BJMP
MENTAL HEALTH PROGRAM MANUAL

"Changing Lives, Building a Safer Nation"

2019
MENTAL HEALTH PROGRAM MANUAL

BJMP 2018
MESSAGE

The Bureau's mandate is to provide humane safekeeping and development of Persons Deprived of Liberty (PDL) under its custody. One of the challenges that beset the Health Service Office of the Bureau is how to ensure the physical and mental wellness of its clientele given its limited resources. This manual is timely as it provides a guideline on the prevention, treatment and rehabilitation of illnesses for PDL and personnel who are vulnerable or are suffering from any form of mental illness.

It is with pride that I congratulate the Health Service Office, specifically, the Neuro-Psychiatric Section, in coming up with this manual that will be very helpful in pursuing and achieving my vision for the Bureau. I know that this is not an easy task considering the great number of PDL who succumb to mental health disturbances due to the unfavourable jail conditions brought about by extreme congestion. With these interventions, we hope to minimize the impact of these factors and improve the coping capabilities of these PDL. This will also be very beneficial to our personnel who are likewise exposed to professional and environmental hazards in jails.

I am happy to note that this manual includes all the possible programs/interventions that will ensure that the needs of all levels of mental state are properly addressed. This will in turn concretize the role of all mental health professionals and will allow them to hone their skills further while helping our clients.

Again, congratulations to the dedicated personnel of the Health Service Office for this significant accomplishment. May you all continue to support our mission of improving the lives of the PDL under our care.

DEOCRACIAS C TARAYAN, CEOE
Jail Director
Chief, BJMP

"Changing Lives, Building a Safer Nation"
MESSAGE

Mental health among Persons Deprived of Liberty (PDL) has always been an issue of concern for the Directorate for Inmates Welfare and Development. It is undeniable that the number of PDL with mental problems is increasing due to the present jail conditions that can sometimes be unfavourable for mental and emotional growth. The BJMP is doing its best to provide services within its capacity to address this growing need. The crafting of this manual is timely and is in tune with the changing times where mental health is dealt with openness and empathy rather than with stigma and discrimination.

In this regard, I would like to congratulate the Neuro-Psychiatric Section of the Health Service Office for crafting this comprehensive manual on the BJMP’s Mental Health Program. This will provide all the mental health workers with a guideline in the proper implementation of all existing and new programs related to mental health. It is our goal to provide all PDL and personnel dealing with mental illness an avenue for immediate attention and treatment through proper screening and detection.

Again, congratulations to all who made this project possible. I hope that this program shall benefit all the PDL and BJMP personnel in all levels of intervention.

EDWIN B. RIEL
Jail Chief Superintendent
Director for IWD

U.P. LAW CENTER
OFFICE OF THE NATIONAL ADMINISTRATIVE REGISTER
Administrative Rules and Regulations
MAR 01 2019
"Changing Lives, Building a Safer Nation"
MESSAGE

It has long been the dream of the Health Service Office to expand the services of our mental health professionals. Their skills are invaluable in addressing the needs of the most vulnerable population. It is undeniable that the number of Persons Deprived of Liberty (PDL) with mental illness is increasing. This is brought about by the increase in jail population and other factors that affect the coping mechanisms of PDL while in incarceration. Personnel are not exempted from this phenomenon as they are likewise vulnerable to existing jail conditions.

As the Chief of the Health Service Office, I am very much thankful to the staff of the Neuro-Psychiatric Section for crafting this manual. It helped me understand what our office can offer to improve the lives of the PDL as well as our own personnel. This manual clearly defines the functions of the mental health professionals and outlines the programs and services that are being offered to ensure the mental wellness of our clientele.

This manual is indeed a significant accomplishment as this is the first time that attention is being given on the preservation/maintenance of mental health and treatment and rehabilitation of patients with mental illness.

I hope that this manual will help us realize our mission and goals of providing humane safekeeping and development of PDL and ensure that our personnel are not only physically but mentally fit as well. My sincerest congratulation to the staff of the NP Section for the hard work they put into developing this manual.

ARTHUR C LORENZO, MD
Jail Senior Superintendent
Chief, Health Service Office

"Changing Lives, Building a Safer Nation"
PREFACE

Since the inception of the Bureau of Jail Management and Penology in 1991, the Neuro-Psychiatric Section of the Health Service Office has been providing services to both Persons Deprived of Liberty (PDL) and personnel with regard to mental health. It likewise played a major role in the recruitment and promotion processes to ensure that newly recruited personnel and those for promotion are psychologically suited for the job/rank applied for. Despite the contributions of the mental health professionals through their practice in their own field of specialization, there remains some vagueness as to their real role in the welfare and development of both personnel and PDL. Knowing that the PDL as well as our personnel belong to the vulnerable group most likely to experience mental health problems, the role of our mental health professionals are of utmost importance. With proper intervention, the development of mental illness can be hampered or minimized.

The crafting of this manual was initiated after a series of discussions and consultations with the mental health professionals of the BJMP, specifically J/SINSP JOY T MANZO, NUP Leilani M. Banotan, NUP Voltaire C. Dulfo, NUP Erna C. Compuesto, NUP Mayflor N. Macapugas, NUP Angelica E. Cabaron, and all the regional Psychologists. Without their invaluable inputs, we may not have come up with this comprehensive manual. We likewise appreciate the assistance of SJO3 Virginia T Tornea in finalizing this manual. We would like to extend our greatest appreciation to the CHIEF of the BJMP, JAIL DIRECTOR DEOGRACIAS C TAPAYAN, CESE for his support and encouragement. May we all continue to work together for the good of the bureau.

Irene S. Lim, MD, DPBP
Chief, Neuro-Psychiatric Section
Health Service Office
# TABLE OF CONTENTS

Message of the Chief, BJMP
Message of the Director for IWD
Message of Chief, Health Service Office
Preface
Table of Contents
References
List of Figures
Guide to Abbreviations

**Chapter I**

Introduction
Definition of Terms
Coverage
Objectives
Conceptual Framework

**Chapter II**

Organization and Administration
Creation and Composition
Staffing and Qualifications
BJMP Mental Health Organizational Structure
Duties and Responsibilities

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Prepared By:  
IRENE S. LIM, MD, DPBP  
Psychiatrist

Noted By:  
ARTHUR C LORENZO, MD  
Jail Senior Superintendent  
Chief, Health Service Office

Reviewed By:  
ALLAN S. IRAL, CESE  
Jail Chief Superintendent  
Deputy Chief for Administration  
of the Jail Bureau/  
Quality Management  
Representative

Approved By:  
DEOGRACIAS C. TAPAYAN, CESE  
Jail Director  
Chief, BJMP

"Changing Lives, Building a Safer Nation"
Chapter III

A. Program interventions
   Guiding Principles 32
   Primary Interventions
      For BJMP PDL 34
      For BJMP Personnel/Recruits 37
   Secondary Interventions
      For BJMP PDL 45
      For BJMP Personnel/Recruits 48
   Tertiary Interventions
      For BJMP PDL 54
      For BJMP Personnel 57
   B. Personnel Capability Building 59
   C. Reporting and Documentation 60
   D. Monitoring and Evaluation 60
   E. Separability Clause, Repealing Clause and Effectivity 61

Mental Health Management Procedures
   For BJMP Personnel 62
   For PDL 65
   BJMP Mental Health Program Reportorial System 68
   BJMP Mental Health Program Reportorial System Diagram 69

Prepared By:
IRENE S. LIM, MD, DPBP
Psychiatrist

Noted By:
ARTHUR C LORENZO, MD
Jail Senior Superintendent
Chief, Health Service Office

Reviewed By:
ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration
of the Jail Bureau/
Quality Management
Representative

Approved By:
DEOGRACIAS C. TAPAYAN, CESE
Jail Director
Chief, BJMP

"Changing Lives, Building a Safer Nation"
# MENTAL HEALTH PROGRAM MANUAL

## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter IV</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling</td>
<td>70</td>
</tr>
<tr>
<td>Phases of Counselling</td>
<td>70</td>
</tr>
<tr>
<td>Attributes of an Effective Counsellor</td>
<td>75</td>
</tr>
<tr>
<td>Basic Counselling Techniques/Skills</td>
<td>77</td>
</tr>
<tr>
<td>What to Do during Counselling</td>
<td>83</td>
</tr>
<tr>
<td>What Not To Do</td>
<td>83</td>
</tr>
<tr>
<td>Red Flag Signs</td>
<td>84</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter V</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health and Psychosocial Support</td>
<td>87</td>
</tr>
<tr>
<td>Phases of MHPSS</td>
<td>87</td>
</tr>
<tr>
<td>Guidelines on the Role/Responsibilities of the MHPSS Facilitators</td>
<td>95</td>
</tr>
<tr>
<td>Pitfalls to avoid in the conduct of MHPSS</td>
<td>98</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter VI</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Psychosocial Therapies</td>
<td>101</td>
</tr>
</tbody>
</table>

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Prepared By: IRENE S. LIM, MD, DPBP Psychiatrist
Noted By: ARTHUR C LORENZO, MD Jail Senior Superintendent Chief, Health Service Office
Reviewed By: ALLAN S IRAL, CESE Jail Chief Superintendent Deputy Chief for Administration of the Jail Bureau/Quality Management Representative
Approved By: DEOGRACIAS C TARAYAN, CESE Jail Director Chief, BJMP

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A. Policy Guidelines in the Selection, Training and Deployment of BJMP Health Personnel in the Conduct of Mental Health and Psychosocial Support (MHPSS) dated October 27, 2015

B. BJMP Revised Policy on Mandatory Reporting of Torture Cases dated August 17, 2015

C. BJMP NHQ SOP Number 2014-04 Re: Comprehensive Rehabilitation for Torture Victims and their Families and those who committed Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment

D. Memorandum dated July 22, 2014 Re: Amended Guidelines on Medical, Neuro-Psychological/ Psychiatric and Dental Evaluation

E. Memorandum dated May 28, 2014 Re: Amended Policy Guidelines on Drug and Alcohol Rehabilitation

F. Memorandum Circular Number 2014-001 dated March 3, 2014 Re: Guidelines on Adopting and Implementing the “Belly Gud For Health- Keeping Fit, Moving Forward, the BJMP Way”

G. Memorandum Circular Number 2013-001 dated January 24, 2013 Re: Revised Rules and Procedures in Recruitment, Screening and Selection of Applicants for Appointment to Jail Officer 1 (JO1)
Figure 1  Conceptual Framework

Figure 2  BJMP Mental Health Program Structure

Figure 3  Mental Health Program Procedure for BJMP Personnel

Figure 4  Mental Health Program Procedure for PDL

Figure 5  BJMP Mental Health Program Reportorial Diagram
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BJMP</td>
<td>Bureau of Jail Management and Penology</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
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<tr>
<td>HSO</td>
<td>Health Service Office</td>
</tr>
<tr>
<td>IWD</td>
<td>Inmates Welfare and Development</td>
</tr>
<tr>
<td>LGUs</td>
<td>Local Government Units</td>
</tr>
<tr>
<td>MHP</td>
<td>Mental Health Program</td>
</tr>
<tr>
<td>MHPSS</td>
<td>Mental Health and Psychosocial Support</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non-Government Organizations</td>
</tr>
<tr>
<td>NHQ</td>
<td>National Headquarters</td>
</tr>
<tr>
<td>PDL</td>
<td>Person Deprived of Liberty</td>
</tr>
<tr>
<td>PeSSP</td>
<td>Peer Support Strengthening Program</td>
</tr>
<tr>
<td>PI&amp;E</td>
<td>Personnel Information and Education</td>
</tr>
<tr>
<td>PNPA</td>
<td>Philippine National Police Academy</td>
</tr>
<tr>
<td>STAR Team</td>
<td>Special Tactics and Response Team</td>
</tr>
<tr>
<td>TCMP</td>
<td>Therapeutic Community Modality Program</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>KKDKK</td>
<td>Katatagan Kontra Droga sa Komunidad</td>
</tr>
</tbody>
</table>

Prepared By: IRENE S. LIM, MD, DPBP Psychiatrist  
Reviewed By: ALLAN S IRAL, CESE  
Approved By: DEOGRAÇIAS C TAPAYAN, CESE  
Noted By: ARTHUR C LORENZO, MD Jail Senior Superintendent  
Jail Director  
Chief, Health Service Office Quality Management Representative

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The Bureau of Jail Management and Penology (BJMP) is a dynamic institution whose mission is to provide humane safekeeping and development of PDL in all district, city and municipal jails nationwide. One of the development programs provided to its clientele is focused on the maintenance of sound mental health and prevention or reduction of emotional and psychological disturbances while incarcerated. The prevailing jail environment, coupled with personal issues, greatly affects the mental health of most PDL. At present, the rate of PDL suffering from acute and chronic mental illness is increasing. This reality needs to be addressed to prevent the continuous rise of affected individuals. The jail should be preventive and rehabilitative rather than a breeding place for the development of mental health problems. A good jail management and provision of relevant programs have a significant bearing on the behaviour of PDL upon release from jail.

The jail personnel, on the other hand, are considered caregivers, hence are not exempted from developing mental health issues. The British Psychological Society in 2015 made a conclusion that “people working in prisons and in secure hospitals in the UK are at considerable risk of work-related stress, exhaustion and depression.”

Prepared By:
IRENE S. LIM, MD, DPBP Psychiatrist

Reviewed By:
ALLAN S IRAL, CESE Jail Chief Superintendent Deputy Chief for Administration of the Jail Bureau/ Quality Management Representative

Approved By:
DEOCRACAS C. TAPAYAN, CESE Jail Director Chief, BJMP

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A study on the prevalence of mental health problems among government employees (DOH-NEC 2001) disclosed that “32% of 327 government employees from 20 government agencies in Metro Manila had experienced mental health problems at least once in their lifetime.” Jail personnel are prone to develop mental health problems due to their close and regular contact with PDL who suffer from various physical, psychological and financial issues coupled with the unpredictability of their behaviour that pose a constant threat to the security of personnel. Adding to these are the aggravating medical, personal and economic issues of the personnel plus other factors in the jail environment. The jail personnel are prone to develop compassion fatigue and burn-out which may lead to adverse health manifestations and eventually to economic consequences if not properly addressed. According to Stele and Risdon (1997), “job stress has been linked to decreased job satisfaction and absenteeism among correctional officers.” In 1998, the World Health Organization (WHO), came up with a report on mental health promotion in Prisons that states that “Mental Health promotion can result in better emotional and physical health, control and correct offending behaviour, reduce the incidence of mental health disorders apart from reducing the severity of the disorder and be an amenable place for rehabilitation and can result in enhanced confidence and social skills.”
The crafting of this manual is timely as PRESIDENT RODRIGO ROA DUTERTE recently signed into a law, Republic Act No. 11036, otherwise known as the "Mental Health Act." The Act enhances the delivery of integrated health services, and the promotion and protection of the rights of persons utilizing psychiatric, neurologic and psychological health services, by appropriating funds therefor. Based on the new law, the State will commit to promote the well-being of people by ensuring that mental health is valued, promoted, and protected; and that mental health conditions are treated and prevented. It also seeks to integrate mental health promotion in educational institution and the workplace to address the stigma and discrimination usually associated with mental health.

At present, the BJMP has established a Psychological Service that caters to both PDL and personnel. However, due to the absence of an institutionalized guideline on the exact services and responsibilities of the concerned personnel, the Service functions on a limited basis. To address the growing psychological/emotional needs of PDL and personnel, a comprehensive Mental Health Program is therefore imperative.
After Care - care, treatment or help given to persons discharged from an institution such as jail, prison or hospital.

Bureau of Jail Management and Penology (BJMP) - is a line agency under the Department of the Interior and Local Government mandated to provide humane safekeeping and development of PDL in all district, city and municipal jails.

Counselling - is the means by which one person helps another through purposeful conversation wherein practical solutions are established to address identified problems.

Critical Incident - is any sudden event or situation, be it natural or man-made, that involves actual, threatened, witnessed or perceived death, serious injury or threat to the physical or psychological integrity of an individual or group.

Development programs - are programs or activities designed specifically for BJMP PDL that address their physical, mental, psychological, behavioural and vocational needs to prepare them for their eventual reintegration into society.
Health Services - include activities and interventions towards the promotion of health, prevention and treatment and rehabilitation of medical and mental health illnesses among clients.

Person Deprived of Liberty - generic term used to refer to a detainee or prisoner.

Mediation - is a settlement of dispute or controversy by setting up an independent person between two contending parties in order to aid them in the settlement of their disagreement.

Mental Health - as defined by the World Health Organization (WHO), is a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make contribution to his or her community.

Mental Health and Psychosocial Support (MHPSS) - is an intervention provided to individuals or groups that had been victims or witnesses to a critical incident for them to gain practical and coping skills and minimize the psychological impact of the trauma.
Pharmacotherapy - is a mode of intervention with the use of chemical drugs/ medicines to attain cure or treatment of an illness.

Primary Intervention - is the first line of intervention focused on the early detection and prevention of illnesses and promotion of wellbeing.

Psychosocial - relates to one’s psychological development or mental health and interaction with the social environment.

Rehabilitation - a process of returning to a good or healthy condition, state or way of living.

Rights-based Jail Management - is the type of management in the jail system anchored on the respect and upholding of the human rights of all PDL under the custody of the BJMP.

Reintegration - the process of transitioning from a state in which an individual was not a functioning member of society into a state where the individual controls and directs his/her own life.
Secondary Intervention - is a level of intervention focused on the diagnosis and treatment of illnesses.

Social Case Study - is a detailed analysis of a person, group, event or community.

Tertiary Intervention - is a level of intervention focused on the rehabilitation and prevention of complications in individuals suffering from illnesses.

Therapeutic Community Modality Program (TCMP) - is a self-help learning modality that uses the community as a vehicle that fosters behavioural change in individuals.

Torture - is an act by which severe pain or suffering, whether physical or mental is intentionally inflicted on a person for such purposes as obtaining from him/her or a third person information or a confession; punishing him/her for an act he/she or a third person has committed or suspected of having committed; or intimidating or coercing him/her or a third person; or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a person in authority or agent of a person in authority.

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Wellness - is a way of life oriented towards optimal health and wellbeing, in which both body, mind and spirit are all integrated by the individual to live life more fully within the human and natural community.
COVERAGE

The BJMP Mental Health Program and other guidelines enumerated in this manual shall be strictly implemented and shall cover the following:

a. PDL committed to all district, city, municipal and special jails nationwide; and

b. All BJMP personnel, Lateral Entry candidates and recruits nationwide

OBJECTIVES

This manual aims to:

a. Present the rationale, conceptual framework and organizational structure of the BJMP Mental Health Program;

b. Provide comprehensive program guidelines in the implementation of the Mental Health Program for PDL and personnel;

c. Assist the mental health teams in facilitating the various mental health program interventions/services; and

d. Provide coordination and reporting mechanisms among the mental health teams at the jail units, regional offices and National Health Service Office.
Both BJMP personnel and PDL are the target beneficiaries of the Mental Health Program of the Bureau. The program is anchored on a holistic approach to provide preventive, curative and rehabilitative mental health interventions in progressive levels.

The primary level focuses on prevention of mental illnesses and promotion of wellness. The secondary level deals with diagnosis and treatment. The tertiary level emphasizes on rehabilitation of mental health illness and prevention of complications. As the level goes up, the number of personnel and PDL catered decreases. This is because the program puts premium on activities to increase level of awareness regarding mental health as the most effective measure of preventing people from succumbing to mental health problems considering the nature of work of personnel and environment of jails. This framework is depicted in Figure 1.

Prepared By:
IRENE S. LIM, MD, DPBP
Psychiatrist

Noted By:
ARTHUR C LORENZO, MD
Jail Senior Superintendent
Chief, Health Service Office

Reviewed By:
ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration
of the Jail Bureau/
Quality Management
Representative

Approved By:
DEOGRAÇIAS C TAPAYAN, CESE
Jail Director
Chief, BJMP

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Figure 1. Conceptual Framework of BJMP Mental Health Program

Prepared By:
IRENE S. LIM, MD, DPBP
Psychiatrist

Reviewed By:
ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration
of the Jail Bureau
Quality Management Representative

Approved By:
DEOGRACIAS C. TAPAYAN, CESE
Jail Director
Chief, BJMP

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Structure/Setting
a. All procedures within the Mental Health Program that pertain to PDL shall be carried out inside the jail facility.
b. All assessments, therapies and counselling for PDL shall be done in a room inside the facility that provides utmost privacy.
c. Assessment or therapeutic procedures for personnel and recruits shall be done at the Health Service Office of the National Headquarters, Regional Offices or jail unit where the specific personnel is assigned.
d. All documents pertaining to mental health shall be handled with utmost confidentiality.

Composition
The BJMP shall organize a Mental Health Team which shall be responsible in the development, planning, implementation, monitoring and evaluation of the Mental Health Program of the Bureau. The following offices shall compose the Mental Health Team:

1. Office of the Program Director – it shall be in charge of the overall supervision and control of all the activities of the Mental Health Team and has authority to review, approve or disapprove recommendations related to the BJMP Mental Health Program.

2. Office of the Deputy Program Director- it shall assist in the conduct and implementation of all programs and services approved by the Program Director.

3. National MHP Neuro-psychiatric Unit - shall be composed of a psychiatrist and shall be in charge of the assessment, evaluation and treatment of PDL, personnel and recruits related to mental health. It shall have direct supervision over the regional mental health team.

Prepared By:
IRENE S. LIM, MD, DPBP
Psychiatrist

Reviewed By:
ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration of the Jail Bureau/
Quality Management Representative

Approved By:
DEGRACIAS C. TAPAYAN, CESE
Jail Director
Chief, BJMP

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Prepared By: IRENE S. LIM, MD, DPBP Psychiatrist
Reviewed By: ALLAN S IRAL, CESE Jail Chief Superintendent
Approved By: DEGRACIAS C. TAPAYAN, CESE Jail Director

Noted By: ARTHUR C LORENZO, MD Jail Senior Superintendent Chief, Health Service Office
Department Chief for Administration of the Jail Bureau/ Quality Management Representative

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4. National MHP Medical Section - shall be composed of medical doctors assigned in the National Headquarters and shall be in charge of the assessment and treatment of PDL and personnel with medical problems. It shall have direct supervision over the regional physicians.

5. National MHP Psychological Section – shall be composed of psychologists/psychometricians who shall be in charge of administering psychological examinations and evaluation and providing psychosocial interventions to PDL and personnel. It shall have direct supervision over the regional psychologists.

6. National MHP Psychiatric Nursing Section – shall be composed of nurses assigned in the NHQ who shall be in charge of the assessment, early detection, management and referral of psychiatric cases among PDL and personnel. It shall have direct supervision over the regional and jail nurses.

7. National MHP Psychiatric Social Work Section – shall be composed of social workers assigned at the NHQ who shall conduct social case studies and psychosocial interventions to PDL and personnel. It shall have direct supervision over regional social workers.

8. National MHP Secretariat – shall be composed of the NHQ personnel who will document all activities of the Mental Health Team, scheduled meetings and deployments during critical incidents, consolidates and submits required reports to the Program Director.

9. Regional NP and Medical Unit – shall be composed of the regional psychiatrist who shall respond to referrals from the jail unit. It shall be responsible for psychiatric and

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Prepared By: [Signature]
IRENE S. LIM, MD, DPBP
Psychiatrist

Reviewed By: [Signature]
ALLAN S. IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration
of the Jail Bureau/Quality Management Representative

Approved By: [Signature]
DEOGRAFRIAS O. TAPAYAN, CESE
Jail Director
Chief, BJMP

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medical evaluation and treatment to both personnel and PDL. It shall report directly to the National MHP Psychiatric/Medical section.

10. **Regional Psychological Unit** – shall be composed of regional psychologists who shall be responsible for psychological evaluation and interventions to both personnel and PDL. It shall report directly to the National MHP Psychological Section.

11. **Regional Psychiatric Nursing Unit** – shall be composed of regional nurses who shall respond to referrals from the jail units and augment in the psychiatric nursing evaluation of PDL. It shall report directly to the National MHP Psychiatric Nursing Section.

12. **Regional Social Work Unit** – shall be composed of regional social workers who shall assist the NHQ social workers in the conduct of social case studies and psychosocial interventions to personnel and PDL. It shall report directly to the National MHP Social Work Section.

13. **Regional MHP Secretariat** – shall be composed of regional personnel who shall monitor and document all activities of the mental health team in the regional level. It shall submit required reports to the National MHP Secretariat.

14. **Jail Psychiatric Nursing Unit** – shall be composed of jail nurses who will be the first responders to referrals on PDL with psychiatric signs and symptoms.

---

**Prepared By:**

IRENE S. LIM, MD, DPBP Psychiatrist

**Noted By:**

ARTHUR C. LORENZO, MD Jail Senior Superintendent Chief, Health Service Office

**Reviewed By:**

ALLAN S. IRAL, CESE Jail Chief Superintendent Deputy Chief for Administration of the Jail Bureau/Quality Management Representative

**Approved By:**

DEOGRACIAS C. TARAYAN, CESE Jail Director Chief, BJMP

"Changing Lives, Building a Safer Nation"
1. **Program Director**
   a. Must be a registered medical doctor in the Philippines
   b. Must have the rank of at least Superintendent
   c. Must have at least two (2) years of supervisory assignment in the BJMP
   d. Must have at least two (2) years of experience as a medical professional

2. **Deputy Program Director**
   a. Must be a registered medical doctor in the Philippines
   b. Must have the rank of at least Chief Inspector
   c. Must have at least two (2) years of supervising assignment in the BJMP
   d. Must have at least two (2) years of experience as a medical professional

3. **Chief, Neuro-psychiatric Unit**
   a. Must be a registered medical doctor in the Philippines
   b. Must have satisfactorily completed four (4) years of residency training in psychiatry in an accredited teaching institution
   c. Must have the rank of at least Senior Inspector and its non-uniformed equivalent
   d. Must have at least two (2) years of supervisory assignment in the BJMP

---

**Prepared By:**
IRENE S. LIM, MD, DPBP  
Psychiatrist

**Reviewed By:**
ALLAN S IRAL, CESE  
Jail Chief Superintendent  
Deputy Chief for Administration of the Jail Bureau/ Quality Management Representative

**Approved By:**
DEOGRACIAS C TARAYAN, CESE  
Jail Director  
Chief, BJMP

---

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II. STAFFING AND QUALIFICATIONS

e. Must have at least two (2) years of experience as a Jail Psychiatrist or a diplomate of the Philippine Board of Psychiatry

4. Chief, Medical Unit
    a. Must be a registered medical doctor in the Philippines
    b. Must have the rank of at least Senior Inspector or its non-uniformed equivalent
    c. Must have at least two (2) years of supervisory assignment in the BJMP
    d. Must have at least two (2) years of experience as a medical professional

5. Chief Psychologist
    a. Must be a registered psychologist in the Philippines
    b. Must have the rank of at least Inspector or its non-uniformed equivalent
    c. Must have undergone the required training in psychological assessment and psychosocial intervention in an accredited teaching institution
    d. Must have at least two (2) years of supervisory assignment in the BJMP
    e. Must have at least two (2) years of experience as a psychologist in the BJMP

6. Chief Psychiatric Nurse
    a. Must be a registered nurse in the Philippines

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b. Must have the rank of at least Inspector or its non-uniformed equivalent

c. Must have undergone the required training in Psychiatric Nursing in an accredited teaching institution

d. Must have at least two (2) years of experience as a jail nurse

7. Chief Social Worker

a. Must be a registered social worker in the Philippines

b. Must have the rank of at least Inspector or its non-uniformed equivalent

c. Must have undergone the required training in Mental Health and Psychosocial Support in an accredited institution

d. Must have at least two (2) years of experience as a social worker in the BJMP

8. Regional Psychologist

a. Must be a registered psychologist or psychometrician in the Philippines

b. Must have the rank of at least Jail Officer 1 or its non-uniformed equivalent

c. Must have undergone the required training on psychological assessment and psychosocial intervention in an accredited learning institution

d. Must have at least two (2) years of experience as a Jail Psychologist

Prepared By: IRENE S. LIM, MD, DPBP Psychiatrist

Reviewed By: ALLAN S IRAL, CESE Jail Chief Superintendent
Deputy Chief for Administration of the Jail Bureau/ Quality Management Representative

Approved By: DEOGRAFIAS C. APAYAN, CESE Jail Director Chief, BJMP

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9. Regional Social Worker
   a. Must be a registered social worker in the Philippines
   b. Must have the rank of at least Jail Officer 1 or its non-uniformed equivalent
   c. Must have at least two (2) years of experience as a social worker in corrections or in other settings
   d. Must have adequate knowledge and training in case management and psychosocial interventions

10. Regional Psychiatric Nurse/Jail Unit Psychiatric Nurse
    a. Must be a registered nurse in the Philippines
    b. Must have the rank of at least Jail Officer 1 or its non-uniformed equivalent
    c. Must have the required training as a psychiatric nurse in an accredited training institution
    d. Must have at least two (2) years of experience as a Jail Nurse

11. Team Secretariat
    a. Must be a graduate of any bachelor's course in the Philippines
    b. Must have the rank of at least Jail Officer 1 or its non-uniformed equivalent
    c. Must have at least two (2) years of experience as a jail personnel

Prepared By: IRENE S. LIM, MD, DPBP Psychiatrist
Noted By: ARTHUR C LORENZO, MD Jail Senior Superintendent Chief, Health Service Office
Reviewed By: ALLAN S IRAL, CESE Jail Chief Superintendent Deputy Chief for Administration of the Jail Bureau/ Quality Management Representative
Approved By: DEOGRACIAS C RAPAYAN, CESE Jail Director Chief, BJMP

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Figure 2. BJMP Mental Health Program Organizational Structure

Prepared By: IRENE S. LIM, MD, DPBP Psychiatrist

Reviewed By: ALLAN S. IRAL, CESE Jail Chief Superintendent
Deputy Chief for Administration
of the Jail Bureau
Quality Management Representative

Approved By: DEOCRACIAS C. TARAYAN, CESE
Jail Director
Chief, BJMP

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1. Program Director is the Chief, Health Service Office
   a. Supervise all activities of the BJMP Mental Health Program (MHP);
   b. Spearhead the process of developing, planning and implementation of the different mental health programs;
   c. Ensure the proper implementation of the MHP;
   d. Report to the Chief of the BJMP all the undertakings of the MHP; and
   e. Review and approve all activities related to MHP.

2. Deputy Program Director is the Chief, Neuro-Psychiatric Unit/ Psychiatrist
   a. Assist the Program Director in all his/her undertakings;
   b. Supervise the conduct of Neuro-psychiatric screening for BJMP applicants and personnel for promotion;
   c. Conduct psychiatric interview to applicants and personnel for promotion;
   d. Conduct psychiatric evaluation and treatment to referred psychiatric patients in jail;
   e. Conduct psychiatric evaluation and treatment to personnel;
   f. Appear in Court as needed in relation to psychiatric assessments of PDL;

Prepared By: IRENE S. LIM, MD, DPBP Psychiatrist
Noted By: ARTHUR C LORENZO, MD Jail Senior Superintendent Chief, Health Service Office
Reviewed By: ALLAN S IRAL, CESE Jail Chief Superintendent Deputy Chief for Administration of the Jail Bureau Quality Management Representative
Approved By: DEOGRA CI TAPAYAN, CESE Jail Director Chief, BJMP

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g. Provide counselling and health education to PDL and personnel on mental health; and
h. Create and supervise training programs for continuing education and updates about mental health for jail practitioners.

3. Medical Officer

a. Supervise the conduct of physical activities of personnel in relation to the “Belly Gud” program of the Bureau;
b. Recommend health-related programs to the Program Director;
c. Conduct physical examination to personnel for promotion, Lateral Entry candidates and BJMP recruits;
d. Evaluate laboratory results of personnel for promotion, Lateral Entry candidates and BJMP recruits;
e. Conduct wellness examination and health education to both personnel and PDL; and
f. Provide treatment and rehabilitation services to both PDL and personnel.
4. Chief Psychologist

   a. Supervise all the activities of all the BJMP Psychologists;
   b. Conduct psychological evaluation on PDL, personnel and applicants/recruits;
   c. Conduct health education and information drive on the Mental Health Program of the bureau;
   d. Conduct psychosocial interventions to PDL and personnel;
   e. Receive, consolidate and submit required reports to the Chief, HSO; and
   f. Design and supervise training programs for continuing education of BJMP psychologists.

5. Chief Psychiatric Nurse

   a. Supervise the activities of the jail psychiatric nurses and monitor the status of psychiatric patients in jails;
   b. Receive reports from jails, consolidate and submit requires reports to the Chief, HSO;
   c. Conduct health education and information drive on the BJMP Mental Health Program to personnel and PDL;

Prepared By: 
IRENE S. LIM, MD, DPBP
Psychiatrist
Noted By: 
ARTHUR C LORENZO, MD
Jail Senior Superintendent
Chief, Health Service Office

Reviewed By: 
ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration
of the Jail Bureau
Quality Management
Representative

Approved By: 
DEOGRACIAS C. TAPAYAN, CESE
Jail Director
Chief, BJMP

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d. Respond to psychiatric referrals from jails;

e. Conduct psychosocial interventions when needed; and

f. Create and implement training programs or continuing education about mental health for jail health practitioners.

6. Chief Social Worker

a. Supervise all activities of the regional social workers;

b. Establish linkages with LGUs, NGOs and other community groups regarding social support and aftercare services for PDL;

c. Conduct psychosocial intervention to PDL and personnel; and

d. Assist in the conduct of psychosocial preparation for PDL prior to release.

7. Regional Psychologist

a. Conduct psychological assessment to PDL, personnel and BJMP applicants/recruits;

b. Conduct regular jail visitations and evaluates referred PDL and personnel in need of psychological intervention;

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c. Closely coordinate and collaborate with jail Psychiatrists on the psychological assessment and treatment of PDL and personnel;
d. Provide counselling to PDL and personnel;
e. Prepare and submit psychological reports of PDL for court ordered evaluation; and
f. Conduct MHPSS for personnel, PDL and people in the community as the need arises.

8. Regional Social Worker

a. Conduct Social Case Study on PDL and personnel based on referrals;
b. Coordinate with LGUs, NGOs and similar agencies for after care interventions;
c. Assist in coordinating with the families of PDL in relation with the psychosocial intervention;
d. Provide Psychosocial interventions on PDL and personnel;
e. Provide case management services to PDL in coordination with IWD units of local jails; and
f. Conduct MHPSS for personnel, PDL and people in the community as the need arises.
9. Jail Unit Psychiatric Nurse
   a. Attend to the medical needs and administers psychiatric medications to PDL with mental illness;
   b. Coordinate and refers psychiatric patients to the jail Psychiatrist and other government psychiatric institutions and upon order by the court to other government psychiatric institutions;
   c. Provide counselling to PDL and personnel;
   d. Provide training for jail personnel on the proper handling and treatment of PDL with psychiatric problems;
   e. Coordinate with IWD personnel/ social worker and other personnel with reference with issues related to health;
   f. Supervise and monitor the performance of jail health practitioners in handling PDL with mental health issues.

10. Program Secretariat
   a. Send communications to all different members of the program structure;
   b. Coordinate with all the members of the Mental Health Team to ensure a smooth flow of activities; and
   c. Consolidate and submit required reports to the Program Director.

Prepared By:  
IRENE S. LIM, MD, DPBP Psychiatrist  
Noted By:  
ARTHUR C LORENZO, MD Jail Senior Superintendent Chief, Health Service Office

Reviewed By:  
ALLAN S IRAL, CESE Jail Chief Superintendent Deputy Chief for Administration of the Jail Bureau Quality Management Representative

Approved By:  
DEOGRAZIAS C TARAYAN, CESE Jail Director Chief, BJMP

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A. Rights-based Jail Management

The Bureau shall ensure that PDL be treated humanely and with respect for their inherent dignity as human beings. It shall ensure that the treatment programs provided shall comply with human rights obligations, be voluntary and provide the highest attainable standards of health and wellbeing. It shall likewise ensure that no PDL will be subjected to discrimination, torture, degrading and other forms of ill-treatment while in jail. They shall be provided with the opportunity to report any actual or imminent threat to their lives and rights while in jail without fear of reprisal.

B. Availability and Accessibility of Mental Health Services

Mental health services shall be available to all jails where there are mental health professionals. All PDL shall have easy access to mental health services such as counselling and consultation regardless of age, gender, race, etc. Through health education, PDL shall be informed of the mental health services available, develop insights on their own mental state and when to seek help when necessary.

Prepared By: IRENE S. LIM, MD, DPBP Psychiatrist
Noted By: ARTHUR C LORENZO, MD Jail Senior Superintendent

Reviewed By: ALLAN S IRAL, CESE Jail Chief Superintendent
Deputy Chief for Administration of the Jail Bureau
Quality Management Representative

Approved By: DEOGRACIAS C TAPAYAN, CESE Jail Director
Chief, BJMP

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C. Confidentiality

The BJMP shall ensure that all documents and records pertaining to the conduct and implementation of the Mental Health Program of the Bureau shall be handled with utmost confidentiality. The records shall form part of the PDL Health Record and shall be kept in a safe place in the Health Service Unit of the jail. Only members of the Mental Health Team can have access to such pertinent documents.
INTERVENTIONS

A. PRIMARY INTERVENTIONS

This level of intervention refers to the promotion of mental health and prevention of the occurrence of mental health problems for jail personnel and PDL.

1. For Persons Deprived of Liberty (PDL)

1.1 Admission and Screening

Upon admission, all PDL shall undergo initial psychological evaluation by the Jail Physician, Nurse or Psychologist to determine the presence or detect early signs of mental disturbance. The primary goal of screening is to detect emergent and urgent problems and determine which PDL might require more extensive assessment and intervention before placement into the general population. This will also serve as a benchmark in designing the appropriate classification, treatment and development plan that will address the specific needs of each individual PDL. Early identification of mental problems leads to better treatment outcomes and prevent further complications.
1.2 Physical Wellness

Persons deprived of Liberty (PDL) with physical/medical conditions are prone to develop mental problems if left untreated. A prelude to a “sound mind” is a “sound body”, hence focus shall be given to the provision of services that promote physical wellness. There is evidence that mental and physical illness may accompany, follow or precede one another as well as evidence indicating that mental disorders increase the risk of physical illness and vice versa. Activities such as regular physical exercises, sunning, music/dance and cultural events and similar activities shall be conducted on a regular basis. The PDL shall likewise be subjected to regular medical wellness assessment to ensure health maintenance.

1.3 Health and Anti-Drug Abuse Education

Any member of the Mental Health Team shall conduct health education/seminars to all PDL on mental health issues and how to develop better coping skills to prevent the occurrence of mental and emotional problems while incarcerated. Seminars may include Stress Management, Anger Management, Coping Mechanisms, Drug Abuse and other mental health-related topics. Since majority of the PDL are accused of drug-related cases, emphasis should be given to the ill effects of drug abuse and the ways on how to avoid using it.
### 1.4 Mental Health and Psychosocial Support (MHPSS)

This intervention is provided to individuals or groups who experience recent critical incidents in their lives. Critical incident refers to an actual or perceived event or situation that creates a significant risk or substantial or serious harm to the physical or mental health, safety or wellbeing of an individual. These extreme life experiences are traumatic enough to evoke reactions of intense fear or helplessness. Such event may temporarily overwhelm the normal capacity of a person to cope and function. If not addressed and attended to, it may cause irreparable damage to the mental and psychological make-up of the victim or participant. This service shall be provided by aptly trained members of the mental health team to lessen the impact of the critical incident in the individual’s life. The Mental Health and Psychosocial Support team of the Bureau shall always be ready to be deployed to jails to provide the intervention to a PDL or group of PDL who are victims or witnesses of recent critical events. *(Refer to Policy Guidelines in the Selection, Training and Deployment of BJMP Health Personnel in the Conduct of Mental Health and Psychosocial Support (MHPSS) dated October 27, 2015)*

### 1.5 Pre-release Psychosocial Preparation

This intervention shall be specific for PDL who are due for release from jails. This is to provide them with adequate understanding and insight for them to develop better coping skills.

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<td>IRENE S. LIM, MD, DPBP Psychiatrist</td>
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<td>DEODORACION S. TAPAYAN, CESE Jail Director</td>
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<td>Noted By:</td>
<td>Jail Chief for Administration of the Jail Bureau/Quality Management Representative</td>
<td>Chief, BJMP</td>
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after release and integration with the community. The Social Worker of the team shall coordinate with the local government units, government organizations and other community groups with regards to the aftercare services for the soon to be released PDL in areas where such services are available.

2. For Personnel and JO1 Recruits

2.1 Neuro-psychiatric (NP) Assessment in the Recruitment Process

All BJMP applicants shall undergo the Neuro-psychiatric Screening to determine their mental and psychological status prior to their employment. The process has two compositions, namely; the psychological examination where the applicants shall undergo a written examination. They will then be subjected to a face to face interview with the Psychologist. The result of the psychological examination shall be forwarded to the Psychiatrist for review. The applicants shall then be scheduled for a face to face interview with the Psychiatrist who will determine whether the applicant will be recommended or not to proceed to the next step. The purpose of the process is to ensure that the new recruits of the BJMP are free from any form of acute or chronic mental disorders at the time of examination. Another purpose is to determine whether the applicant’s mental and psychological state is fit for the position he/she is applying for. Applicants who are not recommended or who are not

Prepared By: 
IRENE S. LIM, MD, DPBP Psychiatrist

Reviewed By: 
ALLAN S. IRAL, CESE 
Jail Chief Superintendent 
Deputy Chief for Administration of the Jail Bureau/ 
Quality Management Representative

Approved By: 
DEOGRAFIAS C. TAPAYAN, CESE 
Jail Director 
Chief, BJMP

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granted clearance to proceed after the NP examination shall not be allowed to retake the examination until the period of six (6) months from the last examination has elapsed. The applicant with gross signs and symptoms of a psychiatric disorder at the time of examination and/or is found positive on drug screening tests, i.e. methamphetamine or tetrahydrocannabinol, will be endorsed as “UNFIT” for the position of a uniformed personnel, hence shall never be allowed to undergo subsequent neuro-psychiatric evaluation for employment purposes. (Refer to the Memorandum Circular Number 2013-001 dated January 24, 2013 Re: Revised Rules and Procedures in Recruitment, Screening and Selection of Applicants for Appointment to Jail Officer 1 (JO1)

2.2 Neuro-psychiatric (NP) Assessment for Lateral Entry

a. Inspector Rank – from civilian status and graduates from the Philippine National Police Academy

b. Senior Inspector Rank – from civilian status specifically for medical doctors, lawyers and chaplains/imams

The examination has two compositions, namely; the psychological examination where the applicant shall undergo a battery of psychological tests consisting of objective and projective tests. The result of the written examination shall be forwarded to the Psychiatrist for clinical correlation and determination of the presence of clinical disorder or mental health

Prepared By: IRENE S. LIM, MD, DPBP Psychiatrist
Reviewed By: ALLAN S IRAL, CESE Jail Chief Superintendent Deputy Chief for Administration of the Jail Bureau/ Quality Management Representative
Approved By: DEOGRCIAS C. TAPAYAN, CESE Jail Director, Chief, BJMP

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disturbances. The Psychiatrist shall likewise determine if the applicant is fit for the position he/she is applying for.

This process will evaluate the applicant as to his/her psychological state, coping skills, cognitive and leadership ability, emotional stability and adaptability.

2.3 Neuro-psychiatric (NP) Assessment for Promotion

All BJMP personnel for promotion shall undergo Neuro-psychiatric (NP) Assessment prior to appointment to the next rank. The objective of this process is to determine if the candidate for promotion is suffering from any form of mental disorder at the time of examination or whether he/she is fit for the position he/she is applying for. This will likewise screen personnel who are in need of psychological or psychiatric intervention.

For a jail officer candidate for the next higher rank, psychological mindedness, leadership skills and style, expressive skills, self-awareness and direction will likewise be evaluated. Those noted to have an ongoing psychopathology who are deemed dangerous to be carrying firearms which may impose a threat to his/her own security and to his/her immediate environment shall be endorsed to the Directorate for Operations for immediate disarming. He/she shall be subjected to further evaluation and treatment. The result of the NP examination shall be valid for a period of six (6) months for those who are cleared and those who are not.
2.4 Wellness Program

The following wellness program for BJMP personnel shall be implemented:

2.4.1 Annual Physical Examination - all personnel shall undergo the annual medical examination to be conducted at the HSO-National Head Quaters for NHQ personnel and at the HSO- Regional Office for regional personnel. They shall be required to submit a set of laboratory examination results as reference to the complete medical assessment. This process is to increase awareness on the importance of health, detect signs and symptoms of illnesses and maintain overall wellness. The process includes annual scheduled drug testing and random drug testing to determine personnel who are prohibited drug users.

2.4.2 "BJMP’s Belly Gud Program" - this program originated from the Department of Health and was adopted by the BJMP to ensure that personnel are provided with the opportunity to improve and maintain their physical condition through the regular conduct of physical activities on specified times during work hours. (Refer to Memorandum Circular Number 2014-001 dated March 3, 2014

Prepared By: IRENE S. LIM, MD, DPBP Psychiatrist

Noted By: ARTHUR C LORENZO, MD Jail Senior Superintendent Chief, Health Service Office

Reviewed By: ALLAN S IRAL, CESE Jail Chief Superintendent Deputy Chief for Administration of the Jail Bureau/ Quality Management Representative

Approved By: DEOGRACIAS C TAPAYAN, CESE Jail Director Chief, BJMP

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Re: Guidelines on Adopting and Implementing the “Belly Gud For Health-Keeping Fit, Moving Forward, the BJMP Way”

2.5 Mental Health and Psychosocial Support (MHPSS)

Personnel who are victims, witnesses or participants of critical incidents shall be provided with debriefing for them to cope better with the situation and prevent the development of more severe psychological or psychiatric issues as a result. The focus shall be on social interventions that aim to remove further stress factors, restore normal social functioning and activities and provide emotional support. This is also aimed at detecting early signs and symptoms of more serious mental illness and the proper disposition of such cases. This activity can also be provided to new recruits prior to deployment for training to prepare them psychologically and during the first week of training to give them the proper avenue to express their feelings, fears and expectations hence prevent any adverse impact as a result of a rigorous training.

2.6 Peer Support Strengthening Program (PeSSP)

This activity is a modification of Mental Health Psychosocial Support (MHPSS) or Stress Debriefing practiced by the Health Service Office. The group process fosters organization of the self during and after the rigid training and prepare them for their
reintegration into the Bureau. The group process gives an environment to ventilate and discuss issues that are disruptive to self and may affect transition functioning and later. The process of conducting MHPSS also applies to PeSSP wherein the facilitator and his/her co-facilitator are mental health practitioners outside of the area involved. The facilitators address the maladaptive coping skills and identify and report participants with imminent behaviour dyscontrol or cognitive disturbances. It is an interactive and hands on group dynamics. While the latter focuses on processing the traumatic incidents experienced by the participants, this activity aims to:

a. Allow the trainees/participants to express their insights about training or their own experiences, ventilate their feelings or personal issues that affect the performance in the training or line of work.

b. Allow each member to share how they cope and help peers develop effective coping strategies to survive future activities.

c. Develop among trainees/participants the skill of listening, enhance empathic and introspective abilities.

d. Enhance the trainees' interpersonal and intrapersonal relationships

Prepared By:

IRENE S. LIM, MD, DPBP Psychiatrist

Reviewed By:

ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration of the Jail Bureau/Quality Management Representative

Approved By:

DEOGRACIAS C TAPAYAN, CESE
Jail Director
Chief, BJMP

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The following personnel who could be recipients of PeSSP program:

1. The newly recognized JO1/Trainees from NJMPTI.
2. The STAR team members who underwent rigid/intensive military training.
3. The PNPA graduates upon assumption to duty as Inspectors of BJMP.

2.7 Structured Counseling and/or Psychotherapy Program

This program is structured to address the psychological and cognitive issues detected upon the conduct of psychological examination during the promotion process. The personnel with “not granted” result or those who are not to be recommended for the next higher rank will be subjected to undergo this program under the contract of voluntary program for counseling and psychotherapy. It is important to know that pre-employment psychological screening does not determine a candidate's sanity or lack thereof. “Not granted” means that the person is not the best candidate for the applied position. With this in mind, the concerned individual may seek counseling to identify his areas of weakness thus help himself or may opt not to, hence cannot be mandated to undergo such. The program aims to help the personnel gain insights about their current psychological status and achieve the state of “well-being.” However, for personnel who manifest overt signs and symptoms of psychopathology, the

Prepared By:
IRENE S. LIM, MD, DPBP
Psychiatrist

Reviewed By:
ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration of the Jail Bureau/Quality Management Representative

Noted By:
ARTHUR C LORENZO, MD
Jail Senior Superintendent
Chief, Health Service Office

Approved By:
DEOGRACIAS C TAPAYAN, CESE
Jail Director
Chief, BJMP

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Psychiatrist shall recommend to the respective Regional Director for the personnel to undergo appropriate evaluation and treatment.

2.8 Health and Anti-Drug Abuse Education

Health education in terms of managing stress, illnesses and financial issues shall be tackled during Personnel Information and Education (PI&E), trainings or seminars. This is aimed at increasing awareness on the proper ways of managing stress at work, home and environment. This likewise includes teachings on health-related issues focusing on the promotion and prevention of various kinds of illnesses and Drug Use and Addiction. Seminar on “Counsellor Wellness” shall be regularly conducted to personnel during PI&E.
B. SECONDARY INTERVENTIONS

This level of intervention refers to the diagnosis and treatment of acute or chronic mental disorder or disturbances.

1. For Persons Deprived of Liberty (PDL)

1.1 Psychiatric Treatment and Referral

PDL assessed to suffer from acute and chronic mental disorders shall be referred to the Bureau Psychiatrist in areas where available for consultation and treatment. In areas where an in-house psychiatrist is not available, the jail health personnel or psychologist shall submit a recommendation to the court for the PDL to be evaluated by a government psychiatrist. Once a court order is issued, the PDL shall be brought to the government specialist. If the patient opts for a private physician, all expenses shall be borne by the said patient.

For PDL who are highly disturbed and need immediate hospitalization, the same procedure shall be followed where a court order is necessary before they can be transferred to a psychiatric facility.
 Reasons for admission to a Psychiatric Hospital:
  - Presence of severe or disruptive psychiatric symptoms
  - Inability of the jail facility to handle the psychiatric patient inside the facility
  - The Court orders the patient to be transferred to a psychiatric facility
  - Presence of imminent danger to self and others per assessment

1.2 Counselling and Mental Health and Psychosocial Support

PDL who are deemed to manifest signs and symptoms of mental disturbance shall immediately be referred to any member of the Mental Health Team to undergo counselling. The duration and schedule of the sessions shall be determined by the Counsellor on a case to case basis. Cases that need immediate psychiatric intervention shall be referred to the Bureau Psychiatrist following the procedure stated above.

PDL who are victims or witnesses of traumatic events shall be provided with mental health and psychosocial support to minimize the impact on the psychological state of the participants.

1.3 Suicide Risk Assessment and Prevention

PDL shall be assessed for suicide risk upon admission and while in incarceration. The jail physician or unit nurse shall be trained on the proper assessment and handling of PDL

Prepared By: 
IRENE S. LIM, MD, DPBP Psychiatrist

Reviewed By: 
ALLAN S IRAL, CESE Jail Chief Superintendent of the Jail Bureau/Quality Management Representative

Approved By: 
DEOGRACIAS O TAPAYAN, CESE Jail Director, Chief, BJMP

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with suicidal tendencies. Based on the risk assessment the jail physician or nurse shall refer the patient to the Jail Psychiatrist or for confinement in a psychiatric facility. Patients who are deemed suicidal shall be placed on suicidal precautions and shall be monitored clockwise to prevent untoward incidents while inside the jail facility.

1.4 Pharmacotherapy

PDL who were prescribed psychiatric medications shall be provided with such on a regular scheduled basis. The psychiatric nurse shall be responsible for the storage, accounting and administration of the medications to the patients. The psychiatric medicines shall be kept in a secured place accessible only to health personnel, specifically to the psychiatric nurse. Patients shall not be entrusted to administer their own medications. The assigned Nurse shall regularly conduct an inventory, ensure the availability of psychiatric medications and shall report to the Psychiatrist any development in the patients’ status. PDL shall never be allowed to have access to the medication room nor handle and administer medicines to patients.

1.5 Mandatory Reporting of Torture cases

All personnel shall report all suspected cases of torture on newly admitted PDL and those inside the jails. They shall follow the procedures stated in the Revised BJMP Policy on

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<tr>
<td>Noted By: ARTHUR C LORENZO, MD Jail Senior Superintendent</td>
<td>Deputy Chief for Administration of the Jail Bureau/ Quality Management Representative</td>
<td>Chief, BJMP</td>
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Mandatory Reporting of Torture Case dated August 17, 2015. This policy is aimed at early detection of torture cases and as a preventive mechanism against the commission of torture while PDL are in jails.

1.5 Treatment of Drug Abusers and Dependents

All PDL who have history of drug abuse or have been confirmed as drug users on drug testing shall undergo neuro-psychiatric evaluation upon referral from the jail unit. These PDL may need counselling and pharmacotherapy based on the assessment of the psychiatrist. Those who are determined to be drug users or pushers shall be referred to the IWD officer of the jail to participate in the Therapeutic Community Modality Program (TCMP) of the Bureau. Drug users who are diagnosed with a concomitant psychiatric illness shall be referred to the Jail Psychiatrist for further evaluation and management.

2. For Personnel

2.1 Psychiatric Treatment and Referral

Personnel who manifest signs and symptoms of psychiatric disorder shall be referred to the Jail Psychiatrist or government/private psychiatrist in the absence of the latter. For those needing hospitalization, the personnel shall be referred to the nearest government...
2.2 Counselling

For personnel who suffer from mild psychological problems that do not necessitate psychiatric intervention shall be provided with counselling by any member of the Mental Health Team. The structure and duration shall be determined by the counsellor. A contract of counseling session and confidentiality will be signed prior to initiation of session. Likewise, the personnel should affix an affidavit that the counseling process is voluntary. Personnel with marital issues, work-related issues and those with deviant behavior may undergo individual or group counseling with the BJMP Psychologist. The objectives of the counseling services are in the prevention and treatment. Preventive measures can arrest possible major psychological issues in the future though appropriate and timely psychological interventions.

2.3 Mental Health and Psychosocial Support

Personnel who experienced recent traumatic incidents shall be provided with Stress

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Debriefing by members of the Mental Health Team. The National Headquarters or the Regional Office MHPSS coordinator upon learning about the incident must coordinate with the local MHPSS BJMP personnel to coordinate with the area administrator for MHPSS deployment. Likewise, the MHPSS Regional coordinator must furnish the National Headquarters MHPSS coordinator their after activity report.

The MHPSS National Coordinator must organize an annual workshop or activity to consolidate, discuss and improve the documentation of MHPSS activities nationwide academic or learning purposes and ensure the welfare of personnel for effective jail service delivery. *(Refer to Policy Guidelines in the Selection, Training and Deployment of BJMP Health Personnel in the Conduct of Mental Health and Psychosocial Support (MHPSS) dated October 27, 2015)*

### 2.4 Counsellor Wellness

The BJMP Counsellors shall undergo regular Wellness seminar and even counselling if necessary to maintain balance and sense of wellbeing while performing their duties as counsellors. Personnel engaged in the facilitation of face to face counselling are prone to issues like counter transference. Personal problems might get in the way of their functions hence resolution of their own issues is necessary to gain optimum level of effectiveness.
Counsellors must also be legally and ethically informed of the Legal and Ethics of Counselling and Psychotherapy in the Philippines.

2.5 Mediation

Mediation is a settlement of dispute or controversy by setting up an independent person between two contending parties in order to aid them in the settlement of their disagreement. The Bureau created a Mediation Team composed of representatives from the Chaplaincy, Legal, Health, Finance and Morale and Welfare services. The function and objective of the Mediation Team is to resolve disputes amicably and avoid possible legal actions if the dispute remains unsettled.

2.5.1 Pre-mediation Counselling (Conjoint)

Mediation is a session for financial or family-related disputes of two individuals who are seeking a non-legal approach to reach an agreement. It has been noted that most parties availing of mediation in the BJMP are married or common law partners who cease to live together or are estranged from each other. Their condition as estranged couples may have accumulated emotional wounds that are suppressed. The mediation proper may trigger painful affect on both parties who can be overwhelming by their heightened emotions which in turn may disturb the intelligent discussion and decisions during the process.
Complex and difficult emotions may surface in the mediation process and leave traces of more emotional confusion when they separate after mediation. To avoid emotional outbursts during mediation, it is advisable for both parties to be given the chance to ventilate feelings prior to the sober, civil and intelligent exchange in the mediation process. It is also in this stage where both parties are notified of the availability of post mediation counselling for those who will be recommended to undergo such.

2.5.2 Post-mediation Counselling

After the mediation process, the team shall determine who will be recommended to undergo post-mediation counselling. The objective is for the parties to regain their optimum level of mental and psychological functioning which were temporarily disrupted by certain life circumstances. The referral shall be based on a voluntary basis. The parties will be referred to the BJMP Clinical Psychologist who shall decide the frequency and duration of the sessions. The following are the specific objectives of post-mediation counselling:

a.) For married couples – a psychological help in the form of marital counselling and/ or marital counselling to process their deep marital issues. This could be an avenue for possible reconciliation.

b.) For individuals – a psychological help in the form of individual counselling/ psychotherapy to address painful issues be it marital or relationship-wise.

Prepared By:

IRENE S. LIM, MD, DPBP
Psychiatrist

Noted By:

ARTHUR C LORENZO, MD
Jail Senior Superintendent
Chief, Health Service Office

Reviewed By:

ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration of the Jail Bureau/ Quality Management Representative

Approved By:

DEOGRACIAS C TAPAYAN, CESE
Jail Director
Chief, BJMP

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Individuals are informed on how to manage relational connections, psychological responsibilities with their children, estranged spouse and other people in general.

c.) For the family – a psychological help in the form of group family counselling and/or group family psychotherapy and foster family cohesion if married couples agree to reconcile and re-establish parents and children’s healthy dynamics despite parent’s separation.
C. TERTIARY INTERVENTIONS

This level of intervention deals with the rehabilitative aspect of treatment where programs are provided to hasten their recovery and prevent further complications.

1. For Persons Deprived of Liberty (PDL)

1.1 Drug Rehabilitation Program

1.1.1 Therapeutic Community (TC)

This is a self-help learning program that uses the community within the jail environment as a vehicle to foster behavioural and cognitive change towards recovery. The PDL are provided with activities where they can learn the positive way of thinking, feeling and behaving in order for them to stay away from their way of life prior to admission. *(Refer to Therapeutic Modality Manual)*

1.1.2 Relapse Prevention Program (Katatagan Kontra Droga sa Komunidad or KKDK)

This is a relapse prevention intervention specifically for persons with substance use disorder for them to develop life skills in order to stop using drugs and maintain sobriety. It is a 15-module program which is conducted to 8-10 inmates/group on a once a week basis and to be facilitated by trained personnel. This is a pre-release psycho-educational program.
specifically for PDL with drug abuse problem who are due for release. This program has three family modules which involve the participation of family members to provide the PDL with support and possible reconciliation to help them easily adapt to life after incarceration. (Refer to KKDK Manual from the Psychological Association of the Philippines).

1.2 Development Programs

The BJMP shall provide the PDL with various development programs to occupy their time and keep their minds active and away from negative thoughts. Such programs shall likewise develop or enhance their coping, intellectual and vocational skills to prepare them for release. These programs are categorized as follows:

a. Cognitive Development:
   1. Educational (Alternative Learning System)
   2. Self-awareness Program- is a form of psycho-education utilizing activities and lectures to help PDL developed insights, enhance their thinking skills and facilitate personal growth through understanding of oneself in relation to his/her environment
   3. Sports and Cultural activities

b. Spiritual/Interfaith development

---

Prepared By:  IRENE S. LIM, MD, DPBP Psychiatrist
Noted By:  ARTHUR C LORENZO, MD Jail Senior Superintendent Chief, Health Service Office
Reviewed By:  ALLAN S IRAL, CESE Jail Chief Superintendent Deputy Chief for Administration of the Jail Bureau Quality Management Representative
Approved By:  DEOGRACIAS C TARAYAN, CESE Jail Director Chief, BJMP

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c. Behavioural development
   1. Therapeutic Community Modality Program (TCMP)
   2. Peer Support Development Program
   3. Counselling

d. Vocational development
   1. Livelihood Program
   2. Skills Enhancement

1.3 Rehabilitation Program for Torture Victims

PDL who are determined to be victims of torture, degrading and other forms of ill-treatment from the outside and within the jails shall be provided with rehabilitation programs using the guidelines set by the BJMP. (Refer to SOP number 2014-04 or the Comprehensive Rehabilitation Program for Torture Victims and their Families)

1.4 Monitoring and Counselling
PDL recovering from mental disturbances shall be regularly monitored to ensure compliance to medications and recovery. Follow up counselling shall be done periodically to ensure continuous recovery and prevention of relapses.

1.5 Aftercare Program

The BJMP through the social workers shall assist soon-to-be-released PDL by coordinating with LGUs, NGOs and other community groups who can support them by way of financial, vocational and other forms which could help them adjust to life after incarceration and facilitate reunion with their respective families.

For PDL with mental illness or were diagnosed to be suffering from mental illness, the relatives or the PDL will be provided with an endorsement/referral card to inform them of the medicines being taken while in jail and the need for subsequent consultation to the nearest or preferred psychiatric facility.

2. For Personnel

2.1 Rehabilitation Program for Torture Perpetrators

Personnel proven to have committed acts of torture, degrading and other forms of ill-treatment towards inmates shall be provided with rehabilitation program to prevent them from
committing the same acts in the future. *(Refer to SOP no. 2014-04 or the Comprehensive Rehabilitation Program for Torture Victims and Their Families)*

### 2.2 Restorative Intervention for Erring Personnel

Personnel proven to be involved in various nefarious activities in jails such as maltreatment of PDL, entry of contrabands, corrupt practices and drug use and supply shall undergo restorative interventions as part of the Integrity Management Program of the bureau. The frequency, duration and length of therapy shall be determined by the assigned counsellor. This intervention shall be conducted in collaboration with the Chaplaincy Service which shall be the main focal unit responsible for the design, planning and implementation of the Integrity Management Program of the Bureau.
PERSONNEL CAPABILITY BUILDING

The primary care providers including the Mental Health team shall be provided with basic training in the recognition and basic management of common mental disorders.

All members of the Mental Health Team should have undergone the required training on their respective fields of specialization in accredited training institutions.

The BJMP shall conduct capability building seminars on the updates on mental health and on their respective fields to all members of the team.

The BJMP shall likewise include topics on mental health in the Program of Instructions (POI) of the NJMPTI for personnel on mandatory schooling.

Prepared By:
IRENE S. LIM, MD, DPBP
Psychiatrist

Reviewed By:
ALLAN SIRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration of the Jail Bureau/Quality Management Representative

Approved By:
DEOGRACIAS C. TAPAYAN, CESE
Jail Director
Chief, BJMP

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REPORTING AND DOCUMENTATION

All activities related to the Mental Health Program of the BJMP shall be properly documented and recorded as evidence of implementation. All members of the Mental Health Team shall be responsible in preparing and submitting reports to the Health Service Office where it shall be collated by the Secretary of the Team.

MONITORING AND EVALUATION

The Mental Health Team and primary care providers in jails shall ensure that the recording systems are set up to allow continuous monitoring, evaluation and updating of mental health activities. Mental health data need to be routinely recorded in patients’ files and integrated in the overall general health information system in order to be used for monitoring, evaluation, planning and service improvement.

Prepared By:
IRENE S. LIM, MD, DPBP
Psychiatrist

Reviewed By:
ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration
of the Jail Bureau/Quality Management
Representative

Approved By:
DEOGRACIAS G. TAPAYAN, CESE
Jail Director
Chief, BJMP

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SEPARABILITY CLAUSE

In the event that any provision or part of the policy be declared unauthorized or rendered invalid by a competent authority, those provisions not affected by such declaration shall remain valid and effective.

REPEALING CLAUSE

All other existing issuances which are inconsistent with this policy are hereby rendered rescinded or modified accordingly.

EFFECTIVITY

This policy shall take effect immediately.

DEOGRACIAS C TAPAYAN, CESE
Jail Director
Chief, BJMP

Prepared By:
IRENE S. LIM, MD, DPBP
Psychiatrist

Reviewed By:
ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration of the Jail Bureau/Quality Management Representative

Noted By:
ARTHUR C LORENZO, MD
Jail Senior Superintendent
Chief, Health Service Office

Approved By:
DEOGRACIAS C TAPAYAN, CESE
Jail Director
Chief, BJMP

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Mental Health Management Procedures

A. For BJMP Personnel

Admission and Screening

Receives referral for

a. promotion
b. psychiatric evaluation
c. recruitment

1. Conducts psychological examination
   * Psychologist
2. Conducts neuropsychiatric interviews
   * Psychiatrist

2. Assesses if personnel has mental issue warranting the different interventions. If none, personnel will be referred for primary interventions as preventive measure. If with mental health concerns, then s/he shall be referred for secondary interventions.

Prepared By:
IRENE S. LIM, MD, DPBP
Psychiatrist

Noted By:
ARTHUR C. LORENZO, MD
Jail Senior Superintendent
Chief, Health Service Office

Reviewed By:
ALLAN S. IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration of the Jail Bureau
Quality Management Representative

Approved By:
DEOGRAECIAS O. TAPAYAN, CESE
Jail Director
Chief, BJMP

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(See detailed descriptions of interventions in Chapter III)

3. Provides primary and secondary interventions whichever is applicable.
   *MHPSS Team
   *Social Worker

4. Decides if personnel needs further rehabilitation

Secondary Interventions
* Initial Psychiatric Treatment
* Mental Health Psychosocial Support
* Counselling
* Pharmacotherapy
* Case management
Mediation
Counselor wellness

Needs Rehabilitation?

Yes

No

Continue secondary interventions

Prepared By:
IRENE S. LIM, MD, DPBP
Psychiatrist

Reviewed By:
ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration of the Jail Bureau
Quality Management Representative

Approved By:
DEOGRACIAS & TARAYAN, CESE
Jail Director
Chief, BJMP

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5. Provides tertiary interventions or refer personnel to outside agency for needed rehabilitation
   * Psychiatrist
   * MHPSS team
   * Social Worker

6. Prepares documentation of each intervention, decision and progress
   * All team members

7. Consolidates accomplishment reports of the program
   * Program Secretariat

Figure 3. Mental Health Procedure for Personnel

Prepared By:

[Signature]
IRENE S. LIM, MD, DPBP
Psychiatrist

Reviewed By:

[Signature]
ALLAN S. IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration of the Jail Bureau
Quality Management Representative

Approved By:

[Signature]
DEOGRACIAS C. TAPAYAN, CESE
Jail Director
Chief, BJMP

"Changing Lives, Building a Safer Nation"
Mental Health Management Procedures

<table>
<thead>
<tr>
<th>Narrative Description</th>
<th>Flowchart</th>
<th>Person Responsible</th>
</tr>
</thead>
</table>

B. For BJMP PDL

1. Conducts admission and screening on inmate

*Jail nurse/ Psychologist

2. Assesses if inmate has mental health issue, if none inmate if recommended for primary interventions as preventive measure.

Start

Conducts initial interview

with mental health issue?

NO

Primary Interventions

* Physical Wellness

* Mental Health Education

YES

Prepared By: IRENE S. LIM, MD, DPBP Psychiatrist

Reviewed By: ALLAN S IRAL, CESE Jail Chief Superintendent Deputy Chief for Administration of the Jail Bureau Quality Management Representative

Approved By: DEOGRACIAS C TARAYAN, CESE Jail Director Chief, BJMP

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If inmate is assessed to manifest mental health concerns such as the following:

- Presence of severe or disruptive psychiatric symptoms
- Inability of the jail facility to handle the psychiatric patient inside the facility
- Court orders the patient to be transferred to a psychiatric facility
- High risk of imminent danger to self and others per assessment

3. Provides primary and secondary interventions whichever is applicable.
   * Jail Psychologist/Nurse
   * Roving Psychiatrist
   *(See detailed descriptions of intervention)*

4. Decides if personnel needs further Rehabilitation

5. Provides tertiary interventions or refer inmate to outside agency or needed treatment
   * Jail Nurse/Psychologist
   * Unit TCMP Focal Person
   * Roving Psychiatrist, KKDK Facilitator

---

**Secondary Interventions**
- Initial Psychiatric Treatment
- Mental Health Psychosocial Support Counseling
- Pharmacotherapy
- Referral
- Case Monitoring

**Tertiary Interventions**
- Drug Rehabilitation Program (TCMP, KKDK)
- Referral to outside agency
- Rehabilitation Program for Torture Perpetrator
- Aftercare Program

---

Prepared By:  
IRENE S. LIM, MD, DPBP  
Psychiatrist

Reviewed By:  
ALLAN S IRAL, CESE  
Jail Chief Superintendent  
Deputy Chief for Administration of the Jail Bureau  
Quality Management Representative

Approved By:  
DEOGRACIAS C. TAPAYAN, CESE  
Jail Director  
Chief, BJMP

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6. Conducts individual case monitoring and documentation  
   *Jail Nurse

7. Prepares monthly consolidated report of mental health cases  
   *Jail Nurse

8. Submits consolidated accomplishment report of jail to regional office  
   *Jail Nurse

Figure 4. Mental Health Procedure for PDL

Prepared By:  
IRENE S. LIM, MD, DPBP  
Psychiatrist

Noted By:  
ARTHUR C LORENZO, MD  
Jail Senior Superintendent  
Chief, Health Service Office

Reviewed By:  
ALLAN S IRAL, CESE  
Jail Chief Superintendent  
Deputy Chief for Administration of the Jail Bureau  
Quality Management Representative

Approved By:  
DEOGRACIAS C TAPAYAN, CESE  
Jail Director  
Chief, BJMP

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BJMP Mental Health Program Reportorial System

1. The Jail Psychiatric Unit primarily manned by the Jail Nurse shall prepare a jail monthly mental health consolidated report which contains the mental cases handled for the month by the unit. The report shall be in a form of a matrix that includes the names, sex and ages of cases, diagnosis if applicable and the interventions provided to them. The report must be noted by the Chief of the Health Service of the unit prior to submission to regional office. The report is due every 5th of the month.

2. The Regional Mental Health Secretariat is responsible in consolidating all jail psychiatric units in the region and prepares a regional monthly mental health consolidated report. The report shall be statistical and narrative. The statistical report must show how many mental cases were attended to (sex segregated), their ages, their diagnoses if applicable and the interventions provided to them. The narrative report shall indicate the analysis of the regional secretariat of their report, actions taken and recommendations. The consolidated report shall be noted by the Chief, Health Service of the region prior to submission to the Health Service Unit-NHQ.

   The regional monthly mental health consolidated report shall be submitted to the National Mental Health Program Secretariat at the NHQ. The report is due every 10th of the month.

Prepared By:
IRENE S. LIM, MD, DPBP
Psychiatrist

Reviewed By:
ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration of the Jail Bureau/
Quality Management Representative

Noted By:
ARTHUR C LORENZO, MD
Jail Senior Superintendent
Chief, Health Service Office

Approved By:
DEOGRACIAS C TAPAYAN, CESE
Jail Director
Chief, BJMP

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3. The National Program Secretariat consolidates the regional reports to come up with a national monthly mental health program report to be submitted to the Program Director who shall be responsible in informing the Chief, BJMP on the mental health program status of the Bureau.

BJMP Mental Health Program Reportorial Diagram

![Diagram showing the flow from Jail Psychiatric Unit to Regional MHP Secretariat to National MHP Secretariat to Chief, BJMP with relevant reports at each step.]

Figure 5. BJMP Mental Health Program Reportorial Diagram

Prepared By:
IRENE S. LIM, MD, DPBP Psychiatrist

Reviewed By:
ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration of the Jail Bureau/Quality Management Representative

Approved By:
DEOGRACIAS C. TAPAYAN, CESE
Jail Director
Chief, BJMP

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Counselling is a professional guidance of the individual by utilizing psychological methods especially in collecting case history data, using various techniques of the personal interview, and testing interests and aptitudes. The goal of counselling is to foster behavioural and emotional change with the provision of psychological and supportive interventions. Any member of the Mental Health Team with adequate knowledge and training can provide counselling to the clients. This can be done either individually or in group.

Phases of Counselling

Phase I - Awareness of the Problem
At this stage client must acknowledge that a problem exist and may prefer to resolve it by himself or herself with or without help.

Phase II – Build rapport with the client
At this stage, the counsellor shall establish rapport with the client where trust and safety are developed. As rapport grows, the counsellor may begin to perceive feelings of which the client is not yet conscious. By cautiously communicating that perception, the counsellor may enable the client to understand and accept or own up his/her own feelings.
The following guidelines can be used by the Counsellor:

1. Seek a non-threatening, comfortable atmosphere where the client feels safe to communicate fully his problems while feeling accepted as a person;
2. During initial contact, the counsellor must convey to the client that he/she is knowledgeable and understanding person who may be able to help;
3. Be calm. Do not express any emotional outburst which will lead to client to stop relating his/her difficulties.
4. Be non-judgmental. Show respect for whatever he/she is. Remember that the values that work for you may not be best for someone else in a different situation.
5. Do not let the client develop a superior-inferior relationship. If the client feels that he is inferior, he or she will be less motivated to reveal and discuss personal difficulties.
6. Be empathetic. The counsellor must convey a message that he/she understands and cares about the client’s feelings.
7. Keep all the information given by the client confidential that can ruin counsellor–client relationship unless for clinical reason.
Phase III – Motivation

Unless motivated, we cannot ensure that the client will change or improve his/her condition. To motivate and encourage a client, an effective counsellor must have the appropriate attributes that will prove effective in gaining the client’s trust and confidence.

Phase IV- Conceptualizing the Problem

The following guidelines are used to explore the problems in depth:

1. In exploring the problem, examine the following areas:
   a. duration and extent/severity of the problem
   b. nature and causes of the problem
   c. what the clients did about the problem
   d. what are the feeling of the clients about the problem
   e. physical/mental capacities and strength

2. When the problem are identified, explore and identify a number of sub-problem

3. In multiple situations, ask the client which he/she perceives most pressing

4. Observe for non-verbal cues

5. Be honest

6. Listen attentively to what the clients are saying

Prepared By:
IRENE S. LIM, MD, DPBP
Psychiatrist

Reviewed By:
ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration
of the Jail Bureau/Quality Management
Representative

Approved By:
DEOGRACIAS G. TAPAYAN, CESE
Jail Director
Chief, BJMP

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Phase V - Exploration of Solutions/Strategies or Alternative Courses of Actions

The client and the counsellor explore and consider alternative courses of solutions and its probable effects or consequences to the strategies identified. The role of the counsellor is to facilitate or assist the client but not to offer solutions. The person to make the decisions should be the client.

Phase VI – Implementation of Strategies

Counselling will be effective if the client follows through his/her commitment to try a resolution to his/her own problems. As a caseworker, the following should be undertaken:

- Form an explicit, realistic contract with the client that helps bring focus to the counselling

- Remember that client should have the responsibility to take action on his/her task to improve his/her situation

Phase VII- Evaluation

A few weeks before termination of the counselling session, the client must be evaluated to determine the change. The following can be asked:

Prepared By:

IRENE S. LIM, MD, DPBP
Psychiatrist

Reviewed By:

ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration
of the Jail Bureau/
Quality Management
Representative

Approved By:

DEOGRACIAS C. TAPAYAN, CESE
Jail Director
Chief, BJMP

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A. How the counselling helped him/her.
B. the strength that the counselling developed
C. the shortcoming of the counselling received
D. problem, if any, for which additional help is desired.

Structure and Setting:

- There should be a joint understanding between the counsellor and client regarding the characteristics, conditions, procedures and parameters of counselling. The initial sessions shall be dedicated to identifying problems, establish goals, treatment planning, scheduling, frequency and duration of treatment and termination.

- Psychological intervention can be done on a one to one or in a group setting depending upon which type the individual will best respond to. Individual counselling is good for people who have difficulty speaking in front of others. However, the advantage of social exposure with group counselling shall also be considered to reduce isolation and the chance to learn from others. The choice should not be mandated or imposed to avoid resistance.

Prepared By:
IRENE S. LIM, MD, DPBP
Psychiatrist

Reviewed By:
ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration of the Jail Bureau/Quality Management Representative

Approved By:
DEOGRAFIAS C. TAPAYAN, CESE
Jail Director
Chief, BJMP

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• Counselling can happen anywhere but should preferably done in a place that is quiet and provides privacy and confidentiality.

Attributes of an effective counsellor:

1. Voluntary – the counsellor must have the capacity to encourage clients to submit to the process voluntarily. Counselling should not be forced on clients who are not yet ready.

2. Genuineness or congruence - the counsellor must be authentic and integrated without a false front and that their inner experience and outward expression do match.

3. Confidential – the counsellor must always be aware of the confidentiality of the interactions and must uphold it at all times.

4. Creative and imaginative – a good counsellor shall be able to identify the connections between the client’s thoughts, feelings and behaviours that the client may not be aware of.
5. Practical – the counsellor shall have the capacity to provide practical guidance in simple, clear messages that will assist the client resolve his/her own conflicts.

6. Respectful – the counsellor must be sensitive to the needs of the client hence respect the conditions set by the client in order to reinforce the client's confidence and trust on the counsellor.

7. Non-judgmental – the counsellor must always maintain an accepting stance and should always remain neutral and free of any form of bias when dealing with client’s issues.

8. Empathic – an effective counsellor must be able to show empathy by not imposing his/her own views or opinion on the client. He/she should be able to understand the client’s feeling by going with the client into his/her world of emotions or feelings or simply put him/herself into the client’s shoes.

9. Action-oriented – this is an approach that is centered on the best way to achieve the identified goals.

Prepared By: IRENE S. LIM, MD, DPBP Psychiatrist
Noted By: ARTHUR C LORENZO, MD Jail Senior Superintendent

Reviewed By: ALLAN S IRAL, CESE Jail Chief Superintendent
Deputy Chief for Administration of the Jail Bureau/Quality Management Representative

Approved By: DEOGRCIAS C TAPAYAN, CESE Jail Director
Chief, BJMP

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10. Good knowledge base – an effective counsellor must have an adequate knowledge on what he/she is doing by acquiring the basic knowledge and mastery on counselling skills and techniques so as not to misguide the client.

11. Practicing ethical behaviour at all times – the counsellor must maintain a professional relationship with the client at all times and avoid dual relationships or any behaviour that could be misinterpreted by the client.

**Basic Counselling Techniques/Skills**

1. **Active Listening** - It is the capacity to hear, understand and communicate understanding as to what message the client is conveying whether verbally or nonverbally and communicate empathy back to the client. Active listening that conveys understanding and interest on the part of the counsellor helps establish rapport and encourages the client to disclose, express feelings and create a mutual knowledge base for both the client and counsellor.
Four components of Active Listening

a. **Attending** – refers to the concern or interest of the counsellor on the client’s form of communication. This serves as the foundation of effective communication between the counsellor and client as it gives attention to the client’s verbal, nonverbal cues and communicating understanding back to the client. This demonstrates that the counsellor is paying attention to the client.

b. **Paraphrasing** – is when the counsellor restates the contents on what the client is saying in order to convey to the client that what the counsellor understands is the same as what the client is conveying. This is to avoid any misunderstanding on both parties.

c. **Reflecting** – is when the counsellor expresses the client’s feelings, either stated or implied. The counsellor tries to perceive the emotional state of the client and respond in a way that displays an understanding of what the client is feeling. It is just like the counsellor expressing what the client is feeling in a way understood by the counsellor.

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d. **Summarizing** - it is the process where the counsellor gathers all the information received from the client, highlighting the important points and feeding it back to the client to make sure that what was received was understood accurately. It provides the opportunity for both parties to clarify vague issues then obtain a sense of movement forward and attain progress in the discussion.

2. **Processing** - is the act of the counsellor in thinking about his/her observations on the client and all the information gathered. This happens while the counsellor is listening to the client before responding. This involves mental processing of the counsellor’s observations of the clients beliefs, knowledge, behaviour and attitude and factors that influence all of these attributes.

3. **Responding** - is the act of communicating information to the client that includes by providing feedback and other means of support for the client to address his/her issues in attaining the objectives of the counselling.

Prepared By:
IRENE S. LIM, MD, DPBP
Psychiatrist

Reviewed By:
ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration
of the Jail Bureau/Quality Management Representative

Approved By:
DEOGRACIAS C TAPAYAN, CESE
Jail Director
Chief, BJMP

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Four components of Responding:

a. **Empathy** - is an action of understanding, being aware of, being sensitive to the feelings, thoughts and experiences of others or simply "putting oneself in the shoes of others". It is an objective experience of how others feel regardless of one's personal experiences.

b. **Probing** - is the counsellor's use of a question or statement to ask for more information or clarification about issues or points which the counsellor thinks are important. By using such questions, the counsellor aims to guide the client to respond in a way that answers the questions to what the counsellor wants to extract. The combined use of closed questions and open ended questions enables the counsellor to extract needed information from the client in a more organized manner.

c. **Interpreting** - is the client's explanation or understanding of the client after observing the client's behaviour, listening and considering other important sources of information. It is the counsellor's feedback on what he/she understands the client
is conveying. It may be stated as “It sounds like you are saying....” It should be stated as suggestions rather than statements. Facts or beliefs so that the client feels that the counsellor is not judgmental.

d. **Silence** - is being present to give time for the client to examine, think and reflect about everything that had been discussed. This skill is useful especially when the client is in big deep emotional experience that giving a moment of silence enables the client to get hold of his/her emotions. This is not used for small issues as it may not be appropriate for the situation.

4. **Teaching** - is the counsellor’s transfer of skills to the client through the use of different techniques and strategies.

**Skills involved in teaching**

a. **Use of repetition** - in order for the client to remember the important aspects of the counselling, the client may restate the information and practice the skills in a repetitive manner to master the knowledge and skills.
b. **Encourage practice** - once the client have learned an effective way of coping, he/she must practice such skills to gain mastery and prevent him/her from going back to his/her old ways.

c. **Give a rationale** - the counsellor should provide the client a clear understanding of why constant practice of the knowledge and skills are important for them to have a good grasp of why these are imperative.

d. **Monitoring and encouraging** - the counsellor must be constantly aware of how the client is doing and must reinforce client’s newfound coping to further enhance his skills.

e. **Use of assignment** - the counsellor must see to it that progress is continuous. Any new learning that may help the client should be given as a homework to practice to determine what works best.

f. **Explore resistance** - any sign that the client is not complying with the treatment plan should be explored to determine if he/she is manifesting signs of resistance. Early determination is important to dissipate whatever resistance is developing.

g. **Praise approximation** - any little effort on the part of the client to improve him/herself should be affirmed to reinforce such behaviour.
h. **Develop a plan** - the counsellor together with the client should come up with a change plan to avoid going back to the old ways by planning out a new way of life and coping styles.

**What to do during counselling**

- Show respect to the client
- Ensure confidentiality
- Give full attention to the client
- Listen more than speak
- Use open-ended questions more
- Allow clients to express emotions but do not show negative reactions
- Do not rush things
- Acknowledge each answer given by the client

**What not to do**

- Moralizing
- Ordering

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**Prepared By:**

IRENE S. LIM, MD, DPBP Psychiatrist

Noted By:

ARTHUR C LORENZO, MD
Jail Senior Superintendent
Chief, Health Service Office

**Reviewed By:**

ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration
of the Jail Bureau/
Quality Management Representative

**Approved By:**

DEOGRACIAS C TAPAYAN, CESE
Jail Director
Chief, BJMP

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"Changing Lives, Building a Safer Nation"
Red Flag Signs

Red Flag Signs - are signs that need to be detected by the counsellor to give him/her the insight as to when to refer the client for professional intervention.

a. Depressive symptoms
   - Symptoms of sadness, hopelessness, lethargy, loss of appetite and pleasure, irritability, insomnia/hypersomnia, feelings of guilt
   - Symptoms of more than 2 weeks
   - Suicidal ideations, history of suicide or suicidal attempts

Prepared By:
IRENE S. LIM, MD, DPBP
Psychiatrist

Reviewed By:
ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration
of the Jail Bureau/
Quality Management Representative

Approved By:
DEOGRACIAS C TAPAYAN, CESE
Jail Director
Chief, BJMP

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b. Manic symptoms
   - Periods of euphoria
   - Poor judgment and impulsivity
   - Distractibility
   - Racing thoughts
   - Agitation and enthusiasm for goals

c. Psychotic symptoms
   - Hallucination
   - Delusion
   - Paranoid ideation

d. Self-harming behaviour
   - Cutting, pulling hair
   - Excessive piercing/tattooing
   - Picking nails until it bleeds
   - Extremely dangerous sports/activities
e. Panic/anxiety attacks
   - Extreme nervousness, palpitations, difficulty breathing

f. Behaviour dangerous to others
   - Homicidal tendencies
   - Violent behaviour which includes indiscriminate firing

g. Addictive Behaviour
   - Drug abuse/dependence
   - Alcohol abuse/dependence

h. Compulsive Behaviour
   a. Gambling
   b. Indiscriminate spending
   c. Uncontrolled sexual activities
   d. Internet addiction

Prepared By:
IRENE S. LIM, MD, DPBP
Psychiatrist

Noted By:
ARTHUR C LORENZO, MD
Jail Senior Superintendent
Chief, Health Service Office

Reviewed By:
ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration
of the Jail Bureau/Quality Management Representative

Approved By:
DEOGRACIAS C. TAPAYAN, CESE
Jail Director
Chief, BJMP

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Mental Health and Psychosocial Support (MHPSS) - refers to the psychological and social concerns of disaster prevention and management and is provided to individuals who are victims or witnesses of critical incidents in order to enable them to regain practical skills needed to live and socialize in the community and teaches them how to cope with the disaster and prevent serious consequences of psychological trauma.

Critical Incidents could be in the form of natural disasters/calamities such as typhoons, earthquakes and flooding or man-made such as fire, riots and other forms of heinous crimes that could potentially harm or threaten the physical and psychological integrity of an individual or group.

Mental Health and Psychosocial Support must be conducted only by trained personnel who have the adequate knowledge and skills about the program.

I. Preparatory Phase

a. Group the participants into 10-12 persons. With this number, everyone will be given the opportunity to share his/her experiences. Too many might be overwhelming for the

Prepared By:
IRENE S. LIM, MD, DPBP
Psychiatrist

Noted By:
ARTHUR C LORENZO, MD
Jail Senior Superintendent
Chief, Health Service Office

Reviewed By:
ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration
of the Jail Bureau/Quality Management
Representative

Approved By:
DEOGRACIAS C TAPAYAN, CESE
Jail Director
Chief, BJMP

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counsellors or maybe intimidating for the participants. Two counsellors can facilitate the session.

b. The venue must be quiet and provides utmost privacy to maintain confidentiality and avoid disruptions while in session.

c. Chairs shall be arranged in circles so that everyone shall be within sight. No tables are needed and in the absence of chairs, mats can be used.

d. Ensure the comfort of the participants to create a warm and accepting atmosphere.

II. Session Proper

a. Introduction

1. The facilitators introduce themselves

2. The participants introduce themselves as to their name, age, status job or any relevant information about themselves. The use of nametags will be helpful.

b. Explanation of process

Before the start of the session proper the facilitators shall explain the following:

Prepared By:
IRENE S. LIM, MD, DPBP
Psychiatrist

Noted By:
ARTHUR C LORENZO, MD
Jail Senior Superintendent
Chief, Health Service Office

Reviewed By:
ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration of the Jail Bureau/Quality Management Representative

Approved By:
DEOGRACIASS C TAPAYAN, CESE
Jail Director
Chief, BJMP

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1. Critical Incident - any event causing unusually strong emotional reactions which have potential to interfere with ourselves and work during event or thereafter in majority of those exposed.

2. Psychosocial Processing (PSP) - to assist individuals, groups, crisis workers to deal positively with the emotional impact of a severe event/disaster and to provide education about the current anticipated stress response as well as information about stress management and contingency planning.

3. Categories of victims:
   - Direct victims - those killed or injured
   - Indirect victims - family, friends, co-workers of the direct victims
   - Hidden victims - crisis workers

   c. Setting of Expectations

      The facilitators lay down the ground rules of the session:
      1. Everything of a personal nature shared or discussed during the session shall be kept confidential and shall remain within the group.
      2. There are no right or wrong answers or ideas

   Prepared By:
   IRENE S. LIM, MD, DPBP
   Psychiatrist

   Noted By:
   ARTHUR C LORENZO, MD
   Jail Senior Superintendent
   Chief, Health Service Office

   Reviewed By:
   ALLAN S IRAL, CESE
   Jail Chief Superintendent
   Deputy Chief for Administration
   of the Jail Bureau/Quality Management Representative

   Approved By:
   DEOGRACIAS C TAPAYAN, CESE
   Jail Director
   Chief, BJMP

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3. Participants should feel free to share or express feelings, thoughts, reactions or simply listen
4. Speak one at a time. Respect the participant who is sharing
5. Participants are allowed to ask clarificatory questions and voice out their expectations

d. Objectives of the session and guidelines in the conduct of MHPSS:

1. Share experiences, feelings and reactions during the critical incidents
   a.) The facilitators shall ask each participant to describe:
      - What happened to him/her
      - How he/she feels then
      - How he/she feels now
   b.) The facilitators shall acknowledge and compliment the group for their openness and willingness to share
   c.) Point out that their feelings and reactions are normal responses to crisis/disaster
2. Provide information and discuss with the participants as to how a critical incident (typhoons, earthquakes, floods, riots, etc.) could affect individuals at home and at work.

The facilitators shall ask the participants what unusual things they have experienced after the event and what they are experiencing now at school, work or at home.

- Physical Stress response
  - How stress has affected our body
- Emotional Stress response
  - How stress has affected the way we feel
- Cognitive Stress response
  - How stress has affected the way we think
- Behavioural Stress response
  - How stress has affected the way we behave
- Spiritual/ values Stress response
  - How stress has affected our view of the world and our relationship with a higher Being

Recognize that the stress response on the critical incident shared by the participants can have an emotional impact and can interfere with one’s functioning. Point out to the

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participants the universality, commonality and normalcy of the said stress response in an abnormal situation.

3. Identify and discuss some coping skills in reducing stress

The facilitators shall provide the participants with information about what coping mechanism means and what are the different ways to cope with stressful situations.

- Ask the participants what have they done or what are they doing to cope with the stressful situations
- Emphasize that the coping skills that they have adapted are some ways of dealing positively with the impact of the event. Affirmation of the coping skills they have utilized will usually boost their morale.

4. Formulate and discuss contingency plans

The facilitators shall ask the participants the following:

- Is there anything which should have been discussed but wasn’t?
- How each one felt after the session?
- Was the session helpful?
- Are there any groups that they can recommend for MHPSS?

Prepared By: IRENE S. LIM, MD, DPBP Psychiatrist
Noted By: ARTHUR C. LORENZO, MD Jail Senior Superintendent Chief, Health Service Office

Reviewed By: ALLAN S. IRAL, CESE Jail Chief Superintendent Deputy Chief for Administration of the Jail Bureau/Quality Management Representative

Approved By: DEOGRACIAS C. TAPAYAN, CESE Jail Director Chief, BJMP
III. Summing-Up/ Termination phase

Focus on ways to help oneself and others

1. Ways to help oneself

- Recognize and accept feelings about the situation
  - your own and those of others
- Accept the current situation
  - plan accordingly
  - keep informed, avoid passing rumors
  - have short-term goals and a routine for the present situation
- Gauge what is a reasonable amount of focus on the situation and
  limit anxiety-producing or burdensome interactions
- Practice self-care; exercise, good physical nourishment and enough
  rest

2. Ways to help others

- Understand other's stress behaviour

Prepared By:
IRENE S. LIM, MD, DPBP
Psychiatrist

Reviewed By:
ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration
of the Jail Bureau/Quality Management
Representative

Noted By:
ARTHUR C LORENZO, MD
Jail Senior Superintendent
Chief, Health Service Office

Approved By:
DEOGRAÇIAS C TAPIYAN, CESE
Jail Director
Chief, BJMP

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• Cultivate calmness – ask group how to take deep breath, relax shoulders, lower voice pitch and speak more slowly

• Listen intelligently, discourage speculation, encourage facts, avoid grinding repetition of a negative nature

• Schedule and participate in community fun, seek out and include the quieter and more isolated community members. Include children and teens.

3. Follow up

Inform participants that the facilitators will speak to them personally in the next 24-48 hours and make arrangement for this. Take note of participants who need more attention especially those who need further evaluation and treatment by a mental health professional.

4. Thank the participants for their attendance

Prepared By:
IRENE S. LIM, MD, DPBP
Psychiatrist

Reviewed By:
ALLAN S IRAL, CESE
Jail Chief Superintendent
Deputy Chief for Administration of the Jail Bureau/Quality Management Representative

Approved By:
DEOGRACIAS C TARAYAN, CESE
Jail Director
Chief, BUMP

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Guidelines on the Role/Responsibilities of the MHPSS Facilitators

I. Preparation before the meeting
   1. Come early to prepare the room. He/she must know the exact place and time of session.
   2. Know the exact number of participants and arrange the chairs in circular manner.
   3. Prepare name tags.
   4. Welcome participants and make small conversations to make them feel comfortable.

II. Knowledge
   1. The facilitator must know and understand the following:
      a. Objective of the session
      b. Content of the session
      c. Activities of the session
      d. Profile of the participants

Prepared By: IRENE S. LIM, MD, DPBP Psychiatrist
Noted By: ARTHUR C LORENZO, MD Jail Senior Superintendent Chief, Health Service Office
Reviewed By: ALLAN S IRAL, CESE Jail Chief Superintendent Deputy Chief for Administration of the Jail Bureau/Quality Management Representative
Approved By: DEOGRACIAS C TAPAYAN, CESE Jail Director Chief, BJMP

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2. Must know well his/her assigned tasks during the session. If a co-facilitator is present, prearranged division of tasks is necessary. Getting to know your co-facilitator before the session is important.

III. Skills

1. Must be able to motivate and encourage the participants to share/express their ideas, opinions and feelings
2. Emphasize that each one can learn something new from each other’s ideas and experiences
3. Clarify with the group that there are no wrong answers. What is important is to be open to one another
4. Ask the group if they are feeling comfortable. Once in a while, ask comments/suggestions from the participants
5. After the session, ask the participants how they feel and what they think about the session? What aspects of the session did they like and didn’t like? What did they learn from the session?
IV. Attitudes

1. Must set a friendly and warm atmosphere by politely inviting each one inside the meeting room. Give importance to everyone. Address each by their first names.

2. Always maintain eye contact with participants. Should note taking during the session becomes important, it is best to ask permission from the participants before the session begins.

3. Acknowledge sincerely the ideas and feelings shared by the participants

4. Be conscious of one’s body language and facial expression

5. Must be flexible and can adjust within the group

6. Mood of the facilitator is very important. It affects the performance and enthusiasm of the group. Feel and look relaxed. Share honestly one’s feelings when appropriate

MHPSS is useful in providing:

1. Ventilation of intense emotions

2. Exploration of symbolic meaning of events to those expected

3. Group support under catastrophic conditions

4. Initiation of the grief process within a supportive environment

Prepared By: IRENE S. LIM, MD, DPBP Psychiatrist

Reviewed By: ALLAN S IRAL, CESE Jail Chief Superintendent Deputy Chief for Administration of the Jail Bureau/ Quality Management Representative

Approved By: DEOGRACIAS C. TAPIYAN, CESE Jail Director Chief, BJMP

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5. Reduction of the fallacy of uniqueness - that the participant is alone in his feelings
6. Reassurance that intense emotions under catastrophic conditions are normal
7. Preparation for the possibility of the development of a variety of symptoms in the aftermath of a serious crisis
8. Education regarding normal and abnormal stress response syndrome and management
9. Encourage for continued group support and professional assistance

**Pitfalls to Avoid in the Conduct of MHPSS**

1. Facilitator is untrained
2. Unavailability of Mental Health Professional to refer to
3. Inadequate facts
4. Debriefing is not a therapy
5. Inadequate networking/coordination
6. Poor community approach
7. Lack of emphasis on confidentiality
8. Writing notes while in session
9. When it is intrusive

Prepared By: IRENE S. LIM, MD, DPBP Psychiatrist
Noted By: ARTHUR C LORENZO, MD Jail Senior Superintendent Chief, Health Service Office
Reviewed By: ALLAN S IRAL, CESE Jail Chief Superintendent Deputy Chief for Administration of the Jail Bureau/Quality Management Representative
Approved By: DEOGRACIAS C TARAYAN, CESE Jail Director Chief, BJMP

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10. Lack of input on the part of the facilitator
11. Role of facilitator is not clear to the group/organization or community affected by the disaster
12. Facilitator is late in the session
13. Participants are seated quite apart
14. None or not enough eye contact
15. Facilitator’s body language seems not to convey concern, warmth or sincerity
16. When there are late comers and other disruptions
17. Language barriers
18. No follow up or appropriate referral
19. No buddy system or a back up to take over in case a facilitator becomes highly emotional
20. Accepting too many groups to be debriefed during the day
Other psychosocial therapies can be offered depending upon the needs of the clients and the capability of the counsellors. Cases that could not be handled by the psychologist or social workers shall be referred to the jail psychiatrists. Inmates and personnel who prefer to have special sessions with private counsellors shall be referred to his/her counsellor or choice. Expenses incident to the referral and professional fees of the outside professional shall be borne by the inmate or personnel. Inmates for outside counselling can be referred upon issuance of Court Order.

1. Specific Counselling

The psychologist in charge will construct counselling program that addresses specific concerns of the personnel.

Issues that may be addressed during specific counselling include the following:

a.) Physically, verbally, psychologically and economically abused personnel
b.) Personnel with intense guilt feelings to include “survivor guilt” after traumatic event.
c.) Phase of Life Crisis
d.) Marital conflict
e.) Relationship issues
f.) Interpersonal issues
g.) Job stress/ work-related stress
h.) Loss of loved ones
2. Psychotherapies
   a) Supportive
   b) Cognitive-behavioural
   c) Insight-oriented
   d) Motivational Interviewing