POLICY OF STATE OF DELAWARE DEPARTMENT OF CORRECTION	POLICY NUMBER F-03	TOTAL PAGES 12
	RELATED NCCHC / ACA STANDARDS: NCCHC: P-F-03 (essential), J-F-03 (essential) MH-G-01 (essential), MH-G-02 (essential), MH-G-03 (essential), O-E-04 ACA: 5-ACI-6A-28 (mandatory), 5-ACI-6A-33, 5-ACI-6A-37, 5-ACI-6A-38	
CHAPTER: 11 BUREAU OF HEALTHCARE, SUBSTANCE ABUSE, AND MENTAL HEALTH SERVICES	**SUBJECT: Mental Health Services**	
APPROVED BY THE BUREAU CHIEF:	**Bureau Chief, Michael Records (signature on file with BHSAMH)**	
APPROVED BY THE COMMISSIONER AND EFFECTIVE THIS DATE	**Commissioner Terra Taylor, June 24, 2024 (signature on file with BHSAMH)**	
APPROVED FOR PUBLIC RELEASE		

I. AUTHORITY: 11 *Del. C.* §6536 Medical Care

II. PURPOSE: To ensure that a range of behavioral health services are available to assist patients with maintaining their best level of functioning throughout incarceration.

III. APPLICABILITY: All Delaware Department of Correction (DDOC) employees and Contract Provider staff, patients, and any outside healthcare provider servicing DDOC patients.

IV. DEFINITIONS: See Glossary

V. SUMMARY OF CHANGES: This policy was updated to require both a receiving screening and a CMHE for all offenders upon intake. Additionally, the policy was changed to allow a non-licensed MH clinician to complete the CMHE as long as a licensed supervisor reviews and signs off on the evaluation.

VI. POLICY:

A. Patients will receive mental health services, when required, at all Level 4 and Level 5 facilities as well as at any Level 3 Bureau of Healthcare, Substance Abuse, and Mental Health Services (BHSAMH) Residential Program. Mental health services may include, but is not limited to the following:

1. Screening and Assessment.
2. Comprehensive Mental Health Evaluations (CMHE).
3. Treatment planning.
4. Diagnosis and treatment.
5. Determination of behavioral health (BH) categories and BH levels of care.
6. Outpatient Services (OP).
7. Intensive Outpatient Program (IOP).
8. Residential Level of Care.

a. Includes the Residential Treatment Unit (RTU).

9. Psychiatric Inpatient Services (IP).
10. Psychiatric Treatment Services.
11. Continuity of Care.
12. Discharge Planning Services.
13. Acute Care – Psychiatric Close Observation (PCO).
14. Emergency Services.

VII. MENTAL HEALTH SERVICES: The mental health needs of patients shall be addressed onsite or by referral to appropriate facilities.

A. Screening and Assessment

1. All patients will undergo an initial receiving screening and receive a Comprehensive Mental Health Evaluation (CMHE) in accordance with BHSAMH Policy E-02 *Receiving Screening* and *Policy E-05 Mental Health Screening and Evaluation.*
2. Referrals for further mental health assessments for those patients with positive screens obtained during intake shall be seen within 24 hours in accordance with DDOC Policy *E-05 Mental Health Screening and Evaluation*.
3. Patients with a verified history of prescribed psychiatric medications (verification shall be through the use of the Delaware Health Information Network - DHIN) shall be referred to a psychiatric provider for evaluation and determination of the psychiatric plan of care.
4. Patients who are screened to be at-risk of suicide and/or self-directed violence shall receive an evaluation in accordance with BHSAMH Policy *B-05 Suicide Prevention and Intervention.*
5. Patients with a history of receiving mental health services, or they develop symptoms of mental illness while incarcerated, shall be referred to mental health for further evaluation.

B. Comprehensive Mental Health Evaluation (CMHE)

1. The Responsible Health Authority (RHA) must approve the evaluation instrument used for conducting a CMHE.
2. The CMHE must be completed by
    a. A licensed Qualified Mental Health Professional (QMHP), or
    b. An unlicensed QMHP with a corresponding review and signature by a licensed supervisor
3. The CMHE must be completed (including a supervisor signature for CMHE's completed by an unlicensed QMHP) within 14 days of the determination of a need for an evaluation or once they are added to the Mental Health Roster.
4. The QMHP shall refer patients to a psychiatric provider for further evaluation when clinically indicated. A Delaware licensed psychiatric provider shall perform a psychiatric evaluation within 7 days of the CMHE referral.

C. Treatment Planning

1. Behavioral health services must be provided according to individual treatment plans (ITPs) developed to address and meet the needs specific to that patient.
2. Clinicians shall conduct a review of the patient's progress in treatment utilizing an objective measure to support clinical decisions to revise, add, complete goals.
3. ITPs are developed by a provider or other qualified healthcare clinician at the time the patient is started in any type of treatment including admission to a

residential program or if started on medically assisted withdrawal (MAW) or medication assisted treatment (MAT).

a. Patients receiving MAW/MAT services may have the healthcare services in their ITP delivered by staff working in the MAW/MAT program or by other providers or agencies with which the MAW/MAT program has arrangements to do so.

4. All ITPs must include, at a minimum:
   a. Current diagnosis.
   b. Current Level of Care.
   c. Frequency of follow-up for evaluation and adjustment of treatment modalities.
   d. Adjustment of psychotropic medications, if indicated.
   e. Referrals for psychological testing, medical testing, and evaluation, including blood levels for medication monitoring as required.
   f. When appropriate, instructions about diet, exercise, personal hygiene, and adaptation to the correctional environment.
   g. Documentation of treatment goals and objectives, interventions necessary to achieve those goals, tasks and/or activities, and notation of the assessment of clinical progress.
   h. Target dates for completion/follow-up of treatment goals.
   i. Treatment plans shall be reviewed with the patient at least once every 90 days for those in a BH 5 Level of Care and at least once every 180 days for all other BH Levels of Care.
   j. The contract provider shall ensure that treatment plan reviews are conducted by a QMHP and documented in the patient's EHR.
   k. The treatment plan review shall entail but is not limited to the following:
      i. Review of the patient’s progress in treatment and determination whether the treatment goals shall be revised.
      ii. Review of the patient’s behavioral health diagnosis and BH category to determine appropriateness based upon the patient's current functioning.
      iii. Review of the patient’s level of care to determine appropriateness based upon the patient's current functioning.
   l. Treatment plans shall be updated anytime there is a clinically significant development in a patient's treatment based on above criteria.
   m. The QMHP shall conduct routine screenings of mental health symptoms to determine progress and/or needs at each individual treatment plan review.
   n. ITPs related to MAW/MAT must also include the following:
      i. The patient’s short-term goals and task associated with achieving the goals.
      ii. The frequency of follow-up for opioid treatment.
      iii. A schedule for MAT drug therapy.
      iv. Individual and/or group counseling specific to MAW/MAT treatment.
      v. The type and frequency of diagnostic testing.
      vi. Treatment objectives for MAW/MAT maintenance therapy. These objectives include at a minimum:

a) Preventing the onset of signs of opioid abstinence for at least 24 hours.
b) Reducing or eliminating drug craving.
c) Blocking the effects of illicitly acquired or self-administered opiates.

5. The ITP should include objectives in educational, vocational, and residential areas, most frequently by requiring participation in facility-based programs or classes.
    a. Depending on the legal status of the patient, the length of the anticipated incarceration, and/or status in the criminal justice system, the treatment plan may identify goals that will not be an immediate focus of treatment. Educational, vocational, or residential plans may need to be deferred or modified.
6. ITPs for patients with significant medical and/or behavioral health problems should reflect multi-disciplinary team (MDT) input, monitoring, and appropriate linkages to treatment either on-site or through a referral.

D. Diagnosis and Treatment

1. Patients monitored by mental health shall have a current working diagnosis in accordance with guidelines set forth in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). This diagnosis shall be derived from the most recent Provider evaluation (Psychiatrist, Psychiatric Mental Health Advanced Practice Registered Nurse, or Psychologist).
2. The contracted provider shall offer treatment services as clinically indicated.
3. Individual sessions shall take place out-of-cell in a safe setting that permits privacy for the patient.
4. Group therapy shall be provided where there is adequate placement for 3-20 individuals per session.
5. All MH programs shall follow indicators found in the Correctional Programs Checklist (CPC) for effectively implementing evidenced-based treatment programs.
    a. Responsibility for overseeing and ensuring compliance with the CPC strategy and criteria is on the contract provider Statewide Behavioral Health Director and the contract provider site Behavioral Health/Mental Health Director.
    b. Each site Behavioral Health/Mental Health Director shall monitor compliance with the CPC on an ongoing basis and submit a quarterly report to the BHSAMH Quality Assurance Administrator. This report shall indicate current compliance with each indicator in the CPC tool.
    c. If an indicator is not compliant there shall be an action plan as to how they plan to become compliant with that indicator.
    d. The quarterly report shall be signed by the site Behavioral Health/Mental Health Director and the Statewide Behavioral Health Director. This report is due by the 15th of the month following the end of the quarter.

E. Behavioral Health Categories and Behavioral Health Levels of Care

1. The contracted provider shall designate patients into one of the following categories:
    a. Not Mentally Ill (NMI).

b. Mentally Ill (MI).
c. Seriously Mental Ill (SMI).
d. Substance Use Disorder (SUD).
e. Co-Occurring Disorder (COD).
    i. Patients will be categorized into one of two categories:
        a) COD/SMI.
        b) COD/MI.

2. The contracted provider shall utilize a behavioral health level of care model to match the appropriate intervention to the patients' need. The levels of care are as follows:
    a. **BH1 Level of Care**: *No history and no current need* - The patient has no known behavioral health treatment history and has been assessed to have no current behavioral health condition.
    b. **BH2 Level of Care**: *Only history and no current need* - The patient has a history of behavioral health treatment but has been assessed to have no current need for services.
    c. **BH3 Levels of Care**: *Outpatient Services* – The patient has been assessed and meets the following criteria:
        i. The patient has a history of behavioral health treatment, and
        ii. The patient has experienced or may be at risk to experience mild psychological distress or transient psychiatric disorder(s) that can be treated with outpatient psychological interventions.
    d. **BH4 Level of Care**: *Intensive Outpatient Services* - The patient has been assessed and meets the following criteria:
        i. The patient meets the criteria of BH3, and
        ii. The patient requires increased hours of highly structured outpatient therapy to include group therapy and individual therapy on a weekly basis.
        iii. BH4 may be utilized as an intervention targeted to prevent worsening of a psychiatric condition, which would result in residential treatment. It may also be utilized as a step-down from residential treatment prior to transition to outpatient level of care.
    e. **BH5 Level of Care**: *Residential Treatment* - The patient has been assessed and meets the following criteria:
        i. The patient meets criteria for BH4, and
        ii. the patient has been assessed to have significant functional impairment requiring placement in a residential care unit.
        iii. The unit will provide a safe and therapeutic environment focused on symptom stabilization, improving activities of daily living, and programming with comprehensive wrap-a-round services from a multidisciplinary team consisting of psychiatric providers, psychologists, medical personnel, clinicians, and other behavioral health professionals.
        iv. Patients in this setting shall receive a minimum of 10 hours of therapeutic, structured activity delivered by a MH professional.
    f. **BH6 Level of Care** - *Inpatient Hospitalization* – The patient has been assessed and meets the following criteria:

i. The patient meets the criteria for BH5, and
ii. The patient requires treatment beyond that available within the Department of Correction.
    a) If the patient were residing in the community, they should meet the criteria for a civil commitment, as defined by state law.
iii. When a patient meets this criteria, he/she will be referred to the Treatment Review Committee (TRC) in accordance with BHSAMH Policy *G-03.1 Non-Emergency Involuntary Medication Administration* for consideration for inpatient hospitalization outside the correctional facility or placement at the Jane E. Mitchell (JEM) Building at the Delaware Psychiatric Center.

F. All patients are eligible for a variety of behavioral health evaluations for admission to sex offender treatment, substance use disorder (SUD), opioid use disorder (OUD), and/or mental health treatment programming at any time during their incarceration.
1. Evaluations, assessments, and admissions to behavioral health treatment programs shall be in accordance with their respective policies. Those policies include but are not limited to the following: DDOC Policy F-03.1 Sex Offender Treatment Services, DDOC Policy F-04 Medically Supervised Withdrawal and Treatment, DDOC Policy F-08 Substance Use Treatment Programs, and/or this policy.

G. Outpatient Services (OP)
1. Outpatient services include, but are not limited to the following:
    a. Identification and referral of inmates with mental health needs.
    b. Crisis intervention services.
    c. Psychotropic medication management, when indicated.
    d. Individual counseling.
    e. Group counseling and/or psychosocial/psychoeducational programs.
    f. Documentation of treatment and follow-up.
2. Outpatients receiving basic mental health services are seen as clinically indicated, but not less than once every 30 days. Patients with a chronic mental illness are seen as prescribed in their individual treatment plan (ITP), but not less than once every 30 days.

H. Intensive Outpatient Services (IOP)
1. The patient has been assessed to meet criteria for outpatient care but demonstrates a need for more intense treatment services than typical outpatient services. IOP may also be used for those requiring a step-down level of care after completing residential treatment. IOP reflects increased hours of highly structured outpatient therapy on a weekly basis.
2. IOP services may be offered in all housing areas or in a specialized unit designated by the Warden.
    a. A Short-term Behavioral Health Program (SBHP) offers IOP services designed to help patients better manage their symptoms of mental illness. Patients who demonstrate a need for stabilization due to an exacerbation of conditions may be referred to the unit. The program is a short-term placement generally not to exceed 90 days to establish stabilization and avoid reentry into acute care.

b. IOP services offered in the SBHP, or the general population shall reflect increased hours of highly structured outpatient therapy on a weekly basis. Intensive outpatient services shall include:

i. Psychotherapy services as available and clinically indicated, to consist of evidence-based practices that reflect recovery, motivational, and supportive approaches.

ii. An ITP shall be completed for the patient upon completion of the mental health evaluation and updated every 90 days or earlier as clinically indicated by the ITP.

iii. Psychiatric services shall be available at least once every 90 days or earlier as clinically indicated by the ITP, in accordance with DDOC Policy *F-03 Mental Health Services*.

iv. The patient shall generally receive a minimum of 9 hours of individual/group therapy (including other structured therapy) per week generally for a 12-week course of treatment.

v. The patient shall receive an assessment after the completion of intensive outpatient services to determine the next appropriate level of care.

I. Residential Level of Care (RTU)

1. A Mental Health Residential Treatment Unit (RTU) is available for those patients with impairment in behavioral functioning associated with serious mental illness (SMI) and/or impairment in cognitive functioning. The severity of the impairment does not require an inpatient level of care, but the patient demonstrates a historical and current inability to function adequately in the general population.
2. The residential level of care program must include, but is not limited to the following:
   a. Documented scope of care,
   b. Documented mission/goal of the program,
   c. Screening and admission guidelines for admission to the program,
   d. Programming and/or appropriate therapies to meet the mental health needs of the patients on the units,
   e. Mental health staff of sufficient numbers and kind in keeping with program purposes,
   f. ITPs for each patient in the program,
   g. Orientation and training for correctional officers assigned to the unit,
   h. Transition plans upon discharge from the RTU,
   i. A clean, safe, therapeutic environment and milieu, including facilities for maintaining good personal hygiene with guidance in the activities of daily living (ADL's), if needed.
3. Recommendation, approval, and placement process for residential level of care:
   a. If the clinical team (typically a mental health clinician, psychiatric provider, and member of security) determines that a patient needs a residential level of care they will make a written recommendation to the facility warden, or designee.
   b. The facility warden, or designee, shall review the recommendation of the clinical team and approve or deny placement in the RTU.

i. If approved, the facility warden, or designee, will facilitate the transfer of the patient to the RTU as soon as possible.
ii. If the warden denies placement in the RTU, the clinical team shall formulate a way to provide services for the patient where the patient resides.
iii. All approvals and denials of placement in the RTU shall result in a notification to the BHSAMH Bureau Chief, or designee, and BHSAMH Behavioral Health Treatment Services Director.

c. The Provider will document the decision in the patient's record. It is the goal for this decision to be made within 72 hours of the recommendation.

4. Documentation requirements for Residential Level of Care:
   a. If the patient does not already have a current CMHE (conducted during current incarceration) and a recent psychiatric evaluation (completed within the last 90 days), a CMHE and a psychiatric evaluation must be conducted within 14 days of placement into residential treatment.
      i. The clinician shall complete or update an ITP upon completion of the CMHE.
      ii. The ITP shall be reviewed every 90 days in the electronic health record (EHR).
         a) Treatment plans shall be updated anytime there is a clinically significant development in a patient's treatment based on the above criteria.
5. Programming requirements for Residential Level of Care:
   a. The Behavioral Health Provider shall offer each patient psychological services on a regular basis while placed in residential treatment. The Residential program shall have a schedule for programming that includes the name, time, duration, and location of program activities.
      i. The Psychiatrist or Nurse Practitioner shall meet with each patient once every 30 days.
   b. The Behavioral Health Provider shall assign each patient a primary clinician who will be supervised by a licensed psychologist.
6. Discharge and Transition for Residential Level of Care:
   a. The Behavioral Health Provider may recommend a patient to be discharged to general population or to a lower level of care when the clinical team, in conjunction with the patient, determines that the patient gained or maximized his or her best level of functioning and is likely to successfully manage in a less restrictive environment. The clinical team shall forward their recommendations to the Warden, or designee, to facilitate the classification process as needed.
   b. The clinical team and the MDT shall review any patient who demonstrates difficulty in effectively participating in or has reached maximum benefit from the program for possible discharge. The clinical team shall forward their recommendations to the Warden, or designee, to facilitate the classification process as needed.
   c. Prior to transferring out of the residential program, the treating clinician shall update the ITP to reflect recommendation for transfer to the next level of care.

d. If time does not allow for recommendations to be added to the treatment plan the ITP shall be completed within 72 hours of discharge.

e. If the patient is being discharged from the residential program to a Level 4 facility the clinician shall work with the patient to complete a comprehensive discharge plan in accordance with BHSAMH Policy *E-10 Discharge Planning*.

f. Patients released from the residential program directly to the community shall complete a discharge plan with their respective clinician and respective discharge and reentry staff in accordance with BHSAMH Policy *E-10 Discharge Planning*. It is the explicit intent of this policy to minimize discharges without services directly to the community whenever possible. Upon the completion of the sentence, it is expected that all reasonable administrative and clinical efforts shall be completed to transition the patient from prison to the appropriate level of community care. Patients shall receive discharge planning services in accordance with BHSAMH Policy *E-10 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., shall be completed on a case-by-case basis, as clinically indicated. All discharge planning efforts shall be documented in the EHR.

g. When a patient is discharged from the RTU to any level of care (general population, higher/lower level of care, Level IV, and/or a community setting) the BHSAMH Bureau Chief and BHSAMH Behavioral Health Treatment Services Director shall be notified by the next business day.

h. Patients who are receiving BH5 level of care but require acute services shall be placed on psychiatric close observation when such a need is indicated.

i. The site mental health director will provide a copy of program schedules to the BHSAMH Quality Assurance Administrator and BHSAMH Treatment Services Director for review and approval.

J. Psychiatric Inpatient Services

1. When commitment or transfer to an inpatient psychiatric setting is clinically indicated:

a. Required procedures are followed.

b. The transfer occurs in a timely manner.

c. The patient is safely housed and adequately monitored until the transfer occurs.

d. Patients receiving mental health services are seen as clinically indicated and as prescribed in their ITP.

e. Mental health, medical, and substance use services are sufficiently coordinated such that patient management is appropriately integrated, medical, and mental health needs are met, and the impact of these conditions on each other is adequately addressed.

K. Psychiatric Treatment Services

1. Psychiatric treatment services shall be provided by a licensed Psychiatrist or Psychiatric Mental Health Advanced Practice Registered Nurse.

2. Psychiatric Treatment Services includes mental health medication management.
3. Patients deemed appropriate for psychiatric treatment services shall receive an initial psychiatric evaluation including but not limited to:
    a. Psychiatric history,
    b. substance use history,
    c. medical history,
    d. family/social history,
    e. physical examination, and
    f. mental status examination.
4. Psychiatric treatment shall address the patient's current diagnosis as reflected in the ITP.
5. the psychiatric provider shall meet with the patient at minimum once per quarterly or more frequently if deemed clinically necessary. Psychiatric provider shall:
    a. Assess current health status.
    b. Complete the Abnormal Involuntary Movement Scale (AIMS) for patients at risk of antipsychotic induced involuntary behaviors. The AIMS shall be completed at minimum every 6 months.
    c. Discuss treatment outcomes with patient understanding and agreement with treatment.

L. Acute Care – Psychiatric Close Observation (PCO)

1. Psychiatric management of acute psychiatric episodes will be in accordance with BHSAMH Policy *G-03 Emergency Psychotropic Medication and G-03.1 Non-emergency Psychotropic Medication.*
2. Patients will receive appropriate interventions and treatment for active homicidal and suicidal thoughts and/or behavior in accordance with BHSAMH Policy *B-05 Suicide Prevention and Intervention*.

M. Special Population

1. Offenders who are less than 21 years of age and are incarcerated for the first time in the DDOC system shall be offered weekly mental health visits by a mental health clinician for the first 30 days of their incarceration, or more often as clinically indicated.
    a. If a session with a mental health clinician is missed due to court, medical appointment, or other situational reason, then the mental health clinician must schedule a make-up session with the offender.
2. Offenders who are less than 21 years of age and housed in a pre-trial unit shall be enrolled in a facility-based Adjustment Group. The Adjustment Group will be delivered in an open-group format, covering topics relevant to offenders who require support to adjust to the correctional setting. Topics may include but are not limited to:
    a. Mental wellness,
    b. Physical care,
    c. Family/friend supports,
    d. Facility specific program/activities,
    e. Adjusting to institution schedule,
    f. Institutional authority,
    g. Accessing medical and behavioral health services, and

h. Other topics as deemed relevant and/or necessary to assist with the offender's adjustment to incarceration.

N. Continuity of Care

1. Continuity of Care will be in accordance with BHSAMH Policy *E-09 Continuity, Coordination, and Quality of Care.*
2. The Multi-Disciplinary Team (MDT) shall be utilized to review and integrate information from mental health, medical, substance use programs, security staff, and other specialty consultations to monitor the coordination of care for each patient and to improve clinical outcomes in accordance with BHSAMH Policy *A-04 Administrative Meetings and Reports*.

O. Discharge Planning Services

1. Discharge planning is in accordance with BHSAMH Policy *E-10 Discharge Planning.*

P. Emergency Services

1. Emergency Services will be in accordance with BHSAMH policy *D-07 Emergency Services and Response Plan* and BHSAMH Policy *G-03 Emergency Psychotropic Medication.*

Q. Tracking and Monitoring

1. The site mental health director, or designee, shall maintain a treatment roster for each facility. This roster shall include, but is not limited to, the following information:
    a. Name,
    b. State Bureau of Identification (SBI) number,
    c. Diagnosis,
    d. Behavioral health category to include co-occurring disorder,
    e. Level of care code,
    f. Medication(s) prescribed,
    g. Date of last mental health visit,
    h. Date of last CMHE,
    i. Treatment plan review date,
    j. Last psychiatric visit,
    k. Last date of AIMS.

R. All mental health services, regardless of the level of care, shall be documented in the patient's EHR. The QMHP shall ensure that each patient's chart will include at minimum:

1. An intake screening.
2. An initial and updated comprehensive mental health evaluation.
3. An initial and all updated individual treatment plan.
4. Progress notes in SOAP format (Subjective, Objective/Observation, Assessment, and Plan) for each mental health service encounter with the patient.
    a. Entries shall be completed within 24 hours after service delivery in the EHR.
    b. Each note shall have the clinician's name/degree/title/date/time; duration of the session completed; location of the session including housing unit and specific location (i.e., interview room, cell-side, office, etc.); and
5. Updated release(s) of information (ROI).

S. Patients have the right to refuse services at any time in accordance with BHSAMH Policy *G-05 Informed Consent and Right to Refuse*.

T. The contracted provider (e.g., medical, behavioral health, pharmaceutical) shall comply with requests to collect, provide, and or analyze data and assist with research activities as needed to comply with various legal requests and inquiries from DDOC or outside entities.

    1. Requests from outside entities must be reviewed and approved by the BHSAMH Bureau Chief, or designee.

U. The Contracted Healthcare Provider shall develop within 30 days of the effective date of this policy, a site-specific procedure for each Level 4 and Level 5 facility implementing this policy and coordinating the procedure with BHSAMH.