GEORGIA DEPARTMENT OF CORRECTIONS **Standard Operating Procedures**		
Policy Name: Mental Health Levels of Care		
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Authority: Commissioner	**Originating Division:** Health Services Division	**Access Listing:** Level II: Required Offender Access

I. Introduction and Summary:

Offenders requiring mental health services will be assigned to levels of care based on a continuum of treatment needs. This procedure is applicable to all Georgia Department of Corrections (GDC) facilities with a mental health mission.

II. Authority:

A. GDC Standard Operating Procedures (SOPs): 508.10 Confidentiality of Mental Health Records, 508.15 Mental Health Evaluations, 508.19 MH Referral and Triage, 508.23 Specialized Mental Health Treatment Unit (SMHTU), 508.24 Psychotropic Medication Use Management, and 508.25 Psychiatric Hospitalization, and;

B. American Correctional Association (ACA) Standards: 4-4350, 4-4368 (MANDATORY), 4-4370 (MANDATORY), 4-4374, and 4-4399; and

C. National Commission on Correctional Health Care (NCCHC): Standards for Mental Health Services in Correctional Facilities.

III. Definitions:

A. **Mental Health Treatment Team** - May consist of, but not limited to the mental health unit manager, mental health counselors, behavior specialists, psychiatrists/advanced practice registered nurses (APRNs), psychologists, mental health nurses, activity therapists, teachers, chaplains, multifunctional correctional officers, designated security staff, and other staff as needed.

B. **Individualized Treatment Plan** - A guide for each offender that has a definition of problem(s), goal(s), and intervention(s) with scheduled updates.

C. **Qualified Mental Health Professional** – Mental health unit managers, psychiatrists, psychologists, APRNs, licensed nurses, licensed professional counselors, licensed master or clinical social workers, licensed marriage and family therapists, mental health counselors, and mental health behavior specialists.

D. **Serious Mental Illness/Serious and Persistent Mental Illness** - A substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality or cope with the ordinary demands of life within the correctional environment and is manifested by substantial pain or disability. Serious mental illness requires a mental health diagnosis and treatment in accordance with an Individualized Treatment Plan (ITP).

E. **Mental Health Outpatient** - Services that are provided to offenders in the general population or any other non-clinical setting at any GDC facility to assist the offender in overall adjustment in the correctional environment and provide treatment for specific needs as identified in an Individualized Treatment Plan.

F. **Supportive Living Unit (SLU)** - Special intermediate care mental health housing designed to serve the needs of the Seriously Mentally Ill offender who is unable to live and function effectively in the general prison population due to the nature of their mental illness. The offender may:

1. Exhibit active symptoms of mental illness and tend to remain Seriously Mentally Ill over time; or

2. Be relatively stable but fragile and tend to decompensate in stressful environments such as that of a general prison population.

3. These units are separate housing units from general population. Interaction with general population and movement within the institution is based on individual mental health treatment needs and functional level. Reintegration, when appropriate, with the general population is important. These units offer a therapeutic milieu with a spectrum of programming designed to support and treat the mentally ill offender based on an Individualized Treatment Plan.

G. **Crisis Stabilization Placement** - Offenders who are in crisis will be placed in an Acute Care Unit (ACU) or Crisis Stabilization Unit (CSU) cell. At facilities without ACU or CSU cells, the offenders will be placed in an observation cell until a transfer can take place to a facility with ACU/CSU cells. Offenders with repeated severe crises who cannot be stabilized in an ACU/CSU may be

considered for transfer to a forensic psychiatric hospital or prison psychiatric facility for placement.

IV. Statement of Policy and Applicable Procedures:

The level of care of the mental health offender will determine availability and types of mental health services, frequency of therapeutic contacts, and mode of discharge planning. It is the responsibility of the assigned mental health counselor to meet with Level II offenders within fourteen (14) days and with Level III and IV offenders within seven (5) days of being placed on the mental health caseload. This includes but is not limited to transfers from other facilities, a counselor change, or level change, etc. When an offender returns from court they must be seen by a mental health counselor within 24 hours or the next working day.

A. Level I – No need for Mental Health Services: Mental health services are not indicated when an offender's ability to adjust and function in general population is not significantly impaired due to the presence of a mental illness.

B. Level II – Outpatient Services:

1. Mental Health Outpatient services are indicated when an offender's ability to function in general population is (1) mildly impaired due to mental illness, or (2) is not currently impaired but needs monitoring due to:

   a. Medication maintenance or a recent discontinuation of psychotropic medication.

   b. A recent discharge from either a SLU or Crisis Stabilization Placement.

   c. A recent history of significant self-injurious behavior or suicidal ideation.

2. Admission Criteria: The decision to provide an offender with mental health outpatient services is based on an evaluation made by a psychiatrist/APRN and/or psychologist. (Reference SOP 508.19, MH Referral and Triage)

3. Services Provided: Outpatient services may include but are not be limited to:
   a. Development of an Individualized Treatment Plan;

b. Psychopharmacological treatment;

c. Psychological testing;

d. Individual counseling/group counseling;

e. Individual therapy/group therapy;

f. All groups, programs and services available to general population offenders, to include assisting with re-entry efforts; and

g. Crisis intervention.

4. Frequency of Contact: Offenders placed on Level II will be seen at least once a month by their mental health counselor unless the Treatment Team determines another timeframe and the frequency of contact is documented in the offender's Individualized Treatment Plan. Each session will be documented in a progress note using the Mental Health Progress Note (M20-02-02).

5. Mental Health Outpatient services are provided in the following settings:

   a. At all facilities with a Mental Health Treatment Team; and

   b. At facilities with a mental health satellite program for isolation-segregation rounds and evaluation of services.

6. Mental Health Outpatient Staffing Organization:

   a. Treatment for Mental Health Outpatient programs will be based on an interdisciplinary approach to the treatment of mental illness. The following disciplines may be involved in providing services:

      1) Mental health unit manager;

      2) Clinical psychologist;

3) Psychiatrist/Advanced practice registered nurse (APRN);

4) Mental health counselors;

5) Mental health nurses;

6) Mental health behavior specialist (in diagnostic facilities);

7) Multifunctional correctional officers;

8) Clinical chaplain;

9) Teacher;

10) Activity therapists; and

11) Medication clinic coordinator.

b. Clinical consultant services for offenders receiving Outpatient Mental Health services will be coordinated by the mental health unit manager. Psychiatric, psychological, and other clinical consultants will provide on-site or tele-mental health services at scheduled times at designated facilities with Outpatient Mental Health services.

7. Discharge Planning: The Treatment Team, led by the clinical director/psychologist, to include the treating psychiatrist/APRN, mental health unit manager and the assigned mental health counselor will decide to discharge an offender. This decision should be documented on a Treatment Team note, Diagnosis List, Individualized Comprehensive Treatment Plan/Review and Utilization Review (on the front of the Comprehensive Treatment Plan). This decision is based on the Treatment Plan goals having been met and maintained without the utilization of psychotropic medication for a time frame judged to be sufficient (a minimum of 60 days) for the offender being treated. (See SOP 508.24, Psychotropic Medication Use Management). The Counselor Discharge Summary Note (M32-01-01). which is Attachment 1, will be placed, along with the mental health record, in

section five (5) of the medical record. The mental health unit manager will ensure that appropriate staff utilizes the current computer systems (Scribe) to reflect level I status.

8. Offenders released from a forensic psychiatric hospital or prison psychiatric facility cannot be returned to a level I facility. Offenders released from a Crisis Stabilization Unit (CSU), or an Acute Care Unit (ACU), cannot be returned to a level I facility until the offender has been evaluated by a psychiatrist/APRN and/or a psychologist and with concurrence from the Treatment Team it is determined this offender can return to a level I facility. Documentation justifying the decision should be placed in section five of the medical record. Contact should be made by the mental health unit manager (via email or phone call) to the receiving facility's deputy warden of care and treatment at the level 1 facility regarding the decision. This communication shall be made by the next business day after the Treatment Team meeting to coordinate transportation of the offender back to the level 1 facility.

9. Offenders diagnosed with a Serious and Persistent Mental Illness (SPMI) cannot be removed from the caseload. They must be placed in the least restrictive environment given their adaptive level of functioning and they should be followed by a mental health counselor and a psychiatrist/APRN or psychologist. An offender can be taken off the caseload if a psychiatrist/APRN or psychologist concludes that the diagnosis of Serious and Persistent Mental Illness was incorrect and then proceeds to make a diagnosis in collaboration with the Treatment Team, correcting the previous diagnostic impression.

10. The scope of services offered by mental health staff to the RSAT program mental health detainees will be restricted to:

    a. Medication management;

    b. Crisis intervention;

    c. Reentry;

d. Maintenance (maintenance detainees can be seen once a month in groups. The mental health counselor, psychiatrist/APRN or psychologist will determine who is appropriate for a maintenance group); and

e. Limited individual/therapeutic counseling.

C. Level III – Supportive Living Unit Services:

1. Level III Supportive Living Unit (SLU) services are indicated when an offender's ability to function in general population is moderately impaired due to mental illness. This designation reflects a tenuous mental status that is easily overwhelmed by everyday pressures, demands, and frustrations resulting in the following: disorganization, impulsive behavior, poor judgment, a deterioration of emotional controls, loosening of associations, delusional thinking, and/or hallucinations. The decision on whether to allow these offenders to participate in general population activities, such as a work detail, a psycho-educational group, school, gym call, and library call is based on their mental status and Individualized Treatment Plan goals.

2. Admission Criteria for Supportive Living Unit Placement:

a. The offender has a moderate mental illness as defined above and as a result of the moderate mental illness has experienced significant impairment in their ability to adjust and function satisfactorily within the general prison population, as determined by the number, intensity, and frequency of mental health services needed, or the offender has stabilized at a higher level of care and can now function within the Supportive Living Unit.

b. The offender must also meet the following criteria:

1) Absence of acute psychotic and/or affective symptomatology requiring a higher level of care (i.e. Crisis Stabilization care or hospitalization).

2) Absence of acute or chronic medical conditions that require intensive or prolonged skilled nursing care or hospitalization.

3) Ability to participate in their treatment and attend treatment appointments.

c. The offender has been recommended for Supportive Living Unit placement by the Mental Health Treatment Team as part of the offender's Individualized Treatment Plan or has been recommended for placement pending the outcome of a mental health evaluation.

3. Level III Supportive Living Unit Program Description:

a. The Supportive Living Unit will provide a structured therapeutic milieu designed to assist moderately mentally ill offenders in functioning psycho-socially and vocationally at the highest possible level within the correctional environment. A broad spectrum of therapeutic activities and groups will be available and utilized as needed based on the specific treatment needs of each offender as identified in the Individualized Treatment Plan.

b. General Operating Principles of the Supportive Living Unit.

1) Offenders housed in the Supportive Living Unit will have daily access to mental health staff. To ensure access to staff and to provide a mechanism for regular monitoring of the Supportive Living Unit population, the mental health counselor(s) assigned to the Supportive Living Unit will conduct daily rounds. Rounds will be conducted at a designated time each day. Problems identified during rounds will be discussed with the clinical director/psychologist responsible for overseeing the therapeutic program.

2) Offenders placed on level III or level IV care will be seen at least twice a month by their mental health counselor. Each session will be documented in a progress note.

3) Offenders released from a forensic psychiatric hospital or prison psychiatric facility, Crisis Stabilization Unit or Acute Care Unit must be followed more closely by their mental health counselor than other level IV, level III, or level II offenders.

4) Offenders should be engaged in therapeutic programming a minimum of two (2) to four (4) hours a day. Based on the needs of the offender, scheduled structured recreation or therapeutic activities may include: work, education, structured therapeutic activities or programs, individual, or group therapy, and/or psychological/psychiatric appointments.

5) A clinical director/psychologist in conjunction with the mental health counselor(s) assigned to the Supportive Living Unit will be responsible for developing, implementing, and overseeing the therapeutic program in the Supportive Living Units.

6) The mental health counselor(s) assigned to the Supportive Living Unit will generally be the primary mental health care provider(s) for the offenders living in that Supportive Living Unit. This person will be responsible for the development (in conjunction with the offender and the Mental Health Treatment Team), implementation and monitoring of the offender's Individualized Treatment Plan.

c. Offender's scheduled activities/programs/treatment will be scheduled through the computer tracking system (Scribe), where available. Activities required as part of the treatment plan are part of the offender's schedule.

d. Program services to include but are not limited to:

1) Structured therapeutic activities to include socialization and reality-orientation programs as well as activity therapy;

2) Individual and group mental health treatment designed to help the individual change behavior as needed and develop more effective coping skills;

3) Psychiatric evaluation and psychopharmacology;

4) Psychological testing and assessment;

5) Patient education on mental illness and psychotropic medications;

6) Medication compliance monitoring and counseling;

7) Psycho-educational programs and groups (such as anger management, mood disorder, stress management, etc.);

8) Activity therapy programs (i.e., pet therapy, horticulture, recreation therapy, physical fitness, Activities of Daily Living (ADL's), etc.);

9) Therapy groups (may be considered if not emotionally overwhelming to the fragile SLU population);

10) Self-help groups include Alcoholics, etc.;

11) Institutional work details;

12) Educational programs;

13) General population counseling programs as clinically indicated to include substance abuse groups/support groups;

14) All other general population services and activities (i.e., store call and yard and gym call) will be made available to all mental health offenders;

15) Community meetings held weekly to include Supportive Living Unit correctional officers/multifunctional correctional officers. Minutes

should be kept during all community meetings. The minutes should include documentation regarding whether there is adequate seating.

4. Level III Supportive Living Unit Staffing Composition: Treatment on the Supportive Living Unit (SLU) will be based on an interdisciplinary approach to the treatment of mental illness. The following disciplines may be involved in providing services within the therapeutic milieu:

    a. Mental health unit manager;

    b. Clinical psychologist;

    c. Psychiatrist/APRN;

    d. Mental health counselor(s);

    e. Mental health behavior specialist (in diagnostic facilities);

    f. Correctional officers/multifunctional correctional officers;

    g. Activity therapist(s);

    h. Mental health nurse or nurse supervisor;

    i. Chaplain;

    j. Teacher; and

    k. Medication clinic coordinator.

5. Discharge Planning:

    a. The Treatment Team, led by the clinical director/psychologist, to include the treating psychiatrist/APRN, mental health unit manager and the assigned mental health counselor will decide to discharge an offender from level III services. This decision should be documented on a

Treatment Team note, Mental Health Diagnosis List (Attachment 4, M20-01-05, SOP 508.09), Individualized Comprehensive Treatment Plan/Review, and Utilization Review on the front of the Comprehensive Treatment Plan.

b. Offenders should generally be stepped down one level of care at a time. Offenders should remain on a level of care (level IV, level III or level II) for at least 60 days before having their level of care reduced.

c. When the Treatment Team is considering reducing an offender's level of care by more than one level and/or reducing it in less than 60 days, then a psychiatrist/APRN or psychologist must evaluate the offender to determine whether to follow the Treatment Team's recommendation. The evaluation must contain:

   1) A review of the offender's mental health history, medication adherence, diagnosis, and mental status.

   2) A statement justifying either agreement or disagreement with the Treatment Team's recommendation.

d. When clinically indicated, treatment will be directed toward transitioning Supportive Living Unit (SLU) offenders into the prison's general population.

e. During the transitioning process, mainstreaming the mental health offenders into general population programs/activities to include work details education programs, and general population programs should take place on a gradually increasing basis in accordance with the offender's Individualized Treatment Plan.

f. Transfer to general population is a clinical decision and will be made when the Mental Health Treatment Team determines that an offender can function effectively in general population.

g. During the transitioning period, close coordination between the Supportive Living Unit (SLU) and Mental Health Outpatient staff must take place to ensure continuity of care.

D. Level IV – Supportive Living Unit Services:

1. Level IV Supportive Living Unit services are indicated when an offender's ability to function in general population is severely impaired due to mental illness. This level reflects active symptoms of a Severe and Persistent Mental Illness (SPMI) with impaired reality testing. These offenders are unable to attend most treatment or recreational groups in traditional settings and may require ancillary services provided in the residential unit such as special education, psycho-educational groups, activity therapy, and library services.

2. Admission Criteria for Level IV Supportive Living Unit Placement:

   a. As a result of the Severe and Persistent Mental Illness, the offender has experienced severe functional impairment (e.g., unable to transition to the cafeteria, a need for an escort to transition within the facility, the need for assistance for sick call access, or the need for a single cell environment for activities of daily living).

   b. Their ability to adjust satisfactorily within the general prison environment may be determined by the number, intensity, and frequency of mental health services needed.

   c. The offender's ability to participate in treatment and attend planned scheduled treatment is limited by their mental illness.

   d. The offender has been recommended for Supportive Living Unit placement by the Mental Health Treatment Team as part of the offender's Individualized Treatment Plan or has been recommended for placement pending the outcome of a mental health evaluation.

3. Level IV Supportive Living Unit Staffing Composition and Program Description:

a. Staffing composition of a level IV Supportive Living Unit will be interdisciplinary as stated above and more intensive than level III Supportive Living Unit given the mental health needs of the offender.

b. The general operating principles of a level IV Supportive Living Unit are identical to those of a level III Supportive Living Unit.

c. Program services in a level IV Supportive Living Unit are identical to those of a level III Supportive Living Unit with the exception that many services are offered in the residential unit rather than elsewhere in the facility.

d. Discharge planning for a level IV offender is similar to a level III offender in a Supportive Living Unit with the exception that most level IV offenders are discharged to a level III Supportive Living Unit rather than to general population.

    1) The Treatment Team, led by the clinical director/psychologist, to include the treating psychiatrist/APRN, mental health unit manager and the assigned mental health counselor will decide to discharge an offender from level IV services. This decision should be documented on a Treatment Team note, Diagnosis List, Individualized Comprehensive Treatment Plan/Review and Utilization Review on the front of the Comprehensive Treatment Plan.

    2) Offenders should generally be stepped down one level of care at a time. Offenders should remain on a level of care (level IV, level III or level II) for at least 60 days before having their level of care reduced.

    3) When the Treatment Team is considering reducing an offender's level of care by more than one level and/or reducing it in less than 60 days, then a psychiatrist/APRN or psychologist must evaluate the offender to determine whether to follow the Treatment Team's recommendation or not follow the recommendation. The evaluation must contain:

a) A review of the offender's mental health history, medication adherence, diagnosis, and mental status.

b) A statement justifying either agreement or disagreement with the Treatment Team's recommendation.

E. Level V – Acute Care Unit (ACU) or Crisis Stabilization Unit (CSU) Placement:

1. Crisis Placement is indicated when:

   a. An offender's ability to function is severely impaired due to acute Serious Mental Illness;

   b. It would facilitate diagnostic clarification;

   c. There is a need for more intensive psychopharmacological intervention;

   d. There is a need for continued observation; and/or

   e. There is a need for continued mental health and medical observation or treatment in the infirmary (CSU).

2. Crisis Stabilization will only take place in designated infirmaries. Offenders in need of acute care or Crisis Stabilization will be placed in an ACU/CSU cell. In facilities without ACU/CSU cells the offender can be placed in an Observation cell until transferred to a facility with ACU/CSU stabilization beds.

   a. Any Qualified Mental Health Professional may admit an offender for Acute Care or Crisis Stabilization.

   b. Although offenders may refuse mental health treatment, they may not refuse Acute Care or Crisis Stabilization Placement if the admitting provider deems it necessary to observe or house the offender in this location.

c. The Qualified Mental Health Professional at the Crisis Stabilization Unit will contact the psychiatrist/APRN to request an admission order within one (1) hour of transfer to the infirmary CSU cell.

d. A psychiatrist/APRN will be on call during off-hours, weekends and holidays for consultation regarding offenders in Acute Care or Crisis Stabilization Placement.

e. Offenders placed in an Acute Care Unit or Crisis Stabilization Unit will be seen by a licensed mental health clinician every work day or a Qualified Mental Health Professional privileged to perform crisis stabilization or evaluation/treatment. A telephone consultation is required between the Qualified Mental Health Professional and the treating psychiatrist/APRN if the psychiatrist/APRN has not interviewed the patient that day. All clinical encounters will be appropriately documented in either the medical or clinical file.

f. Only a psychiatrist/APRN can discharge an offender from a Crisis Stabilization Unit.

g. All non-mental health (level I) offenders admitted to the Crisis Stabilization Unit will have a complete Mental Health Evaluation using Attachment 1, Mental Health Evaluation for Services (M31-01-01) from SOP 508.15 and Attachment 6, Initial Psychiatric/Psychological Evaluation (M60-01-06) from SOP 508.24, before being discharged from the Crisis Stabilization Unit.

h. An offender being stabilized in a designated Mental Health Crisis Stabilization Unit and in restraints longer than 72 hours, may be referred for placement in a prison psychiatric facility using procedures outlined in SOP 508.25, Psychiatric Hospitalization.

F. Level VI Prison Psychiatric Facility: A prison psychiatric facility is indicated when an offender has severely debilitating symptomatology which cannot be safely and adequately treated within an infirmary or Supportive Living Unit and

thus must be transferred to a prison psychiatric facility. (Refer to SOP 508.25, Psychiatric Hospitalization.)

G. Mental Health "Housing" Criteria:

1. Level II offenders should not take up valuable Supportive Living Unit space. They should be placed in general population. If level II detainees are at risk in general population, they can be briefly placed in a Supportive Living Unit (SLU-III) dorm assuming they are not predators. Facility administration should be notified weekly of the Level II detainee's status. The state mental health program supervisor/designee should be sent a copy of these notifications.

2. Level III offenders should live in a Supportive Living Unit dorm (SLU-III) with other level III offenders.

3. Level IV offenders should live in a Supportive Living Unit (SLU-IV) dorm with other level IV offenders. Level IV units are the most staff-intensive and most restrictive units with many activities/programs being brought to the offenders instead of the offenders being brought to the activities/programs. Placing level III offenders in a level IV dorm would violate the least restrictive environment principle.

4. Special mental health treatment unit (SMHTU) placement will be primarily determined by treatment needs. Level of care will be secondary in importance when determining SMHTU housing.

5. Mental health offenders pending movement should not normally be locked down. If it is a level IV offender in a level III facility the offender can be kept in the Supportive Living Unit with close observation, until the transfer can be facilitated. If the offender is a level III offender in a level II facility they can be kept in general population with close observation, until the transfer can be facilitated.

6. The above-recommended criteria are guidelines for mental health placement. It must be noted that there will be exceptions given security concerns, space

problems, and clinical conditions. It is the responsibility of mental health staff to ensure that mental health offenders are appropriately housed.

V. Attachment:

Attachment 1: Counselor Discharge Summary Note (M32-01-01)

VI. Record Retention of Forms Relevant to this Policy:

Attachment 1 shall be placed in the offender's mental health file. At the end of the offender's need for mental health services and/or sentence, the mental health file shall be placed within the offender's health record and retained for 10 years.