	Health Services Procedure: MENTAL HEALTH UNITS	
	NO.	**Date of Origin: 2-27-2019** **Revised:**

REFERENCES: NCCHC **MH-G-02**

Forms:

Purpose:

It is the policy of the Vermont Department of Correction's (DOC) Health Services to provide access to mental health units that will provide comprehensive assessment, evaluation, treatment and prevention of inappropriate placement in segregation for detainees and inmates with mental illness.[1] The mental health unit services will be provided by contracted health services. Mental health units are located in dedicated housing areas and offer stabilization and programming as indicated for those who are psychotic, clinically unstable (including acutely suicidal or at imminent risk of serious self-harm) or waiting for community based psychiatric hospital assessment and/or placement. Mental health ~~unit~~ staff shall work with each inmate to individualize treatment that will decrease clinically significant symptoms, increase safety and wellbeing, and improve activities of daily living (ADL).[2]

Philosophy:

The provision of mental health services is integral to the DOC's commitment to reducing return-to-incarceration rates and supporting successful reentry into the community. To this end, trauma informed co-occurring and evidence-based approaches shall be implemented. The Department, as part of this approach, also provides Mental health units and services which include different levels of care: Crisis Intervention, Acute Mental Health Care and Residential Care. Acute Mental Health Care is an acute level of care which will meet the serious mental health needs of inmates who do not meet or are waiting for hospital level of care.[3]

In an Acute Mental Health Unit (Acute MH Unit) the goal is to prevent further deterioration and harm while providing the opportunity for further evaluation, and stabilization or assessment/referral to a higher level of care. Residential Care Mental Health Unit (RC MH Unit) shall provide inmates with serious mental illness, for whom the stimu~~la~~tion in General Population is deleterious, a respite with supportive services. In the RC MH Unit inmates will be provided programming oriented toward management of symptoms and reinforcement of prosocial behavior.

[1] 28 V.S.A §907.
[2] NCCHC MH-G-02
[3] 28 V.S.A. §907.

Acute Mental Health Unit: Procedure for Admission

The following procedures apply to situations in which an inmate is psychotic, clinically unstable, acutely suicidal, at imminent risk of self-harm, who may have been denied access through involuntary or voluntary hospitalization certification processes, or who may be eligible for hospital level of care and are awaiting placement.

1. Any staff member, contractor, or DOC employee may refer an inmate to mental health or medical services due to concern about the potential risk of emerging psychosis, clinical instability, suicidality and harm to self, or any behavior that is unusual or out of character for an individual.

2. The first priority in the management of a decompensating individual is safety in the facility where he is located when the decompensation develops, which may require placement in a restrictive setting, and/or removal of the means of harm, and/or the provision of constant observation by Correctional Officers either present in person or by means of video camera. Under no circumstances will these restrictive safety measures be regarded as Segregation.

3. Inmates requiring safety interventions initiated by Security staff are to be reported to the Mental Health Professional on site or on call, to report the observations that led to the intervention, and to collaborate about further management. This communication will assist the facility Mental Health Professionals in their subsequent understanding and evaluation of the patient.

4. If an inmate enters the facility in a state of acute decompensation, the DOC booking officer will contact the QMHP on duty. The QMHP will assess the inmate and determine what level of care (LOC) the inmate needs. The QMHP will provide the assessment and LOC recommendation to the Director of Psychiatry and/or Director of Behavioral Health for final approval.

5. In the event of an after-hours need for admission, DOC staff shall contact the Mental Health Professional (MHP) on call who will complete the assessment either in person or via tele psych or through telephone consultation with mental health, medical, and security, depending on the acuity of the inmate. The MHP on call may authorize admission to the Acute MH Unit Care Unit under these circumstances, consulting with the psychiatric provider on call or the Director of Psychiatry and/or Director of Behavioral Health.

6. The inmate will receive a full mental health evaluation the following day if possible, or as soon as possible pending their ability to participate. The mental health evaluation will include but is not limited to; DSM assessment and diagnosis, history of illness, previous treatment, previous medication trials, previous hospitalizations, suicide attempts, current mental status, patient strengths, clinical formulation, short-term treatment plan, etc.

7. If the inmate continues to deteriorate, the Act 78 evaluation procedure will be initiated.

8. At any time, any inmate currently housed in a facility who begins to decompensate can be referred by any DOC staff to a QMHP for assessment and level of care (LOC) recommendation for placement in an Acute MH unit. The QMHP (preferably one who knows the patient, if available)

will evaluate the inmate's psychotic symptoms, clinical stability, suicidality, and imminent risk of self-harm. If, in the clinical judgment of the QMHP the inmate cannot be managed in general population or in the RC Mental Health Unit[4] then placement in the Acute MH Unit shall be considered. The use of segregation for inmates with this clinical presentation is to be avoided.

9. The evaluation, along with recommendation and rationale for admission to the Acute MH Unit, will be provided to the Director of Psychiatry and/or Director of Behavioral Health. The decision for placement in the Acute MH Unit will be made by the Director of Psychiatry and/or Director of Behavioral Health.
10. In the event that the Director of Psychiatry and/or Director of Behavioral Health does not determine the inmate needs to be housed in the Acute MH Unit, the RC MH unit will be considered and if neither unit is appropriate, then a facility level multi-disciplinary team will identify housing plan, treatment plan based on symptom reduction/improvement and behavior plan.
11. If the Director of Psychiatry and/or Director of Behavioral Health determines the inmate meets the criteria for the Acute MH Unit, an MHP will notify security to coordinate movement. If inter-facility transport is necessary, MHP will provide recommendations to facility security about conditions of confinement during transport and will ensure care coordination with the receiving facility's Acute MH Unit.

    Placement in the unit will be made as soon as possible based on the inmate's clinical presentation.

12. Upon admittance to the Acute MH Unit, MHP will provide the inmate an orientation to the unit, orally and in writing at the inmate's level of comprehension, as soon as possible and as is clinically appropriate.

13. The DOC Chief of Mental Health or designee may also at any time request placement in the Acute MH unit to minimize the inappropriate use of Segregation. The DOC Chief of Mental Health will communicate the rationale for Acute Care placement to the MHP responsible for the Acute Care Unit, and the Director of Psychiatry and/or the Director of Behavioral Health.

Progressing to Discharge from Acute Mental Health Unit

1.There is no fixed length of time which an inmate may be housed in an Acute MH Unit. An Acute MH Unit may be the most clinically appropriate setting for an inmate during their incarceration to prevent the inappropriate use of segregation. Discharge will be determined by the inmate's level of functioning and the Director of Psychiatry and/or Director of Behavioral Health determination that the inmate can be successfully and safely returned to general population, step down to the RC MH Unit or other placement. Mental Health personnel will coordinate with DOC upon discharge from the Acute MH Unit.

2. A Crisis stabilization Treatment Plan/Wellness Recovery Action Plan (WRAP) will be developed. The WRAP treatment plan will focus on safety, de-escalation and stabilization.

[4] This is currently Bravo Unit at the Southern State Correctional Facility.

3. Subsequently the Crisis WRAP will be augmented with a daily WRAP. This WRAP will summarize the goals, coping skills and activities that the inmate identifies, and which support the inmate's return to activities of daily living and symptom management.

4. At any point, inmates who fail to stabilize, or show signs of improvement, and who present a danger to themselves or others, will be evaluated for referral by a QMHP for a higher level of care (e.g. hospital level of care).

Discharge

1.Through daily observation and assessment, the MHP will make a determination that the inmate may be appropriate to be returned to general population or step down to the RC MH Unit. The MHP shall provide a recommendation and rationale, documented in a discharge form, to the Director of Psychiatry and/or Director of Behavioral Health. The Director of Psychiatry and/or Director of Behavioral Health in consultation with the MHP shall make a determination for discharge from the Acute MH Unit.

2.Mental Health personnel will coordinate movement of the inmate with DOC.

3.If inter-facility transport is necessary, Mental health personnel shall advise facility security as to conditions of confinement during transport and will ensure care coordination with the receiving facility. Regardless of whether or not the inmate is transported, care coordination will include sharing the discharge form and reintegration recommendations.

4. After discharge from the Acute MH Unit, mental health follow-up will continue on a scheduled basis as long as medically necessary.

Residential Care Mental Health Unit: Procedure for Admission

1. At any time, any inmate currently housed in a facility who begins to decompensate functionally, but does not deteriorate to the level needing Crisis Intervention or Acute Care, can be referred by any DOC staff to a MHP for assessment and LOC recommendation for placement in RC MH unit. The MHP (preferably one who knows the patient, if available) will evaluate the inmate's symptoms and functionality. If, in the clinical judgment of the MHP the inmate cannot be managed in general population then placement in the RC Mental Health Unit[5] shall be considered. The referral will include Psychiatric Diagnosis, current treatment, current symptoms and signs, and CM GAF score.

2. The Director of Psychiatry and/or Director of Behavioral Health will review the referral in consultation with the MHP. Within 48 hours, the Director of Psychiatry, and/or the Director of Behavioral Health, or the on-call psychiatric provider will make a decision regarding placement.

3. If the Director of Psychiatry and/or Director of Behavioral Health determines the inmate meets criteria for the RC MH Unit then the MHP will inform the facility level administration who will

[5] This is currently Bravo Unit at the Southern State Correctional Facility.

coordinate movement. If inter-facility transport is necessary, Mental health personnel shall advise facility security as to conditions of confinement during transport and will ensure care coordination with the receiving facility's RC MH Unit.

4. The DOC Chief of Mental Health or designee may also at any time request placement in the Residential Care MH unit to minimize the inappropriate use of Segregation The DOC Chief of Mental Health will communicate the rationale for the RC MH Unit placement to the MHP responsible for the RC MH Unit, and the Director of Psychiatry and/or the Director of Behavioral Health.

Residential Care Mental Health Unit: Ongoing Evaluation

1.There is no fixed length of time which an inmate may be housed in a Residential Care Mental Health Unit. An RC MH Unit may be the most clinically appropriate setting for an inmate during their incarceration to prevent decompensation. Length of stay will be determined by the inmate's level of functioning and the Director of Psychiatry and/or Director of Behavioral Health's determination that the inmate can be successfully and safely returned to general population.

2.Ongoing Evaluation: Inmates placed in RC MH Units shall be evaluated by MHPs at least every 90 days to assess for level of care and to determine if ongoing placement is clinically warranted. The evaluations should document: Psychiatric Diagnosis, brief summary of symptoms and behavior that resulted in residential mental health unit placement, inmate's progress in treatment and WRAP adherence, current symptoms and behavior, accommodations provided directly by staff or by RC MH Unit environment, and the inmate's functioning to include CM GAF score with attention to ability to function outside of the RC MH Unit. The Director of Psychiatry and/or Director of Behavioral Health shall use these evaluations to determine on-going placement or discharge.

3.Treatment Plan/ Wellness Recovery Action Plan Initial and Ongoing: Will be developed with the inmate to identify coping skills and activities to support the inmate's symptom management and return to general population. Some patients may be discharged directly to General Population with advance notice to help in preparation. Others may benefit from a work or program assignment that they may attend from the RC MH Unit for a limited time prior to moving to GP. After discharge from RC MH Unit, mental health follow-up will continue on a scheduled basis as long as medically necessary.

Discharge

1. Through daily observation and assessment, the MHP will make a determination that the inmate may be appropriate to be returned to general population. The MHP shall provide a recommendation and CM GAF score, documented in a discharge form, to the Director of Psychiatry and/or Director of Behavioral Health. The Director of Psychiatry and/or Director of Behavioral Health in consultation with the MHP shall make a determination for discharge from the RC MH Unit.

2.Mental Health personnel will coordinate with DOC upon discharge from the RC MH Unit.

3.If inter-facility transport is necessary, Mental health personnel shall advise facility security as to conditions of confinement during transport and will ensure care coordination with the receiving facility. Regardless of whether or not the inmate is transported, care coordination will include sharing the discharge form and reintegration recommendations.

Staffing and Programming

The Mental Health Units shall have at a minimum[6]:

a. Continuous (24 hours a day, 7 days a week) coverage by mental health personnel assigned to the unit or on call for the unit.
   1) Mental Health Personnel (MHP) staffing should be sufficient to enable each inmate to have daily contact with an MHP who provides needed therapeutic interventions, coordinates inmate care, and recommends discharge from the unit.
   2) The contractor's staffing plan shall address the number of inmates in the unit, the severity of their mental illness, and the number of the mental health personnel to manage the level of care for each.
   3) Should staffing levels be insufficient to meet the needs of the unit, the Director of Psychiatry and/or Behavioral Health shall notify both the DOC Health Services Administrator and the DOC Chief of Mental Health and p provide them with a remediation plan.
b. Orientation and training for correctional officers assigned to the unit.
   1) DOC staff shall receive specialized training that includes de-escalation skills. (ongoing?)
c. Daily (7 days a week), on-going inmate evaluation by mental health personnel.
d. Programming or appropriate therapies if clinically indicated.
   1) Inmates shall have the appropriate level of clinical monitoring, individual and group evidence-based therapies, and psychosocial activities. All treatment interventions, therapies and activities must be proven effective for the clinical presentation/ diagnosis of the inmate and be individualized for the inmate.
e. Individual treatment plans which shall direct the mental health service needed for each inmate in the mental health unit. Each treatment plan shall include treatment goals, objectives, and interventions for addressing each inmate's unique clinical presentation and to support a restoration of ADLs to support a successful transition to general population or whatever the least restrictive setting may be.[7] At a minimum treatment plans will include:
   i. Goals of treatment
   ii. Objectives
   iii. Interventions, including the dose, frequency, and duration
   iv. Frequency of follow up for evaluation and adjustment of treatment modalities.
   v. Adjustment of psychotropic mediations if indicated.
   vi. Referrals for psychological and medical testing and evaluation including blood levels for medication monitoring as required.
   vii. When appropriate, instructions about diet, exercise, personal hygiene, and adaptation to the correctional environment.
   viii. Documentation of treatment goals and objectives; evidence-based interventions and therapies necessary to achieve those goals and notation of clinical progress.

[6] NCCHC Standard MH-G-02
[7] NCCHC Standard MH-G-03

f. Wellness Recovery Actions Plans will also be developed with inmates residing in mental health units as per this procedure.
g. Housing in a safe and therapeutic environment conducive to symptom stabilization and maintenance of good personal hygiene.
h. Communication
i. The Contractor shall notify the DOC Chief of Mental Health when an inmate is being evaluated for or discharged from either the Acute Mental Health or the Residential Care Mental Health unit.