POLICY TITLE: MENTAL HEALTH SERVICES POLICY NUMBER: 18.6 CHAPTER 18: HEALTH CARE SERVICES		PAGE 1 OF 22
STATE of MAINE DEPARTMENT OF CORRECTIONS Approved by Commissioner: _____		PROFESSIONAL STANDARDS: See Section VIII
EFFECTIVE DATE: September 2, 2003	LATEST REVISION: January 22, 2021	CHECK ONLY IF APA [ ]

I. AUTHORITY

The Commissioner of Corrections adopts this policy pursuant to the authority contained in 34-A M.R.S.A. Section 1403.

II. APPLICABILITY

All Departmental Adult Facilities

III. POLICY

It is the policy of the Department of Corrections to support adult resident mental health by offering mental health services and maintaining continuity of mental health care. To accomplish this objective, these services shall be provided on-site at the facilities and through the utilization of community mental health resources, as appropriate, and shall include an intensive mental health housing unit for the Department (see Department Policy (AF) 18.6.1, Intensive Mental Health Unit). *5-ACI-6A-28 & 4-ACRS-4C-15*

IV. DEFINITIONS

1. Four-point restraints - a four-point restraint totally immobilizes the resident by securing a resident's arms and legs (four points), e.g., by using a restraint bed or gurney. This definition does not include the use of handcuffs, leg irons, and connecting chain used during the transport or internal movement (escort) of residents. This definition does not include the use of stationary restraints.
2. Five-point restraints - a five-point restraint totally immobilizes the resident by securing a resident's arms, legs, and head, chest or thigh (five points), e.g., by using a restraint chair or a restraint bed or gurney. This definition does not include the use of handcuffs, leg irons, and belly chains used during the transport or internal movement (escort) of residents. This definition does not include the use of stationary restraints.

3. Licensed clinician - psychiatrist, psychologist, psychiatric nurse practitioner, licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist.

4. Mental Health Screening (Admission Health Screening) - Completed by nursing staff upon a resident's arrival at a facility, including upon admission to the reception facility or transfer from any facility, and including any history of mental health problems and any current mental health problems to determine, to the extent reasonably possible, if an adult resident poses no significant risk to self or others. This screening may result in a referral for a Mental Health Assessment.

5. Mental Health Assessment – Completed by a licensed clinician and including an in-depth gathering of information about a resident such as by a mental status exam, psychosocial background review, and clinical interview. This assessment may result in a referral for a Comprehensive Mental Health Evaluation.

6. Mental Health Appraisal (Initial Mental Health Evaluation) – Completed by a licensed clinician to identify a resident with mental health needs through the review of information obtained in the mental health screening along with any other information regarding the resident's mental health needs. This appraisal may include a mental status exam, clinical interview, psychological testing, psychological observation, records review, and gathering of collateral information. This appraisal may result in a referral for a Comprehensive Mental Health Evaluation.

7. Mental Health Evaluation (Comprehensive) – Completed by a licensed clinician to evaluate a resident's presenting problem which results in a diagnostic impression and identifies treatment/intervention needs that are used in the development of an individualized treatment plan. The evaluation includes documentation of historical information such as mental health treatment and psychosocial background, a diagnostic interview which should include a current mental status exam, and an evaluation of self-injury risk. Psychometric testing may be conducted to determine personality, intellectual, and coping abilities.

8. Serious mental illness - a substantial disorder of thought, mood, perception, orientation, or memory, including disabling conditions such as schizophrenia, schizoaffective disorder, psychotic disorders due to substance use or a general medical condition, major depression, bipolar disorder, or post-traumatic stress disorder, resulting in significant impairment of functioning.

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VII. PROCEDURES

Procedure A: Mental Health Services, General

5-ACI-6A-28

1. The Commissioner, or designee, shall ensure that the mental health services provided by the Department are approved by the Department's contracted health care services provider as set out in Department Policy (AF) 18.1, Governance and Administration.

2. Each facility's mental health program shall include, but not be limited to, the following services:

   a. screening for mental health problems on admission;

   b. outpatient services for the detection, diagnosis, and treatment of mental illness, to include medication management and/or counseling, as appropriate;

   c. crisis intervention and the management of acute psychiatric episodes;

   d. stabilization of an adult resident with mental illness and the prevention of psychiatric deterioration in the correctional setting;

   e. elective therapy services and preventive treatment, where resources permit;

   f. provision for referral and admission to the Department's Intensive Mental Health Unit or to a state psychiatric hospital for residents whose psychiatric needs exceed the treatment capability of the Department;

   g. processes for obtaining and documenting informed consent; and

   h. follow-up with residents who return from a state psychiatric hospital.

3. The Department's Director of Behavioral Health Services shall annually review and approve this policy and the required staff training regarding this policy. Any recommendations for policy revisions shall be submitted to the Department's

Policy Development Coordinator, or designee. Any recommendations for changes to training shall be submitted to the Department's contracted health care services provider, or the Department's Director of Professional Development, or designee, as applicable.

Procedure B: Mental Health Screenings, Appraisals, and Evaluations

1. A mental health screening of a newly admitted or transferred adult resident shall be performed as part of the admission health screening or medical transfer screening, as applicable, by nursing or other health care staff who are trained to perform the screening within four (4) hours of the resident's arrival at the facility. The mental health screening shall include, but not be limited to:

   5-ACI-6A-31

   a. inquiry to whether the resident:
      1) has current suicidal ideation;
      2) has a history of suicidal behavior;
      3) is presently prescribed psychotropic medication;
      4) has a current mental health complaint;
      5) is being treated for mental health problems;
      6) has a history of inpatient or outpatient psychiatric treatment;
      7) has any recent use of alcohol or addictive substance use, to include the substance used, frequency of use, amount used, and last time used; and
      8) has a history of treatment for substance use disorder.

   b. observation of:
      1) general appearance and behavior;
      2) level of consciousness (alertness, orientation);
      3) evidence of abuse and/or trauma; and
      4) current symptoms of psychosis, depression, anxiety, and/or aggression.

   c. disposition of the resident:
      1) to the housing unit without referral to facility mental health services;
      2) to the housing unit with referral to facility mental health services; or
      3) by referral for emergency treatment or care, including, but not limited to, by initiating the process for a referral to the Intensive Mental Health Unit, in accordance with Department Policy (AF) 18.6.1, Intensive Mental Health Unit, referral for possible placement on a suicide and self-injury watch in accordance with Department Policy (AF) 18.6.2,

Suicide Prevention Plan, or provision of emergency health care services, in accordance with Department Policy (AF) 18.3, Access to Health Care Services.

2. If the screening indicates that an adult resident may be in need of mental health services, a referral for a mental health assessment and/or other mental health services shall be made to mental health staff.

3. A licensed clinician shall perform a mental health assessment and determine whether to refer the resident for a comprehensive mental health evaluation or take other appropriate action, including, but not limited to, placement on a suicide and self-injury watch, referral for psychiatric evaluation, individual or group therapy, or medical services, etc.

4. A licensed clinician shall complete a mental health appraisal on every resident within fourteen (14) days of admission into the reception facility. Staff performing the appraisal shall ensure the provision of mental health care as deemed necessary based on presenting symptoms. Mental health appraisals shall include, but are not limited to: *5-ACI-6A-32*

   a. review of the resident's mental health screening;
   b. review of available historical records of inpatient and outpatient psychiatric treatment;
   c. review of history of treatment with psychotropic medication;
   d. review of history of psychotherapy, psycho-educational groups, and classes or support groups;
   e. review of history of drug and alcohol use and treatment;
   f. review of educational and special education history;
   g. review of history of sexual or physical abuse victimization and predatory behavior and/or problem sexual behavior;
   h. review of history of suicidal or violent behavior;
   i. review of history of cerebral trauma or seizures;
   j. assessment of current mental status, symptoms, condition, and response to incarceration;
   k. assessment of current suicidal potential and person-specific circumstances that increase suicide potential;
   l. assessment of violence potential and person–specific circumstances that increase violence potential;
   m. assessment of drug and alcohol use and/or addiction
   n. review of history of sexual abuse victimization and predatory behavior;
   o. use of additional assessment tools, as indicated;

p. referral to treatment, as indicated; and

q. if necessary, development and implementation of a treatment plan, including recommendations concerning housing, job assignment, and program participation.

If the appraisal indicates that a resident is suffering from serious mental illness, an immediate referral for a comprehensive mental health evaluation shall be made and prior mental health records not previously requested shall be requested, as appropriate.

5. When any staff make a request to mental health staff to evaluate an adult resident, and it is determined by a licensed clinician that a comprehensive mental health evaluation is necessary, it shall be performed within fourteen (14) days of the request. At a minimum, a comprehensive mental health evaluation shall include the following: *5-ACI-6A-33*

   a. review of the resident's mental health screening and appraisal data;

   b. direct observations of behavior;

   c. collection and review of additional data from individual diagnostic interviews and tests (assessing personality, cognitive abilities, coping abilities, and current mental status);

   d. compilation and review of the resident's mental health history; and

   e. development of an overall treatment or management plan, with appropriate referral to include transfer to a mental health facility when the resident's psychiatric needs exceed the treatment capability of the facility.

Procedure C: Diagnostic Services

1. An adult resident shall be referred to psychological diagnostic services either on-site or in the community (e.g., cognitive, personality, neuropsychological assessments and evaluations), as determined necessary by a licensed clinician.

2. All psychological diagnostic testing materials located at the facility shall be maintained and used in accordance with professional standards and testing material instructions.

3. When psychological diagnostic testing is determined necessary, the required test shall be performed at the next possible opportunity if being done on-site or an appointment in the community shall be arranged in a timely manner.

4. When diagnostic services are scheduled to be done in the community, the resident shall be informed that the required test has been scheduled but shall not be told when or where it shall take place, due to security reasons.

5. When diagnostic procedures are scheduled to be done in the community, designated security staff shall be notified by health care staff of the time and place so that security staff can arrange transport. Notification shall be given as soon as possible and, in a non-emergency situation, at least twenty-four (24) hours in advance.

6. The health care staff shall provide the transport staff with a Consultation Request Form from the resident's electronic health care record to be completed by the community provider. The completed form shall be returned by the transport staff to the health care department immediately upon return to the facility. The completed form shall be reviewed by appropriate health care staff and filed in the adult resident's electronic health care record.

7. A licensed clinician shall review, date, and sign all mental health diagnostic test results and shall make a notation of the review in the resident's electronic health care record. A licensed clinician shall review with the resident in a timely manner the diagnostic test results.

8. When any mental health staff who is not medically licensed believes a diagnostic medical service is necessary, the request shall be made to appropriate medical staff. The request shall be reviewed by the medical staff in a timely manner. A notation shall be made in the resident's electronic health care record indicating the results of the review.

Procedure D: Non-Emergency Mental Health Services

1. Non-emergency mental health services for adult residents shall be accessed as follows:
    a. All residents shall have access to all non-emergency mental health services through the use of a resident request slip or a sick call slip (Attachment C to Policy 18.3 (AF), Access to Health Care). Nursing staff collecting a resident request or sick call slip requesting mental health services shall forward it to the mental health staff. These forms shall be readily available to all residents.
    b. All non-emergency mental health requests shall be reviewed by mental health staff within twenty-four (24) hours of receipt (72 hours on weekends). Follow-up services shall be initiated within seven (7) days.
    c. Any staff may initiate a non-emergency mental health referral for a resident who the staff believes is in need of a mental health assessment. When medical staff refer a resident for assessment, the medical staff shall document the referral in the resident's electronic health care record.

Procedure E: Emergency Mental Health Services

1. Emergency mental health services shall be provided in accordance with Department Policy (AF) 18.3, Access to Health Care Services.

Procedure F: Mental Health Therapeutic Restraints, General

5-ACI-6C-13

1. Therapeutic restraints ordered for a mental health reason (i.e., to prevent an adult resident from engaging in serious self-injurious behavior due to mental illness or to administer involuntary psychotropic medications) may be used only when no less restrictive alternatives have been or are likely to prove ineffective.
2. If a resident credibly agrees to stop self-injury or to be administered the medication, as applicable, therapeutic restraints shall not be ordered. (However, non-therapeutic restraints may be used for a security reason as provided in applicable departmental policies, e.g., the resident is on disciplinary segregation status and is being escorted within the facility.)
3. The following provisions shall be adhered to any time mental health therapeutic restraints are used in adult resident care:
    a. therapeutic restraints shall not be used for punishment;
    b. if therapeutic restraints are used, the least restrictive restraints possible shall be used and only for the period of time necessary; and
    c. therapeutic restraints may not be used unless ordered by a licensed clinician, physician, physician assistant, or nurse practitioner. The documentation shall include the order, the mental health reason for the order, the justification for using restraints (to include efforts for less restrictive treatment alternatives), and the justification for the type of restraints ordered.
4. In every case in which therapeutic restraints have been ordered, health care staff shall immediately inform the facility Shift Commander and, if applicable, the IMHU Unit Manager, and health care staff and security staff shall jointly develop a plan for the application of the therapeutic restraints by security staff using only the degree of nondeadly force reasonably believed to be necessary. The application of the restraints shall be video recorded.
5. Only soft restraints that would be appropriate for use in psychiatric hospitals shall be used for therapeutic restraints. These consist of:
    a. leather, rubber, or canvas hand restraints;
    b. leather, rubber, or canvas leg restraints;
    c. leather mitts;
    d. leather, rubber, or canvas waist belt;

e. four-point restraints made of the above materials; and

f. five-point restraints made of the above materials.

6. Metal or plastic restraints, such as handcuffs and leg irons, shall not be used as therapeutic restraints, except in an emergency situation to prevent serious bodily injury to self or others and only if soft restraints are not readily available.

7. A resident may be restrained in a hospital or restraint bed, hospital or restraint gurney/stretcher, Stokes basket, restraint chair, or wheelchair or another chair designed for transporting or moving a resident. A resident may not be restrained in an unnatural position or face down.

8. Whenever therapeutic restraints are used, health care staff shall assess the resident as soon as possible after the application of the restraints and at least every two (2) hours thereafter if the use has not been discontinued in the meantime, and the following shall be checked:

   a. circulation, movement, and sensation in extremities;

   b. respiratory status;

   c. mental status;

   d. vital signs;

   e. that food, water, and use of the toilet has been offered as appropriate; and

   f. that the resident has been offered the opportunity to have each limb removed separately from restraints for the purpose of movement every two (2) hours as appropriate.

9. During the resident's hours of sleep, health care staff may elect not to awaken the resident to complete the assessment.

10. The results of the assessment shall be documented in the resident's electronic health care record, including any reason for security staff not offering food, water, use of the toilet, or movement of restrained limbs. If health care staff elect not to awaken a sleeping resident, that fact shall be documented in the resident's electronic health care record.

11. The need for continued therapeutic restraints of the resident shall be evaluated at least every four (4) hours by health care staff. The results of the evaluation shall be documented in the resident's electronic health care record. If the health care staff believes that the use of therapeutic restraints is no longer necessary, the staff shall contact the licensed clinician, physician, physician assistant, or nurse practitioner requesting an order to discontinue the use of the restraints. The request and the response to the request shall be documented in the resident's electronic health care record.

12. During the resident's hours of sleep, health care staff may elect not to awaken the resident to complete the evaluation. If health care staff elect not to awaken a sleeping resident, that fact shall be documented in the resident's electronic health care record.

13. In any case in which therapeutic restraints are used and bodily injury or compromise to health is apparent, the resident complains of bodily injury or compromise to health related to the use of the restraints, or the security staff otherwise believes it is appropriate. the security staff shall notify appropriate health care staff as soon as possible. The notified health care staff shall take appropriate action, up to and including contacting the licensed clinician, physician, physician assistant, or nurse practitioner to request an order to discontinue the use of the restraints. Any action taken shall be documented in the resident's electronic health care record.

14. A new order, including the reason for the continuation, must be written for every twelve (12) hour continuation in the use of therapeutic restraints.

15. A licensed clinician, physician, physician assistant, or nurse practitioner shall personally examine the resident within twenty four (24) hours of the initial use of therapeutic restraints, if the use has not been discontinued in the meantime.

16. Health care staff shall immediately inform the facility Shift Commander and, if applicable, the IMHU Unit Manager, when the discontinuation of therapeutic restraints has been ordered, and health care staff and security staff shall jointly develop a plan for the removal of the therapeutic restraints by security staff using only the degree of nondeadly force reasonably believed to be necessary. The removal of the restraints shall be video recorded.

17. The Health Services Administrator, or designee, and the Chief Administrative Officer, or designee, shall be notified by health care staff as soon as practicable of any order for the use of therapeutic restraints and of any order to discontinue the use of the restraints.

18. Records relating to the use of therapeutic restraints shall be maintained in the adult resident's electronic healthcare record as set forth in Department Policy (AF) 18.9, Health Care Records and shall, as applicable, in addition to the documentation required above, include, but not be limited to, the following:

    a. the original order for therapeutic restraints and the related documentation required above;

    b. the plan for applying the restraints;

    c. any new order and the related documentation required above;

d. the initial assessment by health care staff and the assessments by health care staff every two (2) hours and the evaluations by health care staff every four (4) hours;

e. the examination within twenty four (24) hours by a licensed clinician, physician, physician assistant, or nurse practitioner;

f. the order for the discontinuation of therapeutic restraints; and

g. the plan for removing the restraints.

19. The Chief Administrative Officer, or designee, shall arrange for a debriefing related to the use of therapeutic restraints following each incident, to include attendance by supervisory security and health care staff, with the debriefing documented and entered into CORIS as part of the documentation related to the incident.

Procedure G: Therapeutic Restraints, Suicide and Self-Injury Prevention

1. Therapeutic restraints may be ordered to prevent an adult resident from committing suicide or inflicting serious self-injury due to mental illness.

2. In an emergency situation, security staff may restrain a resident to prevent suicide or serious bodily injury to self until a decision can be made on whether to order therapeutic restraints. If the Shift Commander, and, if applicable, the IMHU Unit Manager, determines it appropriate, that person shall contact appropriate health care staff as soon as possible after security staff have restrained the resident to request that a licensed clinician, physician, physician assistant, or nurse practitioner determine whether an order for therapeutic restraints is clinically appropriate.

3. If therapeutic restraints are ordered to prevent suicide or serious self-injury, the health care professional ordering the restraints shall also order that the resident be placed under a suicide and self-injury constant watch pursuant to Policy (AF) 18.6.2, Suicide and Self-Injury Prevention Plan.

4. The watch shall be video recorded. Staff conducting the watch shall use the Suicide and Self-Injury Watch form (Attachment A to Policy (AF) 18.6.2, Suicide and Self-Injury Prevention Plan) to document matters relating to the use of the therapeutic restraints, as well as to document other matters as required by that policy.

Procedure H: Therapeutic Restraints, Administration of Involuntary Medication

1. Therapeutic restraints may be used to facilitate the administration of psychotropic medications needed to treat an adult resident with serious mental illness who is refusing the medications. Therapeutic restraints shall not be used to force

unwanted psychotropic medications on a resident who has the capacity to make an informed decision regarding treatment with the medications.

2. Therapeutic restraints shall be discontinued once the medication is administered and, if applicable, the resident is returned to the IMHU from the medical department. (However, non-therapeutic restraints may be used for a security reason as provided in applicable departmental policies, e.g., the resident's level requires the use of restraints when being escorted within the facility.)

3. If the purpose of the restraints is to administer psychotropic medication to a resident who has a legal guardian, the following shall apply:

   a. The facility Chief Administrative Officer, or designee, shall assign a staff person to speak with the resident in an effort to persuade the resident to accept the medication and that effort and the result of that effort shall be document in the resident's electronic health care record.

   b. If the resident continues to refuse the medication, an attempt shall be made by appropriate health care staff to contact the resident's guardian for specific consent to provide the medication, and the attempt and the result of that attempt shall be documented in the resident's electronic health care record.

   c. In addition to the required documentation relating to any use of therapeutic restraints, and in addition to obtaining the consent of the resident's guardian (or, if applicable as set out below, in addition to obtaining a court order), the psychiatrist, physician, physician assistant or nurse practitioner shall specify the medical reason for the medication administration, including why less restrictive or less invasive treatment alternatives with return to voluntary treatment, as soon as clinically feasible, are not being used; when, where and how the medication is to be administered; and the expected duration of the treatment, to include a plan for the use of less restrictive treatment alternatives as soon as possible. The documentation shall also include the guardian's consent (or court order).

   d. Security staff shall be present during the administration of the medication The resident's final refusal of the medication immediately prior to its administration and the administration of the medication shall be video recorded. The resident shall be monitored for adverse reactions and/or side effects.

4. If the adult resident's guardian cannot be contacted and it appears that contact cannot be made in a reasonable period of time, the Chief Administrative Officer, or designee, shall contact the Department's legal representative in the Attorney General's Office to inquire about obtaining the appointment of a different guardian, obtaining a court order for the involuntary administration of the medication, or taking other appropriate action. Note: a court order shall not be requested for the involuntary administration of the medication unless the resident has been admitted

to the Intensive Mental Health Unit and only in accordance with Title 34-A M.R.S.A. Section 3049 and Policy 18.6.1 (AF), Intensive Mental Health Unit.

5. If the purpose of the restraints is to administer psychotropic medication to an adult resident who does not have a legal guardian, the following shall apply:
    a. The facility Chief Administrative Officer, or designee, shall assign a staff person to speak with the resident in an effort to persuade the resident to accept the medication and that effort and the result of that effort shall be document in the resident's electronic health care record.
    b. If the resident continues to refuse the medication, the resident shall be referred to the facility psychiatrist or psychologist for a determination of whether the resident has the capacity to make an informed decision regarding treatment with the medications.
    c. If the resident is determined to have that capacity, therapeutic restraints shall not be used and the resident shall not be administered the medications without his or her agreement.
    d. If the resident is determined to not have that capacity, the Chief Administrative Officer, or designee, shall contact the Department's legal representative in the Attorney General's Office to inquire about obtaining a court order, obtaining an appointment of an emergency guardian, or taking other appropriate action. Note: a court order shall not be requested for the involuntary administration of the medication unless the resident has been admitted to the Intensive Mental Health Unit and only in accordance with Title 34-A M.R.S.A. Section 3049 and Policy 18.6.1 (AF), Intensive Mental Health Unit.
    e. In addition to the required documentation relating to any use of therapeutic restraints, and in addition to obtaining a court order (or the consent of an emergency guardian), the psychiatrist, physician, physician assistant or nurse practitioner shall specify the medical reason for the medication administration, including why less restrictive or less invasive treatment alternatives with return to voluntary treatment, as soon as clinically feasible, are not being used, when, where and how the medication is to be administered, and the expected duration of the treatment, to include a plan for the use of less restrictive treatment alternatives as soon as possible. The documentation shall also include the determination that the resident lacks the capacity to make an informed decision regarding treatment with the medications and the court order (or emergency guardian's consent). To the extent the documentation is included in a request for a court order, it is sufficient to include the documentation filed in court in the resident's electronic health care record.
    f. Security staff shall be present during the administration of the medication. The resident's final refusal of the medication immediately prior to its administration and the administration of the medication shall be video

recorded. The resident shall be monitored for adverse reactions and/or side effects.

Procedure I: Intensive Mental Health Treatment Services for Female Residents

1. Any time an adult female resident is identified by any staff as possibly being a danger to self or others or possibly unable to care for herself due to mentail illness, the staff shall refer the resident for assessment by a licensed clinician.

2. If the resident has been determined by the licensed clinician conducting the assessment to be a danger to self or others or unable to care for herself for mental health reasons or if it is determined by a licensed clinician that a female resident is not responding to mental health treatment within the facility, the resident may be referred for admission to a state psychiatric hospital in accordance with Procedure J below.

3. If a referral for admission to a state psychiatric hospital is not made or if the hospital does not accept the female resident, the female resident shall be provided mental health treatment in a safe environment in a correctional facility.

Procedure J: Mental Health Hospitalization Services

5-ACI-6C-12

1. Referrals for involuntary admissions may only be made to Riverview Psychiatric Hospital or the Dorothea Dix Psychiatric Center.
   a. The mental health staff making the referral for involuntary admission to a state psychiatric hospital is responsible to contact the facility Chief Administrative Officer, or designee, and the Department's Director of Behavioral Health Services, or other designee of the Commissioner (or the Commissioner), prior to contacting Riverview Psychiatric Hospital or Dorothea Dix Psychiatric Center.
   b. The Chief Administrative Officer, or designee, in consultation with the Director of Behavioral Services, or other designee of the Commissioner (or the Commissioner), shall make the final determination as to whether or not an adult resident shall be referred for involuntary admission to a state psychiatric hospital.
   c. A referral for involuntary admission shall only be made when an adult resident with a serious mental illness poses a likelihood of serious harm because of being a danger to self or others or being unable to care for self due to mental illness and only when available Department of Corrections' intervention resources are unable to manage and/or treat the resident.
   d. If a referral for involuntary admission is to be made, the Director of Behavioral Services, or designee, shall contact the appropriate authority at

Riverview Psychiatric Hospital or Dorothea Dix Psychiatric Center, who shall be briefed about the resident and the intended referral.

e. If a referral for involuntary admission is to be made, the facility Chief Administrative Officer, or designee, with the assistance of the Department's legal representative in the Attorney General's Office, shall, with the certification by a duly licensed healthcare examiner (MD/PhD/PA/NP/RN, CS/DO), apply for involuntary hospitalization using the current emergency involuntary admission form ("Blue Paper").

f. If the admission is authorized by a Maine Judicial Officer and if the hospital agrees to accept the resident, when an appropriate bed is available, the sending facility Shift Commander, or other designated security staff, shall make arrangements with the hospital for the transport of the resident.

g. The signed original of the application must be presented to the admissions staff at the hospital upon arrival at the hospital. A copy of the application and judicial authorization shall be placed in the resident's health care record and Administrative Record.

h. The Department of Corrections is not required to provide security for the resident while at Riverview Psychiatric Hospital or Dorothea Dix Psychiatric Center.

2. Referrals for voluntary admissions may only be made to Riverview Psychiatric Hospital or Dorothea Dix Psychiatric Center.

a. The mental health staff making the referral for voluntary admission to a state psychiatric hospital is responsible to contact the facility Chief Administrative Officer, or designee, and the Department's Director of Behavioral Health Services, or other designee of the Commissioner, (or the Commissioner) prior to contacting Riverview Psychiatric Hospital or Dorothea Dix Psychiatric Center.

b. The Chief Administrative Officer, or designee, in consultation with the Director of Behavioral Services, or other designee of the Commissioner, (or the Commissioner) shall make the final determination as to whether or not the resident shall be referred for voluntary admission to a state psychiatric hospital.

c. A referral for voluntary admission may be made when in the judgment of the Chief Administrative Officer it is in the best interest of the resident.

d. If a referral for voluntary admission is to be made, the Director of Behavioral Services, or designee, shall contact the appropriate authority at Riverview Psychiatric Hospital or Dorothea Dix Psychiatric Center, who shall be briefed about the resident and the intended referral.

e. If the hospital agrees to accept the resident, when an appropriate bed is available, the sending facility Shift Commander, or other designated security

staff, shall make arrangements with the hospital for the transport of the resident.

f. Documentation of the referral and the voluntary admission shall be made in the mental health progress notes in the resident's electronic health care record and Administrative Record.

g. The Department of Corrections is not required to provide security for the resident while at Riverview Psychiatric Hospital or Dorothea Dix Psychiatric Center.

Procedure K: Continuity of Mental Health Care

5-ACI-6A-34

1. Mental health staff, in conjunction with medical staff, shall assure continuity of mental health care for adult residents with identified mental health needs, from the time of admission, throughout the incarceration, and at the time of release, for all emergency and routine mental health care services.

2. During incarceration, for a resident with identified mental health needs, mental health services shall be provided in accordance with an individualized mental health treatment plan developed and revised as necessary by a licensed clinician in conjunction with the resident. The plan may include enrollment in the mental health chronic care clinic to be seen monthly. Psychiatric chronic care for residents with serious mental illness shall be provided every ninety (90) days in accordance with Department Policy (AF) 18.5, Health Care.

3. Mental health staff, in conjunction with medical staff, shall take the appropriate steps to coordinate with the resident's case manager to ensure continuity of mental health care upon release, both for residents being released to the community and for residents being released to a jail, to a correctional facility in another jurisdiction, or to a psychiatric hospital.

4. The resident's case manager, in conjunction with medical and mental health staff, is responsible for developing a discharge plan to ensure continuity of mental health care in the community upon release by following the procedures outlined in Department Policy (AF) 27.1, Release and Reentry Planning, as applicable.

5. In addition, when a resident is a class member of the AMHI (Augusta Mental Health Institute) consent decree, the appropriate Department of Health and Human Services staff shall be notified by mental health staff or other staff designated by the facility Chief Administrative Officer at least ninety (90) days prior to the release.

6. If applicable, health care staff shall provide a resident with a supply of psychotropic medication(s) at the time of release in accordance with Department Policy 18.7 (AF), Pharmaceuticals.

Procedure L: Special Housing

1. When an adult resident is placed in a restrictive housing unit or other housing unit on administrative status or disciplinary segregation status, in special management housing on disciplinary restriction or protective custody status, or in the Administrative Control Unit, the Unit Manager, or designee, shall immediately notify the facility health care staff, who shall provide a screening and review no later than one (1) hour after placement. The notification shall be recorded in CORIS. The screening and review shall include, but not be limited to: *5-ACI-4B-28*

   a. inquiry to whether the resident:

      1) has present suicide ideation;

      2) has a history of suicidal behavior;

      3) is presently prescribed psychotropic medication;

      4) has a current mental health complaint;

      5) is being treated for mental health problems;

      6) has a history of inpatient and outpatient psychiatric treatment;

      7) has any recent use of alcohol or addictive substance use, to include the substance used, frequency of use, amount used, and last time used; and

      8) has a history of treatment for substance use disorder.

   b. observation of:

      1) general appearance and behavior;

      2) level of consciousness (alertness, orientation);

      3) evidence of abuse and/or trauma; and

      4) current symptoms of psychosis, depression, anxiety, and/or aggression.

   c. disposition of resident:

      1) no mental health referral;

      2) referral to mental health care service; or

      3) referral to appropriate mental health care service for emergency treatment.

2. If the results of the screening indicate the resident is at imminent risk for serious self-injury or suicide, exhibits debilitating symptoms of a serious mental illness, or requires emergency medical care, a health care professional shall be contacted for appropriate assessment and treatment.

3. A licensed clinician shall meet with the resident and follow-up thereafter as set out in Department Policies (AF) 15.1, Administrative Status, (AF) 15.2, Disciplinary Segregation Status, (AF) 15.3, Protective Custody Status, (AF) 15.4, Disciplinary Restriction Special Management Housing, and (AF) 15.5, Administrative Control Unit and in accordance with the resident's individualized treatment plan, if applicable.

Procedure M: Clinic Space, Equipment and Supplies

1. The Chief Administrative Officer of each facility shall assure that there is sufficient and suitable space, equipment, and supplies to provide on-site mental health services designated for that facility, to include:
    a. the availability of testing materials and other mental health treatment resources;
    b. adequate office space with file cabinets, secure storage for health care records, computers, and writing desks; and
    c. private interview space for both individual assessment and group treatment, desk(s), chairs, and lockable file space when mental health services are provided on-site.

Procedure N: Mental Health Records

1. Mental health care records shall be maintained in the adult resident's electronic healthcare record as set forth in Department Policy (AF) 18.9, Health Care Records and shall, as applicable, include, but not be limited to, the following:
    a. mental health screenings, assessments, and evaluations (e.g., admission health screening and addendum, mental health appraisal, and other mental health assessments and evaluations);
    b. mental health and/or substance use diagnosis;
    c. referral information (e.g., sick call slips and staff referrals);
    d. results of psychological diagnostic tests, assessments, and evaluations;
    e. treatment plans;
    f. progress notes;
    g. mental health technician notes;
    h. information releases, correspondence, etc.;
    i. historical data (e.g., records about prior treatment); and
    j. treatment summary and other discharge records.
2. Records relating to therapeutic restraints shall be maintained as set out in Procedures F, G, and/or H, as applicable.

Procedure O: Mental Health Research

1. Disclosure of mental health information for purposes of research must comply with all legal requirements, including the requirement for authorization by the Commissioner, or designee, and Department Policy 1.24, Research, Evaluation, and Performance Measurement.

2. The Department of Corrections does not permit experimental mental health treatment or other experiments on its adult residents.

Procedure Q: Mental Health Confidentiality and Limits

1. During the mental health assessment, the limitations of confidentiality of information disclosed by the resident to mental health staff shall be reviewed with the resident. The Mental Health Confidentiality and Limits Form (Attachment A) shall be reviewed with the resident and the resident's signature shall be obtained.

2. In a situation where the resident refuses to sign the form, the mental health staff shall document on the form and in the progress notes that the resident refuses to sign. The staff shall inform the resident that the limits set out in the form apply even if the resident refuses to sign and shall document in the progress notes that the resident was so informed.

VIII. PROFESSIONAL STANDARDS

ACA:

5-ACI-4B-28 **(MANDATORY) When an offender is transferred to Restrictive Housing, health care personnel will be informed immediately and will provide a screening and review as indicated by the protocols established by the health authority. The mental health portion of the screening should include at a minimum, but is not limited to:**

Inquiry into:

- **whether the offender has a present suicide ideation**
- **whether the offender has a history of suicidal behavior**
- **whether the offender is presently prescribed psychotropic medication**
- **whether the offender has a current mental health complaint**
- **whether the offender is being treated for mental health problems**
- **whether the offender has a history of inpatient and outpatient psychiatric treatment**
- **whether the offender has a history of treatment for substance abuse**

Observation of:

- **general appearance and behavior**
- **evidence of abuse and/or trauma**
- **current symptoms of psychosis, depression, anxiety, and/or aggression**

Disposition of offender:

- **no mental health referral**

- **referral to mental health care service**
- **referral to appropriate mental health care service for emergency treatment**

If the results of the inmate screening indicate the inmate is at imminent risk for serious self-harm, suicide, exhibits debilitating symptoms of a SMI, or requires emergency medical care, a health care professional shall be contacted for appropriate assessment and treatment.

5-ACI-6A-28 **(MANDATORY) The mental health program is approved by the appropriate mental health authority and includes at a minimum:**

- **screening on intake**
- **outpatient services for the detection, diagnosis, and treatment of mental illness, to include medication management and/or counseling, as appropriate**
- **crisis intervention and the management of acute psychiatric episodes**
- **stabilization of the mentally ill and the prevention of psychiatric deterioration in the correctional setting**
- **elective therapy services and preventive treatment, where resources permit**
- **provision for referral and admission to mental health facilities for offenders whose psychiatric needs exceed the treatment capability of the facility procedures for obtaining and documenting informed consent**
- **follow up with offenders who return from an inpatient psychiatric facility.**

5-ACI-6A-31 **(MANDATORY) All intersystem and intra-system transfer offenders will receive an initial mental health screening at the time of admission to the facility by a mental health trained or qualified mental health care professional. The mental health screening includes, but is not limited to:**

Inquiry into:

- **whether the offender has a present suicidal ideation**
- **whether the offender has a history of suicidal behavior**
- **whether the offender is presently prescribed psychotropic medication**
- **whether the offender has a current mental health complaint**
- **whether the offender is being treated for mental health problems**
- **whether the offender has a history of inpatient and outpatient psychiatric treatment**
- **whether the offender has any recent use of alcohol or addictive substance use, to include frequency of use, amount used and last time used**
- **whether the offender has a history of treatment for substance use disorder or treatment**

Observation of:

- **general appearance and behavior**
- **level of consciousness (alertness, orientation)**
- **evidence of abuse and/or trauma**
- **current symptoms of psychosis, depression, anxiety, and/or aggression**

Disposition of offender:

- **to the general population**
- **to the general population with appropriate referral to mental health care service**
- **referral to appropriate mental health care service for emergency treatment**

5-ACI-6A-32 **(MANDATORY) Inmates who are referred as a result of the mental health screening or by staff referral will receive a mental health appraisal by a qualified mental health person within 14 days of admission to the facility or the referral. If there is documented evidence of a mental health appraisal within the previous 90 days, a new mental health appraisal is not required, except as determined by the designated mental health authority. Mental health examinations include, but are not limited to the following:**

1. **review of the mental health screening**
2. **historical review of the following:**
   a. **available historical records of inpatient and outpatient psychiatric treatment**
   b. **treatment with psychotropic medication**
   c. **psychotherapy, psycho-educational groups, and classes or support groups**
   d. **educational status**
   e. **drug and alcohol use/abuse; treatment**
   f. **sexual abuse-victimization and predatory behavior**
3. **assessment of current mental status and condition, including**
   a. **current suicidal potential and person-specific circumstances that may increase suicide potential**
   b. **violence potential and person-specific circumstances that may increase violence potential**
   c. **drug and alcohol abuse and/or addiction**
4. **use of additional assessment tools, as indicated**
5. **development and implementation of a treatment plan, as indicated, including recommendations concerning housing, job assignment, and program participation**
6. **referral to treatment, as indicated**

5-ACI-6A-33 **Offenders referred for mental health treatment will receive a comprehensive evaluation by a qualified mental health practitioner. The evaluation is to be completed within 14 days of the referral request date and include at least the following:**

- **review of mental health screening and appraisal data**
- **direct observations of behavior**
- **collection and review of additional data from individual diagnostic interviews and tests (assessing personality, intellect, and coping abilities)**
- **compilation of the individuals' mental health history**
- **development of an overall treatment/management plan with appropriate referral to include transfer to mental health facility for offenders whose psychiatric needs exceed the treatment capability of the facility**

5-ACI-6A-34 **(MANDATORY) The following shall be provided to inmates receiving treatment for a diagnosed mental disorder at the time of release from the facility:**

- **arrange for continuity of care if receiving psychotropic medication**
- **make arrangements in accordance with available resources for continuity of care for inmates determined by the mental health or health care staff who need involuntary inpatient commitment**
- **provide inmate with a list of available community resources for inmates with a serious mental illness make every effort to coordinate a linkage with community provider and exchange clinically relevant information with appropriate community provider as needed.**

5-ACI-6C-12 **A transfer that results in an offender's placement in a non-correctional facility or in a special unit within the facility or agency, specifically designated for the care and treatment of the severely mentally ill or developmentally disabled follows due process procedures as specified by federal, state, and local law prior to the move being effected. In emergency situations, a hearing is held as soon as possible after the transfer.**

5-ACI-6C-13 **(MANDATORY) The use of restraints for medical and psychiatric purposes is defined, at a minimum, by the following:**

- **conditions under which restraints may be applied**
- **types of restraints to be applied**
- **identification of a qualified medical or mental health practitioner who may authorize the use of restraints after reaching the conclusion that less intrusive measures would not be successful**
- **monitoring procedures for offenders in restraints**
- **length of time restraints are to be applied**
- **documentation of efforts for less restrictive treatment alternatives as soon as possible**
- **an after-incident review.**

4-ACRS-4C-15 **Access to mental health services is made available to all offenders.**