

NH DEPARTMENT OF CORRECTIONS POLICY AND PROCEDURE DIRECTIVE	CHAPTER <u>Health Services</u> STATEMENT NUMBER <u>6.05</u>
SUBJECT: MENTAL HEALTH SERVICES PROPONENT: <u>Robert MacLeod, Admin. Director</u> <i>Name/Title</i> <u>Medical/Forensic Services 271-3707</u> <i>Office Phone #</i>	EFFECTIVE DATE <u>04/01/08</u> REVIEW DATE <u>04/01/09</u> SUPERSEDES PPD# <u>6.05</u> DATED <u>06/15/07</u>
ISSUING OFFICER: <u>William Wrenn, Commissioner</u>	DIRECTOR'S INITIALS _____ DATE _____ APPENDIX ATTACHED: YES _____ NO _____
REFERENCE NO: See reference section on last page of PPD.	

I. PURPOSE:

To describe the Mental Health services and their delivery process

II. APPLICABILITY:

To all staff, especially those involved in the referral and delivery of mental health services.

III. POLICY:

It is the policy of the Department of Corrections to provide all inmates with access to appropriate mental health services. The goal of such services is to improve the inmate's adjustment to prison and society.

A. The Mental Health Services is staffed by qualified mental health professionals who meet the following requirements:

1. Education, license/certification criteria specified by their professional discipline;
2. Criteria established by statute (RSA 330-A:16) defining alternate qualifications for mental health professionals in state service, noted by the New Hampshire State Division of Personnel;
3. Professionally qualified consultants (e.g., psychiatrists).

B. The Mental Health staff screen inmates and may examine, refer, or consult for diagnosis and treatment any inmate who exhibits significant mental illness.

C. Core provisions of the mental health delivery system include:

1. Mental health initial assessment
2. Evaluations
3. Counseling
4. Psychiatric treatment
5. Emergency services
6. Staff training/suicide prevention/mental health awareness

D. Supervision

The Bureau of Mental Health is administratively a part of the Division of Medical and Forensic Services and is directed and supervised by the Medical Director of Forensic Services. The Medical Director of Forensic Services supervises the Chief of Mental Health

who is a certified/licensed clinical psychologist. The health authority approves policies and procedures.

E. Mental Health Transfers

Any inmate whose mental condition creates a danger to themselves or others shall be transferred to an appropriate facility as per PPD 6.10 Suicide Prevention and Intervention. Except in emergency situations, there will be joint consultation between the Warden, physician, or psychiatric mental health nurse prior to any action taken in the following areas:

1. Housing assignments
2. Program assignments
3. Disciplinary measures
4. Transfer to other institutions when an emergency action has been required, this consultation occurs as soon as possible, but no later than the next workday so as to review the appropriateness of the action.

All inmates to be transferred to facilities for the severely mentally ill or developmentally disabled shall be provided a hearing concerning the transfer unless the inmate signs a voluntary waiver (see PPD 6.10)

IV. PROCEDURES:

A. Initial Mental Health Assessment

1. A trained mental health staff member will individually interview all inmates incarcerated within the Department of Corrections within their first 14 days of incarceration . This screening includes but is not limited to:
 - Inquiry into:
 - Whether the inmate has a present suicide ideation
 - Whether the inmate has a history of suicidal behavior
 - Whether the inmate is presently prescribed psychotropic medication
 - Whether the inmate has a current mental health complaint/current mental health status
 - Whether the inmate is being treated for mental health problems
 - Whether the inmate has a history of inpatient and outpatient psychiatric treatment
 - Whether the inmate has a history of treatment for substance abuse
 - Whether there is a sexual abuse-victimization and/or predatory behavior history
 - Observation of:
 - General appearance
 - Evidence of abuse and/or trauma
 - Current symptoms of psychosis, depression, anxiety and/or aggression
 - Review of:
 - Educational history
 - Psychotherapy, psycho-educational groups and classes or support group history
 - Disposition of offender:
 - To the general population
 - To the general population with appropriate referral to mental health care services
 - Referral to appropriate mental health care services for emergency treatment
2. The inmate will be given a written copy of the mental health confidentiality statement. The policy will be explained to any inmate who needs clarification. If English is not understood and spoken by the inmate, alternate arrangements shall be made to interpret and communicate with the inmate.
3. The mental health staff shall address urgent concerns/needs for professional follow-up immediately.
4. The mental health staff shall, through the referral process address non-urgent concerns/needs for professional follow-up

B. Evaluations

1. Referrals from other departments shall be reviewed utilizing a triage system. The Chief

of Mental Health will review the evaluation for appropriateness and content. The Chief of Mental Health will assign the referral to the appropriate mental health staff to assess.

2. An appropriate assessment will be made within 14 days of receipt of the referral by mental health services staff.

C. Intersystem Transfers

All intersystem inmates will undergo a mental health appraisal by a qualified mental health person within 14 days of admission unless there is evidence that an appraisal was done within the past 90 days unless the designated mental health authority determines that a new appraisal is needed.

D. Counseling/Treatment Planning

1. A formal treatment plan shall be required for every inmate who is prescribed psychotropic medications or who is in the Health Pathways Program. A formal treatment plan is also to be prepared for any inmate who receives mental health treatment through group therapy and/or four or more individual mental health counseling sessions. A collaborative treatment plan will be developed for offenders meeting with both psychiatry and therapeutic staff, the therapeutic staff will ensure the collaboration.
2. After assessment of the individual's needs, the outcome of a referral, request slip or responder call may result in a recommendation for counseling. Counseling may be among the following offerings:
3. Short term individual counseling: After 4 initial visits, documentation is required as to whether the individual is appropriate for continued treatment (e.g. establishment of a treatment plan) or if no further treatment is required at this time.
 - a. If continued treatment is noted in a treatment plan, referral is made for one or more of the following:
 - 1) Problem-focused group therapy as available and as deemed appropriate by the assigned mental health professional. Group therapy will vary in the number of visits. An update of the treatment plan will be required when either the group or therapy is completed or after a set number of visits pre-established by the duration of the group schedule.
 - 2) Individual therapy including referrals to assess the appropriateness of inclusion in Healthy Pathways (see PPD 6.31). Individual therapy will consist of 12 visits for the initial first year of treatment. After 12 visits, the mental health professional will need approval from their immediate supervisor for further visits. The treatment plan will be updated every 6 months.
4. Psychiatric treatment: Referral is made for assessment of medication needs to treat mental health issues. A treatment plan will be established and updated every 6 months if psychiatric medication is prescribed as a result of the assessment.
5. Individuals receiving both psychiatric treatment and counseling shall have only one treatment plan developed collaboratively by the Psychiatric Practitioner and the therapist. These plans will be reviewed in the same manner with every six month updates.

E. Clinical Documentation Requirements

1. The NHDOC has an electronic mental health record referred to as CHOICES, staff are required to use this system to document their interactions with inmates. In the event that the system due to electrical or other unknown reasons, fails, as reported to them by the Office of Information Technology, staff are to use these minimum guidelines to continue documenting their interactions.
 - a. Biopsychosocials will be completed prior to the development of a treatment plan and will include at a minimum:
 - 1) History of Presenting Problems/Presenting Problems/Current Symptoms
 - 2) Psychiatric History/Family History

- 3) Chemical Dependency Treatment History/Family History
 - 4) Military History
 - 5) Cultural/Spiritual
 - 6.) Criminal History
 - 7.) Medical History including medications prior or current
 - 8.) Social History
 - 9) Mental Status
 - 10) Violence Risk
 - 11) Suicide Risk
 - 12) Diagnostic Impressions (Axis I – V)
2. Treatment Plans will follow the format provided within our electronic mental health record and always reflect no less than these areas. Offenders receiving services with both psychiatry and therapeutic staff will have one collaborative treatment plan:
 - a. Diagnosis (Axis I-V)
 - b. Problems as evidenced by
 - c. Goals
 - d. Target Date
 - e. Treatment Strategies
 - f. Responsible Parties (Client/Clinician)
 - g. Signature of Client and Clinical staff involved
 - h. Date Established
 3. Treatment Plan Updates that occur every 6 months will include no less than:
 - a. Current Diagnosis
 - b. Any Changes in Diagnosis
 - c. Progress (Achievements/Setbacks)
 - d. Updated Treatment Goals/Interventions
 - e. Current Medications/Changes in Medications
 - f. Overall Progress
 4. Progress Notes will be completed for every individual counseling or responder contact in the form of a SOAP (Situation; Observation; Assessment; Plan) note in the offender's medical chart.
 - a. During a responder contact, the clinician will document in the chart a complete risk assessment for violence and suicidality when there is a question of harm to self or others as well as a SOAP note for the contact that communicates the reason and outcome of the interaction.
 - b. Elements of a risk assessment at a minimum must include in the SOAP note:
 - 1) These are general risk increasing factors: current suicide attempt or ideation, history of suicide attempts/ideation, psychiatric/mental health history, substance abuse history, depression/hopelessness, history of abuse, rejection by or lack of support system.
 - 2) General risk reducing factors: denial of suicidal ideation/homicidal ideation, no suicide history, no psychiatric/mental health history, no substance abuse history, not depressed or psychotic, medication compliant if on medication, has support system.
 - c. When an assessment is completed on a SHU transfer by a mental health clinician, a suicide risk assessment will be completed and documented in a SOAP note in the offender's medical chart.
 - d. During an individual counseling contact, the clinical staff will document the contact in a SOAP note before the end of the same day of the contact
 - e. Progress notes for group counseling will be completed one time weekly for each participant and a monthly summary that will include at a minimum:
 - 1) Group Behavior Ratings: e.g. interest in group, sharing of emotions, listening skills

- 2) Monthly Evaluation: e.g. participation, discussion of issues, motivation, objectives being met
- 3) Signature of Therapist and co-therapist when applicable
- 5. Discharge Summaries will include at a minimum:
 - a. Client Identification Information
 - b. Initial Diagnosis and Discharge Diagnosis
 - c. Services Provided and Discharge Status
 - d. Presenting Problem and Assessment
 - e. Clinical Course
 - f. Psychiatric Status
 - g. Medications History/Current Medications
 - h. Post-Discharge Plan
 - i. Client Statement/Signature
 - j. Clinical Endorsement
- 6. CHOICES
 These are the steps and visual images of the system that will be required to access in order to effectively document the clinical interactions between mental health staff and inmates.
 - a. First staff sign-on into the system using this screen:



Welcome to Choices!!

User Name:

Password:


- b. Then staff – search using the Inmate Search feature for their client:

Fast Links

- ▶ [Inmate Search](#) - To start Mental Health Documentation
- ▶ [Change Your Password](#)
- ▶ [User Manual](#)
- ▶ [Request Assistance](#)


- c. Once staff select the inmate search feature, they must search using anyone one of these variables to select the correct offender:

Inmate Search 


	ID	Book #	First Name	Last Name	Location	Display	
 Locate an Inmate	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	View All <input type="button" value="v"/>	First Name, Last Name <input type="button" value="v"/>	<input type="button" value="GO"/>

- d. If you search by name you will get a list of offenders and then must select the view option of the correct offender name to begin starting anyone of the mental health documents.
- e. At this point you arrive at the main screen for the selected inmate and all of the documents available through the system as of 2/7/08 are identified below:


Initial Mental Health Screening Information 

 Edit	Last Updated	Interviewer
	1/16/2008 10:36:44 AM	


BioPsychoSocial Information 

 Edit	Last Updated	Interviewer
	1/16/2008 10:37:21 AM	

Treatment Plan Information 


 Edit	Last Updated	Interviewer
	2/7/2008 3:51:34 PM	


Treatment Plan Review Information 


 Edit	Last Updated	Interviewer
	2/7/2008 3:54:20 PM	

SOAP Information 

View	Last Updated	Interviewer
	2/7/2008 3:51:24 PM	Helen Hanks
 Add SOAP		

Discharge Information 

 Edit	Last Updated	Interviewer
	2/7/2008 3:55:15 PM	

Referral Information 

Last Updated	Status	Priority
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Appointment Information 

Last Updated

Type

Status

Blank Forms 

[View](#)

Discharge Letter

[View](#)

Informed Consent for Medication

[View](#)

Consent to Outpatient Behavioral Health Services

f. Using the Edit or View options enters you into the form to begin entering the data.

g. The initial mental health screening includes these areas of data entry:

General

Suicide

Family/Social

Education

Mental Health

Substance Abuse

Mental Status

PREA

Trauma

Interviewer

Review/Finalize

h. The Bio-psychosocial includes these areas of data entry:

Reasons

Family

Marital

Parental

Development

Social

Cultural / Spiritual

Legal

Education

Employment

Military

Leisure

Medical

Medications

Chemical

Substance Abuse

Counseling

Behavior
Interviewer
Review/Finalize

- i. The Treatment Plan includes these areas for diagnostic ruling and goal development for data entry:

Presenting
Mood - Adjustment
Mood-Depression
Mood-Dysthymia
Mood-Mania
Mood-Panic Attacks
Mood-Anxiety
Mood-Other
Mental Status Checklist
Mental Status Additional
Diagnosis Validation
Diagnosis
Considerations
Goals
Interviewer
Review / Finalize

- j. The Treatment Plan Review includes for data entry:

Current Goals
Status
Updated Goals
Interviewer
Review / Finalize

- k. The Discharge Plan includes:

Initial Diagnosis
Exit Diagnosis
Summary Services
Presenting Problem
Clinical Course
Medical / Psychiatric
Post Treatment
Client Statement
Interviewer
Review/Finalize

- l. All Documents require a review and finalize as these are permanent records and legal records, once finalized no changes to the document can be made any errors will have to be documented through a SOAP note or note in the treatment plan review.

7. Referrals to mental health will at a minimum list exhibiting symptoms, current functional impairments, current medications, past and recent mental health treatment, and unusual behavior.

8. Conducting Mental Health Chart Reviews

As part of maintaining an effective quality improvement review of mental health documentation by our clinical staff, clinical leadership, for each site, will conduct chart reviews of at a minimum 10 charts of offenders utilizing mental health services each quarter to ensure treatment planning and other clinical documentation is being documented (see attachment 1).

Completed Chart Reviews will be sent to the Director of Medical & Forensic Services for quality review and to compile a report on the information gathered specifically on documentation compliance and accuracy.

F. Emergency Services

1. Consult PPD 6.10 for instructions regarding suicidal or dangerous behaviors.
2. Urgent referrals between the hours of 0800 and 1600 Monday through Friday should be telephoned into the Mental Health Department. If unable to reach staff by telephone, the unit should follow these instructions depending on the facility location:
 - a. NHSP-Men call Mental Health at 271-1850, if no answer use pager # 564-5701 to contact the daily assigned mental health emergency responder.
 - b. LRF call unit management, health services, and then Mental Health at 271-1850.
 - c. NHSP-Women call on-site Mental Health.
 - d. NCF - Call health services at 752-0345.
3. Non-urgent referrals shall be written using appropriate Mental Health Referral forms and sent to the Mental Health Department at NHSPM, NHSPW, NCF or Health Services at LRF.
 - a. If a Corrections Officer or other staff person observes an inmate exhibiting behaviors indicative of a mental illness, that person shall contact the unit Corrections Counselor/Case Manager or Officer in Charge (OIC) who shall evaluate the inmate for possible referral to Mental Health Services.
4. This is an outline of the circumstances under which the Mental Health Responder should be notified.
 - a. If an inmate is clearly displaying suicidal ideas such as stating that they are going to harm or kill themselves. For example the inmate may talk about “hanging it up” or “ending it all”.
 - b. If an inmate is actively psychotic as exhibited by hearing voices or seeing things that are not really there.
 - c. If the inmate is experiencing an acute episode of anxiety as exhibited by at least four of the following criteria: hyperventilating, shaking, muscle tension, restlessness, fear of losing control or “going crazy”, or nausea.
 - d. If an inmate is observed to be acting in a radically different manner or is displaying bizarre behavior such as isolating themselves from others, not bathing or attending to personal hygiene, or acting overly paranoid and suspicious of others.
 - e. If the inmate replies yes to any of the R&D booking questions regarding suicidal thoughts, attempts, or plans
 - f. ANY inmate being transferred to SHU must be screened for suicide risk and mental health issues.
5. If the inmate does not meet any of the above criteria, the Mental Health Responder should not be notified. If the inmate requests to see mental health for reasons other than those stated above, please supply them with a request slip so that they may schedule an appointment to see a mental health clinician and/or refer them to the Counselor/Case Manager.
6. If an inmate is behaving in any other way that causes you to be suspicious, he should be first screened by the unit Counselor/Case Manager to determine if mental health should

be notified.

F. Inmate's Family Life and Catastrophic Events

Delivering sensitive news to the inmate is a delicate job. The following personnel will be enlisted for this job, in this order of preference as available:

1. Unit Corrections Counselor/Case Manager
2. Other unit management
3. Chaplain
4. Other personnel as appointed by the Administrator on duty.
5. Medical personnel

G. Counseling the Inmate After Catastrophic News

1. The inmate may need some time to think about their news away from the demands of the living unit. It may be appropriate to allow the inmate to sit with the personnel breaking the news for a short period of time. The inmate may want to talk or may wish to be silent.
2. It is recommended that personnel remain watchful of the inmate in the following 24 hours and if signs of mental distress develop beyond uncomplicated grieving, follow PPD 6.10 for response to suicidal or dangerous behaviors.

REFERENCES:

Standards for the Administration of Correctional Agencies
Second Edition Standards

Standards for Adult Correctional Institutions
Fourth Edition Standards

4-4368 thru 4372

Standards for Adult Community Residential Services
Fourth Edition Standards

4-ACRS-4C-15

Standards for Adult Probation and Parole Field Services
Third Edition Standards

Other

MACLEOD/pf

Attachment

**New Hampshire Department of Corrections: Mental Health Services
Chart Review Tool**

Instructions: The Chart Reviewer is to complete this form for each medical chart reviewed to assess the accuracy of the mental health documentation completed for the services rendered to each offender. When this is complete, please return all completed forms to the Director of Medical & Forensic Services for their inclusion in this quality improvement process.

Client's name: _____ ID#: _____ Date of review: _____

Therapist: _____ Reviewed by: _____

Check (√) the appropriate column.

Key : 0 = No 1 = Somewhat 2 = Yes

Background Information

0 1 2

___ ___ ___ Do the signs and symptoms coincide with and clarify the presenting problem?

___ ___ ___ Are the signs and symptoms clearly documented?

___ ___ ___ Does the history indicate stressors and/or circumstances demonstrating a need for services?

___ ___ ___ Is a relevant medical and mental health history included?

___ ___ ___ Does the biopsychosocial information include relevant areas of strength/weakness?

___ ___ ___ Does the biopsychosocial information depict cultural/spiritual concerns?

_____/12 total

Remarks: _____

Diagnostic Information

0 1 2

___ ___ ___ Is the diagnosis concordant with observations?

___ ___ ___ Is the diagnosis clearly validated by DSM symptoms criteria?

___ ___ ___ Are specific impairments due to the diagnosis listed?

_____/6 total

Remarks: _____

Treatment Plan

0 1 2

___ ___ ___ Are the treatment plan problem areas concordant with the diagnosis?

___ ___ ___ Does the treatment plan outline the type of services needed?

___ ___ ___ Are the goals and objectives/strategies realistic or attainable within the estimated time frames?

___ ___ ___ Are the specific objectives measurable or observable?

___ ___ ___ Are the treatment strategies appropriate?

_____/10 total

Remarks: _____

Progress Notes

0 1 2

- ___ ___ ___ Do the progress notes reflect the diagnosis and treatment plan?
- ___ ___ ___ Do the progress notes include specific data supporting continued need for services?
- ___ ___ ___ Are treatment strategies (including meds) clearly identified and assessed?
- ___ ___ ___ Are progress and setbacks of each session assessed?
- ___ ___ ___ Is a specific plan for each subsequent session noted?
- ___ ___ ___ If there are health/safety issues, are they addressed?

_____/12 total

Remarks: _____

Termination Procedures

0 1 2

- ___ ___ ___ Is the reason for termination noted?
- ___ ___ ___ Is the progress toward each goal documented?
- ___ ___ ___ Is the timing of termination appropriate?
- ___ ___ ___ Was a termination letter sent?
- ___ ___ ___ Is a 5 Axis discharge diagnosis included?

_____/10 total

Remarks: _____

Total score: _____ 50

Areas of concern: _____

Areas of strength: _____

Reviewers Comments/Suggestions: _____

Reviewer's signature: _____ Date: ____/____/____