

D. Supervision

Behavioral Health Services is administratively a part of the Division of Medical and Forensic Services; the Division is directed by the Administrator for Forensic services and clinically supervised by the Psychiatric Medical Director. The health authority, Director of Medical and Forensic Services, approves all recommended policies and procedures.

E. Behavioral Health Transfers

1. 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 provider prior to any action taken in the following areas:
 - a. Housing assignments
 - b. Program assignments
 - c. Disciplinary measures (See PPD 5.25)
 - d. 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.
2. All inmates to be transferred to facilities pursuant to RSA 623:1.

IV. PROCEDURES:A. Initial Mental Health Assessment

1. A trained behavioral health staff member will individually interview all inmates incarcerated within the Department of Corrections within their first 14 days of incarceration.

Inmates entering the facility (either through intake or transfer) whose length of stay in the facility is 72 hours or more will be screened for risk of sexual victimization or risk of sexually abusing other inmates using Attachment #2 **POTENTIAL FOR SEXUAL ASSAULT/SEXUAL VICTIMIZATION SCREENING INSTRUMENT** in PPD 5.19 *Prison Rape Elimination Act Procedures*. Mental Health, at the receiving site, will conduct this screening independent of the initial mental health screening in CHOICES if necessary to assure the 72 hours timeline is met.

The Initial Mental Health Assessment 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 inmate/resident:

- To the general population

To the general population with appropriate referral to behavioral health services
 To immediate referral to appropriate behavioral health care services for emergency treatment

This Assessment is completed in addition to the Potential for Sexual Assault/Sexual Victimization Screening Instrument.

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 behavioral health staff shall address urgent concerns/needs for professional follow-up immediately.
4. The behavioral 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 clinical supervisors will review the evaluation for appropriateness and content. The clinical supervisors 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 or unless the designated mental health authority determines that a new appraisal is needed.

D. Therapy/Treatment Planning

1. A formal treatment plan is also to be prepared for any inmate who receives mental health treatment through psychiatry, group therapy and/or four or more individual mental health therapy sessions. A collaborative treatment plan will be developed for inmates/residents meeting with psychiatric providers, clinical staff, sexual offender providers and licensed drug and alcohol counselors, the clinical 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 therapy. Therapy may be among the following offerings:
 - a. Short term individual therapy: 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.
 - 1) If continued treatment is noted in a treatment plan, referral is made for one or more of the following:
 - i) Problem-focused group therapy as available and as deemed appropriate by the assigned behavioral 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.
 - ii.) Individual therapy including referrals to assess the appropriateness of inclusion in severely persistent mentally ill (see PPD 6.31).
 - iii.) The treatment plan will be updated every 6 months at a minimum.
 - b. Psychiatric treatment: Referral is made for assessment of medication needs to treat mental health diagnoses. A treatment plan will be established and updated

every 6 months if psychiatric medication is prescribed as a result of the assessment.

3. Individuals receiving both psychiatric treatment and therapeutic services 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.
4. At any time if clinically indicated, an individual can be referred by a clinician for potential admission and treatment in the Residential Treatment Unit (RTU). Please refer to PPD 6.32 for a detailed explanation of the RTU referral and admission process.
5. Discharge planning will take place at least 9 months prior to the inmate's max release date or notification of parole or upon completion of treatment needs.

E. Psychological Services

1. Psychological services/referrals are supervised and triaged by the Chief psychiatric provider, Administrator of forensic services and Chief Psychologist.
2. Psychological services are staffed by licensed psychologists and qualified psychological associates.
3. The licensed psychology staff may provide clinical supervision to master's level clinicians in individual and structured group formats.
4. The psychology staff provides training and consultation to other staff upon request to the Chief Psychologist/designee (e.g. difficult cases, diagnostic, specialized treatment plans). These requests are responded to within 14 days.
 - a. The psychology staff functions in leadership roles (e.g. clinical oversight, facilitation of meetings, consultation) as directed by the Chief Psychologist/designee or division leadership.
5. The psychology staff provides psychological testing or assessment services upon referral to the Chief Psychologist/designee. These services are available to all facilities, including SPU/RTU.
 - a. Referrals for psychological testing or assessment should present a specific question (diagnostic clarification, cognitive assessment, parole assessment) including data supporting the referral. Referrals will be responded to within 14 days. Referrals should not be made just prior to an inmate leaving a NHDOC institution unless accompanied by data justifying the immediacy of the referral.
6. The psychology staff provides individual and group psychotherapy services on more difficult cases upon referral to the Chief Psychologist/designee.
7. The psychology staff completes all initial mental health intake screenings at New Hampshire State Prison for Men.

F. Clinical Documentation Requirements

1. The Department has an electronic mental health record referred to as CHOICES. Staff is required to use this system to document their interactions with inmates. In the event that the system fails, the staff is to use these minimum guidelines to continue documenting their interactions.
 - a. Bio-psychosocials will be completed prior to the development of a treatment plan and will include at a minimum:
 - 1) History of 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; and/or
 - 12) Diagnostic impressions.
2. Treatment plans will follow the format provided within our electronic mental health record and always reflect no less than these areas. Inmate/resident receiving services with both psychiatry and therapeutic staff will have one collaborative treatment plan:
 - a. Diagnosis; and
 - b. Problems, as evidenced by:
 - i. Goals;
 - ii. Target date;
 - iii. Treatment strategies;
 - iv. Responsible parties (Client/Clinician);
 - c. Signature of client and clinical staff involved; and
 - d. 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; and/or
 - f. Overall progress.
 4. Progress Notes will be completed for every individual therapy or responder contact in the form of a SOAP (Situation; Observation; Assessment; Plan) or DAP (Data; Assessment; Plan) note in the inmate's/residents medical chart.
 - a. During a responder contact, the clinician will conduct a risk assessment (Per PPD 6.10) for when there is a question of harm to self or others as well as document the contact that communicates the reason and outcome of the interaction in the Departments electronic mental health record.
 - b. In the event that the electronic mental health record is not operable, the elements of a risk assessment must include in the SOAP note at a minimum:
 - 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 progress note in the electronic mental health record and on the appropriate form (Per PPD 6.10) in the inmate's/residents medical chart.
 - d. During an individual therapy contact, the clinical staff will document the contact before the end of the same day of the contact.
 - e. Progress notes for group therapy will be completed at a minimum one time weekly for group therapies that offer two sessions of group per week for each participant and for each separate group attended per week will result in a group note per session 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; and/or

- 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; and/or
 - j. Clinical endorsement.
- 6. CHOICES
 These are the steps and visual images of the system that staff 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 selects the Inmate Search feature, they must search using any one of these variables to select the correct inmate/resident:

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 inmates/residents and then must select the view option of the correct inmate/residents name to begin starting any one 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 11/18/2013 are identified below:
 - i. Initial Mental Health Screening Information;
 - ii. Bio-Psychosocial Information;
 - iii. Treatment Plan Information;
 - iv. Treatment Plan Review Information;
 - v. SOAP Information;
 - vi. Progress Notes; and
 - vii. Discharge Information.
- 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****Therapy****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 are required to be reviewed and finalized 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 an Incident Report for review and consideration of extraction from the system.

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 Behavioral Health Chart Reviews
 - a. As part of maintaining an effective quality improvement review of behavioral health documentation by our clinical staff, quality improvement staff will conduct, a minimum of 10 chart reviews of inmates utilizing behavioral health services each quarter to ensure treatment planning and other clinical documentation is being documented (see attachment 1).
 - b. 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 paged into the responder. If unable to reach staff by paging, the unit should follow these instructions depending on the facility location:
 - a. NHSP-Men call Behavioral Health pager # 564-5701 to contact the daily assigned mental health emergency responder.
 - b. NHSP/W call Behavioral Health pager #603-517-6406
 - c. NCF - Call health services at 752-0345.
 3. Non-urgent referrals shall be written using appropriate CORIS Behavioral Health Referral forms and sent to the Behavioral Health Department at NHSPM, NHSPW or NCF.
 - 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 (CC/CM) or Officer in Charge (OIC) who may consider the inmate for possible referral to Behavioral Health Services.
 4. This is an outline of the circumstances under which the Behavioral 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 an 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 an inmate replies yes to any of the booking questions regarding suicidal thoughts, attempts, or plans, upon arrival into Reception & Diagnostic.
 - f. ANY inmate being transferred to restricted housing must be screened for suicide risk and mental health issues.
 5. If an inmate does not meet any of the above criteria, the Behavioral Health Responder should not be notified. If an inmate requests to see Behavioral 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, provide sick call hours and/or refer them to the Counselor Case Manager (CC/CM).
 6. If an inmate is behaving in any other way that causes you to be suspicious, he/she should

screened by mental health.

F. Inmate's Family Life and Catastrophic Events

Delivering sensitive news to an inmate is a delicate job. The following personnel will be enlisted for this job, in this order of preference as available, once the information has been validated through security:

1. Chaplain;
2. Behavioral Health Staff; and/or
3. Medical personnel.

G. Counseling an 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.

H. Monitoring of Behavioral Health Cases in the Special Housing Unit (SHU).

1. Offenders who are severe and persistently mentally ill and/or on psychiatric medications will be monitored every 14 business days while housed in SHU.
2. The Behavioral Health Staff will follow the protocols as outlined in Attachment 1

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

National Commission on Correctional Health Care
Standard for Health Services in Prisons: 2008

P-E-04 & P- G-04

Other

HANKS/clr



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Special Housing Unit (SHU) – Behavioral Health (BH) Procedures

Treatment Services Offered

Function	Court-Ordered	Parity Service to General Population	Other
14 Day Clinical Appointments	Holliday Court Order 2005 – paragraph 8 of the 2001 Settlement Agreement	NA	
Quarterly Group requirement	Holliday Court Order 2003 – #28	Yes – with regard to group service availability	
SHU Mental Health Rounds	No	No	To provide another venue for maximum security inmates to access BH services
Risk Assessment and suitability review for all who are housed in SHU prior to cell assignment Check to see medications are provided.	Yes		Risk Management result of Root Cause Analysis and agreement with NHLA
Training for SHU Correctional Staff	2001 Laaman Settlement Mental Health- #21		
Mental Health Sick Call		Yes	
Follow-up on Refusals to participate in 14 day clinical appointments; Complete SHU chart reviews 5 per month.		No	To increase effectiveness of 14 day clinical appointments
SHU/CCU Group Continuity		No	Create an open group for participants between these two housing units to increase treatment opportunities and continuity
Moving Forward	No	No	To assess SHU inmates preparedness for change and assess readiness for other mental health interventions which may include a referral to Residential Treatment Unit (RTU)

*** References to SHU shall also indicate C-Tier for Goffstown

SHU 14 Day Clinical Appointments by Non-Prescribing Clinician Protocol

Purpose: This protocol outlines the required steps to take when conducting the as ordered (Holliday 2005) “In accordance with paragraph 8 of the 2001 Settlement Agreement, clinical appointments shall be scheduled at least every 14 days with each inmate in SHU who is prescribed psychotropic medications or is in the Healthy Pathways Program” (currently SPMI policy)

Location: Pursuant to Paragraph 8 of the 2001 Settlement Agreement, “These clinical visits shall take place outside of the inmate’s cell in a clinically appropriate setting in SHU that ensures both privacy and safety.

Function:

1. These clinical appointments with a MHU clinician shall be in addition to prescriber medication management visits and “rounds” conducted in SHU.
2. These encounters are documented in CHOICES in a Progress note indicating in the first section under “Other” as “**SHU 14 day clinical appointment**”. If in addition to the clinical appointment, the Clinician is seeing the inmate for other purpose (eg. PPD 6.10), the clinician must also check off the other applicable boxes.
3. If the inmate refuses to meet, this must also be documented in a Progress note in Choices. The Clinician needs to document any and all interventions used to motivate the inmate to leave their cell to meet for the clinical appointment as well as the refusal.
4. A Clinician from the Mental Health Services unit will be designated as primarily responsible for completing these clinical appointments, additional support from another Clinician as designated by the Administrative Clinical Leader will be assigned during times of planned and unplanned time off from work. A spreadsheet (Excel Format) has been created and is located on the Prison drive entitled – “SHU Medication Monitoring.xls”
5. These Appointments will be scheduled through the SHU OIC on the day of the appointment. An appointment list is given to the SHU OIC in the absence of the Clinician responsible, the Responder of the day will follow the same procedures to cover this Court Required responsibility. For planned absences this will be coordinated a week in advance of the leave. For unscheduled absences, the Clinician will keep a schedule in a central location, as indicated in #4, so the Responder can access these appointments as necessary for coverage.
6. The Clinical appointments will include at a minimum
 - a. A Mental Status Examination
 - i. Appearance
 - ii. Interaction
 - iii. Speech
 - iv. Mood/Affect
 - v. Thought Process
 - vi. Thought Content
 - vii. Suicidality
 - viii. Violence
 - b. A review of their medications and any reported side-effects for triaging to Psychiatry
 - c. A subjective statement of the inmates current emotional status
 - d. An Assessment of diagnosis/es with reflection of psychiatry’s perspective
 - e. A Plan of care that may or may not include changes to an existing treatment plan, referral to counselor case manager, assignment to a new Mental Health Group, a triage to medical staff, or other inmate specific outcome based on the clinical appointment
 - f. A report will be generated monthly of these clinical appointments and forwarded to the Administrator of Outpatient based Prison Behavioral Health Services, the Chief Psychiatrist, the Division Director, and Quality Improvement Administrator

Quarterly Group Requirement

Purpose: In response to the requirement outlined in the 2003 Laaman Amended Settlement concerning SHU, the Department agrees to provide a psycho-social skill development program in SHU. Such program will be provided at such times as appropriate, in consultation with the Mental Health Unit. The Service shall be offered in SHU at least two (2) times per year. The Division of Medical & Forensic services has

indicated these will operate in quarterly cycles with offering 4 times a year for offenders referred in SHU by the staff assessing needs.

Location: Special Housing Unit (SHU) in the therapy booths facilitated by a member of the mental health staff.

Function:

- 1.) The clinician assigned to facilitate groups will meet with Psychiatry overseeing the care for SHU mental health clients and determine based on diagnostic groupings, symptoms, and goals of their treatment plans the appropriate evidence-based group treatment intervention.
- 2.) The clinician will document all group intervention using CHOICES in the group notes per PPD 6.05

SHU Mental Health Rounds

Purpose: To enhance access of SHU inmates to mental health services while they are subject to living within a maximum security setting. SHU inmates who experience different levels of security assignments may experience unpredictable long and short term reactions to approaches to single cell occupancy, segregation, punitive segregation as well as longer term existence within a restricted maximum security setting. Inmates with and without mental health history may have some risk of developing or exacerbating a mental health illness.

Location: Special Housing Unit (SHU), to occur outside individual cells, in a treatment room designed for this level of encounter not on the tier outside their door.

Function: At a designated time(s) the assigned mental health clinician will walk all the occupied tiers within the SHU and inquire at each cell whether its occupant is in need of a mental health contact

Risk Assessment and suitability review for all who are housed in SHU prior to cell assignment

Purpose: As a result of a Root Cause Analysis of a completed suicide, we conduct initial screenings on all offenders being sent to SHU for housing for risk assessment purposes and suitability.

Location: Special Housing Units in the Department of Corrections, including C-Tier at the Women's Facility

Function: SHU at NHSP: Men

- 1.) Prior to being placed in a cell, mental health will conduct a suicide risk assessment and suitability review of the offender's placement in SHU. If mental health is not on-site, nursing staff will conduct the assessment within health services. All staff will complete appropriate clinical documentation recording the assessment and outcome of assessment in the offender's health record or CHOICES, the electronic mental health record. A standardized suicide risk assessment will be completed and sent to be filed in the offender health record.
- 2.) If the offender presents at risk through the mental health or nursing assessment, alternative housing arrangements will be made and the staff will follow the policy as outlined in PPD 6.10 to secure the offender for their safety.
- 3.) Offenders will not be placed in SHU dayrooms on pre-cautionary watches.

Function: C-Tier at NSHP-Women

“Tank” Placement Due to Suicidality

- 1.) If an offender is placed in the “tank” due to suicidality, prior to being placed in a cell, mental health/nursing after conducting a suicide risk assessment will consult with on-site psychiatry and if not available will page the on-call psychiatry staff to affirm the appropriate placement of the offender.

“Tank” Placement for Clearance to C-Tier

- 1.) Prior to being placed in a cell on C-Tier, mental health will conduct a suicide risk assessment and suitability

review of the offender's placement in C-Tier. If mental health is not on-site, nursing staff will conduct the assessment within health services. All staff will complete appropriate clinical documentation recording the assessment and outcome of assessment in the offender's health record or CHOICES, the electronic mental health record. A standardized suicide risk assessment will be completed and sent to be filed in the offender health record.

- 2.) If the offender presents at risk through the mental health or nursing assessment, alternative housing arrangements will be made and the staff will follow the policy as outlined in PPD 6.10 to secure the offender for their safety. Psychiatry will be consulted.

Training for SHU Correctional Staff

Purpose: In response to the 2001 Laaman Settlement – Mental Health section 21.) – Training of correctional officers/security staff shall be increased to accommodate additional training in daily interaction with mentally ill inmates and additional suicide prevention training. Priority for such training shall be for correctional officers assigned to SHU.

Location: Appropriate training venues/ On-Site SHU

Function:

- 1.) On a quarterly basis, a trainer will provide for all three shifts within SHU a training that addresses the purpose of this function.
- 2.) Attendance will be documented and the curriculum will be submitted to the Director of Medical & Forensic Services and the DOC Administrator of Quality Assurance for monitoring

Follow-up on Refusals to participate in 14 day clinical appointments

Purpose: To enhance SHU inmate participation in 14 day clinical appointments and to examine if there are any existing barriers to such participation

Location: Special Housing Unit (SHU), identical to the procedure for 14 day clinical appointments

Function: A list of inmates who declined their 14 day clinical appointment will be forwarded by the clinical mental health clinician conducting the 14 day clinical appointments to an assigned mental health clinician (Chief Psychologist) who will offer each inmate further assessment

SHU/CCU Group Continuity

Purpose: To identify cognitive and behavioral barriers to general ability to socialize and function within a general population (GP) setting, and to enhance this functioning

Location: Special Housing Unit (SHU) Inmates in the therapy booths; In Closed Custody Unit (CCU) on the mental health unit, both facilitated by a member of the mental health staff

Function: Inmates will be identified from SHU or CCU sick call, 14 day clinical appointments, as well as provider contacts and referred to SHU/CCU group.

Moving Forward

Purpose: To assess SHU inmates preparedness for change and assess readiness for other mental health interventions which may include a referral to RTU

Location: Special Housing Unit (SHU) Inmates in the therapy booths

Function: Inmates will be identified via the clinical meetings of the SHU mental health team. Material covered in group will be targeted to the need of the group (e.g. PTSD, Coping Skills, etc.).