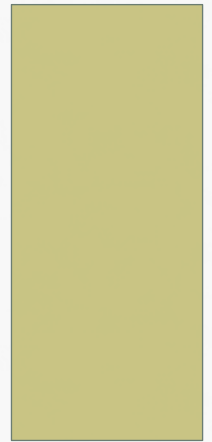
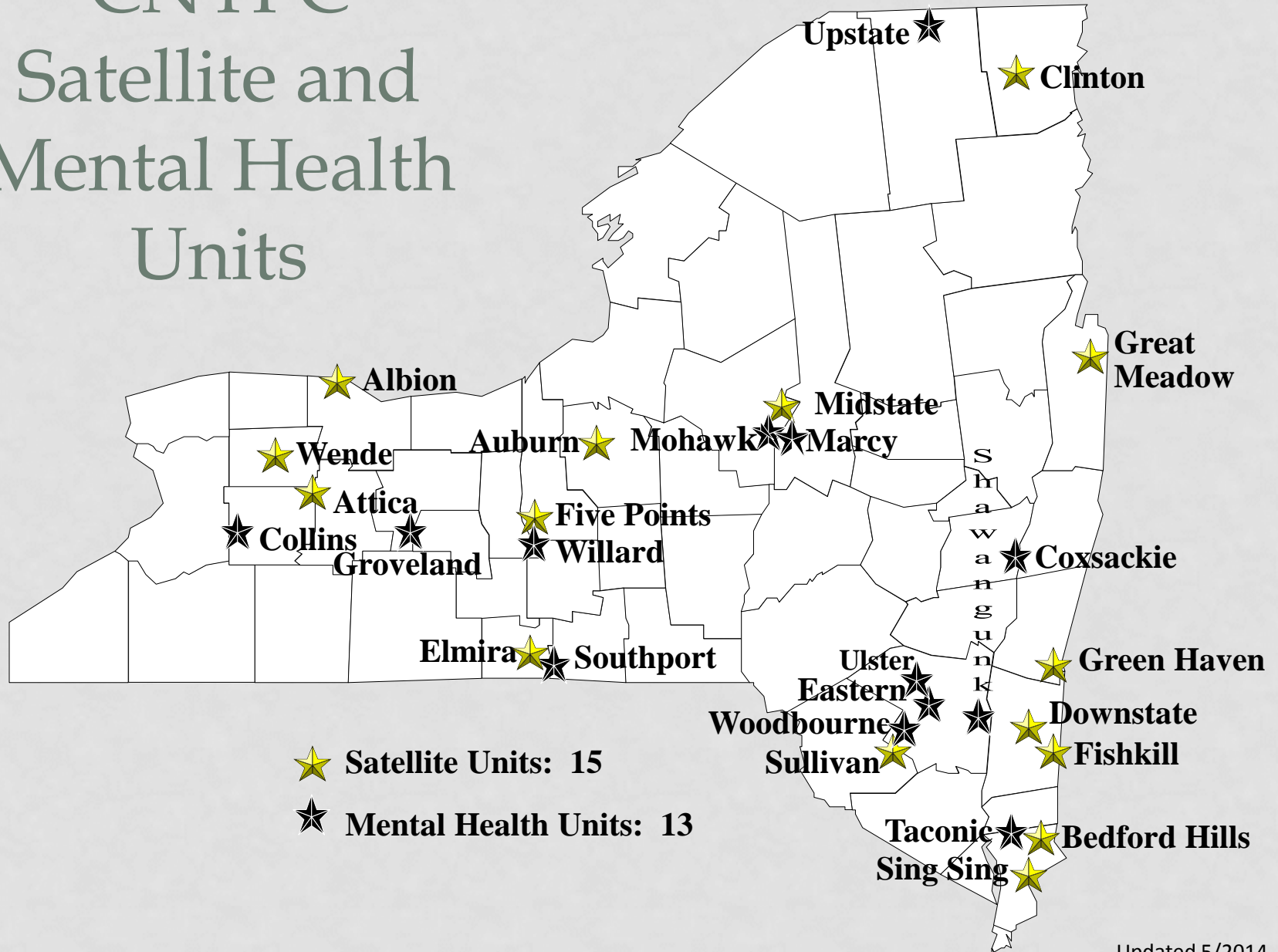


Central New York Psychiatric Center Corrections Based Operations Reception Process

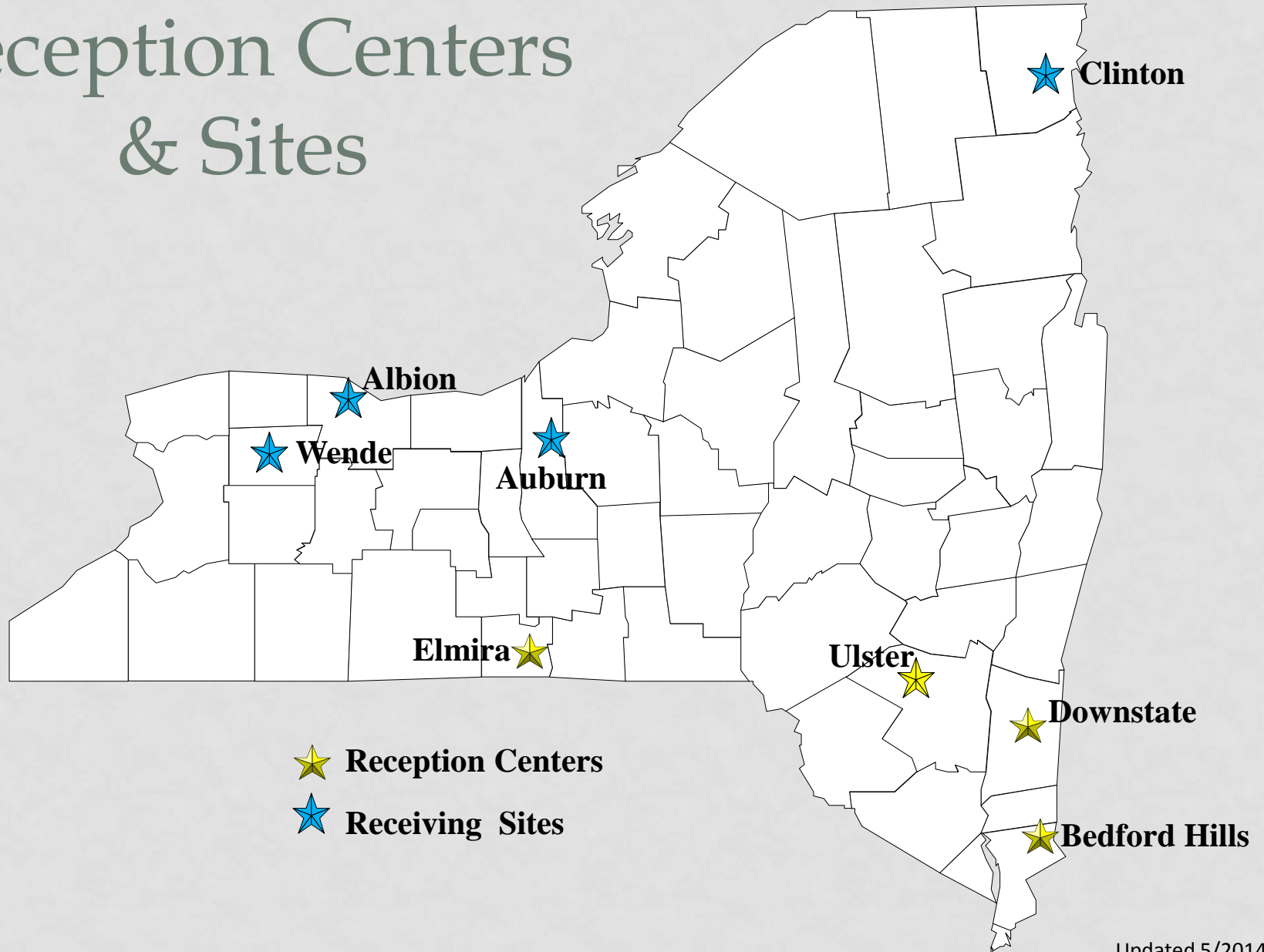
Peter J. Russell, Director of Corrections Based
Operations



CNYPC Satellite and Mental Health Units



Reception Centers & Sites



Reception Intake Process

- Transfer of Custody
- ID with fingerprint scanner
- Pat frisk and BOSS chair
- Strip frisk/delousing/shower
- Hair and beard shaved*
- Sign for rule book, net bag, property
- Given suicide prevention and PREA handouts
- ID cards
- Medical and Mental Health Interviews
- Housing: Security, Medical and/or MH needs

Mental Health Screening Process

- Suicide Screening Guidelines
- CNYPC Mental Health Screening- Structured Interview
- Mental Health Screening/Admission Form



STATE OF NEW YORK - DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION
RECEPTION / SUICIDE PREVENTION SCREENING GUIDELINES

This form is designed for use at all reception and intake centers. At all reception/intake sites, DOCCS will make inmates available for OMH to conduct a suicide screening on the day of the inmate's arrival. If OMH is not available, DOCCS Health Services staff will be responsible for completing Form 3152RC. In cases where DOCCS Health Services staff completes the suicide screening, OMH is responsible for additionally screening the inmate for suicidal risk within 48 hours of the inmate's arrival. Please note that in cases of a regular (non-emergency) referral to Mental Health, an additional Form #3150, "Mental Health Referral" is not required. The #3152RC non-emergency referral form will function as the mental health form.

Inmate's Name:	Sex:	DOB:	DIN:	Date:	Time:	Current Conviction(s)
Name of Facility:		Name of Screening Person:		Inmate showed serious psychiatric problems during prior incarceration: YES _____ NO _____		
				Prior Mental Health Level: _____		

CHECK APPROPRIATE COLUMN FOR EACH QUESTION.

	Column A YES	Column B NO	General Comments/ Observations
OBSERVATIONS OF TRANSPORTING OFFICER:	***		
1. Transport officer believes that inmate may be a suicide risk. If YES, notify Mental Health and Area Supervisor.			
PERSONAL DATA:			
2. Inmate has experienced a significant loss within the last 6 months (e.g., loss of relationship, death of a close family member).			
3. Inmate held a position of respect in the community (e.g., professional, public official) and/or alleged crime is shocking in nature. If YES, notify Mental Health.	***		
4. Inmate has psychiatric history (received counseling regularly, taking psychotropic medications recently, on a 10-day outcount).			
5. Inmate is thinking about killing himself. If YES, notify Mental Health and Area Supervisor.	***		
6. Inmate has previous suicide attempts (check wrists, neck and head for signs of self-mutilation).			
7. Inmate has recently received distressing news of legal situation.			
8. Inmate feels there is nothing to look forward to in the future. (Expresses feelings of hopelessness).	***		
BEHAVIOR/APPEARANCE:			
9. Inmate show signs of depression (e.g., crying, withdrawn).			
10. Inmate appears overly anxious, afraid or angry.			
11. Inmate's hygiene appears to be deteriorating.			
12. Inmate is acting and/or talking in a strange manner (e.g., cannot focus attention, hearing or seeing things – things which are not there).			
13. Inmate has been giving away property.			
14. a. Inmate is apparently under the influence of alcohol or drugs.			
b. If YES, is inmate incoherent or showing signs of withdrawal or mental illness. If YES to either (a) or (b), notify the Watch Commander/Medical and Mental Health.	***		
CRIMINAL HISTORY:			
15. New to Corrections (first bid and county time).			

Actions:

- If any box marked with *** is checked, make an immediate (emergency) phone referral to Mental Health and notify the Watch Commander.
- If any of the other YES boxes are checked in the Behaviors/Appearances section, make a regular (non-emergency) referral to Mental Health.

Mental Health notified? Yes No

If yes, type of Mental Health Notification? Regular (Non-Emergency) Referral Immediate (Emergency) Phone Referral

If regular referral, how was notification made? Phone In-Writing In-Person

If immediate (emergency) referral name and title of clinician contacted is required:

_____ Name _____ Title

- If for any other reason you feel there is a problem with the inmate, notify Mental Health and call the Watch Commander.

The source of a mental health referral is protected from disclosure under Mental Health Law, Section 33.13 and 33.18, if such disclosure would be detrimental to the referral source, to the patient, or to other persons.

Distribution: White - OMH *If no OMH referral was "required" or the facility does not have OMH staff, white copy to guidance file. Canary - Watch Commander
Pink - Medical

308 MED (MH)6/11

Central New York Psychiatric Center

SCREENING/ADMISSION NOTE
(OUTPATIENT)

Patient's Name:

C# No.:

Date of Birth:

Unit Name:

DIN No.:

Section I : Screening Visit 1

Chief Complaint (Include person(s) providing information):

History of Present Illness:

Mental Status:

Assessment of Suicide Risk: Describe suicide risk warning signs/triggers (IS PATH WARM, Prison Based or Individual) which are present or indicate none are present:

If suicide risk warning signs are present, describe the effect on patient's functioning & plan to address in treatment:

Disposition:

- No Indication for active mental health services
 Active Screen for further assessment
 Admit to mental health services (Complete Section IV)

STAFF SIGNATURE:

TITLE:

DATE:

Section II : Screening Visit 2

Screening Assessment (include reason for assessment/ and updates/changes to mental status):

Assessment of Suicide Risk: Describe suicide risk warning signs/triggers (IS PATH WARM, Prison Based or Individual) which are present or indicate none are present:

If suicide risk warning signs are present, describe the effect on patient's functioning & plan to address in treatment:

Disposition:

- No Indication for active mental health services
 Active Screen for further assessment
 Admit to mental health services (Complete Section IV)

Reception Intake Evaluations

Reception Facility	Structured Interview Only	Full MH Screening- Not Admitted	Full MH Screening- Admitted to Services	Total Intake Screenings
Bedford	705	175	653	1,533
Clinton	321	17	118	456
Downstate	5,202	980	2,975	9,157
Elmira	2,651	606	615	3,872
Ulster	5,005	222	344	5,571
Wende	1,846	391	634	2,871
Total	15,730	2,391	5,339	23,460

Information Available to Reception Staff

- Custodial Transfer Information Sheet
- Health Transfer Information Sheet



STATE OF NEW YORK
DEPARTMENT OF CORRECTIONAL SERVICES

Custodial Transfer Information
{ Pursuant to Section 601A of Correction law }

Sending Facility:		Date: 04 /03 / 2014	
Last Name:		First Name:	MI
Alias, Last Name:		First:	
Date of Birth: Mo. / Day / Year 04/28/1983		DIN:	
In Custody Since: Mo. / Day / Year 01/ 23/ 2014		NYSID	

Known Physical or Mental Problems:		Yes	No (See Medical)
	Immediate Medical Attention Required <i>Refer to medical</i>	NO	Potential Victims
	Medication <i>Refer to medical</i>	YES	Enemies (Location)
NO	Escape / Att. Escape / Hostage Taking	NO	Work Performance
NO	Assaultive Toward Staff / Inmates	NO	Arson (Custody)
NO	Drugs, Weapons, Other Serious Contraband	NO	Restrictions
NO	Self-injury / Self-injury Attempt <i>Refer to medical</i>	NO	Other
NO	Central Monitoring Case		

**Explain any item checked above to assist receiving staff that deal with inmate.
NO PROBLEMS DURING THIS INCARCERATION.**

Adjustment to Confinement:		<input checked="" type="checkbox"/> Good	<input checked="" type="checkbox"/> Fair	<input type="checkbox"/> Poor
Prepared by:		Signature: <i>[Signature]</i>		
Title: Deputy		Tel: (585)753-4139 OR 4137 OR 4140		

Security Review:	
Name:	Signature:
Title:	

HEALTH TRANSFER INFORMATION PURSUANT TO SECTION 601 (a) CORRECTION LAW

NAME: (Last) (First) (MI) 10/30/1983 DOB NYSID/DIN/Class&Movement

Medications: List or attached profiles:

NAME DOSAGE ROUTE FREQUENCY Trazodone 100mg @ tabs Po qhs

MH Medication ?

MEDICAL SECTION COMPLETED BY:

Print Name/Title/Facility/Phone w/extension

1 ext / 04/07/2014 Date

MENTAL HEALTH INFORMATION:

- 1. Is the inmate currently receiving mental health services? [X] No [] Yes. If yes, list diagnoses: Axis I: Axis II: Axis III: Current psychiatric symptoms:
2. Is the inmate on psychiatric medication(s)? [X] No [] Yes. If yes, list medication, dose, frequency, and compliance. If injectable, indicate last date given:
3. Is the inmate currently in specialized housing for inmates with mental health illness? [X] No [] Yes
4. Is the inmate assaultive? [X] No [] Yes. If yes, provide history:
5. Is the inmate currently on a suicide watch? [X] No [] Yes Date
Has the inmate recently been on suicide watch? [X] No [] Yes Date To:
Has the inmate made a suicide attempt during this incarceration? [X] No [] Yes Date
Has the inmate engaged in self-injurious behavior? [X] No [] Yes Date
If "Yes" to any of the above, briefly describe:
6. Has the inmate ever been psychiatrically hospitalized? [X] No [] Yes
7. Any psychiatric hospitalizations during this incarceration? [X] No [] Yes
If "Yes" to either, hospital and date (Attach discharge summary)

Not a patient?

Not on MH meds?

MENTAL HEALTH SECTION COMPLETED BY:

Print Name/Title/Facility/Phone w/extension

ext / 04/07/2014 Date

HEALTH TRANSFER INFORMATION PURSUANT TO SECTION 601 (a) CORRECTION LAW

Name: _____
 (Last) (First) (MI) (DOB) NYSID/DIN/Class & Movement

Medications: List or attached profiles:

NAME	DOSAGE	ROUTE	FREQUENCY
Effexor XR	75mg	PO	QD
Trazodone	100mg	PO	QHS
Remeron	15mg	PO	QHS



MEDICAL SECTION COMPLETED BY: _____

Print Name/Title/Facility/Phone w/extension

_____ 12/21/14
 Date

MENTAL HEALTH INFORMATION:

- Is the inmate currently receiving mental health services? No Yes. If yes, list diagnoses:
 • Axis I: Major Depressive D/O with Anxiety, Alcohol Dependence, by Hx
 • Axis II:
 • Axis III:
 Current psychiatric symptoms: 1/4 followed by mental health dx due to history of chest adjustment related problems, and recent 2/14 hospitalization - 1/4 stable
- Is the inmate on psychiatric medication(s)? No Yes. If yes, list medication, dose, frequency, and compliance.
 If injectable, indicate last date given: 1/4 compliant with medication
- Is the inmate currently in specialized housing for inmates with mental health illness? No Yes
- Is the inmate assaultive? No Yes. If yes, provide history: _____
- Is the inmate currently on a suicide watch? No Yes Date ____/____/____
 Has the inmate recently been on a suicide watch? No Yes Date ____/____/____ To: ____/____/____
 Has the inmate made a suicide attempt during this incarceration? No Yes Date ____/____/____
 Has the inmate engaged in self-injurious behavior? No Yes Date ____/____/____
 If "Yes" to any of the above, briefly describe: _____
- Has the inmate ever been psychiatrically hospitalized? No Yes
- Any psychiatric hospitalizations during this incarceration? No Yes
 If "Yes" to either, hospital and date (Attach discharge summary) 1/4 hospitalized at St Elizabeth's Hospital for 2 weeks in 2013 see attached



MENTAL HEALTH SECTION COMPLETED BY: _____

Print name/title/facility/phone # w/extension

_____ 2/13/14
 Date

Mental Health Extended Orientation- Elmira

For those inmates presenting with increased suicide risk or victimization

- Housed in separate area
- Increased security rounds
- Increased contact with mental health staff
- Not moved to general population until recommended by mental health staff