Indiana NeuroDiagnostic Institute
Clinical Program Manual

The NeuroDiagnostic Institute of Indiana is a state-operated acute psychiatric hospital with the goal of providing excellence in mental health treatment. Our hospital serves as a specialty consult treatment facility for high-acuity behavioral health disorders. NDI's organizational charter and mission foster training and research programs to establish the best acute individual care by quality providers. To accomplish this mission, the hospital staff combines a range of clinical services: psychiatry, psychology, medical, psychiatric nursing, pharmacy, nutrition and dietetics, rehabilitation therapy, social work, transitional care, academic education and spiritual care.

Individual intake

Individuals are referred by a community mental health center. Referral packets should contain current mental status including most recent psychiatric assessment; risk factors such as self-harm, aggression, elopement and falls; physical exam within 30 days of referral; commitment papers; legal papers including guardianship, wardship, advance directives, do not resuscitate orders and probation details; current treatment plan; current psychological testing; all financial information; a current tuberculosis test results and ANSA/CANS assessments indicating the need for hospitalization. Forensic patients who refuse a tuberculosis test in the jail will be given one after arrival on the patient unit. Youth packets must also include immunization records, school history and IEP and birth certificate. Anyone with an IQ below 70 will generally be better served by bureau of developmental disabilities services than in a state psychiatric hospital. The initial referral form also includes a specific measurable recovery goal as well as primary and secondary treatment needs, anticipated length of stay, CMHC discharge plan and post hospitalization needs that can be incorporated into the individual's treatment and used to evaluate discharge readiness through the individual's stay.

Those referred are typically individuals who have a serious and persistent mental illness and have not responded to a full course of treatment in a less restrictive setting or require transfer from another facility for continued intensive treatment. Clinical descriptors include history of repeated acts of endangering self or others, documented failure to respond to a variety of conventional treatment protocols and management efforts in a less restrictive setting, severe incapacitating emotional symptoms inhibiting appropriate social and familial interactions and further skilled observation and evaluation as provided by a 24-hour structured therapeutic environment available only in a psychiatric hospital setting.

Once accepted for treatment, youth individuals are admitted to the hospital on a voluntary commitment, meaning they are signed in for treatment by their parent or guardian. Adult individuals are involuntarily placed through a civil commitment proceeding or a criminal placement for those who are incompetent to stand trial or who have forcible felony charges pending. Individuals are admitted from 7:30 a.m. to 3:30 p.m. Monday through Friday. A family member or friend is always welcome to help support an individual during admission.

After arriving at NDI, an individual's belongings are separated from the individual and inspected for safety reasons. All belongings will be put through a sanitation process and laundered prior to being sent to the unit. This process takes about 24 hours. Security personnel supervise walking through a metal detection device and/or use a metal-detecting wand to scan an individual in the sally port before entering the facility. Hospital staff discourage expensive items and encourage clients to label all their belongings prior to arrival. All cash, credit cards, debit cards and/or prepaid cards will be locked for safe keeping during the hospitalization by security. Admission staff members collect demographic information missing from the referral packet received by the CMHC, attempt to have all conditions of admission signed by the individual and attempt to take a photo of the individual. This information is then entered into the electronic medical record. Once the face sheet, labels and M-Page are

generated from the EMR, the unit staff will escort the individual to the unit for introduction to his/her team and unit orientation.

Staff members from clinical disciplines, including psychiatry, psychology, social work, occupational therapy recreational therapy, dietetics and chaplaincy, provide initial assessments to determine comprehensive areas of need to be addressed by the multi-disciplinary treatment team as well as individual strengths that can be used to empower the individual for success. These assessments are then used to create a treatment plan to monitor progress toward goals and assess for discharge readiness.

Clinical programming

Program goals

- To provide individual-centered care that allows individuals to participate in their recovery process.
- To ensure all hospital disciplines are operating collectively for the betterment of the individual.
- To maintain a center of excellence by utilizing best practices, evidence-based treatments and accreditation standards.

Objectives

Clinical program staff will:

1. Apply the trauma-informed care model in every aspect of the individual's care.
2. Assess, develop and implement a measurable and individualized treatment plan that is tailored to the individual's mental health and medical care necessary for recovery.
3. Collaborate with intra-hospital disciplines, gatekeepers, families and outside resources regarding the individual's care before, during and after his/her return to the community.
4. Establish a positive therapeutic working relationship with the individual through the practice of evidence-based psychotherapies emphasizing trauma-informed principles and educational groups/programs that enable the individual to reclaim a sense of self, engage in treatment and be an active participant in life.

Trauma-informed care model

SAMHSA trauma-informed care six principles:

1. Safety

Throughout the organization, staff and the people they serve feel physically and psychologically safe.

2. Trustworthiness and transparency

Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients and family members of those receiving services.

3. Peer support and mutual self-help

These are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety and empowerment.

4. Collaboration and mutuality

There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. One does not have to be a therapist to be therapeutic.

5. Empowerment voice and choice

Organization aims to strengthen the staff, client and family members' experience of choice and recognizes that every person's experience is unique and requires an individualized approach. This builds on what clients, staff and communities have to offer, rather than responding to perceived deficits.

6. Cultural, historical and gender issues

The organization actively moves past cultural stereotypes and biases, offers culturally responsive services, leverages the healing value of traditional cultural connections and recognizes and addresses historical trauma.

Treatment teams

The treatment team is responsible for directing individual treatment to ensure that every aspect of care facilitates individual progress toward wellness and discharge. The team assures that the clinical and material needs of the individual are met. The treatment team meets weekly to review individual treatment plans and progress toward goals. The team also determines when the individual is ready for discharge. Members of the team may meet daily for "rounds" to discuss current levels of functioning, concerning behaviors and other urgent needs that cannot wait for weekly treatment team review.

An individual's treatment team is led by the assistant clinical director and must also include a physician, unit director/nurse and social worker. Additionally, psychologist, rehabilitation therapist, transitional care specialist, pharmacist, dietician and chaplain may attend treatment team meetings and be consulted on individual care. A teacher of record is consulted for youth individuals and adult individuals who attend school. Individuals and, where applicable, their families/guardians/gatekeeper/DCS are invited to participate in treatment team meetings to discuss ongoing treatment and discharge plans.

Goals

- To create an individualized person-centered treatment plan.
- To review individual progress toward goals.
- To determine when individuals are ready for discharge.
- To increase individual (and family) contact with the treatment team.
- To allow for individual treatment needs to be assessed by all relevant parties on an ongoing basis.

Treatment plans

Treatment plans set goals and objectives for an individual's treatment with the ultimate goal of release into a less-restrictive environment. Treatment plans are formulated and maintained by an individual's treatment team and updated every 30 days. Gatekeepers, family members and DCS may attend team meetings because it is important for individuals to maintain ties with their community and families. These are sources of support once an individual leaves the hospital.

Individual behavior plans may be implemented by treatment teams to help motivate or specifically address individual needs and issues. Behavior plans are designed to enhance treatment plans to help each individual meet their goals.

Safety assurance: Individual and facility-based commitments

Safety is a primary component of the hospital's mission. This concept is introduced the first day of an employee's orientation, the first day an individual is admitted to our hospital and as part of any visitation to the hospital by individual families or care coordinators.

Our multidisciplinary team approach trains, tracks and addresses safety from numerous angles. Our staff development team provides extensive training for our employees in CPR, de-escalation techniques and safety maneuvers to help prevent people from being a danger to themselves or others. NDI recognizes that individual safety assurance is part of our daily duty, licensure maintenance and general mental health education protocols. This commitment is monitored by our quality assurance department, which is responsible for keeping a watchful eye on how we maintain our individual environment.

We also approach safety at the individual level. Our individuals have a wide array of psychological issues. This drives the need to promote individualized safety plans at the time of admission based upon the individual's condition and ongoing plan adjustment while he/she is in our care. Situations such as seclusion, restraint, injury, or threats to others trigger an individual's safety plan review at that time. These plans are shared with the individual's family and any other clinical organization that may extend care to the individual off-grounds.

When an individual stabilizes and is under consideration for discharge, case history and current safety plan are shared in discharge planning and determination of best environment after leaving NDI.

Access and programming

Adult access to hospital areas

The access program is designed to ensure individuals are safe in the hospital and able to participate in treatment appropriate to their level of functioning as they prepare for discharge. Individuals are assigned access to different areas of the hospital based upon staff evaluation of safety. Specific behaviors may be deemed unsafe and require additional monitoring as determined by the treatment team. There are two types of access.

Unit restricted/on precautions

Individuals are on unit restriction when there is a specific risk to their safety or the safety of others if they go off the unit. This is typically tied to being on "precautions."

Reasons for unit restriction: new admission*, any unsafe behavior, including physical assault, AWOL or attempted escape, self-injurious behavior, or suicidal ideation, stealing, destruction of property, possession or use of drugs or alcohol, sexual involvement, verbal, or written threats (including profanity directed at others with the intent to verbally abuse or provoke others), significantly disruptive behavior in groups/activities on or off the unit.

**New admissions are admitted as unit restricted and placed on specific precautions based on history at admission for a minimum of 72 hours. At 72 hours, the precautions will discontinue if there have been no further incidents or concerns. Individual will remain unit restricted until treatment team determines the individual is appropriate to go off the unit.*

Unit restriction

- Individual does not leave the unit unless for medical purposes with staff. Adult clients may resume regular group/treatment schedule including both on and off unit groups once they have shown they can be safe and are no longer an imminent risk to self or others. Precautions that necessitated unit restriction may continue even if the individual is able to resume attending groups off the unit. Individual should attend on unit groups during this time.
- Being absolved from unit restriction is on an individual basis. Individual must follow unit rules and be off precautions to be eligible to leave the unit.
- Although precautions will discontinue 72 hours after last incident, the treatment team will decide when individual is appropriate for escort access. Individual will remain unit restricted until the team meets to discuss at morning report.

Groups

Adult group sessions are scheduled at 8:30 a.m., 9 a.m., 10 a.m., 1 p.m. and 2 p.m. (See appendix.) In addition, all adult units have a morning meeting at 8:30 a.m. Attendance at these group sessions is an essential part of the individual's recovery. Participation in groups is required in order to attend more leisurely activities. For youth individuals group leaders, complete blueprint cards outline in the foundations program at the end of each group session.

Meals

Adult and youth meals are served on unit in the dining specified area. Meals times are from 7:15–8:15 am for breakfast, 11:30 a.m.–12:30 p.m. for lunch and 5–6 p.m. for dinner. Individuals will also receive snacks at 7:30 p.m. Youth receives additional snack at 3:15 p.m. to comply with the national school snack program. All food must be consumed in designated areas.

Visitation and home visits

In-hospital visits are permitted as arranged by an individual's social worker and with a doctor's order. Individuals may go on home visits if they are not on precautions and have no significant behavioral issues within 24 hours of the visit. All home visits must be approved by the assistant clinical director.

School

Adult individuals up to age 21 may attend Indianapolis Public School classes at the hospital. They may work toward a high school diploma or certificate of completion.

Youth programming

The NDI Youth Foundations Program is based on concepts from the ARC model, trauma-informed care, adolescent DBT skills training and general behavioral principals.

In the NDI Youth Foundations Program, patients will work through a series of four phases as they progress through the program. These phases will track overall progress through the program. Patients will move through the phases at their own pace. Note: not everyone will make it through all four phases before they discharge.

Each phase will have three goals they will work on specific to that phase. Patients will have to complete these goals to move up to the next phase. Moving up phases is important because it shows progress and readiness towards discharge. Each phase also has special privileges that only patients in that phase or higher can have. The higher the phase, the better the privileges! Some privileges are automatic, and some privileges must be unlocked daily by earning stars.

Once a patient promotes up to the next phase, they will remain on that phase until they promote to the next phase. In other words, patients will not be placed back on the previous phase.

The four phases are (GPBM):

- Groundwork phase (orientation).
- Planning phase (developing skills).
- Building phase (putting into action).
- Moving phase (discharge).

There are three goals for every phase:

1. Attachment (social) goal: How you connect and interact with others.
2. Regulation goal: How you use emotion regulation skills; how you are dealing with distress and intense emotions.
3. Competency goal: Getting the job done; being able to do what is expected of you and meet daily tasks and demands (e.g., following directions, attending school, participating in school and groups, taking your medications).

Precautions/behavior plans

Individuals who exhibit behavior deemed a danger to themselves or others will be assessed for precautions by the RN and/or physician. Individuals will remain on precautions for 72 hours. Items from the individual's room will be removed for safety reasons. All newly admitted individuals will be on precautions for at least the first 72 hours so that they can be assessed. The type of precaution will reflect the specific behavior displayed.

Off-grounds activities and visits are not allowed while on precautions except visits adjacent to the unit. A physician order is required to discontinue a precaution.

Behavior plans

Individual behavior plans may be implemented by treatment teams to help motivate or specifically address individual needs and issues. Behavior plans are designed to enhance the treatment plan to help each individual meet individual goals. Any behavior plans that contradict the behavioral program should be brought to the attention of the assistant clinical director and respective assistant director of nursing.

If property destruction is involved, community service may be required to assist in making restitution. A list of required community service or reparations will be written in the care plan.

While cursing alone may not place an individual on assault precautions, cursing with threats of violence toward others is not acceptable. Actual contact with another individual is not necessary for staff to place an individual on assault precautions as a preventive measure.

Meals

Youth meals are served on the living units on the third floor. Meals are served from 7–8:30 a.m. For breakfast, 11 a.m.–12:45 p.m. For lunch and 5–6 p.m. For dinner. Individuals will also receive snacks at 3:15 p.m. and 7 p.m. All food must be consumed in designated areas. Level appropriate individuals may be escorted to the canteen, but all snacks must be consumed before returning to the unit.

Visitation and home visits

Individuals are permitted to have visitors as arranged by their social worker and with the doctor's order. Individuals not on precautions may leave on home visits at the discretion of the treatment team. An individual will not be allowed to go on a visit if he/she had a significant behavioral problem within 24 hours of the visit. The assistant clinical director must approve all home visits.

School

School records are requested before admission so an individual's education may continue. Indianapolis Public Schools teachers instruct elementary through high school classes at the hospital. Every effort is made to help individuals with their education, so they do not get behind.

Discharge

Social workers are responsible for a large portion of the discharge process. Ongoing contact occurs with the gatekeeper, department of child services and the family/guardian beginning at the time of admission. When it is determined that a patient is ready for discharge, social workers submit a pre-discharge packet to the gatekeeper via viewpoint. This will include the most recent treatment plan, psychiatric assessment, psychosocial assessment, medication list and any other specifically requested information for the gatekeeper including a summary of care provided during hospitalization. The patient is added to the discharge waitlist on the same day that the pre-discharge packet is uploaded into viewpoint. Upon receiving discharge date and intake appointment information, social work completes the internal 590 form. Social worker then completes the pre-discharge/aftercare referral form within the electronic medical record.

Adult social workers and, to some degree, youth social workers assist with choosing a placement for post-discharge in cooperation with the gatekeeper and/or DCS. NDI staff also obtain information to determine the need for prescriptions, in addition to a seven-day medication supply, for individual transfer to another facility. Social workers provide education on the process of obtaining IEP/school assistance and acquiring school records. Social workers complete referral packets for placements, make requests for expedited bureau of developmental disability services and coordinate appointments for assessments/interviews. They contact Medicaid for the youth and have benefits transferred to the new placement or changed to non-residential if youth are transitioning to home or foster/group homes. For adults, social workers help individuals apply for Medicaid one week prior to discharge and notify Medicaid liaison of application date and request that individual be removed from 590 coverage. If necessary, a guardian will sign the Medicaid application. For youth and adults, social workers contact social security administration to indicate that NDI will no longer be the payee and indicate new addresses and payees. Once individuals are discharged, social workers submit signed discharge forms to health information services and to the gatekeeper via viewpoint.

Upon admission, the social worker, treatment team, client, family/guardian and gatekeeper begin discussing options for discharge and placement back into the community so a plan can be immediately drafted. Special concern is given for those clients who have chronic health issues or are on medications that are difficult to manage in the community. All clients are informed that they have the right to change gatekeepers, upon discharge, if they wish.

Regular contact between the team and the gatekeeper, via the social worker, will occur and when the necessary requirements for discharge have been met, the gatekeeper and the social worker will begin working toward placement in the agreed upon less-restrictive environment.

The social worker will meet with family and potential caregivers to provide the viewpoint discharge summary and all necessary education, support and referrals (especially for those individuals who will reside with family) to assist in continuity of care.

Psychiatry: Overview

Program description

The psychiatry section of the NDI is comprised of adult, adolescent and child services. Since this is a referral hospital, background history and information are received and reviewed prior to admission. Individuals may arrive from anywhere in the state, including transfers from other state hospitals. These individuals typically have already had considerable exposure to mental health care and have not responded to treatment. They arrive under a regular commitment and, in certain cases, a voluntary commitment under legal guardian signature. Others may be sent to the hospital under the status of incompetent to stand trial.

Program goals

- An individual's mental health history and symptoms are reviewed, as well as current/historic medications and their effects.
- Individual assessments are conducted upon admission to help determine objectives and desired outcomes.
- Individuals are also assessed for other diseases and, if present, they are referred to NDI's internist for physical examination and recommended treatment.
- Following assessment, psychotropic medication is administered when appropriate. This may involve continuation and adjustment of current dosing, addition of another appropriate psychotropic or start of a new medication.
- For individuals on ICST status, their goals are to become competent to return to court and stand trial with the help of legal education classes, while their psychotropic medications are monitored.

Psychiatry: Children and adolescents

Program description

The child and adolescent psychiatrists prescribe and manage psychotropic medications in order to improve individual symptoms. Psychiatrists perform routine assessments of individual psychiatric symptoms and monitor for medication effects and side effects.

Program goals

- To assess individual mental status and psychiatric symptoms.
- To prescribe and manage psychotropic medications in order to maximize benefits and minimize harm to the individual

Psychology

Program description

The psychology department is composed of licensed psychologists and master's level clinicians with diverse areas of expertise including severe mental illness, addictions, trauma, neuropsychology, forensics and pediatric psychology. Based on the scientist-practitioner model, the psychology department adheres to the American psychological association's ethical principles and code of conduct and is dedicated to following a biopsychosocial perspective of health and illness and providing cutting-edge best practice in inpatient care.

Members of the psychology department employ empirically validated assessment measures, clinical observation and a thorough review of medical records and collateral information to ascertain each patient's neurocognitive/behavioral/emotional/psychological difficulties, functional limitations and strengths. After establishing diagnostic clarity, psychologists identify targeted and individualized interventions. Approaches to treatment include, but are not limited to, cognitive-behavioral therapy, dialectical behavior therapy, integrated psychological therapy, neurofeedback, motivational interviewing, interpersonal psychotherapy, psychoeducation, biofeedback and mindfulness-based interventions. Members of the psychology department actively engage in direct patient care via individual/group/family psychotherapy and function as consultants to other members of the multidisciplinary team, providing specific insights and recommendations regarding therapeutic approaches, behavior management and discharge planning. Recognizing the high prevalence of complex trauma among our patients, the psychology department also provides ongoing staff education in order to create a therapeutic institutional milieu that promotes trauma-informed care and a chronic calm. Finally, consistent with the hospital's mission, psychologists conduct research to better understand the impact of treatment and improve the quality of care.

Program goals

- Collaborate with psychiatry to ascertain diagnostic clarity.
- Improve patients' overall well-being via individualized, evidence-based treatment.
- Create an institutional milieu based on a chronic calm and trauma-informed care.
- Evaluate treatment outcomes.

Program objectives

- Complete initial/referred psychological assessments and competency evaluations in a timely manner.
- Facilitate case conceptualization conferences and individualized treatment planning.
- Provide individual/group/family psychotherapy and document patient progress in a timely manner.
- Attend multidisciplinary meetings to provide guidance on therapeutic approaches, behavior management and discharge planning.
- Attend hospital management and committee meetings in order to bring about positive changes to the institutional milieu and patient care.
- Provide staff education and training.
- Supervise practicum students.
- Develop and conduct treatment outcome research.

General medical services / co-morbidity (disease) treatment

Medical services will be provided to NDI individuals by an internal medicine physician. This includes close consultation plus management of and implementation of standard-of-care practices to address co-existing medical problems. Common areas of focus include, but are not limited to, asthma, chronic obstructive pulmonary disease, diabetes management, hypertension, sleep apnea and hyperlipidemia (high cholesterol).

In the event a medical problem requires more specialized assessments, the internist will initiate appropriate and timely consultation with specialty physicians. Furthermore, consultations by the internist will be performed on individual units as a convenience to individuals.

Included in such medical services will be repair and treatment of minor lacerations, abrasions, musculoskeletal injuries or other common immediate care concerns.

General medical services are provided both on unit and at the on-site Larue Carter Clinic. Emergent and complex medical conditions are treated at medical-surgical hospitals or specialty clinics. Any such off-premises treatments require an NDI attendant to accompany an individual during transportation and, in some circumstances, while an individual is admitted elsewhere.

Psychiatric nursing

Program description

Nursing staff members are on the front line of assessment and treatment of our individuals, providing 24-hour direct care by registered nurses, licensed practical nurses, qualified medication attendants, certified nursing aides and behavioral health recovery attendants. Direct care describes a wide variety of duties including medication administration, assistance with or provision of personal care and activities of daily living, assessment and care of physical illnesses and disabilities, education and monitoring of individual risk factors and safety considerations.

The nursing department collaborates with a variety of professionals from various disciplines to determine and provide the best possible care for individuals through nursing care plans and participation in ongoing interdisciplinary treatment planning activities according to individualized individual need.

Program goals

- To maintain a safe environment for individuals while providing for their physical and emotional needs.
- To establish a therapeutic rapport with each assigned individual through consistency, trust, respect and non-judgmental attitude.
- To assist individuals with identifying and managing psychiatric symptoms to achieve the least restrictive environment.
- To accurately administer medications and assess for effects and side effects.

Pharmacy

Program description

The clinical pharmacist provides pharmaceutical care and cost reduction strategies as an active participant in the health care and treatment team. The pharmacist monitors all drug therapy for efficacy and adverse effects and maintains all data in the clozapine registry. The pharmacist completes medication reconciliation at admission and readmission and provides recommendations and guidance to prescribers. The pharmacy is one of the founding participants in the pharmacy and therapeutics committee, which maintains and updates the hospital formulary and oversees all medication-related issues in the hospital.

Program goals

- To facilitate evidence-based medication treatment implementation in both psychiatric and medical conditions.
- To monitor drug efficacy and prevent adverse events through laboratory result monitoring.
- To maintain and enter all data into the national clozapine registry in accordance with FDA requirements.
- To participate in the treatment team through medication recommendations.
- To perform individual discharge counseling to facilitate outpatient compliance with medication regimens when requested.
- To perform medication reconciliation and formulary compliance suggestions.

Program objectives

- The clinical pharmacist will attend treatment teams and provide advice and guidance on drug selection.
- The clinical pharmacist will monitor drug therapy for duplications and drug interactions and will intervene with the prescriber when necessary.
- The clinical pharmacist will review all laboratory results and provide feedback when needed to the prescriber.
- The clinical pharmacist will monitor lab values required by the clozapine registry and will initiate compliance with the clozapine risk evaluation and mitigation strategy program guidelines when values require it.
- The clinical pharmacist will provide medication regimen counseling to discharging individuals at the request of the prescriber.
- The clinical pharmacist will provide usage and compliance data on medication as required by the pharmacy and therapeutics committee for continuous quality improvement.

Nutrition and dietetics

Program description

The registered dietitian nutritionist is the nutrition expert on an individual's treatment team. The RDN completes nutritional assessments and provides guidance and education to individuals in individual and group settings. The RDN also provides education to an individual's family, significant others and staff.

The RDN collaborates with professionals from other disciplines to determine and provide optimal nutrition to each individual.

Program goals

- To assess individuals' nutritional needs and make recommendations for treatment based on the identified needs.
- To review and revise plans, as needed, to improve nutritional care for individuals while taking their safety and emotional needs into consideration.
- To establish a therapeutic rapport with each assigned individual through consistency, trust, respect and a non-judgmental attitude.
- To assist individuals with identifying and achieving their nutritional goals.
- To provide drug-nutrient interaction education to individuals.
- To monitor meals to ensure compliance with individuals' diet prescriptions.

Program objectives

The RDN will:

- Complete initial nutritional assessment within five business days of individual's admission and annual nutritional assessment during the month of the anniversary of the individual's admission.
- Write diet and nutrition supplement orders for pending physician's signature prior to implementation.
- Identify nutritional diagnosis and collaborate with the individual and treatment team to address these concerns.
- Lead nutrition educational groups based on the needs identified in the assessments.
- Complete additional documentation for each individual. This includes progress notes, consults and diet orders on an as needed basis.
- Observe meals to ensure compliance with individual's diet order.
- Evaluate quality of meals and provide input to the food service department.

Rehabilitation therapy

Program description

The rehabilitation department offers recreational and leisure education groups and activities to individuals. Therapists are key members of the treatment team. They develop and implement educational groups and recreational activities based on individual needs as identified through assessment.

Our treatment service is designed to restore, remediate and rehabilitate a person's level of functioning and independence in life activities, to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition.

Rehabilitation therapists utilize a wide range of activity and community- based interventions and techniques to improve the physical, cognitive, emotional, social and leisure needs of individuals. Through these groups and activities help individuals reduce depression, stress and anxiety and help increase confidence and socialization.

Program goals

- To provide an assessment to identify individual needs to create an individualized treatment program.
- To provide active treatment based on the specific, needs of each individual, as noted in his/her treatment plan.
- To provide leisure education and community reintegration in structured social settings to promote improvement in overall well-being to be successful in a least restrictive environment.

Program objectives

The rehabilitation therapist will:

- Complete additional documentation for each individual. This includes monthly progress notes and therapeutic notes after each group attended.
- Identify individual RT goals and work with the treatment team to place individuals in active treatment groups based on the needs identified in the initial assessment. This program plan will be incorporated into the treatment plan.
- Provide everyone with opportunities for leisure education, recreational activities and community reintegration outings.
- Work with each individual to incorporate specific interests and community resources into therapy to achieve optimal outcomes that transfer to their real-life situations.

Social work

Program description

Social workers assess individual treatment needs and oversee the creation of an individualized treatment plan for each individual. They formulate, develop and implement specific treatment strategies for each patient in individual, family and group settings. Social workers assess individual progress toward goals and analyze data related to individual outcomes to determine discharge readiness. They facilitate placement and post-discharge services for individuals who are discharge-ready and provide feedback to the gatekeepers on individual post-discharge needs. Social workers are the liaisons between the treatment team and those outside the hospital, including individual families, gatekeepers, Division of Mental Health and Addiction/Office of General Counsel, Department of Child Services, Indianapolis Public Schools, Bureau of Developmental Disability Services, court-appointed special advocates, guardians ad litem (court appointed), attorneys, schools, probation officers and other residential facilities. They provide education to families and coordinate individual visits. Social workers also help individuals with their material needs by assisting with money management; benefit applications, such as Medicare D, Medicaid, Social Security, BDDS, Section 8 housing, CICOA, PASSR and prescriptions; and acquiring identification and documentation, such as ID cards, Social Security cards, birth certificates, marriage licenses and green cards.

Program goals

- To provide an assessment of individual needs to establish a basis for the creation of an individualized treatment plan.
- To provide active treatment based on the specific needs of each individual, as noted in a treatment plan.
- To provide fluid communication between all who are involved in individual care internally and externally.
- To facilitate individual discharge planning and coordination of post-discharge services.

Program objectives

The social worker will:

- Complete biopsychosocial assessments 24 hours of individual admission and annually during the month of the anniversary of the individual's admission.
- Create an individualized treatment plan for each person within 24 hours of admission and again within five business days of admission. The plan will be reviewed every 30 days for all individuals.
- Complete the following additional documentation for each individual: progress notes on a weekly basis for the first eight weeks following admission; therapeutic intervention/group progress note weekly and progress notes as noted on individual treatment plans. Additionally, social workers will complete a progress note within 24 hours of admission and discharge.
- Complete individual discharge in viewpoint, complete after-care and inpatient discharge within the electronic medical record, providing information on individual progress, post-discharge needs and follow up appointments within 24 hours of individual discharge.

Transitional care

Program description

Discharge planning begins immediately after admission and continues throughout the individual's hospital stay. The transition from an inpatient mental health care setting back into the community can lay the foundation for a lifetime of continued success. Our goal is to transition with intention and strategy. The transition care program is designed to focus on keeping the client involved in communication and treatment decisions being made. This approach will help to increase a feeling of personal investment, higher levels of motivation and boosted engagement.

- Transition care will focus on life skills, defined as "any knowledge or ability that is helpful in one's day to day experience." They are tools necessary to make the most of one's life.
- Transition care will offer instruction in groups and in a 1:1 coaching that explore all areas of self-sufficiency, self-care and communication, aiming to lower social isolation and loneliness, decrease occurrences of chronic relapses/rehospitalization and reduce repeat legal offenses.
- Use motivational interviewing approach to assist clients in making positive changes in their lives and increase feelings of hope and personal confidence.
- Focus on importance of aftercare and prioritize the role of primary care and follow up appointments after discharge
- Incorporates elements of CBT with role plays, discussions and exercises to help change incarceration thinking/habits
- Transition groups primarily focus on the following skill areas: life skills training, coping skills, independent living, employment, practical money management, self-management, resiliency, positive habits, self-awareness, relationships and community resources.

Program goals

- To provide assessment of individual needs to create an individualized treatment program.
- To provide active treatment based on the specific individual needs of each client, as noted in a treatment plan.
- To assist individuals with exploring their strengths and identifying their own personal goals.
- Create a positive environment that will foster learning, exploration and open discussions through the integration of life skills resources, group work and question and answer sessions.
- Provide groups and activities to increase individual engagement and active participation in life.
- Provide off campus opportunities when applicable to demonstrate and practice skills in community setting
- Increase individuals' awareness of how to utilize community supports and access resources.

Program objectives

The transition care specialist will:

1. Welcome individuals and ensure that they feel respected and supported, while maintaining communication that is consistent, open, respectful and compassionate.
2. Complete initial assessment within five business days of individual's admission.
3. Identify individual goals based on the needs identified in the initial assessment. This plan will be incorporated into the treatment plan.
4. Participate in case conceptualization conferences and individualized treatment planning.
5. Lead educational groups based on the needs identified in the assessments.
6. Encourage individuals to have a voice and be actively engaged in the decision-making process in their own treatment planning, also allowing room for feedback and dialogue.
7. Providing peer support/engagement in groups, where individuals may have a similar experience or shared understanding and can benefit from isolation felt from trauma, struggles with mental illness and/or legal issues.
8. Increase individuals' awareness and ability to identify, access and utilize community resources.
9. When applicable, complete follow-up calls for individuals after discharge to remind individual of the need for follow-up mental health treatment.

Academic educational services

Youth will be assessed for academic needs. The school liaison will review the record and look for any indication of an individualized education plan from the last school attended, test results indicating the individual's ability level and the last grade attended. When applicable, credits will be reviewed to determine appropriate class placement. The hospital provides educational opportunities for all students from middle school through graduation.

NDI works with Indianapolis Public Schools to help students fulfill their educational requirements. IPS teachers three middle school/high school classes and a computer-based classroom. Each student is assigned a teacher of record who assists with specific needs. Teachers instruct special education classes as well as English, mathematics, science and social studies. The school year follows the IPS calendar.

Teachers provide the treatment team with monthly notes and review each plan with team members.

Each classroom has a behavioral health recovery attendant assigned to it to assist with any behavioral issues. If unique or severe problems arise, the educational liaison or assisted clinical director is consulted.

Consistent communication among educators, unit staffers and remaining treatment team members is very important. Treatment team members review educational notes each morning and discuss concerns.

Educational services are offered to all students with an IEP. IPS will continue to offer services to all students up to 22 years old. General education students may participate through the school year in which they turn 18 or until they graduate, whichever occurs sooner. Students who are eligible for special education services may receive services through the school year in which they turn 22 or until they graduate or receive a certificate of completion.

A certificate of completion, a high school diploma, a recommendation to continue with adult educational programming or vocational opportunities are all possibilities.

Program goals

- Minimize loss of knowledge and skills while a person is hospitalized.
- Build on knowledge and skills students already have acquired.
- Provide opportunity for high school students to recover credits they may have missed.
- Help students learn the value and necessity of lifelong learning.
- Help students develop positive learning skills such as achieving self-direction, asking for help and learning how to access available resources.

Program objectives

Educators will:

- Develop a picture of each student's current achievement by:
- Review prior academic records and available assessment reports.
- Conduct formal and/or informal content-specific assessments.
- Talk with the student and her/his parent(s)/guardian(s).
- Provide appropriately challenging instruction, based on the initial assessment, periodic formative assessment and Indiana state academic standards.
- Convene case conference committee meetings for students eligible for special education services within 10 school days of a student entering school to develop an appropriate individualized education program.
- Report each student's progress to the treatment team monthly.
- Report each student's progress to her/his parent(s)/guardian(s) at least quarterly.
- Provide information about the student's progress, current achievement and challenges to the receiving school when he/she is discharged.

Spiritual care / chaplaincy

Program description

The program offers spiritual care services to the hospital's multi-faith population and integrates these services throughout the hospital.

Program goals

- Offer a consistent spiritual presence across the hospital to provide support to individuals, staff and families.
- Facilitate better communication among individuals and staff members to improve quality of individual care, as well as staff morale and retention.
- Participate in and support interdisciplinary efforts throughout the hospital.
- Provide educational opportunities to enhance awareness and inclusion of spiritual issues as part of quality health care.

Program objectives

Chaplain educator/ the institute for clinical pastoral training certified supervisor will:

1. Provide a model of love through presence, word and deed.
2. Recognize and respond to spiritual needs.
3. Provide daily ministry of presence and support for individuals and staff.
4. Offer weekly interfaith worship services.
5. Facilitate spirituality groups on individual care units to expand active treatment offerings.
6. Consult with interdisciplinary staff and faith representatives as required.
7. Complete initial spiritual assessments.
8. Provide spiritual resources as requested and appropriate.
9. Offer accredited clinical pastoral education programs through ACCET as recognized by the U.S. Department of Education for graduate-level seminarians and community faith representatives desiring continuing education.