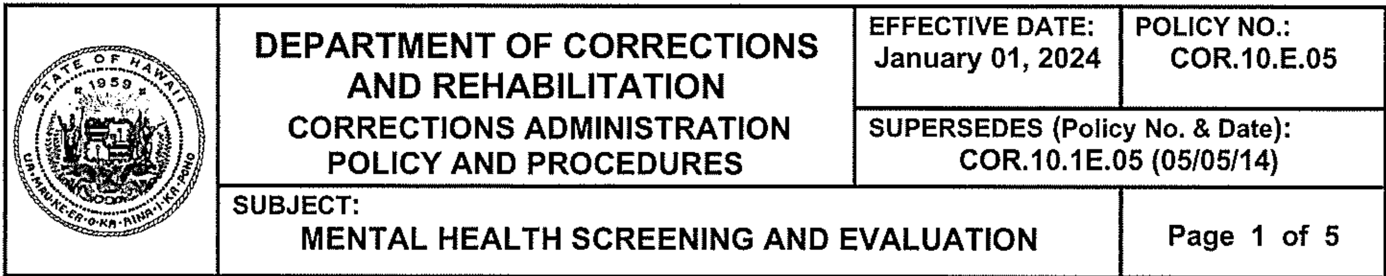


	DEPARTMENT OF CORRECTIONS AND REHABILITATION CORRECTIONS ADMINISTRATION POLICY AND PROCEDURES	EFFECTIVE DATE: January 01, 2024	POLICY NO.: COR.10.E.05
		SUPERSEDES (Policy No. & Date): COR.10.1E.05 (05/05/14)	
	SUBJECT: MENTAL HEALTH SCREENING AND EVALUATION		Page 1 of 5

1.0 PURPOSE

The purpose of this policy is to ensure that all incarcerated individuals receive an initial mental health screen to identify serious mental health needs requiring additional mental health evaluation and urgent mental health needs requiring priority mental health intervention.

2.0 SCOPE

This policy shall apply to all correctional facilities within the Department of Corrections and Rehabilitation (DCR).

3.0 REFERENCES, DEFINITIONS & FORMS

.1 References

a. Hawaii Revised Statutes, Section 26-14.6, Department of Public Safety; and Section 353-A, Director of Corrections and Rehabilitation, Powers and Duties.

b. Standards for Health Services in Prisons. National Commission on Correctional Health Care, (2018).

c. Standards for Health Services in Jails. National Commission on Correctional Health Care, (2018).

d. Standards for Mental Health Services in Correctional Facilities. National Commission on Correctional Health Care, (2015).

.2 Definitions

a. Qualified Mental Health Professional (QMHP): Psychiatrists, clinical psychologists, psychiatric social workers, psychiatric nurses, and others who by their education, credentials, or experience are permitted by law to evaluate and care for the mental health needs of patients.

b. Violent Behavior: An interpersonal altercation. In *Expressive Violence*, the goal is to injure the other person; whereas, in *Instrumental Violence*, the goal is to get something from the other person (usually the result of criminal intent).

NOT CONFIDENTIAL

c. Screening for Intellectual Functioning: Includes inquiry into history of developmental and educational difficulties and, when indicated, referral for application of standardized psychological intelligence tools.

.3 Forms

a. DCR 0580, Post-Admission Mental Health Screen.

b. DCR 0575, Informed Consent for Mental Health Services.

c. DCR 0574, Authorization to Release Medical Information.

d. DCR 0581, Mental Health Treatment Plan.

4.0 POLICY

.1 Initial mental health screening is performed as soon as possible, but no later than fourteen (14) calendar days after admission to the correctional system.

.2 Initial mental health screening may be conducted by qualified mental health professionals or qualified health care professionals who have received documented training.

.3 The initial mental health screening includes a structured interview with inquiries into:

a. A history of:

1. Psychiatric hospitalization, psychotropic medication, and outpatient treatment
2. Substance use hospitalization
3. Withdrawal seizures
4. Detoxification and outpatient treatment
5. Suicidal behavior
6. Violent behavior
7. Victimization
8. Special education placement
9. Cerebral trauma
10. Sexual abuse
11. Sex offenses

b. The status of:

1. Mental health symptoms and psychotropic medications
2. Suicidal ideation
3. Drug or alcohol use
4. Drug or alcohol withdrawal or intoxication
5. Orientation to person, place, and time

c. Emotional response to incarceration

d. Screening for intellectual functioning (i.e., intellectual disability, developmental disability, learning disability)

.4 Incarcerated individuals who screen positive for a serious mental health need are referred to Qualified Mental Health Professionals or Licensed Mental Health Professionals for further evaluation.

.5 Mental health evaluations of incarcerated individuals with positive screens are completed within thirty (30) days or sooner if clinically indicated.

.6 Results of the initial mental health screen and the mental health evaluation are documented in the health record.

.7 Incarcerated individuals who require acute mental health services beyond those available on-site are transferred to an appropriate facility or agency.

5.0 PROCEDURES

.1 Upon identification of an incarcerated individual who has entered the correctional system, but no later than fourteen (14) calendar days after admission to the correctional system, a Qualified Mental Health Professional or a trained Qualified Health Care Professional administers the initial mental health screening procedure, which includes:

a. Completion of the Informed Consent for Mental Health Services form (DCR 0575).

b. Administration of the Post-Admission Mental Health Screen (a.k.a., PAMHA; DCR 0580).

c. Completion of the Authorization to Release Medical Information form (DCR 0574), to obtain pertinent mental health evaluation and treatment

information and/or to communicate with community-based mental health professionals for purposes of continuity of care, as applicable.

d. Upon identification of an inmate with a serious mental health need, initiation of the Mental Health Treatment Plan (DCR 0581).

e. Chart review of the inmate's health record.

f. Notification to the inmate on how to access mental health services at the facility.

.2 Qualified Mental Health Professionals notify facility staff about safety, treatment, housing, or programming needs of incarcerated individuals, upon completion of the Authorization to Release Medical Information form (DCR 0574), and/or as allowed by Federal and State laws. Incarcerated individuals with intellectual disabilities, developmental disabilities, and learning disabilities are referred to the Education Program. Incarcerated individuals with serious medical needs are referred to the appropriate Qualified Health Care Professional.

.3 Incarcerated individuals who screen positive for a serious mental health need are referred to Qualified Mental Health Professionals or Licensed Mental Health Professionals for further evaluation.

.4 Qualified Mental Health Professionals conduct mental health evaluations (e.g., Suicide Risk Evaluation, Psychiatric/Medication Evaluation, Psychological Evaluation, Psychiatric Nursing Evaluation, PREA Evaluation), of incarcerated individuals with serious mental health needs, as identified by the initial mental health screen, within thirty (30) days of referral or sooner if clinically indicated. The urgency of the serious mental health need identified by the mental health screen determines the response time for the mental health evaluation.

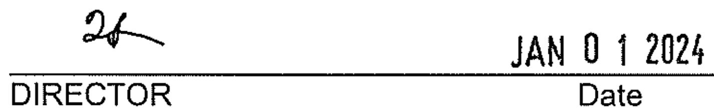
.5 Results of the initial mental health screen and the mental health evaluation are documented in the health record, as applicable.

.6 Incarcerated individuals who require acute mental health services beyond those available on-site are transferred to an appropriate facility or agency.

APPROVAL RECOMMENDED:

Deputy Director for Corrections　　　　Date

APPROVED:



DIRECTOR　　　　Date

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

POST-ADMISSION MENTAL HEALTH SCREEN

NAME: ______________________________ SID:_______________ DOB:___/___/______ FACILITY:________

How are you feeling today?

YES NO Have you ever had an **Emotional, Mental or Psychological** problem?

YES NO Did you receive any counseling, therapy or **Treatment** for your problem(s)?
What was it for?

When? Where? From Whom?

YES NO Have you ever taken **Psychotropic Medication** for the above condition?
Prescribed by (MD or Psychiatrist):
Name of **Current Psychotropic Medications**:

YES NO Have you ever been in a **Psychiatric Hospital**?
Where? When?
Why?

YES NO Have you ever tried to hurt yourself or **Attempt to Commit Suicide**?
How many times? When?
How did you attempt suicide?
What medical and mental health treatment did you receive?

YES NO Have you ever **Hurt Yourself on Purpose** when not trying to attempt suicide?
When? What did you do?

YES NO **Are you now thinking of Killing Yourself**?

YES NO Do you **See Things or Hear Things** other people do not see or hear?
Describe:

YES NO Do you believe you have **Special Powers** that others do not have?
Describe:

YES NO Have you ever used **Drugs, Including Alcohol**?

[*Drug of Choice]	Route	Frequency	Amount	Last Use
☐ Alcohol				
☐ Crack/Cocaine				
☐ Ice/Methamphetamine				
☐ Marijuana				
☐ Opioid				
☐ Spice				
☐				

How many times have you been in Detox? Last time (date)?
How many times have you been in Outpatient Treatment for Alcohol and/or Drug Abuse?
Name of Program(s):

YES NO Do you have any **Illnesses/Health Problems** related to substance abuse?
☐ Hepatitis ☐ Withdrawal Seizure ☐ Traumatic Injury ☐ Infection ☐ Other:

YES **NO** Have you ever had a severe **Head Injury** requiring treatment? When?
What happened?

Highest Grade Completed in School**:** Year of Graduation/GED:
YES **NO** While in school, were you ever in **Special Education (SPED) Classes**?
Why did you receive SPED services?
What grade level(s)?

What is your **Current Offense/Charges**?
YES **NO** Have you ever been **Convicted** of a **Sexual Offense**?

YES **NO** Have you ever experienced a **Loss of Control** that resulted in serious **Harm to Someone?**
When?
What did you do?
Goal: ☐ Injure the other person ☐ Get something from the other person

YES **NO** Have you ever been a **Victim of Criminal Violence**?
Describe:

YES **NO** Have you ever been **Sexually Abused or Sexually Assaulted**?
Describe:

Oriented to: ☐ Person ☐ Place ☐ Time

Emotional Response to Incarceration: ☐ Adaptive ☐ Dysfunctional
Describe:

YES **NO** Is a **Referral for Further Evaluation** recommended?

Referred to: ☐ Psychiatrist ☐ Clinical Psychologist ☐ Psychiatric Social Worker ☐ APRN
☐ Psychiatric Nurse ☐ Medical Doctor ☐ Registered Nurse ☐ Other:

Reason For Referral (Details Documented in Comments Section Below):

- ☐ Suicide Risk Evaluation
- ☐ Psychiatric/Medication Evaluation
- ☐ Psychological Evaluation
- ☐ Nursing/Medical Evaluation
- ☐ Mental Health/Psychiatric Treatment
- ☐ Standardized Psychological Intelligence Testing
- ☐ PREA Evaluation/Treatment
- ☐ Other:

Comments:

Print Name of Mental Health Staff | Signature/Title of Mental Health Staff | Date

INFORMED CONSENT FOR MENTAL HEALTH SERVICES

NATURE AND PURPOSE

I understand that mental health services may include the use of a variety of psychosocial and pharmacological therapies, as well as psychological assessments and/or diagnostic evaluations. The purposes of mental health services are to alleviate symptoms of serious mental disorders, attain improved functioning, and prevent relapse. Additional goals of treatment may include the development of self-understanding, enhanced coping skills, and self-improvement. I am aware that mental health services are available upon request (e.g., by submitting a medical request, telling the nurse at sick call).

BENEFITS/RISKS

I understand that while psychosocial and pharmacological therapies may provide significant benefits, it may also pose risks. Psychosocial therapies may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications may have unwanted side effects.

FEES

All screenings, examinations, and treatments required by the Department of Public Safety or nationally accepted correctional standards are free. Inmate requested non-emergency medical services have a $3.00 co-payment fee.

PRIVACY STATEMENT

In general, I understand that the information shared with mental health professionals is confidential and mental health information will not be released to external agencies without my consent. I further understand that there are specific limitations to this confidentiality in which it may be necessary to discuss information about my treatment with others. Examples of such conditions include, but are not limited to, the following:

1) if there is a risk of imminent danger that I may harm myself or others;
2) if there is suspicion that a child is being sexually or physically abused or is at risk of such abuse;
3) if a court order is issued for the release of medical and/or mental health records;
4) if my mental state and history is an issue in civil, personal injury, or other forms of grievances;
5) if personnel within the Department of Public Safety have a need to know.

CONSENT TO MENTAL HEALTH SERVICES

I authorize and consent to mental health care, including psychiatric and psychological assessment and treatment, which my treating physician and other mental health providers find to be necessary and which is given or performed at their direction. I understand that mental health services are provided by a range of mental health professionals, some of whom are in training. All professionals-in-training are supervised by licensed staff. I understand that I may refuse mental health services at any time.

I acknowledge that this facility has not made any guarantees to me as to the results of psychiatric and psychological assessments and treatments. If I have any additional questions regarding this consent form or about my diagnosis, evaluation, treatment, risks or complications, alternative forms of assessment and/or treatment, and anticipated course and results of treatment, I may discuss them with members of my treatment team.

I certify that I have read this Informed Consent for Mental Health Services form and that I am the patient, or the patient's authorized representative. On my own behalf (and on behalf of the patient) I accept and agree to participate in mental health services offered to me and to be bound by the above, a copy of which will be made available to me upon request.

X ______________________________ Print Name of Patient or Authorized Representative

X ______________________________ Print Name of PSD Representative

X ______________________________ Signature of Patient or Authorized Representative Date

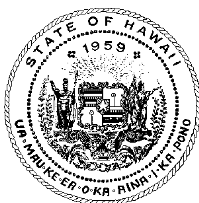
X ______________________________ Signature of PSD Representative Date

☐ **The patient is unable to sign for the following reason(s):**

______________________________ Reason(s)

X ______________________________ Print Name of PSD Representative

X ______________________________ Signature of PSD Representative Date



STATE OF HAWAII

DEPARTMENT OF PUBLIC SAFETY

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To:_________________________________ FROM:____________________________________

(DR./Facility in Possession of Record) (MD/Person/Facility Making the Request)

_________________________________ ____________________________________

(Address) (Address)

_________________________________ ____________________________________

(City) (State) (Zip Code) (City) (State) (Zip Code)

I authorize the release of the following protected health information ______________________________________

____ _

for the purpose of my (select one):

☐ continued health care

☐ other: ____

I understand I have the right to revoke this authorization by writing a letter to the requestor anytime prior to the actual release of information. I understand that this authorization is valid for one year from the "Date of Signature." I will not hold the person/agency in possession of my protected health information liable for the further dissemination of the information once it is released to the requestor. Treatment, payment, continued enrollment in a health plan, eligibility benefits, coercion, or remuneration are not conditions of this authorization.

_________________________________ ____________________________________

(Print Name of Patient/Representative) (Signature of Patient/Representative

_________________________________ ____________________________________

(Date of Birth) (Date of Signature)

My signature below indicates that I also authorize the release of the following protected health information: (Initial all that apply):

________ Mental health/behavioral health/psychiatric care/ psychiatric treatment records

________ Alcohol/substance abuse treatment records

________ HIV screening and diagnostic results/treatment records

I understand the sensitive nature of the information and that if the protected health information is entered as evidence in a court case they become public record.

_________________________________ ____________________________________

(Signature of Patient/Agent) (Signature of Witness)

_________________________________ ____________________________________

(Date of Signature) (Date of Signature)

Original: Person or Facility in Possession of the PHI
Yellow: Medical Record
Pink: Inmate

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

MENTAL HEALTH TREATMENT PLAN

NAME: ______________________

Facility: ______________________

Module: ______________________

SID: ______________________

DOB: ______________________

Date Treatment Plan Initiated: ______________

Date Review Due: ______________________

DIAGNOSES:

____

____

____

____

____

____

IDENTIFIED PROBLEM

- ☐ Suicidal Ideation/Communication/Behavior
- ☐ Self-Mutilation/Self-Injurious Behavior
- ☐ Violent/Aggressive Behavior
- ☐ Depression
- ☐ Mania/Hypomania
- ☐ Schizophrenia/Psychosis
- ☐ Substance Abuse/Dependence
- ☐ Anxiety
- ☐ PREA
- ☐ Other: ______________________

SPECIAL NEEDS CONSIDERATIONS

Serious Mental Health Need

- ☐ Severe and Persistent Mental Illness
- ☐ Therapeutic Restraints Contraindicated

Developmental Concern

- ☐ Developmental Disability
- ☐ Adolescent
- ☐ Frail or Elderly

Other

- ☐ Sex Offense History
- ☐ Language/Cultural Differences
- ☐ ______________________

Medical Condition

- ☐ Chronic Disease
- ☐ Terminal Illness
- ☐ End-stage Renal Disease
- ☐ Serious Communicable Disease
- ☐ Pregnant

- ☐ Known Drug Allergies: ______________

Physical Disability

- ☐ Visual Impairment
- ☐ Hearing Impairment
- ☐ Mobility Impairment

STRENGTHS

- ☐ Motivated for Treatment
- ☐ Adequate Support System
- ☐ Medication Adherent
- ☐ Positive Attitude
- ☐ Other: ______________________
- ☐ Receptive to Treatment
- ☐ Compliant with Staff Directions
- ☐ Task Oriented
- ☐ Other: ______________________
- ☐ Other: ______________________

LONG TERM TREATMENT GOALS

- ☐ Complete incarceration safely and successfully.
- ☐ Stop illegal behaviors by using legal means to meet needs.
- ☐ Accept responsibility for decisions or behaviors that have resulted in incarceration.
- ☐ Decrease mental illness symptoms and/or eliminate substance use.
- ☐ Develop effective relapse prevention and risk management strategies.
- ☐ Other: ______________________
- ☐ Other: ______________________

SHORT-TERM TREATMENT OBJECTIVES	Status
☐ Take psychotropic medications as prescribed.	
☐ Report side-effects and effectiveness of psychotropic medication to staff.	
☐ Maintain self-control and remain safe while incarcerated.	
☐ Accept redirection, time-out, and/or changes in housing placement.	
☐ Reduce altered thought processes.	
☐ Establish a regular pattern of sleep.	
☐ Establish and maintain appropriate hygiene, grooming, and other daily living skills.	
☐ Actively participate in psychosocial treatment programming.	
☐ Demonstrate ability to focus attention and participate at an appropriate level of goal-directed activity.	
☐ Identify beliefs and other barriers to treatment compliance (e.g., medication, programming, evaluation).	
☐ Identify and explore behaviors and/or symptoms that have led to legal involvement.	
☐ Explore, identify, and verbalize thoughts and feelings related to mental illness.	
☐ Develop effective communication and coping skills to manage anger, stress, depression, anxiety, impulsivity, and/or other psychological symptoms and behaviors.	
☐ Develop a realistic sense of abilities and self-esteem.	
☐ Improve self-efficacy.	
☐ Develop relapse prevention and risk management strategies.	
☐ Reduce Acute Risk Factors	
☐ Enhance and/or Maintain Protective Factors	
☐	

INTERVENTIONS	Frequency	Staff Code
☐ Provide education about the use, expected benefits, and side-effects of psychotropic medications.	☐ Daily ☐ Weekly ☐ As Needed	01 05 02 06 03 07 04 08
☐ Medication Monitoring: Adherence, Effectiveness, and Laboratory Testing.	☐ Daily ☐ Quarterly ☐ As Needed	01 05 02 06 03 07 04 08
☐ Provide a structured therapeutic environment with consistent rules and predictable daily routines.	☐ Daily	01 05 02 06 03 07 04 08
☐ Decrease external stimuli and orient to reality.	☐ Daily ☐ As Needed	01 05 02 06 03 07 04 08
☐ Crisis Intervention Services	☐ As Needed	01 05 02 06 03 07 04 08
☐ Interdisciplinary Behavioral Modification Program	☐ As Needed	01 05 02 06 03 07 04 08
☐ Psychiatric follow-up evaluation, psychotropic medication re-evaluation, and/or adjustment.	☐ Monthly ☐ Quarterly ☐ As Needed	01 05 02 06 03 07 04 08
Psychosocial Treatment Programming:		
☐ Individual Counseling and/or Individual Therapy	☐ Weekly ☐ Monthly ☐ As Needed	01 05 02 06 03 07 04 08
☐ Social and Independent Living Skills Training (e.g., instructions about diet, personal hygiene, adaptation to the correctional environment)	☐ Daily ☐ Weekly ☐ As Needed	01 05 02 06 03 07 04 08
☐ Therapeutic Activities Group	☐ Daily ☐ Weekly ☐ As Needed	01 05 02 06 03 07 04 08
☐ Psycho-education concerning mental illness and treatment	☐ Daily ☐ Weekly ☐ As Needed	01 05 02 06 03 07 04 08
☐ Recreational Activities (including instructions about exercise)	☐ Daily ☐ Weekly ☐ As Needed	01 05 02 06 03 07 04 08
☐ Develop Wellness Recovery Action Plan	☐ Daily ☐ Weekly ☐ As Needed	01 05 02 06 03 07 04 08
☐ Mental Health Rounds	☐ Daily ☐ As Needed	01 05 02 06 03 07 04 08
☐ Manage Risk for Self-Harm	☐ Daily ☐ As Needed	01 05 02 06 03 07 04 08
☐ Develop Safety Plan	☐ Daily ☐ As Needed	01 05 02 06 03 07 04 08
☐ Refer for Psychological Testing and Evaluation	☐ As Needed	01 05 02 06 03 07 04 08
☐ Refer for Medical Testing and Evaluation	☐ As Needed	01 05 02 06 03 07 04 08
☐ Substance Abuse Treatment	☐ Daily ☐ Weekly ☐ As Needed	01 05 02 06 03 07 04 08
☐		

Status Key: **OM = Objective Met** **I = Improvement** **NC = No Change** **DC = Discontinued**

Patient:	Date:	Authorized Representative:	Date:
Psychiatrist (01):	Date:	Clinical Psychologist (02):	Date:
Psychiatric Social Worker (03):	Date:	Registered Nurse (04):	Date:
Corrections Recreation Specialist (05):	Date:	Occupational Therapist (06):	Date:
Para-Medical Assistant (07):	Date:	Other (08):	Date: