ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.80	Page 1 of 12
	Effective Date: February 15, 2021	
	Distribution: A	
	Supersedes: 113.80 (10/15/17)	
Approved by: Tony Parker		
Subject: BEHAVIORAL HEALTH SERVICES ADMINISTRATION AND DELIVERY		

I. AUTHORITY: TCA 4-3-603 and TCA 4-3-606.

II. PURPOSE: To clarify administrative responsibilities at each organizational level of the Tennessee Department of Correction (TDOC) behavioral health service system and to identify behavioral health services within the TDOC system.

III. APPLICATION: All TDOC employees, including contracted health and behavioral health professionals, and privately managed institutions.

IV. DEFINITIONS:

A. Ancillary Programmatic Services: Programmatic services presented in a psycho-educational format that are not clinical in nature.

B. Behavioral Health Administrator (BHA): A licensed or qualified mental health professional approved by the Warden/Superintendent and the Director of Behavioral Health Services to assume the responsibility of coordinating the delivery of behavioral health services.

C. Behavioral Health Treatment Services: A continuum of biological and psychological treatment services for inmates at risk of, or suffering from, mental, behavioral, and/or substance related disorders, that significantly interfere with their ability to function in prison. The services are multidisciplinary, eclectic, and consistent with generally accepted behavioral health practices and institutional requirements.

D. Clinical Director: A licensed psychologist with health service provider designation approved by the Warden/Superintendent, BHA, and Director of Behavioral Health Services to provide clinical direction and oversight of the facility's clinical needs.

E. DSM: The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders.*

F. Office of the Inspector General (OIG): A TDOC staff member designated by the Commissioner to oversee compliance of all providers under contract that provides programs and services in accordance with Policy #205.02.

G. Licensed Independent Mental Health Professional (LIMHP): A Licensed Psychiatrist, Advanced Practice Nurse (APN), Psychologist with health service provider designation; Senior Psychological Examiner; Licensed Clinical Social worker; or licensed professional counselor with health service provider designation. These individuals shall meet all educational competency and licensure/certification criteria mandated by their regulatory boards.

H. Mental Health Appraisal: A screening assessment used to determine the need for a mental health evaluation. (See Policy #113.84)

I. Mental Health Screen: An initial mental health screen at the time of admission to the facility by a mental health trained or qualified mental health care personnel. (See Policy #113.20)

J. Mental Health Treatment Team: A multidisciplinary assessment and service planning team whose primary responsibility is to deliver mental health services to inmates with mental illness.

K. Non-Compliance Report (NCR): Report issued by the Clinical Contract Monitor (CCM) to the contractor electronically (through the OIG) detailing any finding of non-compliance with the terms of the contract or applicable policies, citing the contract/policy sections that have been violated, the details of the violation, and providing the contractor a space to respond.

L. Qualified Mental Health Professional: For purposes of this policy only, a licensed independent mental health professional (LIMHP) includes a Licensed Psychological Examiner, or other individual who is professionally licensed/certified as a therapeutic professional, or an unlicensed mental health provider having a Master's Degree in the behavioral sciences.

M. Summary of Non-Compliance Reports (SNR): Reports by the CCMs summarizing any new or unresolved NCRs, the contractor's response/corrective action, verification of corrective action, and TDOC management comments.

V. POLICY: The administration of behavioral health services within the TDOC is structured to promote systemic continuity and consistency in quality of care. Each institution shall make behavioral health services available to those inmates requiring such services.

VI. PROCEDURES:

A. Departmental Responsibility: The TDOC is responsible for the overall administration and provision of behavioral health services for the inmate population.

1. TDOC Director of Behavioral Health Services Responsibilities: The TDOC Director of Behavioral Health Services is responsible to the TDOC Chief Medical Officer (CMO) for the overall planning, coordination, organization, and monitoring of the Department's mental health service delivery system. The TDOC Director of Behavioral Health Services or designated staff has the following duties:

a. Develops and maintains plans for the operation of a coordinated behavioral health services delivery system for institutional and community-based inmates, and safe keepers under TDOC's jurisdiction.

b. Studies behavioral health services organization, operations, and services and makes recommendations for improvements affecting policy, staffing, economy, and quality.

c. Coordinates behavioral health services contract monitoring, inspections, and staff visits at institutions and makes recommendations to the Wardens/Superintendent, and BHAs for improvements in behavioral health services delivery.

d. Assists in the negotiation and selection of contractual arrangements with behavioral health providers and reviews all contractual agreements for behavioral health services.

e. Approves the course curriculum and design for behavioral health services in-service training developed by the behavioral health service providers as outlined in Policies #513.07 and #513.12.

f. Approves the course curriculum and design for mental health services in-service training developed by the behavioral health service providers in clinical skills in areas listed below but not limited to;

1. Mental health needs of inmate population (special needs)
2. Behavior management techniques
3. Mental health issues with female population
4. Aging/palliative care
5. Trauma-informed care
6. Confidentiality of mental health record
7. Suicide/self-injury prevention
8. Signs and symptoms of mental illness, substance abuse/relapse and neurocognitive disorders/neurodevelopmental disabilities
9. Assessment and diagnosis of mental disorders
10. Crisis intervention

g. Monitors the monthly behavioral health statistics and submits to the CMO and OIG an annual report of behavioral health services for the preceding fiscal year.

h. Serves as a resource and provides staff support for institutional staff, Central Office Directors, Deputy/Assistant Commissioners, and other staff as necessary.

i. Monitors the performance of private behavioral health services contractors to ensure that services are provided according to contract and state expectations.

2. Behavioral Health Contract Monitoring: All contracts shall be monitored according to the frequency specified in the contract or more often as indicated by the performance level of the individual contract and in accordance with Policy 205.02.

B. Institutional Responsibilities:

1. The daily delivery of behavioral health services at each institution will be in accordance with standards, policies, and procedures established by the Division of Behavioral

Health Services and contained in statewide TDOC policies and procedures. Organizationally, institutional behavioral health programs will come under the direct authority of the Associate Warden of Treatment (AWT). The AWT will administratively supervise state employed Behavioral Health Administrators. The contractor will be accountable to the AWT and Warden/Superintendent, for the performance of the BHAs employed by the contractor in keeping with the terms of the behavioral health contract. Each institution shall have a Clinical Director unless otherwise specified by the Director of Behavioral Health Services. The Clinical Director's work shall be under the general management of the BHA. The Clinical Director in collaboration with the BHA will determine the program clinical needs. The BHA will conduct annual performance appraisal reports on all other behavioral health staff. The contractor has the ability to make clinical assignments (related to provision of behavioral health care) to state staff working in this area (i.e. assignments, meetings, etc.).

2. In TDOC operated institutions where the behavioral health staff are hired by a vendor contracted through TDOC, the organizational structure will be the same as above. The vendor will have administrative oversight and will hire employees. The Director of Behavioral Health Services will be involved in the interviewing and selection process of the behavioral health administrator positions. The hiring of other behavioral health staff is subjected to the approval of the on-site administrative staff. The BHA, the AWT and/or Warden/Superintendent will review all decisions regarding the hiring of behavioral health contract personnel and will make any concerns known to the Director of Behavioral Health Services and the CMO. All administrative decisions regarding work schedules, job duties, use of leave, etc. are established by the AWT or the Warden with the vendor. BHAs or designee will maintain semi-monthly time sheets for all vendor employees, and all hours will be accounted for monthly.

3. At State and privately management institutions, a psychiatrist shall be designated to be accountable for final clinical judgments concerning psychiatric treatment and its adjuncts, (subject to current contract provisions).

4. The provision of effective behavioral health care is a joint effort between facility administrators and behavioral health service providers and can be achieved only through cooperative efforts from both parties. Matters of behavioral health treatment involving clinical judgments other than those pertaining to the prescription of psychotropic medications are the sole province of the Clinical Director. However, these services must be provided in keeping with the security regulations of the institution and TDOC as well as confidentiality for institutions, community supervision settings, and when telehealth is utilized in accordance with Policy #113.52.

5. Adherence to licensure laws shall be maintained in accordance with Policy #113.10 for behavioral health professionals. Any conflicts shall be addressed and resolved in accordance with accepted professional standards of practice, provider to provider in an appropriate manner, elevating the concerns or conflict to the institutional level and/or Director of Behavioral of Health when other efforts have been exhausted.

6. The BHA shall meet at least quarterly with the AWT or Warden/Superintendent and present a written report on the institutional behavioral health care program. The purpose of such meetings shall be to review statistics, identify problems, and offer resolutions

concerning the effectiveness and quality of the institutional behavioral health care programs. The quarterly report shall be forwarded to the Director of Behavioral Health Services. The BHA and the Clinical Director shall attend statewide and/or regional behavioral health services meetings. Other members of the behavioral health service staff may attend these meetings periodically upon request of the Director of Behavioral Health Services. The purpose of these meetings shall be to identify problems and resolutions pertaining to the behavioral health care system and to improve the coordination and delivery of behavioral health services on a system-wide basis.

7. The BHA shall verify the credentials of behavioral health services professionals prior to employment. Credentials/Qualification Verification, CR-2943, should be utilized in this process. Verification of current credentials and job plans shall be on file in the facility. Private contractors who provide professional services at TDOC facilities shall verify credentials according to contract requirements.

8. The BHA/Designee shall each workday review and approve all completed Monitoring Reports, CR-2004s, used to document Mental Health Seclusion/Suicide Monitoring on inmates while in that status. Documentation of the review shall be provided by initialing and dating the CR-2004 at the top of the page on the date it was reviewed.

9. Mental Health Treatment Team Staff:

   a. The Mental Health Treatment Team meeting shall promote on-going communication and professional growth focused on improving mental health care. Every institutional mental health department shall have a mental health treatment team that will prioritize inmates with the most severe mental health needs and who therefore require the most intervention from the services system.

   b. There will be a Mental Health Treatment Team meeting at least weekly. The Behavioral Health Administrator shall lead the treatment team and be responsible for coordinating, delegating, and documenting team activities. Attendance shall be required for mental health providers having direct involvement in the mental health treatment of an inmate. At a minimum, attendance at mental health treatment teams shall require the following individuals to be present:

      (1) Behavioral Health Administrator

      (2) Psychiatrist or Advanced Practice Nurse

      (3) Psychologist serving in the position of Clinical Director as designated by mental health contract provider for state operated facilities, state psychologist or psychologist at privately managed facilities

      (4) Mental Health Clerk (state operated facilities)

      (5) Any additional mental health staff, licensed or otherwise, who have direct involvement in the mental health needs or programming of an inmate.

   c. The Behavioral Health Administrator may, at their discretion, require any mental health team member to attend the treatment team meetings. Based upon each

institution's staffing pattern and the mental health needs of the inmate, the following personnel may be required to be part of the treatment team:

(1) Warden/Superintendent/designee

(2) Health Services Administrator and/or Director of Nursing

(3) Security staff and/or Unit Management Staff

(4) Correctional counselor

d. Facilities that have a remote annex are not required to hold a separate weekly team meeting. The BHA can hold one treatment team meeting at the main facility, for both sites. The annex must have a behavioral health staff representative at each weekly meeting.

e. The licensed psychiatrist shall be the mental health clinical authority for admissions/discharge from Deberry Special Needs Facility and the Special Needs Unit at Tennessee Prison for Women.

10. Treatment Team Activities: Members of the treatment team shall work together in a coordinated and efficient manner and operate within their duly authorized scope of practice. Team activities include, but are not limited to, the following:

a. Conducting weekly team meetings and providing documentation through sign in sheets and minutes maintained by the Behavioral Health Administrator

b. Creating and monitoring individualized treatment plans which provide a detailed account of the inmate's intervention needs and level of care

c. Reviewing individualized provider caseload for recommendations

d. Conducting regular meetings with inmates to monitor and assess his/her psychiatric functioning and evaluate for decompensation

e. Evaluating the effectiveness of the treatment plan goals as clinically indicated

f. Coordinating with treatment providers referrals to other mental health and medical staff as needed

g. Consulting with various institutional staff to assist with decisions regarding issues such as classification, housing, and disciplinary action

h. Planning for the inmate's aftercare upon discharge from the institution and release back to the community

i. Keeping security and unit management staff informed

C. Manual of Unit Operation: In accordance with Policy #102.02, each institutional behavioral health service operation shall maintain a unit manual of documents that readily defines the

departmental and institutional behavioral health services positions relative to administrative and personnel requirements, and the behavioral health services provided in the care and treatment of inmates. Each institution's unit manual shall be reviewed and approved by the Behavioral Health Administrator and reviewed annually by all behavioral health staff.

1. The manual design, contents, and placement shall serve as a readily available reference providing an operational guide to current personnel, and as an orientation guide for new employees.

2. Depending on the institutional mission, the manual may consist of one or more volumes, and shall include, at a minimum, the following information:

    a. Copies of all current Behavioral Health Services #113.80 Policy Series, with their CR Forms, (departmental and institutional policies and procedures.) Privately managed facilities shall maintain copies of all applicable #113.80 Policy series and corporate policies

    b. Verification that all new behavioral health employees have reviewed the Behavioral Health policy series.

    c. Verification that all behavior health employees have reviewed the Behavioral Health Policy Series annually.

    d. The BHA shall obtain the full legal signature and initials of each Behavioral Care Professional authorized to document in the health record. The Signature Legend, CR-2775, shall be utilized for this purpose and maintained by the BHA.

3. The master manual should be located in the BHA's office and a copy placed in an accessible area for employee reference where needed.

4. All policies, procedures, and services within the behavioral health care delivery system shall be reviewed at least annually by the BHA. The BHA shall document this review by signature and date on each #113.80 series institutional policy and procedure contained in the unit manual. (If necessary, the BHA shall make suggested revisions to institutional policies and forward to the AWT or Warden/Superintendent, for approval. Changes made to clinical services shall be reviewed by appropriate clinical staff.)

D. Behavioral Health Service Delivery: Behavioral health treatment services shall be prioritized over ancillary programmatic services in allocation of department and institutional resources, e.g., staffing, space, scheduling, equipment, etc. Inmates may be transferred between institutions so that the appropriate level of care can be provided to an identified inmate. Each institution shall provide the following behavioral health services at a minimum:

1. The most current *Diagnostic and Statistical Manual of Mental Disorders* shall be utilized for diagnostic purposes.

2. Screening for behavioral health problems on intake as approved by the behavioral health professional.

3. Outpatient services for the detection, diagnosis, and treatment of mental illness.

4. Crisis intervention and the management of acute psychiatric episodes, suicide prevention or emergency medication.

5. Stabilization of the mentally ill and the prevention of psychiatric deterioration in the correctional setting, including referrals to the Treatment Review Committee as indicated in accordance with Policy #113.87.

6. Elective therapy and preventive treatment where resources permit.

7. Referral and admission to Supportive Living Units, designated Level II Facilities, Crisis Stabilization Placement, for offenders whose psychiatric needs exceed the capability of the facility.

8. Referral and admission to other types of programming for special populations, including but not limited to restrictive housing programming, substance use disorder programming/treatment, sex offender programming.

9. Consultation services (including telehealth consultation with other prison, departments and staff).

10. Procedures for obtaining and documenting informed consent.

11. Case Management services including discharge/transition/aftercare planning (including both transfer to other institutions and release to the community).

12. Inmates who are expiring their sentence and are demonstrating acute symptomatology that present a potential danger to self or others shall necessitate that the following actions be taken by a behavioral health professional:

    a. Immediately contact the statewide mental health crisis line at 1-800-809-9957.

    b. The referring behavioral health professional shall provide clinical information to the Director/Coordinator of the Mobile Crisis Team via the most appropriate communication channel, following up with a formal discharge summary as discussed below.

    c. The crisis team will assess the inmate and upon completion determine the need for hospitalization.

    d. Behavioral health will ensure that a Mental Health Transfer Summary, CR-3327, containing the clinically relevant information (i.e., diagnosis, medications, risk level, as available, past treatment and future treatment recommendations, and past/current self-injurious, suicidal, or homicidal behaviors, and any other applicable data) is forwarded to the mobile crisis team for their delivery to any outpatient or community-based provider.

    e. If the offender has been granted parole and has been deemed to be a risk to himself or the public upon or prior to release, notification to the Board of Parole to determine if a mental health treatment mandate shall be listed, or a rescission hearing held, in addition to the District Director in the county of where the inmate

will be paroled to in efforts to ensure continued behavioral health treatment is addressed.

13. Behavioral health staff may request that inmates who are seeking psychiatric intervention sign a release of information when a prior history of psychiatric, psychological or substance usage exists.

14. The BHA shall request that the Institutional Parole Specialist (IPS) be present during treatment team meetings that involve discharge planning for inmates being released on parole.

15. All mental health staff shall receive for 12 hours of continuing professional education/staff development in clinical skills annually in areas listed below but not limited to;

    a. Mental health needs of inmate population (special needs)

    b. Behavior management techniques

    c. Mental health issues with female population

    d. Aging/palliative care

    e. Trauma-informed care

    f. Confidentiality of mental health record

    g. Suicide/self-injury prevention

    h. Signs and symptoms of mental illness, substance abuse/relapse and neurocognitive disorders/neurodevelopmental disabilities

    i. Assessment and diagnosis of mental disorders

    j. Crisis intervention

VII. ACA STANDARDS: 5-ACI-6A-07, 5-ACI-6A-28, 5-ACI-6B-01, 5-ACI-6B-02, 5-ACI-6C-06, 5-ACI-6D-01, 5-ACI-6D-10, 5-ACI-6B-13, and 4-RH-0027.

VIII. EXPIRATION DATE: February 15, 2024

TENNESSEE DEPARTMENT OF CORRECTION
MONITORING REPORT

BHA Review _____
Initials **Date**

_____
INSTITUTION

INMATE: _____ **TDOC ID:** _____ **LOCATION:** _____

SPECIAL INSTRUCTIONS:

COMMENTS/BEHAVIOR OBSERVED

COMMENTS: Indicate restraints loosened, which limbs exercised, food/fluid intake and amount, fluid output, toileting, ADLs, etc.

ACTIVITY CODE LIST: *Use abbreviations below*

1. Other (See Comment)
2. Loud
3. Delusional
4. Hallucinating
5. Crying
6. Inappropriate Laughter
7. Incontinent
8. Restless/Pacing
9. Rocking of body
10. Hostile/Threatening
11. Swearing/Name Calling
12. Fighting Restraints
13. Kicking
14. Punching: a. Door b. Wall
15. Self Mutilation
16. Smearing Excrement
17. Spitting
18. Incoherent
19. Talking
20. Glaring
21. Quiet
22. Sleeping (+ chest movement)
23. Inappropriate Sexual gestures:
    a. Disrobing
    b. Masturbating
24. Hygiene: a. Oral b. Shave
    c. Shower d. Bath
    Nutrition:
25. a. Fluid Encouraged (q ___hr)
    b. Assisted w/diet while awake
    c. Refused Nutrition
26. Appetite: a. Good b. Fair c. Poor
27. Restraint(s)
    a. 4 Point: Leather ☐ Soft ☐ Vinyl ☐
    Other: _____
    Wrist: Right ☐ Left ☐
    Ankle: Right ☐ Left ☐
    b.Vest
    c. Helmet
28. Circulation checked
29. Exercise (q ___hr)
    a. ROM ea. Extremity
    b. Position Changed
    c. Ambulate
    d. Discontinued Restraints
30. Offer Toileting
31. Skin: a. Assessed intact
    b. Assessed *(See Comments)*

DATE	TIME	ACTIVITY CODE(S)	INITIAL	DATE	TIME	ACTIVITY CODE(S)	INITIAL	DATE	TIME	ACTIVITY CODE(S)	INITIAL

INITIAL	SIGNATURE/TITLE	INITIAL	SIGNATURE/TITLE	INITIAL	SIGNATURE/TITLE

MONITORING REPORT

INSTITUTION

INMATE/PATIENT: ______________________ **TDOC ID:** ______________________ **DOB:** ______________

DATE	TIME	ACTIVITY CODE(S)	INITIAL	DATE	TIME	ACTIVITY CODE(S)	INITIAL	DATE	TIME	ACTIVITY CODE(S)	INITIAL

INITIAL	SIGNATURE/TITLE	INITIAL	SIGNATURE/TITLE	INITIAL	SIGNATURE/TITLE

TENNESSEE DEPARTMENT OF CORRECTION
SIGNATURE LEGEND

DATE	SIGNATURE	INITIALS	PRINTED NAME	TITLE

TENNESSEE DEPARTMENT OF CORRECTION
CREDENTIALS / QUALIFICATION VERIFICATION

_____
INSTITUTION

Applicant: _____ Social Security Number: _____

This will certify that I have reviewed the above-named applicant's application and verified information with regard to:

_____ Previous Employment History

1. _____
2. _____
3. _____

_____ References

1. _____
2. _____
3. _____

_____ Education

1. _____
2. _____
3. _____
4. _____
5. _____

_____ Licensure / Certification (if applicable) License Number: _____

_____ CPR ☐ Yes ☐ No

_____ Other (explain): _____

Comments: _____

_____

_____

_____

Note: A copy of diploma or transcript, license or certificate (if applicable), and continuing education information shall be submitted to accompany the application.

I recommend the above named applicant to be appointed to the position of: _____,

effective on _____.
(date)

_____ _____
Signature – Health/Behavioral Health Administrator or Designee Date

CR-2943 (Rev. 04-17) White-Personnel File Canary-Health Administrator's file

TENNESSEE DEPARTMENT OF CORRECTION
MENTAL HEALTH SUMMARY

_____
INSTITUTION

INMATE NAME: _____ TDOC ID: _____
Last First Middle

DOB: _____ Gender: _____ Race _____ Custody Status: _____ Release Date: _____

FOLLOW-UP APPOINTMENT DATE:: _____

REFERRAL TO RECEIVING FACILITY (Contact Person): _____

COMMUNITY MENTAL HEALTH CENTER (Specify Branch) Telephone/Address: _____

DSM DIAGNOSIS: _____

HISTORY OF SUICIDAL OR SELF-INJURIOUS BEHAVIORS: _____

ASSESSMENT [Problem(s), Behavioral Observations, Clinical Impressions, Estimation of Intellectual Ability, MSE): _____

TRIGGERS AND/OR EARLY WARNING SIGNS OF DECOMPENSATION: _____

PATIENT INSIGHT/MOTIVATION/COMPLIANCE: _____

PRIOR TREATMENT HISTORY: _____

FUTURE TREATMENT RECOMMENDATIONS: _____

_____ _____
Signature of Staff Date

_____ _____
Signature of Staff Date