COBB COUNTY COMMUNITY SERVICES BOARD

Policy # 8023	Criminal Justice Mental Health Evaluation	Service Delivery
Origination Date: March 26, 2002		
Revision Date: March 2004; March 24, 2006; June 29, 2007; June 10, 2008; June 10, 2009, October 16, 2013, August 2, 2016, January 15, 2019		
Reviewed Date: February 2005, September 23, 2012		
Approved: Foster Norman **Foster Norman, Executive Director**		

POLICY:

It is the policy of the Cobb County Community Services Board that upon an individual's incarceration, the inmate will be screened for the presence of mental disorder. The results of the mental health screening are maintained as part of the inmate's medical records.

PROCEDURE:

1. On the day an inmate is received for admission, the intake officer interviews each inmate to identify inmates who are mentally disordered or developmentally disabled. During the interview, the officer will seek "yes" answers from the following questions:
   a. Have you ever been admitted to a psychiatric facility?
   b. Are you currently having or have you had thoughts of hurting yourself in the last six months?
   c. Does the arresting officer or transporting officer believe that the inmate is a medical, mental health or suicide risk now?
2. Upon completion of the intake screening, the medical professional makes the disposition decision as to whether the inmate can be released to General Population or General Population with referral to mental health services, or whether an inmate needs an immediate referral to mental health services.
3. Referral to a qualified mental health professional will also be made in the following circumstances:
   a. The detention officer's observation of the inmate's behavior during the course of incarceration.
   b. The inmate requests mental health services.
   c. Nursing staff, family members, probation staff, community mental health staff and others request an assessment based upon observed behaviors that indicate the probability that mental health services are needed.
4. A mental health evaluation is completed by the psychiatric staff when referrals are made from the mental health team. The mental health team conducts assessments on inmates to determine referral to the psychiatrist.
5. The inmate who is assessed to be mentally ill and requests treatment may be referred to R-POD or the sheltered housing unit subsequent to security clearance.
6. Clinical documentation by qualified mental health specialists is maintained in the inmate's health care record.

COBB COUNTY COMMUNITY SERVICES BOARD

Policy # 8078	Screening and Assessments	Service Delivery
Origination Date: March 1998		
Revision Date: June 2004; March 21, 2006; July 26, 2007; February 24, 2009; September 2, 2009, June 19, 2013, October 17, 2016, December 18, 2018, August 2, 2019 **Reviewed Date: March 2005, August 23, 2010,**		
Approved: _____ **Foster Norman, Executive Director**		

POLICY:

It is the policy of the Cobb County Community Services Board (the Board) to assess each individual's biopsychosocial status as a part of the initial screening, assessment process and throughout the course of treatment. The purpose of a comprehensive assessment is to identify care needs, the appropriate type of care to be provided, and any needs for further assessment. Substance use components are included in the full assessment. The initial biopsychosocial assessment and later assessment data that are gathered are documented as a part of the individual's clinical record and incorporated into the individual's plan of care. Further assessment of individuals is determined according to the individual's needs and desires for care, care setting and individual response. The Board utilizes valid and reliable assessment tools that meet the requirements set forth by federal, state or other grant funded programs for use as methods of screening and assessing the severity of symptoms and level of functioning. To ensure the quality and consistency of assessment services provided to individuals through specification of the purpose, scope and nature of assessments provided and identification of staff qualifications for collection, analysis and interpretation of these data. A Psychiatric/Diagnostic Assessment is an essential component of a comprehensive biopsychosocial approach helping to establish diagnosis/diagnoses and formulating a treatment plan for all individuals with mental illness and other individuals as needed. It is also the policy of the Board to provide screening for physical health needs of individuals that determines the need for an assessment by a Registered Nurse. The Board will also assist individual/family in obtaining a psychological evaluation when the need has been identified during the assessment, treatment, or continuing care process. When a psychological evaluation is determined to be necessary, these services are provided through a referral to an outside agency or individual.

PROCEDURE:

1. Throughout the course of treatment individuals are screened for any life threatening conditions, needs for emergency or urgent treatment, and for severe conditions that seriously impact treatment or rehabilitation.
2. The initial screening, either by phone or face-to-face, begins the assessment process. Assessment data is analyzed to produce synthesized information about client's needs for care and services, to identify needs for further assessment or reassessment and to determine the care and approaches needed to meet individual's needs based on the

assessment data.

3. The initial screening and admission assessments of all individuals include determination of the individual's functional status, individual strengths, which may be incorporated into treatment planning, abilities, and individual preferences/requests for treatment.
4. All individuals will receive an evaluation to determine history or current Substance Use during the assessment process.
5. Assessment data, which is gathered on all individuals during the initial assessment process and throughout the course of treatment, includes information as appropriate to the individual's circumstances and if appropriate and when possible, information from family members and collateral sources, relevant to the individual's behavioral health history, on:
   a. current physical, current substance use, psychological and social functioning
   b. assessment of life threatening conditions and risk status;
   c. assessment of the need for nutritional evaluation;
   d. history of emotional, behavioral and substance-related problems or treatment, including:
      i. current use of community and natural resources/supports;
   e. environment and home situation;
   f. leisure and recreation;
   g. education;
   h. spirituality;
   i. relevant childhood history;
   j. financial status, needs and concerns;
   k. usual social and peer group and environmental context;
   l. family circumstances and need for family participation in care;
   m. Sexual orientation
   n. history of alcohol and other drug use including age, of onset, duration, patterns and consequences of use;
   o. history of physical problems associated with dependence;
   p. use of alcohol and other drugs by family members;
   q. type of previous treatment and responses to treatment;

6. Clinical staff who provides initial face-to-face clinical assessment of the individual is responsible for ensuring that the appropriate assessments are fully completed to the extent possible. The primary treating clinician is responsible for ensuring that complete assessment and reassessment data is obtained for the individual and that any additional needed assessments that are clinically indicated are arranged for the individual. Qualified and credentialed staff performs all clinical, medical and nursing assessments.
   a. Some possible assessment tools that may be utilized for screening and assessing the severity of symptoms and level of functioning and depending upon the individual's level of service, needs and program guidelines may include; but, are not limited to:
      i. Activity Therapy Assessment
      ii. ASAM
      iii. ANSA/CANS
      iv. ASI
      v. Columbia Suicide Severity Rating Scale (C-SSRS)

vi. Criminal Justice Mental Health Evaluation
vii. HRST
viii. LOCUS
ix. Mental Status Examination
x. State-Trait Anger Expression Inventory - 2 - Interpretive Report
xi. The Strengths and Impairment Scale- Screening
xii. TIP 42
xiii. Vocational Profile

7. An agency psychiatrist, APRN, LCSW or LPC completes the psychiatric/diagnostic assessment through a face-to-face contact with the individual and after review of the assessment data.
    a. Diagnosis/Diagnoses should be compatible with the latest edition of Diagnostic and Statistical Manual (DSM), adhering to state and professional standards.
    b. Individuals admitted to the Behavioral Health Crisis Center will have a Psychiatric/Medical Assessment completed within 24 hours to include presenting history, pertinent medical and psychiatric history, physical exam and review of systems, pertinent social history, mental status exam, and diagnosis.
    c. An entry will be made in the progress notes in the individual's clinical record. The note will address recommended management including psychopharmacological and non-psychopharmacological intervention as well as any updates in diagnosis.
    d. The psychiatrist, APRN, LCSW or LPC will write a progress note in the individual's record when updates to the psychiatric assessment is clinically indicated.
8. All individuals will receive a Nursing Assessment during the initial assessment process. The on-going need for a nursing assessment may be determined at any time during treatment. The referral for on-going nursing assessments is based upon findings related to recent physical health changes, chronic medical conditions, chronic pain or regular use of any medication, including non-prescribed medications.
    a. Only a Registered Nurse will complete a nursing assessment.
    b. For all individuals admitted to the Behavioral Health Crisis Center, nursing assessments will be completed within 8 hours of admission.
    c. For all individuals admitted to residential, including the Hartmann Center, nursing assessments will be completed on day of admission.
    d. Before individuals are admitted to any outpatient substance use programs, nursing assessments will be completed.
    e. For individuals admitted to mental health, developmental disabilities and child and adolescent outpatient and day programs, nursing assessments will be completed as determined by physical health indications.
    f. The nursing assessment is documented in the electronic clinical record or on the paper form if the ECR is unavailable.
    g. The RN will assess the need for immediate consultation with the program physician to review before recommending additional follow-up as indicated. The scope and intensity of referrals for further assessment is determined by the individual and treatment team after consideration of the individual's clinical need and desire for further assessment or care.

h. The RN informs the individual and/or family member of findings during the assessment process in a manner that is understandable to the individual/family and matches teaching approaches and content to the individual/family's level of understanding. This is documented in the progress notes and specifically addresses the individual/family's responses.
i. The RN reports all significant physical problems in the treatment team, which may potentially interact or affect the treatment of behavioral health conditions, including any condition for which the individual regularly is prescribed medication or any chronic pain.

9. When a physician or licensed psychologist determines that a psychological evaluation is needed or when a court-ordered psychological assessment is requested these services are provided through a referral to an outside agency or individual.
    a. When a psychological evaluation is determined to be necessary, these services are provided through a referral to an outside agency or individual.
    b. Psychological evaluation is considered as an adjunct to other assessments according to the following criteria:
        i. when there is a clinically significant decline in neurological or psychiatric functioning;
        ii. when severe, aberrant behavioral disturbances exist;
        iii. when there is a failure to progress in treatment,
        iv. when further data on psychological/neuropsychological status or functioning are felt to be necessary in determining treatment needs, and
        v. when a psychological is needed to help an individual obtain residential placement.
    c. For individuals in DD (Developmental Disability) psychological evaluations are obtained from the school system, other provider where individual has received services, or the regional office for Intake and Evaluation.
10. Staff is credentialed to perform the above assessments through the Human Resource Department using agency-wide policies and procedures and departmental specific policies and procedures.
    a. Competency to perform the assessment function is documented during the agency's performance appraisal process and/or competency checklists and kept in Human Resources.
11. The assessment process is conducted in collaboration with the individual, and when appropriate, in collaboration with family members, in order to ensure a comprehensive, individual-focused approach. All individuals are assessed with regard to their treatment preferences and expressed needs as well as cultural and learning readiness treatment needs.
12. Results of the initial screening and assessment indicate the individual's need for care, type of care to be provided, acuity level and setting for care as well as determined needs for further assessment. All individuals are informed of the results of the assessment as part of the treatment planning and ongoing care process.
13. A licensed co-signatory on an assessment indicates a request for the ordered services. An MD/APRN signature indicates an order for medical services listed in the Services

Requested module. At the Hartmann Center, the management team reviews the clinical assessment and recommends admission based on the program admission criteria. If the individual does not meet criteria, the referral source is notified.

14. Identification of discharge planning needs is an integral part of the assessment process. Discharge planning begins at the point of the initial assessment through the clinician's work with the individual and, as appropriate, family members in understanding the individual and family members' perspectives and goals, needs, priorities and strengths. These data elements, along with other assessment data are incorporated into the treatment and discharge planning process.
15. The completed assessment is maintained online as a part of the online medical/clinical records.

Individuals with Developmental Disabilities:

1. Assessment for developmental disability services is initially determined through an individualized application process submitted directly to the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), Regional Intake & Evaluation Office.
2. Individualized services, supports, care and treatment determinations are made on the basis of an assessment of needs with the individual. The purpose of the assessment is to determine the individual's hopes, dreams or vision for their life and to determine how best to assist the individual in reaching those hopes, dreams or vision, including determining appropriate staff to deliver these services. Assessments should include, but are not limited to, the following:
    a. The individual's: Hopes and dreams, or personal life goals;
    b. Perception of the issue(s) of concern; Strengths; Needs; Abilities; and Preferences.
    c. Medical history;
    d. A current health status report or examination
    e. Appropriate diagnostic tools such as impairment indices, psychological testing, or laboratory tests;
    f. Social history;
    g. Family history;
    h. School records (for school age individuals);
    i. Collateral history from family or persons significant to the individual, if available.
    j. Review of legal concerns including: Advance directives; Legal competence;
    k. Legal involvement of the courts; and Legal status as adjudicated by a court.
3. Additional assessments should be performed or obtained by the provider if required to fully inform the services, supports, care and treatment provided.
4. After this has been completed certain evaluative clinical information and/or an interim Individualized Service Plan are shared with DD Services to be reviewed for screening/planning purposes in preparation for addressing the service referral.
5. An initial interview and discussion meeting is then held at DD Services program level to determine whether or not sufficient service resources or capacity are available to meet the candidate's needs. If so, a formal decision is reached to select the DD Services Department by the participant and/or authorized representative.