than 1 year
Average	144.24 days	45.14 days
Median	327 day	157 days

The data system is able to track the amount of time a particular individual has spent in restrictive housing and this information has been provided to the Inspector General for Corrections on a monthly basis since July 1, 2016. Table 10 contains the current list of 57 inmates who have spent over 180 days in restrictive housing as of September 15, 2016. Information that could identify inmates or staff has been removed from this table for confidentiality purposes.

Table 10 Restrictive Housing Placements over 150 days - September 15, 2016

Facility	Status IS, LTRH	Date Assigned	SMI Y or N	Reason for Placement	180th Day	Days in RH
LCC	LTRH	1/4/2003	YES	SMHU Treatment, Severely Mentally Ill, Staff Assaultive Behavior Initial LTRH Placement Date of 7/28/16, Review 10/28/16)	7/2/2003	5003
LCC	LTRH	10/12/2006	YES	SMHU Treatment, Assaults to Staff, Frequent Self-Harming Behavior. LTRH Placement Date of 8/18/16, LTRH Review Date of 11/16/16.	4/9/2007	3626
LCC	LTRH	2/15/2007	YES	SMHU Treatment, Staff assault at NSP, Currently Refusing to participate in treatment and SMHU Programming, Multiple attempts to sexually and physically assault staff.	8/13/2007	3500
LCC	LTRH	2/27/2007	YES	SMHU Treatment, History of assaults on staff	8/25/2007	3488
LCC	LTRH	1/17/2009	YES	SMHU Treatment, Assaulted Staff at LCC (OTC since 3/15/16)	7/15/2009	2798
LCC	IS	1/21/2009	YES	SMHU Treatment, Threats to harm Staff, pending transfer to MHU (D-Unit). IS date of 8/22/16.	7/19/2009	2794
LCC	LTRH	7/21/2010	YES	SMHU Treatment, Initial LTRH Placement date of 7/14/16, review date of 10/12/16. Currently non-compliant with treatment and is on an IMO for being non-medication compliant.	1/16/2011	2248
LCC	LTRH	8/5/2012	YES	SMHU Treatment, repeated assaults on other inmates, inappropriate sexual behavior towards female staff. LTRH Placement Date of 8/18/16, LTRH Review Date of 11/16/16.	1/31/2013	1502
LCC	LTRH	4/24/2013	YES	SMHU Treatment, Threats to staff, disruptive behavior, self-harming behavior.	10/20/2013	1240
LCC	LTRH	7/17/2014	YES	SMHU Treatment, Refused to lock down, threatening staff, refused to be restrained, Assaultive Behavior to Staff and Inmates, Attempted Escape on 05/27/2016. LTRH placement date of 8/11/16, with a review date of 11/9/16.	1/12/2015	791
LCC	LTRH	10/10/2014	YES	SMHU Treatment, Initial LTRH Placement date of 7/14/16, review date of 10/12/16. Physical Assaults on 3 staff.	4/7/2015	706

Facility	Status IS, LTRH	Date Assigned	SMI Y or N	Reason for Placement	180th Day	Days in RH
LCC	LTRH	10/21/2014	YES	SMHU Treatment, Pending a Regional Center review, Aggressive behavior towards staff.	4/18/2015	695
LCC	LTRH	11/21/2014	YES	Staff Assaultive, removed from SMHU Treatment.	5/19/2015	664
LCC	LTRH	2/12/2015	NO	Initial LTRH placement on 7/14/16. LTRH review on 10/12/16. Long history of threats to staff, barricading in cell/shower requiring extraction teams, non-compliance with staff directives.	8/10/2015	581
NSP	IS	3/10/2015	No	Safekeep awaiting sentencing	9/5/2015	555
LCC	LTRH	3/25/2015	YES	SMHU Treatment, Frequent Unprovoked Assaults on other inmates and Staff.	9/20/2015	540
TSCI	LTRH	5/12/2015	NO	Participated in large inmate disturbance/Refused housing/continuous threats to kill staff if moved to GP	11/7/2015	492
LCC	IS	5/29/2015	YES	SMHU Treatment, Assaulted Staff at NSP. Pending transition to D-Unit at this time.	11/24/2015	475
LCC	IS	6/5/2015	YES	SMHU Treatment, very paranoid about other inmates and staff wanting to harm him as part of his illness. IS Pending GP Bed Space on A1.	12/1/2015	468
LCC	LTRH	6/5/2015	YES	SMHU Treatment, transferred from NSP to participate in Treatment on 7/14/16.	12/1/2015	468
TSCI	LTRH	6/17/2015	NO	Continuous threats toward staff-Has agreed to participate in behavior plan. Removed from PC on 6/23/15 for placement on AC (LTRH) LTRH Review scheduled: 08/09/2016	12/13/2015	456
TSCI	LTRH	7/6/2015	NO	Mulitiple incidents of Staff assault at LCC. Transferred to NSP on 07/12/2016 from TSCI. Multiple staff assault at NSP. Transferred back to TSCI on 08/03/2016	1/1/2016	437
TSCI	LTRH	8/24/2015	NO	Staff assault (NSP)/STG activity/Threats toward 5-16-2016-"Stab that Pig"/ VRP @TSCI LTRH Review scheduled: 07/12/2016	2/19/2016	388
TSCI	LTRH	9/4/2015	NO	Assault on another Inmate with a weapon causing serious bodily injury LTRH Review scheduled: 08/02/2016	3/1/2016	377
TSCI	LTRH	9/22/2015	NO	Staff assault (TSCI) Serious Assault- Ofc. Livezey	3/19/2016	359
LCC	LTRH	10/27/2015	YES	SMHU Treatment for Severe Mental Illness. LTRH Placement Date of 8/18/16, LTRH Review Date of 10/17/16.	4/23/2016	324
TSCI	LTRH	11/21/2015	NO	Staff assault (TSCI) Cpl. Briggs. UOF on 6/15/2016 refusal to lockdown	5/18/2016	299
LCC	LTRH	12/3/2015	YES	SMHU Treatment, Multiple Sexual/Physical Assaults on Staff, Sexual Activities. LTRH placement date of 8/11/16, with a review date of 11/9/16.	5/30/2016	287
TSCI	LTRH	12/18/2015	NO	Pending IMO hearing-Disruptive behavior in R.H. LTRH Review Scheduled: 07/26/2016	6/14/2016	272
LCC	LTRH	12/25/2015	YES	SMHU Treatment, Assaulted Staff at DEC. Initial LTRH placement on 7/28/16, Review date of 10/28/16. Currently OTC since 9/8/16.	6/21/2016	265
NSP	LTRH	1/12/2016	No	Serious assault on staff at TSCI	7/9/2016	247
TSCI	LTRH	1/12/2016	NO	Staff Assault (NSP); STG issues LTRH Review Scheduled: 07/19/2016	7/9/2016	247
TSCI	LTRH	1/20/2016	NO	Assault of Inmate in SMU West GP (3 on 1) LTRH Review Scheduled: 07/12/2016 (LTRH)	7/17/2016	239
TSCI	LTRH	1/20/2016	NO	Assault of Inmate in SMU West GP (3 on 1)	7/17/2016	239
LCC	LTRH	1/28/2016	YES	SMHU Treatment, Is on an Involuntary Medication Order (IMO) due to extemely disruptive behavior. LTRH placement date of 8/11/16, with a review date of 11/9/16.	7/25/2016	231
NCYF	LTRH	2/10/2016	NO		8/7/2016	218
TSCI	LTRH	2/18/2016	NO	Assault of Inmate at TSCI (2 on 1) (Recommend LTRH) LTRH Review Scheduled: 08/16/2016	8/15/2016	210
TSCI	IS	2/18/2016	NO	Assault of Inmate at TSCI (2 on 1) (Recommend LTRH) LTRH Review Scheduled: 08/16/2016	8/15/2016	210
NSP	LTRH	2/19/2016	No	Altercation and attempted assault on staff LTRH TRD 12/7/2016	8/16/2016	209
TSCI	LTRH	2/21/2016	NO	STG Activity (LTRH)	8/18/2016	207
TSCI	LTRH	2/21/2016	NO	STG Activity (LTRH)	8/18/2016	207
TSCI	LTRH	2/21/2016	NO	STG Activity (Possible out-of-state Transfer)	8/18/2016	207

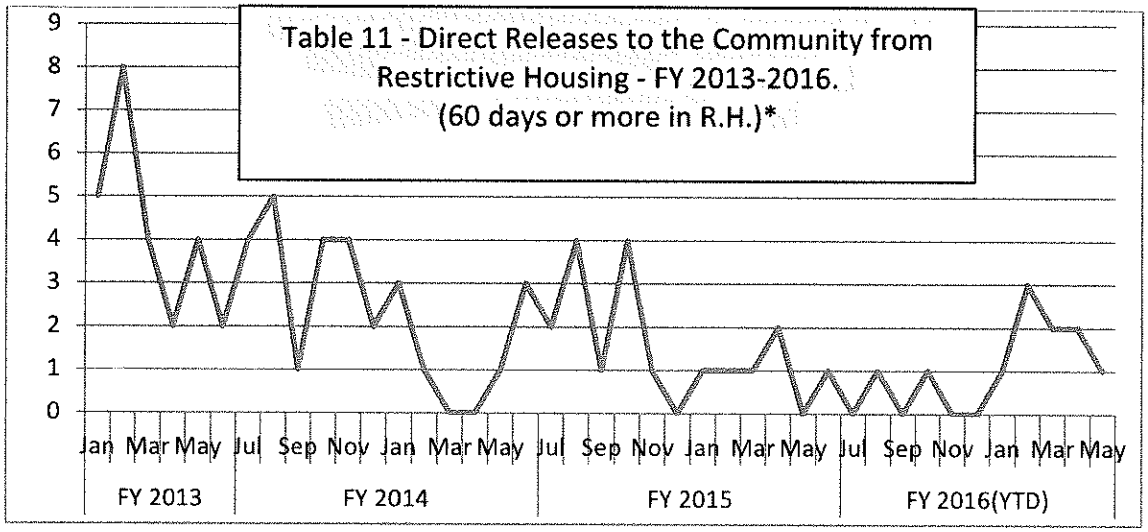
Facility	Status IS, LTRH	Date Assigned	SMI Y or N	Reason for Placement	180th Day	Days in RH
TSCI	LTRH	2/22/2016	NO	Assault of Inmate in SMU West GP (3 on 1) (LTRH) LTRH Review Scheduled: 08/16/2016	8/19/2016	206
TSCI	LTRH	2/27/2016	NO	Continuously refuses to move to HU1. Approved for HU1 placement on 3/25/16. Placed on PC 06/30/2016 Refused to Move to HU 1 on 08/02/2016	8/24/2016	201
TSCI	LTRH	2/28/2016	NO	Unable to live in any NDCS GP	8/25/2016	200
TSCI	LTRH	2/29/2016	NO	Assault of Inmate in SMU West GP (4 on 1) (LTRH) LTRH Review Scheduled: 08/02/2016	8/26/2016	199
TSCI	LTRH	3/4/2016	NO	Possession of a homemade weapon 6" Metal rod sharpend to a fine point (LTRH) LTRH Review Scheduled: 08/16/2016	8/30/2016	195
TSCI	LTRH	3/4/2016	NO	Possession of a homemade weapon 6" Metal rod sharpend to a fine point (LTRH)	8/30/2016	195
TSCI	LTRH	3/7/2016	NO	Staff assault in SMU West (4 on 1) (LTRH) LTRH Review Scheduled: 08/16/2016	9/2/2016	192
TSCI	LTRH	3/7/2016	NO	Staff assault in SMU West (4 on 1) (LTRH)	9/2/2016	192
TSCI	LTRH	3/7/2016	NO	Staff assault in SMU West (4 on 1) (LTRH)	9/2/2016	192
TSCI	LTRH	3/7/2016	YES	Staff assault in SMU West (4 on 1) (LTRH)	9/2/2016	192
TSCI	IS	3/9/2016	NO	Staff Assault at NSP. Kicked staff in the groin and stomach while being escorted. MDRT:Remove from LTRH-Pending appropriate Bed space in GP.	9/4/2016	190
LCC	LTRH	3/9/2016	NO	Physical Assault on Staff at NSP causing significant injury. LTRH Placement Date of 8/18/16, LTRH Review Date of 10/13/16.	9/4/2016	190
NSP	LTRH	3/14/2016	No	Assault on inmate LTRH review 11/30/2016	9/9/2016	185
NSP	LTRH	3/14/2016	No	Assault on inmtae LTRH review 11/30/2016	9/9/2016	185
NSP	LTRH	3/14/2016	No	Assault on inmate LTRH review 11/30/2016	9/9/2016	185

Releases directly to the community

Another central objective of the department's ongoing restrictive housing reform is to reduce the number of individuals who discharge directly from restrictive housing to the community. Consistent with the department's mission to keep people safe, the new restrictive housing rules require individuals who are in restrictive housing 120 days prior to release to be reviewed by the Central Office MDRT. The Deputy Director of Operations works with the facility to develop a release plan to transition the person out of restrictive housing and into general population, mission specific housing or treatment/behavioral focused housing prior to release. Additional processes are being established to ensure that individuals who have spent over 60 days in restrictive housing in the 150 days prior to their release have specialized reentry plans developed to avoid mandatory discharge from restrictive housing. NDCS is also collaborating with the parole board to reduce mandatory discharges and provide opportunities for inmates who have spent significant time in restrictive housing to transition into the community on parole prior to release.

Table 11 provides a summary of the number of direct releases to the community from restrictive housing over the past three fiscal years. This table is limited to individuals who have spent 60 days or more in restrictive housing prior to release in order to highlight the focus on reducing the number of Longer Term Restrictive Housing inmates releasing directly to the community. The number of individuals released directly to the community after spending any amount of time in restrictive housing in FY 2016 was 49, down from 58 in FY 2015 and 78 in FY 2014. Inmates spend short periods of time in restrictive housing prior to release occur for a variety of reasons. Some inmates nearing release will request

placement in protective custody or engage in conduct to get placed in restrictive housing in order to avoid issues with other inmates, as a result of the stress of pending release, or because they think that there are no consequences due to their impending release. These placements are projected to decrease significantly moving forward under the new restrictive housing rules as alternatives to restrictive housing are put in place for these types of issues.



*This metric has changed since July 1, 2016 and the Department is now tracking all direct releases to the community regardless of length of stay.

Protective Custody

In the fall of 2015, NDCS reorganized protective custody using the mission specific housing philosophy to establish protective management units at TSCI and LCC. These units operate in a manner which provides programming on the unit, group recreation opportunities and other privileges which allow them to operate more like a general population unit. Over 90 percent of inmates who were previously in protective custody in other institutions have been moved into these protective management units. As NDCS continues to expand its mission specific housing options, such as faith based or veterans-only housing, the need for protective custody should decrease as these mission specific units can serve a secondary function as safe havens for vulnerable populations.

As of June 30, 2016, there were a total of 349 inmates housed in protective management units at TSCI and LCC. As noted above in Table 4, there were 810 total assignments to protective custody during FY 2016. The Department's data system does not currently have the capability to aggregate the specific reasons why individuals were placed in protective custody. The vast majority of placements into protective custody are at the request of the inmate based upon fears for their own safety. NDCS is tracking placements into protective custody under the new rules and regulations and will be able to improve documentation in this area in future reports.

Comparable Statistics from other states

The most comprehensive comparison of state restrictive housing policies and practices over the last several years has been "Time in Cell: The Limon ASCA 2014 National Survey on Administrative Segregation in Prison", conducted by the Arthur Limon Public Interest Program at the Yale Law School in cooperation with the Association of State Correctional Administrators. Published in August 2015, this report collected information from 46 jurisdictions on a number of topics and represents the most current comparison data available for the nation as a whole. The entire report can be downloaded from the Yale website.

Table 12 presents a national comparison of the average length of stay for individuals in administrative segregation during 2014. Table 13 presents the number of inmates held in administrative segregation in 2011 and 2014 and as a percentage of the total inmate population for participating jurisdictions. The average demographics of administrative segregation inmates among 22 participating states in comparison to the total correctional population is found in Table 14.

Table 12 – Average Length of Stay in Administrative Segregation Fall 2014

	Less Than 90 Days		90 to 180 Days		6 Months to 1 Year		1 to 3 Years		More Than 3 Years		TOTAL
Alaska	189	83%	17	7%	12	5%	9	4%	1	0%	228
Arkansas	583	53%	199	18%	203	18%	81	7%	43	4%	1,109
Colorado	55	27%	46	22%	101	49%	5	2%	0	0%	207
Connecticut	71	30%	60	26%	47	20%	29	12%	26	11%	233
D.C.	159	94%	6	4%	3	2%	1	1%	0	0%	169
Iowa	128	90%	7	5%	5	4%	2	1%	0	0%	142
Kansas	156	28%	135	25%	118	21%	114	21%	26	5%	549
Kentucky	717	90%	61	8%	12	2%	4	1%	0	0%	794
Massachusetts	287	82%	48	14%	15	4%	2	1%	0	0%	352
Missouri	869	63%	261	19%	183	13%	58	4%	6	0%	1,377
Montana	45	94%	1	2%	2	4%	0	0%	0	0%	48
Nebraska	31	18%	53	30%	55	31%	29	17%	7	4%	175
New York	0	0%	0	0%	1	4%	3	13%	19	83%	23
North Carolina	76	89%	2	2%	4	5%	2	2%	1	1%	85
Oregon	56	23%	83	33%	79	32%	24	10%	6	2%	248
Pennsylvania	637	60%	159	15%	38	4%	56	5%	170	16%	1,060
Rhode Island	4	16%	7	28%	1	4%	11	44%	2	8%	25
South Carolina	304	63%	52	11%	52	11%	30	6%	45	9%	483
South Dakota	14	13%	11	11%	38	37%	25	24%	16	15%	104
Texas	353	5%	356	5%	755	12%	2,174	33%	2,853	44%	6,491
Virginia	119	35%	55	16%	71	21%	46	14%	47	14%	338
Washington	106	36%	37	12%	66	22%	56	19%	33	11%	298
Wisconsin	22	23%	12	13%	21	22%	35	36%	6	6%	96
Wyoming	2	4%	26	58%	4	9%	10	22%	3	7%	45

Source: Time in Cell: the Limon ASCA 2014 National Survey on Administrative Segregation in Prison, pg 29

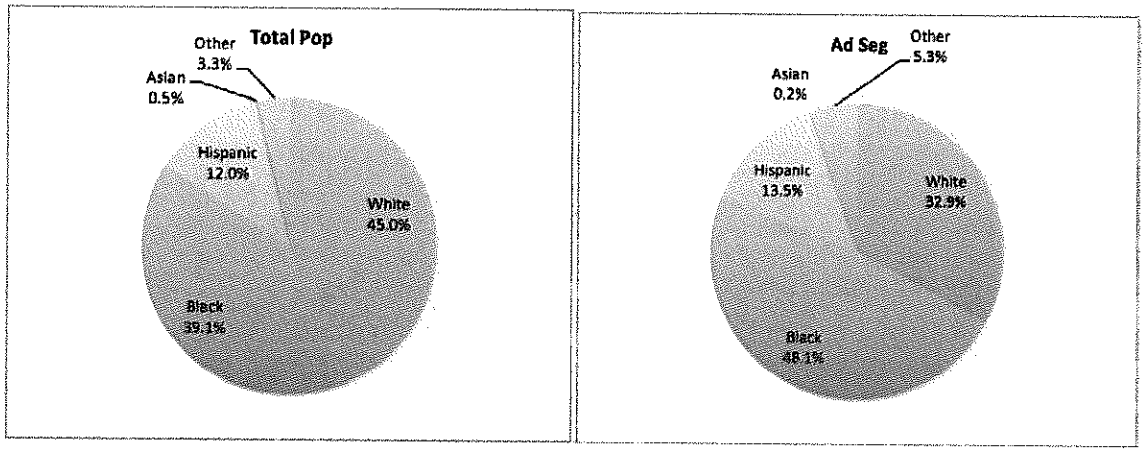
The benefit of the Yale study is that it was able to request states provide data in a comparable format and received participation from most jurisdictions in the US. The Yale group conducted an updated survey for 2015, but the data has not been published and will be included in the next edition of this report. NDCS has surveyed surrounding states to gather information on the use of restrictive housing, but each state defines restrictive housing slightly differently and excludes different populations (ie PC or a forensic mental health unit) from being considered as restrictive housing, making comparisons difficult.

Table 13 – Percentage of Custodial Population (Both Sexes) in Administrative Segregation Compared to Percentage of Custodial Population in Any Form of Restrictive Housing

	Total	Ad Seg		All Restrictive Housing	
Alabama	24862	729	2.9%	1253	5.0%
B.O.P.	171868	1656	1.0%	11387	6.6%
Colorado	20944	207	1.0%	662	3.2%
Connecticut	16564	74	0.4%	592	3.6%
Delaware	5977	330	5.5%	847	14.2%
D.C.	2067	62	3.0%	174	8.4%
Florida	100869	2416	2.4%	8936	8.9%
Georgia	52959	1625	3.1%	1658	3.1%
Indiana	28318	692	2.4%	1789	6.3%
Iowa	8172	142	1.7%	542	6.6%
Kansas	9529	557	5.9%	664	7.0%
Kentucky	12103	794	6.6%	794	6.6%
Massachusetts	10475	313	3.0%	518	4.9%
Michigan	44925	1122	2.5%	2004	4.5%
Missouri	31945	1277	4.0%	3929	12.3%
Montana	2519	48	1.9%	52	2.1%
Nebraska	5162	173	3.4%	685	13.3%
New Hampshire	2714	17	0.6%	270	9.9%
New Jersey	18968	1092	5.8%	1687	8.9%
New York	53613	23	0.0%	4198	7.8%
North Carolina	37695	85	0.2%	3052	8.1%
North Dakota	1632	23	1.4%	63	3.9%
Ohio	50554	1553	3.1%	2064	4.1%
Oklahoma	27488	1183	4.3%	1317	4.8%
Oregon	14591	239	1.6%	1025	7.0%
Pennsylvania	49051	1060	2.2%	2339	4.8%
South Carolina	21575	483	2.2%	1735	8.0%
South Dakota	3627	105	2.9%	221	6.1%
Tennessee	21030	445	2.1%	2626	12.5%
Texas	150569	6301	4.2%	6301	4.2%
Utah	6995	95	1.4%	832	11.9%
Washington	16554	296	1.8%	806	4.9%
Wisconsin	21996	96	0.4%	1363	6.2%
Wyoming	2074	50	2.4%	110	5.3%

Source: Time in Cell: the Limon ASCA 2014 National Survey on Administrative Segregation in Prison, pg15

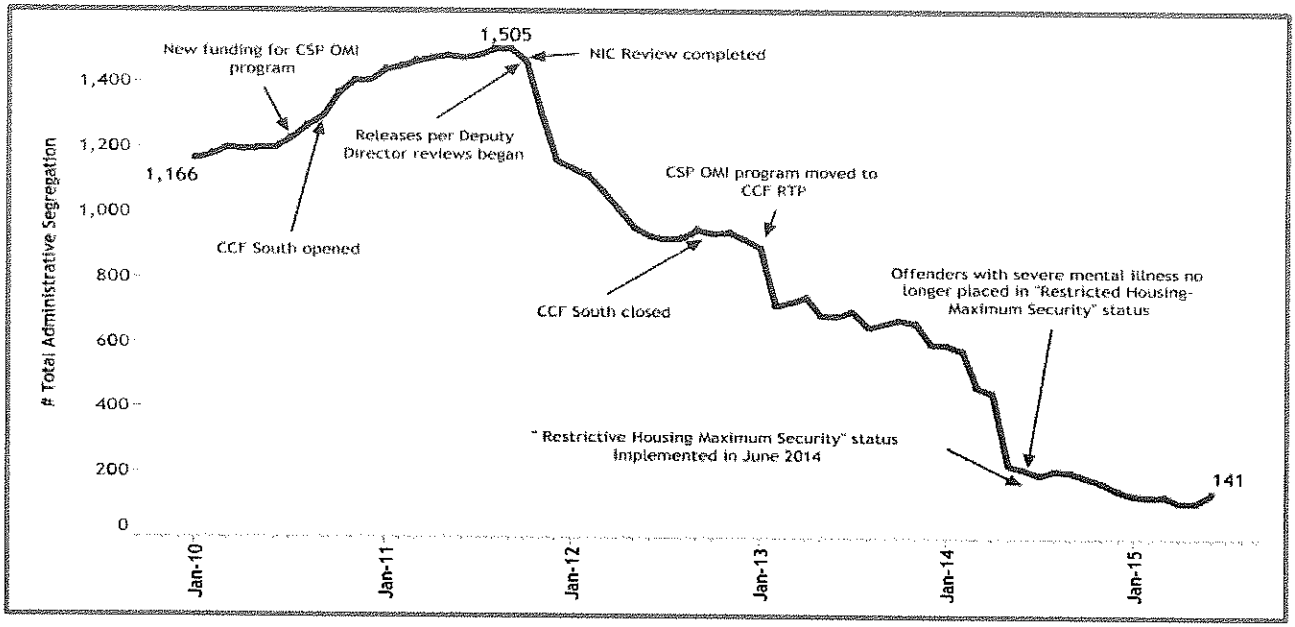
Table 14 – Average Demographic Composition of Total Male Population as Compared with Male Administrative Segregation Population (Fall 2014) ($n = 22$)[135]



Source: Time in Cell: the Limon ASCA 2014 National Survey on Administrative Segregation in Prison, pg 24

Colorado has been implementing restrictive housing reform for several years and produces an annual restrictive housing report. Figure 1 highlights the five year reform process that Colorado has been engaged in and the progress they have made in reducing the administrative segregation population over time. Figures 2 and 3 document the success Colorado has had in reducing the percentage of inmates held in administrative segregation and reducing discharges from restrictive housing to the community.

Figure 1. Administrative segregation population trends with timeline of key reform initiatives



Source: SB 11-176 Annual Report: Administrative Segregation for Colorado Inmates (Jan 1, 2016)

Figure 2: Percentage of total prison population in administrative segregation / Restrictive Housing - Maximum Security

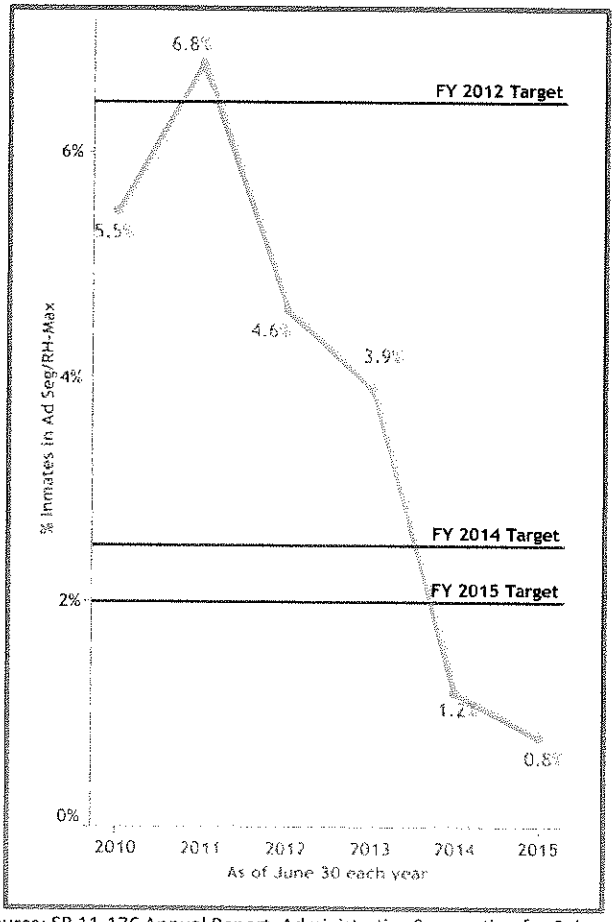
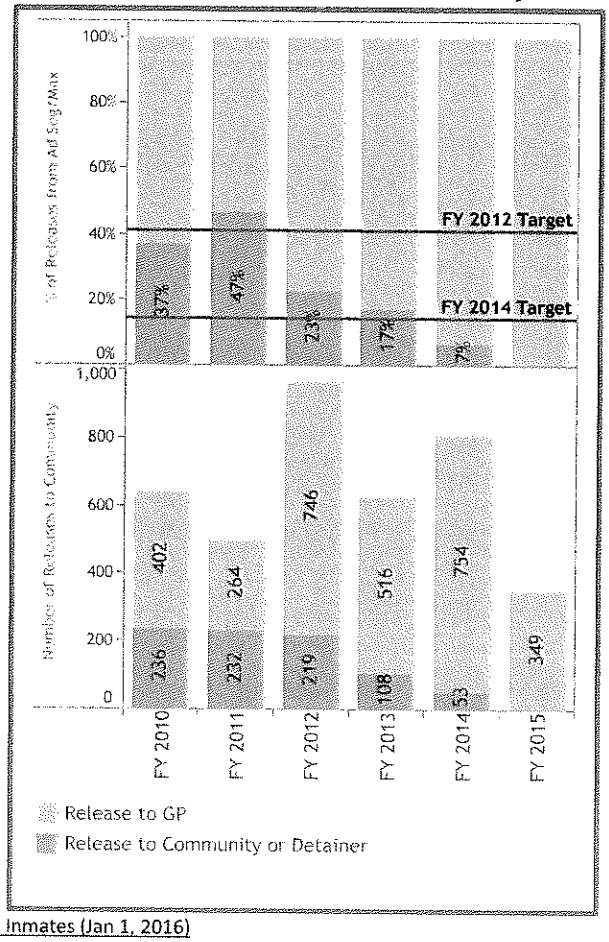


Figure 3: Releases directly to community from administrative segregation / Restrictive Housing - Maximum Security



Source: SB 11-176 Annual Report: Administrative Segregation for Colorado Inmates (Jan 1, 2016)

Conclusion

Nebraska is still in the beginning stages of the restrictive housing reform process. While NDCS has implemented significant changes to restrictive housing policies and procedures effective July 1, we are continuing to gather data and learning from experiences in other jurisdictions. A group of staff visited New Mexico earlier this year to learn about their approach to restrictive housing reform and security threat group populations. The recommendations from the VERA Safe Alternatives to Segregation Initiative, which is providing technical assistance to NDCS in its restrictive housing reform effort, are also expected this fall. There remains significant work to be done and NDCS is confident the goal of reducing the use of restrictive housing to those situations where it necessary for the safety and security of the inmate, others, and the institution can and will be achieved.

Managing the risk of our most challenging inmates is not simple or easy, and reforms take time to implement as the Colorado experience has demonstrated. When approached thoughtfully and implemented with fidelity while communicating with both inmates and staff, significant progress can be made. NDCS will continue to collect and analyze data on the implementation of restrictive housing reforms and share it with policymakers as it becomes available. We look forward to continuing to work with the Legislature, Governor and other stakeholders to reform the use of restrictive housing within NDCS and make our communities, prisons, inmates, staff and all Nebraskans safer.

Smith, Julie D.

om: Carbaugh, Abby L
Sent: Friday, August 05, 2016 9:12 AM
To: Smith, Julie D.
Cc: Beaty, Jeffry
Subject: RE: Emergency grievances

Hi Julie,

Attached is the updated grievance information. I wasn't sure if you needed calendar year or fiscal year, so both are included below. Please note that there are some records where no completion date has been entered into the database (only about 15 since 2010). These records were included in the count of grievances filed, but not used to calculate the response time information. If you have questions or need any additional details, please let me know.

	# Emerg Grievances Filed	Avg Response Time (in Days)	# with Same Day Response	% with Same Day Response
CY2013	703	**1.192582026**	540	77%
CY2014	928	**1.45995671**	712	77%
CY2015	1208	**1.466221852**	876	73%
CY2016(YTD)	551	**1.463369963**	431	78%
NOTE: Response time information excludes records where no response date has been entered.				

	# Emerg Grievances Filed	Avg Response Time	# with Same Day Response	% with Same Day Response
FY2013	675	**1.08320951**	530	79%
FY2014	776	**1.352258065**	594	77%
FY2015	1194	**1.352148273**	906	76%
FY2016	1004	**1.646292585**	741	74%
FY2017(YTD)	93	**0.460674157**	75	81%
NOTE: Response time information excludes records where no response date has been entered.				

Thanks,
-Abby

****

Abby L. Carbaugh, Ph.D.
Research Administrator
Nebraska Department of Correctional Services
P.O. Box 94661
Lincoln, NE 65809
Office: 402-479-5760
Cell: 402-203-2211
E-mail: abby.carbaugh@nebraska.gov

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NEBRASKA
DEPARTMENT OF
CORRECTIONAL
SERVICES

Scott R. Frakes, Director

DATE: October 3, 2016

TO: NDCS Staff Members

FROM: Diane Sabatka-Rine, Deputy Director – Operations
Mike Rothwell, Deputy Director – Programs

RE: Restrictive Housing

In his 'FRAKES Files' last week, Director Frakes talked about meeting with 50 staff members where communication and restrictive housing were the two most-mentioned issues. He addressed communication, and today, we would like to address restrictive housing.

During the last legislative session, the Legislature introduced and passed LB 598. This bill – now statute – required us to make significant changes to how we utilize restrictive housing by July 1, 2016. On the national front, the use of restrictive housing has been a hot topic for a while now and many states are making similar changes.

We made intentional efforts to communicate the changes to staff throughout the agency by conducting 'town halls' at each facility (with RH). But, it's hard to communicate, in one meeting, the kind of changes we're making and effect the change to our culture that is needed. We put out written communication about the new rules and regulations and the new policy, but, again, it's hard to effect culture change through policy.

Communication could have been better and we are working to increase and improve communication so that all NDCS employees understand the why and the how of restrictive housing reform.

The best case scenario would have been to spend time developing incentives and alternatives to restrictive housing before making these significant changes. The timing of the legislation did not allow us to do that. Instead, it was necessary to make the changes to restrictive housing first and then identify the alternatives. While we all would have liked to have done this in reverse order, we are very supportive of the reforms and believe we meet our mission and keep people safe when restrictive housing is used to mitigate risk and not as a punishment.

If an inmate assaults a staff member, the inmate will be placed on immediate segregation, be referred for longer-term restrictive housing, and may lose up to two years good time. This has not changed and will not change. It is a felony to assault a staff member and we will refer those cases to the county attorney's office. Once the referral is made, the county attorney has the authority to decide whether or not to proceed with prosecution. We are developing a process to be informed on these incidents and to share information with staff as it is available.

We often hear that we've "taken away" the means to punish inmates and that not having disciplinary segregation is the reason staff assaults are increasing. We hear what you are saying. We do not see the connection. Staff assaults started increasing in May, 2015, which is 13 months before disciplinary segregation was eliminated.

Our role is not to punish inmates. The court imposed the punishment. Our mission is keep people safe. We can only do that if we change behavior. Using disciplinary segregation or restrictive housing as punishment has no positive impact on changing behavior. If a person presents a risk for violence, keeping them away from others will help to ensure they don't have the opportunity to harm someone else for that time, but there is no permanent or lasting change by placing someone in restrictive housing or disciplinary segregation. Prison is the disciplinary segregation for the community. A person commits a crime and they are segregated from the public for a time. We know that "just" removing someone from the community does not make them better or more law abiding. Why do we think removing someone from the general population in prison for a time will make them more respectful or obedient? We've heard complaints about TVs in restrictive housing. Providing the TV is a benefit to the inmate, but it can also be a distraction to the inmate and occupy their time. When their time is occupied, it is less likely they will engage in negative or disruptive behavior following the incident that led to their placement in restrictive housing. If the individual does engage in that behavior, it may be appropriate to remove the TV from the cell. Again, the goal is not to make life horrible, it's to affect behavior change.

If going to prison doesn't make a person more compliant, why would going to restrictive housing inside prison make that same person more compliant? To facilitate behavior change, we are implementing a new program, 'Living Skills', specifically for inmates in restrictive housing. It encourages personal growth in a DVD-based format and covers values and responsibilities, interpersonal skills, refusal skills, making decisions and setting and attaining goals. These activities can be done individually in-cell or in small groups with a facilitator. We're also identifying additional programming to be available through the closed circuit TV system and will have that available soon.

We hear staff members talk about how "we do too much" for the inmates or that we're creating a "kinder, gentler" environment. This just isn't an argument that makes sense. It's not clear what we're doing too much of. The things we are increasing are pro-social activities, programming opportunities, treatment opportunities and the timeliness of treatment and programming.

We have heard staff members say "the administration only cares about the inmates" or "the administration cares more about inmates than staff." We care about each member of this team and we want each of you to be safe. We want you to feel safe, we want you to feel valued, we want you to know that your opinion matters, we want you to connect to our mission and we want you to believe that the work you do every day keeps people safe.

The purpose of this agency is to manage inmates and provide opportunities to change behavior, which is how we keep people safe. So, if you feel like the focus is on the inmates, it's because, collectively, our job is to focus on inmates. That's how we keep people safe.

Please consider how these changes are going to keep you safe inside prison and keep you and your families safe in the community.