POLICY TITLE: INTENSIVE MENTAL HEALTH UNIT POLICY NUMBER: 18.6.1 CHAPTER 18: HEALTH CARE SERVICES		PAGE 1 OF 9
STATE of MAINE DEPARTMENT of CORRECTIONS Approved by Commissioner:		PROFESSIONAL STANDARDS: See Section VIII
EFFECTIVE DATE: December 13, 2011	LATEST REVISION: November 28, 2022	CHECK ONLY IF APA [ ]

I. AUTHORITY

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

II. APPLICABILITY

All Departmental Adult Facilities

III. POLICY

The Department of Corrections recognizes the need to provide structured intensive mental health services in specialized mental health housing units to accommodate the needs of residents experiencing serious mental health problems.

IV. DEFINITIONS

1. Licensed clinician – psychiatrist, psychologist, psychiatric mental health nurse practitioner, licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist.
2. Persistent disabling personality disorder - a substantial personality disorder, including disabling conditions such as borderline personality disorder, resulting in significant and persistent impairment of judgment, behavior, and the capacity to cope with the ordinary demands of life within a correctional facility environment.
3. Psychiatric treatment provider – psychiatrist or psychiatric mental health nurse practitioner.
4. 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.
5. Severe cognitive impairment - a substantial disorder affecting cognitive functioning, including disabling conditions such as traumatic brain injury, significantly sub average intellectual functioning or autism spectrum disorders, resulting in a lack of capacity to cope with the ordinary demands of life within the correctional facility environment.

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VII. PROCEDURES

Procedure A: Intensive Mental Health Unit, General

1. If an adult facility has an Intensive Mental Health Unit (IMHU), it is a housing unit for residents with serious mental illnesses, persistent disabling personality disorders, or severe cognitive impairments who require structured intensive mental health services, to include evaluation and treatment, in a specialized mental health housing unit. The IMHU may provide services to any resident in need of help during a psychiatric, psychological, or emotional crisis, which may include a resident requiring adjustment to psychotropic medication, presenting a danger to self or others, or unable to care for self, or a resident who has a severe and persistent mental illness or personality disorder or cognitive impairment.

2. The IMHU shall have twenty-four (24) services such as nursing and availability of a licensed clinician, behavioral health trained correctional officers, and clinical programming. ***5-ACI-6A-38 & 5-ACI-6A-39***

3. The purpose of the IMHU is to help residents function at their optimal levels, under the least restrictive conditions necessary, while working towards the reduction of criminogenic risk factors. The goal is to improve quality of life, prepare residents for return to general population housing units, if possible, and, when appropriate, prepare residents for release back into the community, return to jail, admission to a state mental health institute, or transfer to an out-of-state correctional facility.

4. The IMHU shall operate under the general direction of the Deputy Commissioner, or designee, and the Regional Behavioral Health Director for the Department's contracted mental health care provider. The IMHU day-to-day operations shall be supervised by the IMHU Unit Manager, who shall report to the Deputy Commissioner, or designee. The IMHU treatment programming shall be overseen by the IMHU Behavioral Health Director, who shall be a licensed clinician who provides clinical supervision and case consultation. ***5-ACI-6A-39***

5. In addition to the IMHU Unit Manager and the IMHU Behavioral Health Director, the IMHU multidisciplinary unit treatment team (IMHU treatment team) members may include, but are not limited to, the following: ***5-ACI-6A-39***

a. Psychiatric treatment provider- to provide psychiatric case consultation and medication oversight.

b. Licensed clinician – to help determine a diagnosis and treatment interventions and provide individual and group treatment.

c. Registered nurse – to provide nursing care.

d. Correctional acuity specialists (who shall be certified as corrections officers) - to provide daily interaction with and observation and monitoring of residents; coordinate and assist in implementing individualized treatment plans; assist residents individually and in groups in order to identify resident issues and assist in their resolution; and provide security.

e. Behavioral health technician – to develop and implement activities and therapeutic interventions designed to reinforce practice of daily living skills and coping skills.

6. Staff working in the IMHU shall be required to attend all mandatory training as set out in Department Policy 4.3, General and Job-Specific Training, any unit-specific training, and, if applicable, any training required to maintain professional licensure.

7. When the resident is in need of a higher level of evaluation or treatment than can be provided in the IMHU, they may be referred by the Department for admission to a state mental health institute as set out in Department Policy (AF) 18.6, Mental Health Services. ***5-ACI-6A-37***

Procedure B: Intensive Mental Health Unit Referral and Admission

1. Any time any staff identifies an adult facility resident as possibly being a danger to self or others or unable to care for self due to possible serious mental illness, persistent disabling personality disorder, or severe cognitive impairment, or as exhibiting judgment or behavior indicative of one of the above illnesses or conditions, the staff shall immediately notify the Shift Commander.

2. The Shift Commander shall immediately contact a facility licensed clinician, if available on-site. If no licensed clinician is available on-site, the Shift Commander shall contact facility nursing staff.

3. The licensed clinician or nursing staff, as applicable, shall assess the resident as soon as possible and, in any case, no later than within two (2) hours of the contact. The assessment shall be performed in person.

4. If nursing staff performs the assessment, the nursing staff shall contact the on-call licensed clinician to discuss the results of the assessment and receive instructions on provisions for the appropriate supervision of the resident.

5. If nursing staff performs the assessment, the facility Behavioral Health Director, or designee, shall arrange for an in-person assessment by a facility licensed clinician no later than the next working day.

6. In all cases, staff notifying the Shift Commander shall stay with the resident until the Shift Commander is notified. The Shift Commander shall put into place provisions for the appropriate supervision of the resident, including, if applicable, continuous and

uninterrupted direct observation and supervision by security staff as set out in Department Policy (AF)18.6.2, Suicide and Self-Injury Prevention Plan, until the mental health assessment is completed and a licensed clinician determines that such supervision is no longer necessary.

7. If an assessment indicates the resident to be a danger to self or others or unable to care for self due to serious mental illness, persistent disabling personality disorder, or severe cognitive impairment, the licensed clinician shall notify the facility Behavioral Health Director, or designee, who shall determine if a referral to an Intensive Mental Health Unit (IMHU) is appropriate, and if determined appropriate, shall contact the Regional Behavioral Health Director, or designee.

8. The facility Behavioral Health Director, or designee, may also contact the Regional Behavioral Health Director, or designee, to discuss a referral of a resident to the IMHU for an adjustment to psychotropic medication or for other services that may require placement in the IMHU.

9. The Regional Behavioral Health Director, or designee, shall make the determination as to whether the resident will be admitted to the IMHU in consultation with the Deputy Commissioner, or designee.

10. The decision whether to admit an individual to the IMHU who has been referred to the IMHU pursuant to Title 34-A M.R.S.A. Section 3069-A, 3069-B, or 3069-C shall be made by the Deputy Commissioner, or designee, in consultation with the Regional Behavioral Health Director, or designee.

11. If an admission is approved:
    a. the Regional Behavioral Health Director, or designee, shall notify the facility Behavioral Health Director, or designee, and the IMHU Manager, or designee, who shall notify the IMHU Admissions Coordinator, or designee;
    b. the facility Behavioral Health Director, or designee, making the referral shall document the referral and the decision to approve the admission in the resident's electronic health care record;
    c. the IMHU Admissions Coordinator, or other designated staff, shall document the admission in the resident's electronic health care record and shall notify the Department Director of Classification, or designee, of the admission;
    d. the IMHU Unit Manager, or designee, shall document the IMHU admission in CORIS; and
    e. the Department Director of Classification, or designee, shall notify the Chief Administrative Officer, or designee, of the sending facility, if the resident is being transferred from another Department facility, the jail administrator, or designee, if the resident is being transferred from a jail, or the Superintendent, or designee, if the resident is being transferred from a state mental health institute.

12. In the case of an individual who has been referred to the IMHU pursuant to Title 34-A M.R.S.A. Section 3069-A, 3069-B, or 3069-C, if the individual is admitted to the IMHU, in addition to the above documentation, the paperwork provided by the Department of Health and Human Services (DHHS) shall be scanned into the resident's electronic health care record.

13. If the admission to the IMHU of a Department resident is not approved, the Regional Behavioral Health Director, or designee, shall notify the facility Behavioral Health Director, or designee, who shall document the referral and the decision in the resident's electronic health care record.

14. In the case of an individual who has been referred to the IMHU pursuant to Title 34-A M.R.S.A. Section 3069-A, 3069-B, or 3069-C, if the individual is not admitted to the IMHU, the paperwork provided by DHHS and the reason the individual was not admitted shall be maintained by the IMHU Admissions Coordinator, or other designated staff.

Procedure C: Orientation to and Conditions in the Intensive Mental Health Unit

1. Upon admission to the unit, the resident shall receive a health evaluation by a unit nurse and a mental health evaluation by a licensed clinician. If the clinician determines that the resident requires a constant watch, the resident shall be placed on the watch and on the lowest level in the IMHU.

2. Within twenty-four (24) hours of admission, the Unit Manager, or designee, shall ensure the resident receives an orientation to the IMHU and that the orientation is documented in CORIS. The orientation shall include written information regarding schedules and the privilege level system, as well as verbal explanations of this and other relevant information.

3. Posted on each cell door shall be the resident's photograph, MDOC number, status, any exceptions to the conditions below, any suicide and self-injury watch, and any other pertinent information.

4. Residents in the IMHU shall be provided basic living conditions that approximate those of general population residents. These conditions include cell capacity, lighting, heat and ventilation, water for drinking and washing, and operable toilets.

5. Residents in the unit shall receive the same meals as provided to general population residents. An exception may be made when a resident is throwing food or otherwise using food or a food service implement in a manner that is hazardous to self, staff, or other residents. Alternative meal service shall be on a case-by-case basis, based only on safety considerations, shall meet basic nutritional requirements, and shall only occur if an exception is made by the security staff, provided the staff obtains the approval of the Unit Manager or, if the Unit Manager is not on duty, the Shift Commander, and the Health Services Administrator, or designee, prior to or immediately after the exception. The Unit Manager or Shift Commander shall consult with the IMHU Behavioral Health Director, or designee.

6. In such a case, the resident may be given the same meal in a different form or a different meal of similar nutritional value. The approvals for a resident to receive alternative meal service shall also be recorded in the unit log. In addition to recording the information in the unit log, the staff person making the request shall complete an Incident Report in CORIS that is reviewed by the Unit Manager. The approval for alternative meal service shall be reviewed by the IMHU treatment team within three (3) working days. The restriction shall last only as long as necessary and shall not exceed seven (7) days.

7. Residents in the unit may be served meals with trays and utensils consistent with reasonable precautions designed to protect safety, security, and orderly management of the facility.

8. Residents in the unit shall be provided access to mail, phone calls, legal, religious and reading materials, basic items needed for personal hygiene, showers, out of cell time, clothing, linens and bedding, access to daily laundry services and barber and medical services similar to general population residents, except to the extent that they must be limited consistent with reasonable precautions designed to protect safety, security, and orderly management of the facility.

9. Residents in the unit shall have similar access to programs and services as general population residents including, but not limited to, the following: educational services, work opportunities, commissary, library services, social services, religious services and/or programs and guidance and recreational programs, except to the extent that they must be limited consistent with reasonable precautions designated to protect safety, security and orderly management of the facility.

10. A resident in the IMHU shall be subject to restraints and other security precautions during transports. A resident in the IMHU may be subject to restraints and other security precautions during out of unit movements and at other times in accordance with the resident's level and unit post orders.

11. A resident in the IMHU unit may be restrained using stationary restraints (restraints attached to the floor, a wall or an immovable object) provided the use of stationary restraints has been approved by the Commissioner, or designee, for the particular type of activity (e.g., while making a phone call, during group therapy, etc.) and provided the stationary restraints are used only under the conditions approved by the Commissioner, or designee, and only for the duration of the activity.

12. A resident in the IMHU shall receive privileges, including personal property items, as provided by the IMHU level system. ***5-ACI-6A-39***

13. Within one (1) week of admission, the IMHU treatment team shall meet with the resident to develop an individualized treatment plan, to include the provision of programs and services, and recommend the appropriate level for the resident. If applicable, the team shall also review and recommend additional security precautions for the resident (outside the presence of the resident). ***5-ACI-6A-38***

14. The IMHU treatment team shall meet with the resident at least monthly, or more frequently as determined necessary by the team based on the resident's acuity level, to review and, if appropriate, recommend changes to the individualized treatment plan and the resident's level, and, if applicable, recommend additional security precautions (outside the presence of the resident).

15. The Unit Manager, or designee, shall make determinations as to the resident's level and necessary security precautions, after considering the recommendations of the IMHU treatment team.

16. The resident may progress through the levels as determined by the Unit Manager, or designee, after considering the recommendation of the IMHU treatment team.

17. A resident may be returned to a lower level as determined by the Unit Manager, or designee, after considering the recommendation of the IMHU treatment team.

18. If a resident in the IMHU engages in behavior that would meet one or more of the criteria for administrative status, the resident may not be placed on that status, but the Unit Manager, or designee, may return the resident to a lower level pending the next meeting of the IMHU treatment team, which shall take place within one (1) week of the resident being returned to the lower level.

19. If a resident in the IMHU commits a disciplinary violation and if, pursuant to Department Policy (AF) 20.1, Resident Discipline, the resident receives a disposition of disciplinary segregation, that disposition shall be reduced by the Chief Administrative Officer, or designee, to a disposition of disciplinary restriction, unless the resident has since been discharged from the IMHU.

20. If a resident in the IMHU commits a disciplinary violation and if, pursuant to Department Policy (AF) 20.1, Resident Discipline, the resident receives a disposition of disciplinary restriction, the disciplinary restriction shall be served in the IMHU, unless the resident has since been discharged from the IMHU.

21. A resident in the IMHU shall be checked by security staff at variable intervals not to exceed fifteen (15) minutes, unless placed on a higher level of supervision in accordance with Department Policy (AF) 18.6.2, Suicide and Self-Injury Prevention Plan.

Procedure D: Involuntary Medication ***5-ACI-6C-08***

1. If a resident in this unit is unable or unwilling to consent to medication for serious mental illness that has been determined appropriate by a facility psychiatric treatment provider, and the psychiatric treatment provider determines the person poses a substantial risk of physical harm to self or others, or there is a reasonable certainty that the person will suffer severe physical or mental harm due to an inability to avoid risk or protect themself adequately from harm, the psychiatric treatment provider may request the Chief Administrative Officer, or designee, to apply to the court for an order for involuntary medication pursuant to Title 34-A M.R.S.A. Section 3049. The order may be requested on an emergency basis.

2. If the Chief Administrative Officer, or designee, agrees to apply for a court order, the psychiatric treatment provider shall ensure the completion of Attachments A.1 through A.4, as applicable, and provide the completed forms to the Department's representative in the Attorney General's Office for presentation to the court. A copy of the forms and of any resulting court order(s) shall be included in the resident's health care record.

3. If a court order is obtained, the medication shall be administered in accordance with Department Policy 18.6 (AF), Mental Health Services.

Procedure E: Intensive Mental Health Unit Discharge

1. A Department resident admitted to the IMHU may be discharged from the IMHU under either of the following circumstances:

a. the resident no longer needs the structured intensive mental health services of the IMHU; or

b. the resident's mental health needs exceed the level of treatment that can be provided on the IMHU, in which case the resident shall be referred for admission to a state mental health institute or for transfer to an out-of-state correctional facility with a higher level of treatment.

2. When appropriate, the IMHU treatment team shall make a recommendation regarding the discharge of the resident from the IMHU.

3. The Regional Behavioral Health Director, or designee, shall make the determination as to whether the resident will be discharged from the IMHU in consultation with the Deputy Commissioner, or designee.

4. The decision whether to discharge an individual who had been referred to the IMHU pursuant to Title 34-A M.R.S.A. Section 3069-A, 3069-B, or 3069-C shall be made by the Deputy Commissioner, or designee, in consultation with the Regional Behavioral Health Director, or designee, and may be based on any reason.

5. A person admitted to the IMHU shall be discharged from the IMHU when the person has been discharged from their term of imprisonment or otherwise discharged from the criminal justice system (in the case of a pre-trial detainee, the person has been placed on bail, charges have been resolved with no further imprisonment, or the person has been found not criminally responsible).

6. If the discharge is approved or required:

   a. the Regional Behavioral Health Director, or designee, shall notify the IMHU Behavioral Health Director, or designee, and the IMHU Unit Manager, or designee, who shall notify the IMHU Admissions Coordinator, or designee;

   b. the IMHU Behavioral Health Director, or designee, shall complete a discharge summary in the resident’s electronic health care record;

   c. the IMHU Admissions Coordinator, or other designated staff, shall document the discharge in the resident’s electronic health care record and shall notify the Department Director of Classification, or designee, of the discharge;

   d. the IMHU Unit Manager, or designee, shall document the IMHU discharge in CORIS; and

   e. the Department Director of Classification, or designee, shall notify the Chief Administrative Officer, or designee, of the receiving facility, if the resident is being transferred to another Department facility, the jail administrator, or designee, if the resident is being returned to a jail, or the Superintendent, or designee, if the resident is being admitted to a state mental health institute.

7. When it is anticipated that a resident in the IMHU will remain in the unit until release to the community, within nine (9) months of projected release to the community, the IMHU Behavioral Health Director, or designee, shall contact a discharge planner from the Department’s contracted mental health care provider and an Intensive Case Manager from the Department of Health and Human Services (DHHS) to develop a comprehensive release plan.

8. Prior to the resident's discharge from the IMHU, the IMHU Behavioral Health Director, or designee, shall contact the discharge planner and the Intensive Case Manager to coordinate the resident's release.

9. The facility Health Services Administrator (HSA), or designee, working with the IMHU Admissions Coordinator, or other designated staff, shall ensure the provision of discharge information, instructions on further treatment needs, and a supply of medication(s) in accordance with Department Policy (AF) 18.7, Pharmaceuticals directly to the resident upon release to the community, unless the provision of the medications is contraindicated as determined by the prescriber.

10. When it is anticipated that a resident in the IMHU will be returned to a jail, admitted to a state mental health institute, or transferred to an out-of-state correctional facility, the HSA, or designee, working with the IMHU Admissions Coordinator, or other designated staff, shall ensure the forwarding of the discharge summary, instructions on further treatment needs, and the medication administration record, and a supply of medication(s) in accordance with Department Policy (AF) 18.7, Pharmaceuticals to the receiving facility.

VIII. PROFESSIONAL STANDARDS

ACA

5-ACI-6A-37 **Offenders with severe mental illness or who are severely developmentally disabled receive a mental health evaluation and, where appropriate, are referred for placement in non-correctional facilities or in units specifically designated for handling this type of individual.**

5-ACI-6A-38 **A Mental Health Residential Treatment Unit is available for those inmates with impairment in behavioral functioning associated with a serious mental illness and/or impairment in cognitive functioning. The severity of the impairment does not require inpatient level of care, but the inmate demonstrates a historical and current inability to function adequately in the general population. There should be a specific mission/goal of the program, sufficient qualified staff to meet needs of program, screening process for the program, Individual Treatment Plans for inmates in the program, safe housing to meet the therapeutic needs of the inmate and transition plan upon discharge from the residential treatment unit.**

5-ACI-6A-39 **Inpatient Care Unit is for those who are in need of inpatient mental health treatment. These units should have 24-hour services such as nursing and availability of a QMHP, behavioral health trained correctional officers, and clinical programming. Individual Treatment Plans which will define the types and frequency of contacts with mental health staff for inmates in the program, housing to meet the therapeutic needs of the inmate and transition plan upon discharge from the inpatient care unit.**

5-ACI-6C-08 **(MANDATORY) The involuntary administration of psychotropic medication(s) to an offender is governed by applicable laws and regulations of the jurisdiction. When administered, the following conditions must be met:**

- **authorization is by a physician who specifies the duration of therapy**
- **less restrictive intervention options have been exercised without success as determined by the physician or psychiatrist**
- **details are specified about why, when, where, and how the medication is to be administered**
- **monitoring occurs for adverse reactions and side effects**
- **treatment plan goals are prepared for less restrictive or less invasive treatment alternatives with return to voluntary treatment, as soon as clinically feasible.**