



PRISONS
Health and Wellness Services
Policies and Procedures

Title	Behavioral Health Services			
Section	AD I-7	Issue Date November 12, 2020	Supersedes Date New	Next Review Date November 2021

References:

Performance-Based Standards and Expected Practices for Adult Correctional Institutions, 5th Edition
5-ACI-6A-28 (M), 5-ACI-6A-29, 5-ACI-6A-37, 5-ACI-6A-38, 5-ACI-6A-39, 5-ACI-6B-13; 5-ACI-6D-02 (M); North Carolina Psychology Practice Act; 21 NCAC Chapter 54; Social Worker Certification and Licensure Act; 21 NCAC Chapter 63

I. PURPOSE

To establish and delineate facets of behavioral health services that shall be available to those offenders with a serious mental illness (SMI) as well as others who are identified with less severe mental health needs. To identify methods in accessing behavioral health services. To identify behavioral health staffing, organizational structure, and responsibilities.

II. SCOPE

Applies to the North Carolina Department of Public Safety (DPS), Division of Adult Corrections and Juvenile Justice, Division of Prisons.

III. DEFINITIONS

- (a) **Behavioral Health Clinician** – A behavioral health staff person providing services as a psychologist, as defined by the North Carolina Psychology Practice Act and 21 NCAC Chapter 54, or as a Clinical Social Worker (LCSW or LCSWa), as defined by the Social Worker Certification and Licensure Act and 21 NCAC Chapter 63. Related positions will require the staff person to be appropriately licensed or under an approved supervision contract with the licensing boards. Psychology and Social Work student-trainees who meet appropriate criteria and are under an approved Academic Affiliation Agreement for a masters or doctoral-level internship, practicum, or field-placement may also fall under this definition.
- (b) **Serious Mental Illness (SMI)** – Psychotic Disorders, Bipolar Disorders and Major Depressive Disorder; any diagnosed mental disorder (excluding substance abuse disorders) currently associated with serious impairment in psychological, cognitive, or



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behavioral functioning that substantially interferes with the person’s ability to meet the ordinary demands of living and requires an individualized treatment plan by a qualified mental health professional(s).

IV. POLICY

- (a) The behavioral health program is approved by the Director of Behavioral Health and includes screenings on intake, outpatient services, crisis intervention, management of acute psychiatric episodes, stabilization of the mentally ill, prevention of psychiatric deterioration, elective therapy services, preventive treatment, provision for referral and admission to mental health facilities for offenders whose psychiatric needs exceed the treatment capacity of the facility, procedures for obtaining and documenting informed consent, follow up with offenders who return from an inpatient psychiatric facility, substance-use specific treatment services, and aftercare planning for community re-entry.
- (b) Behavioral health services shall be available to all offenders identified with a serious mental illness and those with less severe mental health needs related to emotional, cognitive and behavioral deficits.

V. RESPONSIBILITIES

- (a) The Director of Behavioral Health maintains responsibility for the Behavioral Health Program including the Social Work Services Program, the Alcoholism and Chemical Dependency Program (ACDP), and the Clinical Services Program [Outpatient Services, Specialized Clinical Programs, Residential Services, and Inpatient Services (in conjunction with the Chief of Psychiatry)].
- (b) The Director of Behavioral Health supervises the Director of Social Work, the Chief of ACDP, and the Deputy Director of Behavioral Health.
- (c) Psychiatric services are provided under authority of the Chief of Psychiatry.

VI. ACCESS TO SERVICES

- (a) Offenders may be referred or self-refer for outpatient behavioral health services at any time during their incarceration by completing the Referral DC-540 on paper or electronically through the electronic medical record at which time they will be screened



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and triaged by a Behavioral Health Clinician in accordance with Health and Wellness Policy A - 12; Intersystem and Intrasystem Behavioral Health Services Screening, Appraisal, and Assessment.

- (b) Referral sources for outpatient services include but are not limited to:
 - (1) Staff members completing an intake screening at the Reception Diagnostic (Processing) Centers;
 - (2) Staff members who complete an OPUS Mental Health Screening Inventory (MHSI);
 - (3) Staff members who interact with the offender at any time during incarceration, including those from health services, nursing, dental, custody, the clergy, or approved non-DPS staff (e.g., instructors from community colleges providing educational programs to offenders); and
 - (4) An offender may self-refer by verbal contact with staff or by completing a Mental Health Referral DC-540.
- (c) Generally, routine behavioral health and psychiatric services are provided on an outpatient basis by staff covering the related facility.
- (d) Offenders in need of a higher level of care or a more specialized clinical program may also be referred directly for inpatient, residential, and specialized clinical programs by the primary therapist, a covering behavioral health clinician, a behavioral health supervisor, or a representative from regional or division-level behavioral health and psychiatric leadership.
- (e) Specialized Clinical Programs are made systematically available to offenders for elective therapy services and preventive treatment.
 - (1) Day Treatment services are available for individuals with Intellectual and Developmental Disabilities and/or SMI per Health & Wellness Policy TXI - 6; Behavioral Health Day Treatment.
 - (2) Therapeutic Diversion Units as an alternative to Extended Restrictive Housing



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placements for individuals with a serious mental illness and behavioral issues per Health & Wellness Policy TXI - 15; Therapeutic Diversion Units.

- (3) Sexual Offense Accountability and Responsibility (SOAR) program are made available for individuals with a sexual offense history per Health & Wellness Policy TXI - 17; Sexual Offense Accountability and Responsibility Program.
- (f) A Mental Health Residential Treatment Unit is available for those offenders with impairment in behavioral functioning associated with a serious mental illness and/or impairment in cognitive functioning.
 - (1) The severity of the impairment does not require inpatient level of care, but the offender demonstrates a historical and current inability to function adequately in the general population.
 - (2) There should be a specific mission/goal of the program, sufficient qualified staff to meet needs of program, screening process for the program, individual treatment plans for offenders in the program, safe housing to meet the therapeutic needs of the offender, and transition plan upon discharge from the residential treatment unit.
- (g) An Inpatient Mental Health Treatment unit is available for those offenders in need of inpatient level treatment (Central Prison for males and the North Carolina Correctional Institute for Women (NCCIW) for females).
 - (1) These units should have 24-hour nursing services and availability of Behavioral Health Clinicians, behavioral health trained correctional officers, and clinical programming.
 - (2) Individual treatment plans which will define the types and frequency of contacts with mental health staff for offenders in the program, housing to meet the therapeutic needs of the offender, and transition plan upon discharge from the inpatient treatment unit.
- (h) Referrals for inpatient and residential services should be completed in accordance with state statutes and Health Services Policy CC - 7; Transfer Procedures for Referral to Mental Health, with appropriate utilization of the DC-133r form for all voluntary and involuntary transfers/referrals.



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- (1) Any necessary consultations regarding the appropriateness of a referral to a higher level of care will be resolved by the Program Manager or designee of the facilities involved.
- (2) If a resolution cannot be accomplished, the Psychological Program Manager or designee may submit the case to the Assistant Director of Behavioral Health for the region in which the referral originated for a consultation as to what services are needed and placement in which specialized treatment facility, if any, is most appropriate to meet the treatment needs of the offender.
- (3) If necessary, the Director (or Deputy Director) of Behavioral Health and/or Chief of Psychiatry may be consulted to make a decision on service need and placement.

VII. IMPLEMENTATION OF SERVICES

- (a) Behavioral Health Service levels will be designated by a coding system to ensure proper facility placement and continuity of care. The following codes should be used:
 - (1) M – grades
 - (A) M1: Not currently identified in need of on-going Behavioral Health services. No active treatment plan for a clinical behavioral health service.
 - (B) M2: Currently evaluated in need of on-going therapeutic services for a diagnosed mental disorder. Requires an active treatment plan for a clinical behavioral health service.
 - (C) M3: Currently evaluated in need of on-going therapeutic services for a diagnosed mental disorder that also includes care from a psychiatrist. Requires an active treatment plan for a clinical behavioral health service.
 - (D) M4: Currently receiving residential treatment services. Requires an active residential treatment plan.
 - (E) M5: Currently receiving inpatient mental health treatment services. Requires an active inpatient treatment plan.



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(2) R – grades

(A) R1: Not evaluated as having an Intellectual Disability.

(B) R2: Evaluated as having an Intellectual Disability. Should also have a related DSM diagnosis and be on the DD (Developmentally Disabled) Caseload

(3) DD – Y/N Flag

(A) DD = No: Indicates the individual has been evaluated and does not qualify for placement on the Developmental Disability (DD) Caseload

(B) DD = Yes: Indicates the individual has been evaluated as qualifying for and is on the Developmental Disability (DD) Caseload.

(b) There shall be available, system-wide, outpatient behavioral health services covering all M-grades, custody levels, and health services acuity levels.

(c) Services shall be provided by a combination of psychiatric, psychological, ACDP, and social work staff as clinically indicated.

(d) Services shall be provided in the most effective and clinically indicated manner, as documented by behavioral health staff, in order to meet the offender’s behavioral health treatment needs.

(E) Upon initiation of outpatient services, the offender shall provide informed consent. An informed consent (DC - 947) and limits of confidentiality (DC – 945) form shall be signed by the offender, witnessed by a staff person, scanned into the electronic healthcare record in the document manager section, and attached to the corresponding document.

(i) Additional aspects of informed consent may be outlined in program specific orientation materials for offenders participating in Specialized Clinical Programs.

(ii) The DC-133r serves as the consent for treatment and due process document in residential and inpatient settings.



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VIII. QUALITY ASSURANCE, PERFORMANCE IMPROVEMENT, AND PROGRAM REVIEW

- (a) Quality assurance activities are a continuing responsibility of the Behavioral Health Services section and each service delivery site. Quality assurance is also a shared responsibility within the multidisciplinary framework of the facility, the prison system, and the overarching Health & Wellness system within the department.
- (b) The Director of Behavioral Health and the Chief of Psychiatry appoint representatives from Social Work, Psychology, and Psychiatry to participate in the Health & Wellness Continuous Quality Improvement (CQI) Committee along with representatives from other disciplines and sections requested by the Director of Quality Assurance.
- (c) Each Behavioral Health Clinical Services site will have the following Quality Assurance activities (at a minimum):
 - (1) Clinical and professional supervision per this policy and adherent to representative licensing board requirements.
 - (2) Clinical privileging for Psychologists, Clinical Social Workers, and Psychiatrists.
 - (3) Record review by behavioral health supervisors.
 - (4) Client care evaluation studies to include suicide death reviews, transgender accommodation committee reviews, HCON evaluations, and other significant case reviews as identified by the facility interdisciplinary team and/or behavioral health supervisors.
 - (5) Clinical peer review per Health & Wellness Policy ADII - 2, Peer Review.
 - (6) Employee education and training consistent with Prison Policy A .0900, Employee Training.
 - (7) Documented program evaluation through Annual Administrative Code Reviews by the Assistant Director of Behavioral Health (or designee) for the related region.
 - (9) Evidence of corrective action for any Performance Improvement Plans.




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- (e) The Behavioral Health Services section will establish and implement a written quality assurance plan that is reviewed and revised annually for Behavioral Health describing how quality assurance activities will be carried out to include, but need not be limited to, the following:
 - (1) A process for monitoring and evaluating the quality and appropriateness of client care, incorporating a review of significant incidents (to include suicides).
 - (2) A plan for professional and clinical supervision of behavioral health staff.
 - (3) Establishment and implementation of program evaluation activities.
 - (4) Strategies for improving client care.
 - (5) Evidence of corrective action.

- (f) The Behavioral Health Staffing Plan will include the following aspects which will be reviewed on an on-going basis and assessed on an at-least annual basis:
 - (1) Staffing decisions based on defined staffing metrics as a part of on-going staffing analyses.
 - (2) Consideration of geographical and logistical issues in providing services to certain areas when completing a staffing analysis.
 - (3) Collecting, trending, and analyzing of defined data combined with planning, intervening, and reassessing services.
 - (4) Evaluating defined data, which will result in more effective access to care, improved quality of care, and better utilization of resources.



 Todd E. Ishee

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 Date



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