RHODE ISLAND DEPARTMENT OF CORRECTIONS

POLICY AND PROCEDURE

DIRECTOR: Wayne P. Salisbury Jr.

POLICY NUMBER:	EFFECTIVE DATE:	SUBJECT:
18.77 DOC	10/01/2025	BEHAVIORAL HEALTH SERVICES

LAST REVIEWED:	SECTION:	SUPERSEDES: N/A
10/2025	HEALTH CARE SERVICES	

AUTHORITY: Rhode Island General Laws (RIGL) § 42-56-10 (22), Powers of the director

REFERENCES: NCCHC standard MH-A-01; MH-A-02; MH-A-03; MH-A-04; MH-A-07; MH-A-08; MH-C-01; MH-C-03; MH-D-05; MH-E-01; MH-E-03; MH-E-04; MH-E-06; MH-E-09; MH-E-10; MH-G-01; MH-G-03; MH-H-01; MH-H-02; MH-I-01; MH-I-04, the most recent versions of RIDOC policies: 1.09 DOC, Policy and Procedure Administration; 9.49 DOC, Prison Rape Elimination Act (PREA) Policy; 11.01 DOC, Inmate Discipline; 13.10 DOC, Inmate Grievances; 18.05 DOC, Continuous Quality Improvement and Physician Peer Review; 18.09 DOC, Death of Inmates Under RIDOC Supervision; 18.12 DOC, Infection Control Program; 18.17 DOC, License/Certification of Health Care Services and Allied Health Professionals; 18.18 DOC, Continuing Education for Qualified Health Care Services Personnel; 18.23 DOC, Health Care Services Staffing Levels; 18.30 DOC, Receiving Screening and Mental Health Evaluation of New Commitments and Transfers; 18.34 DOC, Daily Handling of Non-Emergency Medical Requests; 18.43 Health Evaluation of Inmates in Administrative or Disciplinary Confinement; 18.52 DOC, Inmates with Alcohol or Other Drug Problems, Intoxication, Withdrawal and Treatment; 18.59 DOC, Confidentiality of Inmate Health Information to include Electronic Medical Records; 18.65 DOC, Use and Emergency Use of Forced Psychotropic Medication; Suicide Prevention SOP

INMATE/PUBLIC ACCESS: YES	AVAILABLE IN SPANISH: YES

I. PURPOSE:

To establish guidelines for providing behavioral health services at the Rhode Island Department of Corrections (RIDOC).

II. POLICY:

A. All inmates have access to care to meet their behavioral and mental health needs.

B. All aspects of an inmate's behavioral health care are coordinated and monitored from commitment to release.

C. All treatment encounters are documented in the electronic medical record (EMR).

D. The Responsible Mental Health Authority (RMHA) arranges for all levels of behavioral health care and ensures quality, accessible and timely behavioral health services for inmates.

III. DEFINITIONS:

1. **Level I (Acute) SPMI Level of Care** – means the level of mental health care provided for inmates who have been designated as SPMI and are presenting with significant and acute clinical symptoms that require them to be diverted to an observational status or a specialized housing unit.

2. **Behavioral Health Services** - the unit within Health Care Services tasked with providing behavioral health services, including all mental health services as well as any issues that impact an inmate's mental health. **This unit includes all RIDOC Behavioral Health Clinicians, psychiatry and other staff involved in the provision of behavioral healthcare to the incarcerated population.**

3. **Behavioral Health Clinicians** – Individuals who have a Masters degree in Mental Health Counseling, Clinical Social Work, Psychology or Forensic Psychology or a related clinical field and who possess or are eligible to possess and in the process of actively pursuing the following credentials: Licensed Mental Health Counselors (LMHC), Licensed Clinical Social Workers (LCSW), Licensed Independent Clinical Social Workers (LICSW), Licensed Marriage and Family Therapists (LMFT), or Licensed Psychologist.

4. **Clinical Administrator** - The individual responsible for the implementation of all behavioral health services.

5. **Clinical Caseload** - Non- seriously and persistently mentally ill (SPMI) inmates who are identified by a Qualified Mental Health Professional (QMHP) as meeting the criteria for individual counseling/therapy.

6. **Clinical Supervisor** - The individual who directly supervises the Behavioral Health Clinicians under the direction and supervision of the Clinical Administrator.

7. **Level III (Outpatient) SPMI Level of Care –** means the level of mental health care for people designated as SPMI by nature of their diagnosis but who have been asymptomatic and out of an acute phase of their illness for a prolonged period and who may be prescribed psychotropic medication but do not demonstrate any functional impairment or any reported need for counseling.

8. **Psychiatric Caseload** - Non-SPMI inmates who are receiving psychiatric treatment services including medication management and ongoing monitoring of symptoms.

9. **Qualified Mental Health Professional (QMHP) –** All those qualified to evaluate and care for the mental health needs of inmates. This designation includes: Behavioral Health Clinicians, psychiatrists and psychiatric nurse practitioners who are contracted to provide services.

10. **Responsible Mental Health Authority –** The Clinical Administrator is the Responsible Mental Health Authority (RMHA) and provides mental and behavioral health care services.

11. **Seriously and Persistently Mentally Ill (SPMI) –** The designation given to an inmate that has been identified by a QMHP as meeting the criteria for having a serious and persistent mental illness based on their clinical diagnosis and/or level of functional impairment. These individuals will receive psychiatric and clinical services by virtue of their SPMI status. Refer to section IV.S.1 for more information.

12. **Specialty Care** - Specialist provided mental health care (e.g., psychiatry, psychology, neurology, neuropsychology, and addiction medicine) provided at a RIDOC facility, or at a specialty care clinic or a specialist's office.

13. **Sub-acute SPMI Level of Care –** means the level of mental health care provided for inmates who have been designated as SPMI and are presenting with clinical symptoms and/or functional impairment that can be managed in the general population.

14. **Triage Meetings** – a multi-disciplinary meeting conducted in each facility that includes custody, medical, behavioral health services, adult counselors, educational and programming staff as well as any other relevant staff, on either a monthly or quarterly basis.

IV. PROCEDURES:

A. Access to Behavioral Health Services

1. All inmates committed to the care, custody and control of RIDOC have access to care to meet their behavioral and mental health needs.

2. The RMHA has the overall responsibility to see that adequate behavioral health services are available and works to identify and eliminate any barriers to inmates receiving those services in a timely manner consistent with the most recent version of RIDOC policy 18.00 DOC, Treatment Philosophy and Access to Care.

   The RMHA arranges for all levels of behavioral health care to provide quality, accessible and timely behavioral health services for inmates. The Clinical Supervisor will act as the RMHA should the Clinical Administrator not be available. In the absence of both the Clinical Administrator and Clinical Supervisor, or if there should be a vacancy in the position of Clinical Administrator, the Medical Program Director appoints an acting Clinical Administrator to also serve as the RMHA.

B. Clinical Autonomy

Clinical decisions and actions regarding behavioral health services provided to inmates are solely the responsibility of the behavioral health unit.

C. Credentials

1. All QMHPs are required to have the education and credentials needed to evaluate and care for the behavioral health needs of inmates.

2. The RMHA ensures that newly hired Behavioral Health Clinicians undergo a credentialing verification process that confirms current licensure, certification and education.

D. Training for Behavioral Health Clinicians

1. All Behavioral Health Clinicians are appropriately oriented and participate annually in continuing education appropriate for their position.

2. All Behavioral Health Clinicians receive an orientation every two (2) years, or more frequently, as determined by the RMHA.

3. An initial, basic orientation occurs on the first two (2) days of employment and the content of the orientation may vary depending on the roles and responsibilities of the new clinician but should include, at a minimum:

    a. Relevant security, behavioral health, and medical policies and procedures;

    b. Response to facility emergency situations;

    c. The staff member's functional position description;

    d. Appropriate boundaries in inmate-staff relationships.

4. A documented, in-depth orientation occurs within ninety (90) days of employment that includes, at a minimum:

    a. All behavioral health and relevant policies/procedures not included in basic orientation;

    b. Typical mental health needs of the inmate population;

    c. Infection control and use of standard precautions;

    d. Confidentiality of electronic health records and information.

5. Behavioral Health Clinicians receive a minimum of twelve (12) hours of continuing professional education per year.

6. Documentation of all training shall be placed in the employee's personnel file.

E. Administrative Meetings and Reports

1. The provision of Behavioral Health Services is discussed at multi-disciplinary triage meetings which are held at least quarterly.

2. Behavioral Health Clinician staff meetings are held at least monthly to review administrative issues.

3. Meeting minutes are created and distributed to meeting attendees.

   a. Copies of meeting minutes are retained for reference.

   b. Meeting minutes are not considered public records.

4. Statistical reports of Behavioral Health Services are generated at least monthly, including but not limited to performance measures, number of inmates designated SPMI by facility, serious suicide attempts and deaths in custody by suicide. They are provided to the RMHA and other staff as deemed appropriate and used to monitor trends in the delivery of behavioral health care.

F. Continuous Quality Improvement (CQI) and Clinical Performance Review

1. Continuous Quality Improvement (CQI)

   A continuous quality improvement (CQI) program that monitors and improves behavioral health care is implemented consistently with the most recent version of RIDOC policy 18.05 DOC, Continuous Quality Improvement and Physician Peer Review.

2. Clinical Performance Review

   a. The clinical performance of the Behavioral Health Clinicians is reviewed at least annually.

   b. These reviews are confidential and incorporate at least the following elements:

      (1) The name of the staff member being reviewed;

(2) The date of the review;

(3) The name and credentials of the reviewer;

(4) A summary of the findings and corrective action, if any; And confirmation that the review was shared with the individual being reviewed.

c. The Clinical Supervisor of Behavioral Health Services or designee reviews clinical encounters in patient charts entered by QMHPs for a randomly selected week. These chart reviews, as well as any corrective actions taken, are documented in a report and occur at minimum, quarterly.

G. Communication Regarding Inmate's Behavioral Health Needs

1. Communication occurs between appropriate non-clinical staff and QMHPs regarding inmates' behavioral health needs that must be considered during intake, classification and other relevant decisions in order to preserve the health and safety of that inmate, other inmates or staff.

2. For any observation by non-clinical staff of inmates who present an imminent risk of harming him/herself, procedure is followed as outlined in the most recent version of the RIDOC Suicide Prevention SOP.

3. Non-clinical staff are advised, verbally or in writing, of inmates' behavioral health needs that may affect housing, work and program assignments; admissions and transfers into facilities and disciplinary processes.

4. Such communication is documented in the EMR.

H. Privacy and Confidentiality

1. All clinical encounters and discussions of inmate information are conducted in a private, confidential setting and carried out in a manner designed to encourage the inmate's subsequent use of behavioral health services.

2. All assessments conducted by QMHPs shall be conducted in an out-of-cell, confidential setting unless there is a contraindication to remove the inmate from their cell.

    a. Any cell-side encounter shall be noted in the EMR with the clinical contraindication documented.

    b. The method of recording entries and the format of the clinical record is approved by the RMHA.

3. For more information, please refer to the most current version of RIDOC policy 18.59 DOC, Confidentiality of Inmate Health Information to include Electronic Medical Records.

I. Behavioral Health Services Staffing

Behavioral Health Services staffing is determined for each facility based upon the level of need and population served. For more information, please refer to the most recent version of RIDOC policy, 18.23 DOC, Staffing Levels.

J. Psychiatric Hospitalization and Specialty Care

1. Psychiatric hospitalization and specialty care are provided to inmates in need of those services.

2. Clinical need dictates the time required to receive the ordered services; in general, waiting times should not exceed average waiting times in community practice.

    a. For inmates who are SPMI and are displaying significant functional impairment, a referral is made for residential or behavioral management treatment unit placement.

    b. For inmates who are displaying acute suicidal ideation, incidents of self-harming behavior or who need of increased observation, a placement on suicide precautions or psychological observation will be made as outlined in the most recent version of the RIDOC Suicide Prevention SOP.

c. For inmates who are refusing treatment and who may present as either a risk to themselves or others and/or who lack insight into the benefits of treatment or risks of refusal, a request for court-ordered medications (petition for instructions, or PFIs) is filed with the mental health court. For more information, please reference the most recent version of RIDOC Policy 18.65 DOC, Use and Emergency Use of Forced Psychotropic Medications, and RIDOC Policy 18.68 DOC, Right to Refuse Treatment

d. Administration of emergency psychotropic medications may be ordered by any prescribing provider consistent with the most recent version of RIDOC Policy 18.65 DOC, Use and Emergency Use of Forced Psychotropic Medications,

e. Consistent with the most recent version of RIDOC Policy 18.65 DOC, Use and Emergency Use of Forced Psychotropic Medications, in the event that an inmate's treatment needs are determined to exceed the threshold of what can be provided in a correctional setting, a request for a specialized services transfer to the Rhode Island State Psychiatric Hospital (RISPH) is submitted to the forensic unit.

K. Information on Behavioral Health Services

Information about the availability of, and access to, behavioral health services is communicated verbally and in writing to inmates within twenty-four (24) hours of their commitment including how to access emergency and routine clinical services; availability of services, and the grievance process for behavioral health-related complaints.

L. Initial Assessment and Evaluation

All inmates receive an initial behavioral health evaluation conducted by a Behavioral Health Clinician. This evaluation is conducted within fourteen (14) days of admission. Inmates with a positive assessment for behavioral health treatment needs are referred either to psychiatry or scheduled for a clinical follow-up with a Behavioral Health Clinician based upon the level of clinical need presented. During clinical appointments, QMHPs make timely assessments in a clinical setting. (Refer to 18.30 DOC, Receiving Screening and Mental Health Evaluation of New Commitments and Transfers)

1. Inmates are assessed for any substance use, withdrawal or intoxication as well as for any current or past treatment for substance use disorders, consistent with the most recent version of RIDOC policy 18.52 DOC, Inmates with Alcohol or Other Drug Problems: Intoxication, Withdrawal and Treatment.

2. Inmates are identified and referred on an as-needed basis depending upon their verbal request, submission of a sick call slip, referral by staff of an observed symptom or concerning behavior and/or referral from outside providers, consistent with the most recent version of RIDOC policy 18.34 DOC, Daily Handling of Non-Emergency Medical Requests and Sick Call for more information.

M. Caseloads

1. All inmates who are receiving psychiatric and/or mental health treatment services who are not designated SPMI are identified through the EMR with the designations "psychiatric caseload" and "clinical caseload". These caseload lists will be maintained in the EMR.

2. Clinical Caseloads

   a. Inmates on the clinical caseload are seen by Behavioral Health Clinicians at minimum once every ninety (90) days with frequency of sessions based upon the level of need presented.

   b. For mental health counseling, the designation of "clinical caseload" will be added to the EMR by the Behavioral Health Clinician as they add inmates to their clinical caseloads.

3. Psychiatric Caseloads

   a. At the time of commitment, if an inmate is on active psychiatric medication, the designation of psychiatric caseload will be added to the EMR by a QMHP.

   b. At any point during confinement, if an inmate is started on medication or initiated into psychiatric services, the designation of psychiatric caseload will be added to the EMR by a QMHP.

   c. Inmates on the psychiatric caseload are seen per the clinical determination of the treating psychiatrist.

4. SPMI Caseloads

For the process of SPMI designation, please refer to section IV.S.1 for more information.

N. Transfer Screening

1. A transfer screening is performed by a Behavioral Health Clinician on all interfacility transfers. This screening consists of a review of each transferred inmate's EMR or summary within twelve (12) hours of arrival to ensure continuity of care.

2. Inmates transferred from an intake facility who do not have a completed initial mental health assessment are to be evaluated at the receiving facility, within in a timely manner.

3. The behavioral health staff performing the chart review documents such review in the inmate's EMR.

4. When an inmate designated as SPMI is transferred, Behavioral Health Clinicians at the sending facility should inform Behavioral Health Clinicians at the receiving facility of this designation, as well as, any other condition(s) that require special or immediate attention, such as special medication and/or treatment needs.

O. Continuity and Coordination of Behavioral Health Care

1. Throughout an inmate's confinement all aspects of their behavioral health care are coordinated and monitored from admission to discharge.

   a. Clinician interventions are consistent with the current community standard of care and are implemented in a timely manner. Any deviation from the standard practice is clinically justified, documented and shared with the inmate.

   b. Specialty evaluations and consultations such as neuropsychological evaluations and forensic evaluations are completed in a timely manner, reviewed by treating providers and documented in the EMR. Diagnostic and treatment results are used to inform treatment planning, as appropriate.

c. When an inmate returns from a forensic psychiatric admission or receives emergency care at an outside hospital that pertains to behavioral health, they are assessed by the receiving nurse, and any recommended changes in treatment are referred to the on-call physician. Behavioral health services are notified.

d. An inmate's clinical treatment does not change when they are moved to a different facility due to classification purposes or by administrative transfer. Inmates will continue to receive the same level of care regardless of housing assignment.

P. Treatment Plans

1. Behavioral health services are provided according to individual treatment plans. A treatment plan is a series of written statements specifying a patients particular course of therapy and the roles of QMHPs in carrying it out, typically a SOAP note.

2. Documentation of a treatment plan may vary in format provided the required content is addressed and at minimum, each plan should document subjective, objective, assessment and plan (SOAP) notations and must include, at a minimum:

a. frequency of follow-up for evaluation and adjustment of treatment;

b. adjustment of psychotropic medications, if indicated;

c. referrals for psychological testing, medical testing and evaluation including blood levels for medication monitoring;

d. when appropriate, instructions about diet, exercise, personal hygiene and adaptation to the correctional environment, and;

e. documentation of treatment goals and objectives, interventions necessary and notation of clinical progress.

Q. Infection Prevention and Control

1. QMHPs in contact with inmates are trained to use standard precautions to minimize the risk of exposure to blood and body fluids of infected inmates.

2. QMHPs should receive annual updates regarding infection control practices. For more information, please refer to the most recent version of RIDOC policy 18.12 DOC, Infection Control Program.

R. Informed Consent and Refusal of Behavioral Health Care

1. All inmates are provided with the risks and benefits of treatment interventions as well as risk and benefits of refusal. Medication-based interventions are documented in the EMR by psychiatry. See RIDOC policy 18.68 DOC, Right to Refuse Treatment.

2. Any refusal of a behavioral health intervention is documented in the EMR with a refusal of treatment form and chart entry. If the inmate does not sign the form, it is noted on the form by a QMHP as witness.

S. Identification and Treatment of Seriously and Persistently Ill (SPMI) Inmates

1. Designation

An inmate has a serious and persistent mental illness when they have been determined by a QMHP to meet at least one (1) of the following criteria:

a. The inmate meets the required symptoms, duration of symptom presentation and associated impairment in level of functioning as required to meet the diagnostic criteria for, or is diagnosed at the initial or any subsequent assessment conducted during the inmate's confinement with, one (1) or more of the following types of diagnoses:

(1) Schizophrenia Spectrum and Other Psychotic Disorders; or

(2) Treatment-resistant/treatment-refractory Major Depressive Disorder (MDD), examples include MDD severe, or MDD with psychotic features, or MDD with catatonia, or Persistent Depressive Disorder; or

(3) Bipolar I Disorder or Bipolar II Disorder; or,

(4) a DSM-5 mental disorder that is frequently characterized by delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms, or perceptions of reality, that persist for the duration of time

required for diagnosis that led the individual to experience clinically significant functional impairment, associated impairments in activities of daily living, that have a seriously adverse effect on life or on mental or physical health; or,

(5) A neurocognitive disorder that results in a significant functional impairment or other behavior that has a seriously adverse effect on life or on mental or physical health; or,

(6) Borderline personality disorder that is manifested by frequent episodes of psychosis or depression, and results in a significant functional impairment that has a seriously adverse effect on life or on mental or physical health with associated instability of interpersonal relationships, self-image, affect and marked impulsivity that interfere with independence in daily activities, at a minimum, requiring assistance with complex instrumental activities of daily living; or,

(7) The inmate has been determined by a QMHP at any point while incarcerated to be experiencing clinically significant symptoms, distress or impairment in important areas of functioning and as a result of these target symptoms and associated impairments in activities of daily living, the individual requires a higher level of mental health evaluation, supervision, monitoring and treatment services.

b. Throughout an inmates' period of confinement, referrals for possible SPMI designation are made by a QMHP to the Clinical Administrator, or designee.

c. The Clinical Administrator or designee is responsible for entering the designation of SPMI in the o EMR.

d. Any staff member who identifies possible concerns for an inmate needing assessment of whether they would meet SPMI criteria can make a referral to a QMHP at any point in time.

e. A section of the multi-disciplinary triage meetings is dedicated to the discussion of SPMI inmates housed in the facility as well as providing an additional mechanism for any staff to make a referral for an inmate to be assessed for possible SPMI designation.

2. Treatment

a. Based on an acuity tier system of Level I (acute), Level II (sub-acute) and Level III (outpatient) level of care, the frequency of encounters is as follows by current protocol:

(1) Level I (Acute)

Depending upon the severity of their clinical presentation, an inmate may be determined to be in need of acute intervention, which may include any or a combination of the following:

(a) Referral to the Residential Treatment Unit or Behavioral Management Unit, which are non-acute mental health units for placement; or,

(b) Placement on an observational status where they would be seen by a QMHP every twenty-four (24) hours for suicide precautions (i.e., constant observation or crisis management status) or within every forty-eight (48) hours for psychological observation; or,

(c) A request for transfer to a forensic hospital level of care will be submitted.

(2) Level II (Sub-Acute)

(a) Sub-acute SPMI inmates are seen by a QMHP at least once within every thirty (30) day period for an out-of-cell assessment. Cell-side assessments will be conducted only if the QMHP determines coming out of the cell to be clinically contraindicated and any such determination shall be documented in the EMR.

(b) Sub-acute SPMI inmates will be seen more frequently based upon their request and staff referral.

(3) Level III (Outpatient)

(a) Outpatient SPMI inmates are assessed by psychiatry at the frequency determined to be clinically appropriate by

the prescribing provider, but no less than every ninety (90) days.

(b) All psychiatric evaluations are conducted out-of-cell unless the prescribing provider determines it to be contraindicated, and any such determination shall be documented in the EMR.

(c) SPMI inmates at this level of acuity will be seen more frequently based upon their request and staff referral.

NOTE: SPMI inmates may move between levels at different points in time depending upon their presentation.

3. Tracking

Monthly data is maintained on the number of SPMI inmates in custody by facility.

T. Inmates in Administrative and/or Disciplinary Confinement

The mental health of inmates in administrative and/or disciplinary confinement is monitored regularly. For more information, please refer to the most recent versions of RIDOC policy 11.01 DOC, Inmate Discipline., and RIDOC policy 12.27 DOC, Conditions of Confinement.

U. Emergency Services

1. The RMHA arranges for emergency behavioral health care twenty-four (24) hours a day, seven (7) days a week.

2. The Clinical Administrator and/or Clinical Supervisor are on-call for emergencies after-hours and have off-site access to the EMR to access inmate information.

3. On-call psychiatry coverage is provided twenty-four (24) hours per day, seven (7) days per week for urgent psychiatric treatment needs.

V. Policies and Procedures

All written policies and procedures regarding behavioral health services address each applicable standard in the Standards for Mental Health Services in Correctional Facilities and all policies are reviewed at least annually. For more information, please refer to the most recent version of RIDOC Policy 1.09 DOC, Policy and Procedure Administration.