

POLICY OF STATE OF DELAWARE DEPARTMENT OF CORRECTION	POLICY NUMBER G-04.1	PAGE NUMBER 1 OF 13
	RELATED NCCHC and ACA STANDARDS: P-G-04; 4-4368; 1-HC-3A-06 (ref. 4-4399); MH-G-02; 4-4372; 4-4348; 4-4350	
CHAPTER: 11 BUREAU OF CORRECTIONAL HEALTHCARE SERVICES	SUBJECT: SPECIAL NEEDS UNIT	
EFFECTIVE DATE: 04/13/2009	REVISED: 04/13/2009; 07/28/2015, 01/12/2016	
APPROVED FOR PUBLIC RELEASE		

- I. AUTHORITY: Bureau of Correctional Healthcare Services
- II. PURPOSE: To provide alternative placement for offenders who are experiencing behavioral health disorders including: mental illness (MI), serious mental illness (SMI) or co-occurring disorders who have significant functional impairment who are unable to effectively reside in a general population setting.
- III. APPLICABILITY: All Department of Correction employees, vendor staff, offenders, and any outside healthcare provider servicing DOC offenders.
- IV. DEFINITIONS: See glossary.
- V. SUMMARY of CHANGES:
- This policy has significantly changed and shall be reviewed in its entirety.
- VI. POLICY: The Department of Correction (DOC) will maintain a Special Needs Unit (SNU) at designated facilities as determined by offender population and their needs. These units will provide a range of behavioral healthcare services to offenders who are not able to maintain their best level of functioning in general population with the intent to improve their recovery. The SNU will provide a therapeutic placement to sustain the offenders' ability to function safely in a correctional environment.
- A. Any correctional, medical, or clinical staff member may refer an offender to mental health for possible placement in the SNU.
1. A psychiatrist, psychologist, psychiatric nurse practitioner or mental

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health clinician shall complete a Special Needs Unit Referral Report which shall be placed in iCHRT.

2. A psychiatrist, psychologist or psychiatric provider shall review the report for appropriateness and completeness.
3. The offender must be referred to a primary care physician or nurse practitioner to rule out any medical complications or conditions or precluding factors to placement on the SNU. This well-visit shall be documented in iCHRT.
4. The clinical team comprised of: the mental health clinician, the psychiatric nurse practitioner and the psychiatrist or psychologist, and a member of Security as designated by the Warden, will recommend if the SNU is an appropriate housing placement.
 - i. If the offender is not recommended for SNU placement, the offender shall be placed on the Behavioral Health Roster.
5. A member of the clinical team shall forward the final report to the facility Warden, the vendor's Clinical Director for Behavioral Health, and the site Mental Health Director. A copy shall be placed in iCHRT.
 - i. Within 72 hours of receiving the report, the facility Warden or designee shall review the recommendation of the clinical team and approve or deny placement in the SNU.
 - ii. If the offender requires a transfer to another facility with a SNU, the receiving Warden or designee shall receive a copy of the referral and must approve or deny the recommendation of the clinical team within 72 hours.
 - iii. Upon the Warden's approval of the clinical recommendation for the offender to be placed in the SNU, the site Mental Health Director shall ensure that the offender is placed on the Multi-Disciplinary Team (MDT) list for clinical progress updates at the next scheduled meeting in accordance with BCHS Policy A-04.
 - iv. In situations where an offender is not recommended for placement in the SNU, the facility Mental Health Director shall ensure the offender is added to the MDT list for continued monitoring as appropriate.
6. The Warden and/or designee shall determine the housing placement to manage the offender's current behavior until a transfer to the SNU is possible.

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7. Offenders must be reviewed and classified by the DOC Classification Unit as appropriate.
- B. The offender shall have a comprehensive mental health evaluation (CMHE) and a psychiatric evaluation within 14 days of placement into the SNU.
 1. The clinician shall complete or update an individualized treatment plan (ITP) upon completion of the CMHE.
 2. The ITP shall be updated and/or reviewed every 90 days in iCHRT.
 - C. Each offender shall receive behavioral health services on a regular basis while placed in the SNU.
 1. Each offender shall be seen by the psychiatrist or a psychiatric nurse practitioner once every 30 days.
 2. The mental health clinician shall receive supervision on a monthly basis by a psychologist or post-doctoral fellow to be documented in iCHRT.
 - D. Each offender will participate in at least 15 hours per week of structured evidence-based programming by a clinician to maximize their level of functioning.
 1. Each offender shall be seen by a clinician for individual therapy once per week.
 2. Each offender will participate in group therapy at least 12 hours per week facilitated by a clinician.
 3. Each offender will participate in therapeutic activities, spiritual services, self-help activities and/or educational activities at least 3 hours per week.
 4. If an offender refuses to engage in treatment services, the site mental health director will assess and evaluate continued appropriateness for the program and recommend to the Warden and clinical team consideration of transfer to alternative housing.
 - E. Each offender shall have a minimum of 7 hours per week of unstructured time outside of cell to include but not limited to socialization, leisure activity, free time, and/or recreation.
 - F. Offenders housed in the SNU may be discharged to general population when the clinical team, in conjunction with the offender, determines that the offender gained or maximized his or her best level of functioning and is likely to successfully manage a less restrictive environment. The clinical team shall forward their recommendations to DOC in order to facilitate the classification process as needed.
 1. Prior to a transfer to another location outside of the SNU, including a Level 4 facility, the treating clinician and the offender shall complete an

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updated ITP to reflect the level of care that is required for a successful transition. An offender's ITP is completed after the CMHE pursuant to section B (1).

- i. If the offender is removed from SNU prior to an updated ITP, the clinician shall complete an ITP within 72 hours of discharge.
 2. Offenders released from the SNU directly to the community shall complete a discharge plan with their respective clinician (see attachment). Offenders shall receive discharge planning services in accordance with BCHS Policy E-13, Discharge Planning. Additional steps, such as contacting and coordinating care with family members, working with The Delaware Division of Substance Abuse and Mental Health (DSAMH) Eligibility and Enrollment Unit to identify the appropriate level of care, etc., will be completed on a case by case basis, as clinically indicated. All discharge planning efforts shall be documented in iCHRT.
- G. The specific timelines and required actions in this policy will not supersede the requirement to place an inmate on psychiatric observation when such a need is indicated.
- H. The provider at each Level 4 and Level 5 facility shall develop site-specific procedures to (a) implement the policy and (b) to coordinate the procedural process with BCHS.

DELAWARE DEPARTMENT OF CORRECTION

Correctional Facility

SPECIAL NEEDS UNIT REFERRAL

Offender Name: _____ SBI: _____ DOB: _____

1. Mental Health / Medical History: _____

2. DSM Diagnoses (include all healthcare diagnoses): _____

3. Current Mental Status: _____

4. Current Functioning (include any signs, symptoms, and/or behaviors observed by mental health staff and/or correctional officers that indicate need for placement on the Special Needs Unit): _____

5. History of Self-Injurious/Suicidal Behavior (include dates and length of stay of any recent placements on psychiatric observation): _____

6. Medications prescribed, including duration, dosage, route, and compliance:

7. Interventions that have been implemented to treat in general population:

8. Identify benefits expected by transferring offender to Special Needs Unit:

9. Special conditions or recommendations the MDT Review Committee needs to be aware of:

I therefore recommend that the above referenced offender be transferred to the Special Needs Unit located at the following facility: _____

Signature of Psychiatrist

Date

Signature of State Director of Behavioral Health

Date

Signature of facility Warden

Date

Signature of receiving facility Warden

Date

Delaware Department of Correction
Discharge Plan

Offender Name _____ Gender _____ SBI# _____
 SSN# _____ DOB _____ Date _____
 Facility Name _____ Anticipated Release Date _____

A. Risk Level, Treatment, and Criminogenic Needs

Was the offender's assessment instruments reviewed? Yes _____ No _____ LSI-R score _____
 High _____ High/Moderate _____ Moderate _____ Low/ Moderate _____ Low _____
 ASI score/level _____ RNR _____

Interventions Needed

B. Identification Documents

Social Security Card	Yes ___ No ___	Veteran Identification Card	Yes ___ No ___
Birth Certificate	Yes ___ No ___	Passport	Yes ___ No ___
Alien Registration Card	Yes ___ No ___	State ID/Driver's License	Yes ___ No ___
Picture Identification	Yes ___ No ___	Certificate of Naturalization	Yes ___ No ___
HS Diploma/GED	Yes ___ No ___	Military Discharge Papers	Yes ___ No ___

C. Benefit Eligibility

Public Assistance	Yes ___ No ___	Food Stamps	Yes ___ No ___
Medicaid	Yes ___ No ___	Medicare	Yes ___ No ___
SSD/SSI	Yes ___ No ___	Health Care	Yes ___ No ___
Veteran Benefits	Yes ___ No ___	Other	_____

D. Housing

Does the offender expect to be released to known housing? Yes ___ No ___ If yes
 Address at Release _____
 City _____ State _____ Zip Code _____
 Phone _____ Primary Caretaker/Significant Other _____
 Children in household Yes ___ No ___ If yes, # _____ Others in household Yes ___ No ___
 If yes, identify _____

Is the offender expected to be released to a shelter? Yes ___ No ___
 If yes, name _____ Address _____

Is the offender expected to be released to a Sober House? Yes ___ No ___
 If yes, name _____ Address _____

Is the offender expected to be released to a Nursing Home? Yes ___ No ___ If yes, name _____
Address _____

Is the offender expected to be released to a treatment facility? Yes ___ No ___
If yes, name _____ Address _____

Is housing assistance required? Yes ___ No ___ If yes, type _____

E. Health Care

Primary Health Care Needed Yes ___ No ___ If no provider _____
Date of last physical _____ If yes, referral to _____

Mental Health Provider Needed Yes ___ No ___ If no provider _____
If yes, referral to _____
Medication needed Yes ___ No ___ If yes, name _____

Substance Use treatment needed Yes ___ No ___ If yes, provider _____
Level of care required Intensive Outpatient _____ Out patient _____
Residential _____ Sober House _____ Self-Help _____

F. Employment

Job skills training needed Yes ___ No ___ If yes, enrolled in I-ADAPT Yes ___ No ___
Area of interest _____ Job placement needed Yes ___ No ___
If no, employer _____ Position _____
Anticipated start date _____ If Yes, special skills _____

G. Prison Program Completion

Substance Use Programming Yes ___ No ___ Name _____
Self-Help Yes ___ No ___ Facility _____
Domestic Violence Yes ___ No ___ Name _____
Education Yes ___ No ___ Level _____
GED Yes ___ No ___ Level _____
Offender Worker Yes ___ No ___ Position (s) _____

Parenting Yes ___ No ___ Name _____
Mental Health Yes ___ No ___ Level of Service _____
Sexual Offender Treatment Yes ___ No ___ Completion Yes ___ No ___ Duration _____
I-ADAPT Enrollment Yes ___ No ___

Post-Release Referrals

Aging & Disability Yes ___ No ___ If yes, Provider _____

Contact time/date _____ Contact Person _____

Goal to address this issue _____

Challenges /problems to address this issue _____

My action plan to address the above goal _____

Target Completion Date _____ Staff action to meet goal _____

Comments _____

Employment Yes ___ No ___ If yes, Provider _____

Contact time/date _____ Contact Person _____

Goal to address this issue _____

Challenges /problems to address this issue _____

My action plan to address the above goal _____

Target Completion Date _____ Staff action to meet goal _____

Comments _____

Substance Use Treatment Yes ___ No ___ If yes, Provider _____

Appointment time/Date _____ Contact Person _____

Goal to address this issue _____

Challenges /problems to address this issue _____

My action plan to address the above goal _____

Target Completion Date _____ Staff action to meet goal _____

Comments _____

Mental Health Treatment Yes ___ No ___ If yes, Provider _____

Contact time/date _____ Contact Person _____

Goal to address this issue _____

Challenges /problems to address this issue _____

My action plan to address the above goal _____

Target Completion Date _____ Staff action to meet goal _____

Comments _____

Medical Yes ___ No ___ If yes, Provider _____
Contact time/Date _____ Contact Person _____
Goal to address this issue _____
Challenges /problems to address this issue _____

My action plan to address the above goal _____

Target Completion Date _____ Staff action to meet goal _____
Comments _____

Housing Yes ___ No ___ If yes, Organization _____
Contact time/Date _____ Contact Person _____
Goal to address this issue _____
Challenges /problems to address this issue _____

My action plan to address the above goal _____

Target Completion Date _____ Staff action to meet goal _____
Comments _____

Health Care Benefits Yes ___ No ___ If yes, Organization _____
Contact time/Date _____ Contact Person _____
Goal to address this issue _____
Challenges /problems to address this issue _____

My action plan to address the above goal _____

Target Completion Date _____ Staff action to meet goal _____
Comments _____

Financial/Benefits Yes ___ No ___ If yes, name _____
Contact time/Date _____ Contact Person _____
Goal to address this issue _____
Challenges /problems to address this issue _____

My action plan to address the above goal _____

Target Completion Date _____ Staff action to meet goal _____
Comments _____

Self-Help Yes ___ No ___ If yes, location _____
Contact time/Date _____ Contact person _____
Goal to address this issue _____
Challenges /problems to address this issue _____

My action plan to address the above goal _____

Target Completion Date _____ Staff action to meet goal _____
Comments _____

Education Yes ___ No ___ If yes, name _____
Contact Time/Date _____ Contact Person _____
Goal to address this issue _____
Challenges /problems to address this issue _____

My action plan to address the above goal _____

Target Completion Date _____ Staff action to meet goal _____
Comments _____

Other Yes ___ No ___ If yes, name _____
Contact time/Date _____ Contact Person _____
Goal to address this issue _____
Challenges /problems to address this issue _____

My action plan to address the above goal _____

Target Completion Date _____ Staff action to meet goal _____
Comments _____

Other Yes ___ No ___ If yes, name _____
Contact time/Date _____ Contact Person _____
Goal to address this issue _____
Challenges /problems to address this issue _____

My action plan to address the above goal _____

Target Completion Date _____ Staff action to meet goal _____
Comments _____

Full plan completed and discussed with offender Yes ___ No ___ Date _____

Offender Name Date

Counselor Signature Date

Supervisor Signature Date

- Adapted from Transition to Jail Community Initiative Implementation Toolkit
Delaware Department of Correction June 2015

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American Correctional Association: Standards for Adult Correctional Institutions, 2014 Standards Supplement 4-4368.

American Correctional Association: Performance-Based Standards for Correctional Health Care in Adult Correctional Institutions, 2002 1-HC-3a-06 (ref. 4-4399).

National Commission on Correctional Health Care: Standards for Mental Health Services in Correctional Facilities, 2015. MH-G-02

Approval:

Date of Policy/Revision	BCHS Bureau Chief, Marc Richman, Ph. D	Date	Robert Coupe, Commissioner	Date
		1/13/16		1/12/2016