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Department of Corrections and
Department of Health and Human Services

Joint Plan of Action

Submitted to the Commission to Improve Sentencing,
Supervision, and Management of Prisoners
Pursuant to
Maine Public Law, Chapter 711, Section A-23

December 8, 2004

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Executive Summary

Plan Required. The Department of Corrections (DOC) and the Department of Health and Human Services (DHHS) are required by Maine Public Law 2004, Chapter 711, Section A-23, to submit this joint plan of action to the Joint Standing Committee on Criminal Justice and Public Safety of the 122nd Maine Legislature. The plan addresses the needs of people with mental illness who are involved in the criminal justice system. The two departments worked closely with the many stakeholders—including the Maine Sheriff's Association, the Maine Association of Jail Administrators, and six ad hoc work groups—as they gathered ideas and developed recommendations for the plan.

Underpinnings. A look at relevant facts and studies nationally and from Maine reveals that addressing the needs of people with mental illness involved in the criminal justice system is challenging not only here in Maine, but also throughout the entire county. National and Maine perspectives and evidence-based approaches constitute the underpinnings of the plan.

Goals and Strategies. The plan's overarching goal is to prevent people with mental illness from repeatedly cycling in and out of the criminal justice system. Working toward the following principal goals will move the State of Maine closer to stopping this revolving door for people with mental illness:

Goal 1. Divert people with mental illness, when appropriate, from the criminal justice system in the first place.

Goal 2. Improve mental health services for people with mental illness who are involved in the criminal justice system.

Goal 3. Improve transition re-entry planning from prison or jail.

Goal 4. Foster mutual responsibility for meeting the needs of people with mental illness who are involved in the criminal justice system, while at the same time ensuring public and community safety.

Goal 5. Ensure that there are consistent, effective mental health services for the mutual clients of Riverview Psychiatric Center and DOC.

In carrying out these goals, DOC and DHHS will use the following strategies. Whenever possible, the departments will:

- Use evidence-based approaches and programs.
- Base decisions on today's fiscal realities, recognizing the need to consolidate and achieve efficiencies while improving services.
- Actively collaborate and work across jurisdictions, systems, and disciplines.
- Encourage family members, friends, and community-based organizations that are not providers to help address the needs of people with mental illness who are involved in the criminal justice system.
- Involve consumers and advocates in carrying out these goals.

Action Steps. The joint plan of action includes 11 multi-part action steps, summarized as follows:

Goal 1: Diversion

Action Step 1: Diversion. DOC and DHHS will support and encourage the counties to build on diversion mechanisms that currently are being used, as well as to develop additional mechanisms. The departments support both pre-booking and post-booking diversion mechanisms.

Goal 2. Mental Health Services

Action Step 2: Basic Services. DOC and DHHS will work with county jails to ensure that people with mental illness or co-occurring mental health and substance abuse disorders receive appropriate, basic behavioral health services.

Action Step 3: Addressing More Complex Needs. DHHS and DOC will establish a Forensic Treatment Team to plan for and find appropriate services for the relatively small group of high-risk, high profile people with mental illness who have particularly complex needs. The Team will have the capacity to mobilize very quickly to resolve crisis situations that occur either in the community or in jail. The departments also will work with a few of the county jails to create specialized jail space and staffing tailored to address the specific complex needs of this group of people.

Action Step 4: Purchasing Medications and Services. DHHS and DOC will work with the jails to encourage collective purchases of medications, psychiatric services, and medical services.

Action Step 5: Community Hospitals. DHHS and DOC will work with community hospitals to address their concerns relating to emergency services, inpatient psychiatric care, and general medical care for people with mental illness who are involved in the criminal justice system.

Goal 3: Transition Re-Entry Planning

Action Step 6. Re-Entry Planning. DOC and DHHS will encourage and support DOC correctional facilities and county jails to begin re-entry planning as soon as possible after a person is booked. The departments will continue to support existing local collaborative planning efforts that focus on county jail inmates with mental illness or co-occurring disorders, and will recommend similar efforts in counties where this is not yet happening.

Goal 4: Mutual Responsibility

Action Step 7: Memorandum of Understanding. DOC and DHHS will enter into a memorandum of understanding spelling out how they will collaborate on the implementation of the action steps in the joint plan of action.

Action Step 8: Joint Standards and Protocols. DHHS and DOC will develop and implement joint standards and protocols to guide planning for and treatment of people with mental illness who are involved in the criminal justice system. In implementing this action step, the departments will make sure that state level standards and protocols are flexible enough to allow for local strategies that are responsive to local issues.

Action Step 9: Training. DOC and DHHS will collaborate with the Maine Criminal Justice Academy and NAMI-Maine to develop and deliver a *curriculum* to help professionals better meet the needs of people with mental illness in the criminal justice system. Whenever possible and practicable, the departments will share training resources and will use videoconferencing for training and consultation activities.

Action Step 10: Measuring Effectiveness. DOC and DHHS will design and implement an evaluation process to measure the effectiveness of interventions specified in these action steps.

Goal 5: Mutual Clients of Riverview Psychiatric Center (RPC) and DOC

Action Step 11: RPC and DOC. RPC and DOC will enter into a memorandum of agreement describing a number of steps that will ensure that there are consistent, effective mental health services for their mutual clients.

Next Steps. The next steps by DOC and DHHS will be to develop an implementation timeline, analyze the cost of implementing the action steps, present a resource reallocation plan for implementing the action steps, and finalize a memorandum of understanding to guide the implementation of the action steps.

I. Introduction

A. Joint Plan of Action

The 121st Maine Legislature passed "An Act to Further Implement the Recommendations of the Commission to Improve the Sentencing, Supervision, Management and Incarceration of Prisoners," which the Governor signed into law on May 12, 2004. One section of this law included as *Attachment A* (Maine Public Law, Chapter 711, Section A-23) required the Department of Corrections and the Department of Health and Human Services to:

- Develop a joint plan of action "to address mental illness in the criminal justice community";
- Invite the Maine Sheriffs' Association to participate;
- Deliver the plan to the Joint Commission to Improve the Sentencing, Supervision, Management, and Incarceration of Prisoners; and
- Present the plan by no later than January 1, 2005 to the Legislature's Joint Standing Committee on Criminal Justice and Public Safety.

B. Purpose of Report; Definitions

The purpose of this report is to present the joint plan of action. The two departments look forward to discussing it with both the Joint Commission to Improve the Sentencing, Supervision, Management, and Incarceration of Prisoners and the Maine Legislature. As used in this report, the following terms have the following meanings:

APIC (assessment, planning, identifying, and coordinating) is considered by the federal Substance Abuse and Mental Health Services Administration to be a best practice approach to community re-entry from jails for inmates with co-occurring mental health and substance abuse disorders.

An Axis I disorder means a chemical disorder, such as schizophrenia, depression, or bipolar disorder.

An Axis II disorder means a personality disorder. For the purposes of this document, mental retardation is not included.

Boundary spanners, described in the Subcommittee on Criminal Justice of the President's New Freedom Commission on Mental Health, are people who are adept at operating across systems and have credibility within multiple systems.

CIT means Crisis Intervention Team.

A person with co-occurring disorders has mental health and substance abuse disorders at the same time.

DHHS means the Maine Department of Health and Human Services.

DOC means the Maine Department of Corrections.

MOU means a memorandum of understanding.

SAMHSA means the federal Substance Abuse and Mental Health Services Administration.

C. Sources of Information

The joint plan of action is based on information gathered from a number of sources. First, state level discussions identified a number of opportunities for collaboration between DOC and DHHS. These are described in *Attachment B.*

Second, the two departments have gathered and reviewed the information from both the state and national levels, describing the scope and the substance of issues relating to people with mental illness in the criminal justice system, as well as evidence-based programs and approaches that might offer solutions to the challenges here in Maine.

Third, DHHS and DOC, assisted by the Maine Sheriffs' Association and the Maine Association of Jail Administrators, identified 6 priority issues relating to people with mental illness in Maine's county jails— diversion, discharge planning, hospitalization, medications, behavioral management vs. mental illness, and community provider issues. *Attachment C* lists the members of the 6 work groups created to address these issues. More than 40 people participated in work group meetings during September and October 2004. The recommendations offered by the work groups are included in *Attachment D.*

D. Organization of Report

Section I of the report is this introduction. Section II provides a context for Maine's joint plan of action. A look at relevant facts and studies nationally and from Maine reveals that addressing the needs of people with mental illness involved in the criminal justice system is challenging not only here in Maine, but also throughout the entire county. Section III examines national and Maine perspectives and evidence-based practices, which constitute the underpinnings of the joint plan of action. Section IV describes people with mental illness and presents the major components of the joint plan of action, including goals and strategies, action steps, and next steps.

II. Context for Joint Plan of Action

A. Relevant National Facts

Addressing the needs of the large number of people with mental illness involved in the criminal justice system is not only an issue here in Maine. It is a challenge everywhere in the nation.

President George W. Bush launched the New Freedom Commission on Mental Health to address problems in the current mental health service delivery system that allow people to fall through they system's cracks.[1] With regard to people with mental illness involved in the criminal justice system, the Commission found the following:

- The rate of serious mental illness for people who are in prison or jail is about three to four times that of the general U.S. population. About 7% of all incarcerated people have a current serious mental illness. The proportion of people in prison or jail with a less serious form of mental illness is substantially higher.[2]
- People with serious mental illness who come in contact with the criminal justice system are often poor, uninsured, disproportionately members of minority groups, homeless, and living with co-occurring substance abuse and mental health disorders. They are likely to continually recycle through the mental health, substance abuse, and criminal justice systems.[3]
- When people with mental illness are put in prison or jail, they often do not receive appropriate mental health services. Many lose their eligibility for income supports and health insurance benefits that they need to re-enter and re-integrate into the community after they leave prison or jail.[4]

The New Freedom Commission on Mental Health appointed several subcommittees to explore various facets of the Nation's mental health service delivery system. The Subcommittee on Criminal Justice reported the following:

- On a given day, there are approximately 93,000 people with serious mental illnesses in U.S. prisons, 44,000 in U.S. jails, and 320,000 under corrections supervision in the community. Only around 40,000 patients are in state mental hospitals throughout the country on a given day.[5]
- Using a broader definition of serious mental illness than used for the 7% estimate, the Federal Bureau of Justice Statistics found a 16% prevalence rate of mental illness among correctional detainees.[6]
- Best estimates indicate that 75% of all people with serious mental illness in the criminal justice system have a co-occurring substance abuse disorder.[7]
- Most people with mental illness who are arrested are charged with crimes of public nuisance, petty larceny, drug possession, and/or assault without battery (e.g. pushing or shoving a police officer during apprehension.)[8]

The mental health system and the police have had a long history of interaction,[9] and there has been an enormous influx of persons with mental illness into the criminal justice system since the early 1990s.[10] The National Institute of Corrections cites several factors, which likely have contributed to this surge:

- The closing or downsizing of state psychiatric hospitals;[11]
- The lack of an adequate range of community support programs and chronic under-funding of public services;
- Restrictive insurance and managed care policies that curtail access to more

intensive services;

- Poverty and transient lifestyles of many people with serious mental illness, which brings them in contact with the police; and
- The likelihood that adults with serious mental illness have a co-occurring disorder.

The courts have made it clear that correctional facilities are legally and constitutionally required to provide adequate mental health services for inmates in their custody.[12] However, as the National Institute of Corrections points out, correctional facilities have not had the physical facilities, staff, training, or clinical resources needed to address the needs of inmates with serious mental illness.[13]

Five years ago, the Council of State Governments launched the nationwide Criminal Justice/Mental Health Consensus Project to figure out how to address the challenges of addressing the needs of persons with mental illness in the criminal justice system. In June 2002, the Consensus Project released a comprehensive report, based on information generated by meetings of 100 criminal justice and mental health policymakers and practitioners from across the U.S.; surveys of state and local government officials in 50 states; interviews with administrators of innovative programs; and materials describing research, promising programs, policies, and legislation. The Consensus Project Report included 47 policy statements and described 4 recurring themes—improving collaboration, training staff, measuring and evaluating outcomes, and building an effective mental health system.[14]

B. Relevant Maine Facts

In its January 2004 report, the Maine Commission to Improve the Sentencing, Supervision, Management and Incarceration of Prisoners found the following:[15]

- While Maine's the crime rate declined between 1995 and 2002, its incarceration rate rose dramatically.
- The shortage of treatment options for people with mental illness is one of six factors responsible for overcrowding in Maine's prisons and jails.

Also in January 2004, the Maine Civil Liberties Union issued a report on its survey of inmates incarcerated in the DOC system to determine their views of their own health status and services received. Of the 1,240 inmates who responded, close to 60% reported that they have substance abuse problems and 38.5% described themselves as having mental illness and/or emotional problems, including depression.[16]

In September 2002, NAMI-Maine, the Maine Sheriff's Association, and the Maine County Commissioner's Association issued a report stating that between 1998 and 2002, 4 inmates at the Maine State Prison committed suicide, 10 county jail inmates committed suicide, and several others survived serious suicide attempts.[17]

In December 2001, the Legislature's Joint Standing Committee on Criminal Justice and Public Safety issued a report about the needs of persons with mental illness who are incarcerated. The Committee's findings included the following:[18]

- 25% of Maine inmates are reported to be in mental health therapy or counseling programs.
- There is a high incidence of persons with co-occurring mental health and substance abuse disorders involved in the criminal justice system.
- A person with mental illness who does not receive adequate treatment while incarcerated may leave jail in worse condition than when he or she arrived.
- County jails have inadequate resources to meet the needs of persons with mental illness.
- County jails need a more standardized process to assess the needs of people with mental illness, greater treatment capacity, better crisis response mechanisms and resources, and improved discharge planning and aftercare.
- The lack of community mental health resources makes it difficult to divert people with mental illness away from jails and into more appropriate treatment settings.

C. Studies of Maine's County Jails

Over the past few years, there have been at least 3 studies of people with mental illness in Maine's jails, the most recent of which was conducted by the former Department of Behavioral and Developmental Services (now DHHS). In its June 2004 report on the results of this study, DHHS organized the findings into five core areas:

- *Screening and Evaluation.* Every Maine jail screens and evaluates inmates. Some use a standard tool from DOC, while others use tools they have developed. It is not clear whether the screens at all jails address the issues of suicide potential, mental health history, and current medications. When screening indicates that there are mental health issues, the timeliness of referral varies depending on the availability of community resources.
- *Crisis Intervention and Short-Term Treatment.* Every Maine jail has formal or informal arrangements to provide crisis services. Immediate crisis services are available to jails, but the timeliness of follow-up for consultation and medication reviews is not assured. One of the more limited service areas is 24-hour availability of psychiatrists. There are statewide contracted services to draw upon, but there is variation in their use by jails and in their relationship and availability to jails.
- *Discharge Planning.* Every Maine jail may refer inmates with mental illness to a DHHS Intensive Case Manager (ICM) for discharge planning. The ICMs and jails agree that this relationship works well. In some jails, other agencies also are involved (e.g. some community support agencies follow

clients who land in jail). Jails need more assistance with case management and discharge planning. The current approach is built largely on relationships and history, rather than on protocols of who is responsible for what.

- *Court Liaison.* The law requires DHHS to designate individuals throughout Maine to act as a liaison to the District Court, Superior Court, and DOC. Sometimes the ICM plays this role. There is not consensus among Maine jails about who the liaison should be and what the duties should be. There are few referrals from the courts or DOC for this service.
- *Diversion.* Diversion programs—such as Volunteers of America, Maine Pre-Trial, and the Ride Along Program—are highly regarded by Maine jails. However, such programs do not exist throughout the State. There is an interest in increasing diversion programs and in wider use of crisis services to divert people with mental illness from the jails.

In its study, DHHS also identified a number of other issues of significant interest and concern:

- *Training.* Maine jails find NAMI-Maine's Crisis Intervention Team (CIT) program and training at the Maine Criminal Justice Academy to be helpful in preparing officers to help people with mental illness. While there is a range of opinions among jails about what the content of training should be, updates on basic mental illness and how to manage behaviors are frequently mentioned. NAMI-Maine delivers a 12-hour mental health curriculum in the jails that has been approved by the Criminal Justice Academy.
- *Medication.* Maine jails have contracts with providers who may prescribe and administer medication. DHHS is concerned about a number of medication management issues (e.g. inmates taken off medications, changing medications, delays in receiving medications both as inmates and when released to the community, and lack of timely psychiatric consultation). Jails report success in routine medication management, but experience delays in new prescriptions for and administration of psychotropic drugs.
- *Hospitalization.* Maine jails actively seek further assessment and treatment for inmates who need care beyond the jail. They express frustration about the time it takes to transport an inmate, wait with an inmate in the hospital emergency room, and make referrals for inpatient care. When seeking alternative placements, the needs and expectations of jails are not always congruent with the determination of psychiatric programs. Jails feel that the local and state hospitals are often unresponsive, while the hospitals may have inadequate resources to manage a person safely or may believe that the admission criteria have not been met.
- *Blue Paper Process.* The blue paper process is used differently in different parts of Maine. The timing of the involuntary commitment process sometimes is determined by bed availability rather than by medical necessity. Maine jails have questions about who is responsible for completing various parts of the form and about what constitutes harm to self or others.

In November 2002, the Maine Disability Rights Center visited 11 county jails. During the 8 months prior to these visits there had been 6 reported suicides at 4 jails. The Center found that the treatment of suicidal inmates (i.e. strip down and isolation cell) means that inmates often do not tell jail staff about their suicidal thoughts.

Also in 2002, NAMI-Maine conducted a survey of Maine county jails. For the 7 jails responding to the survey, NAMI-Maine found the following:[19]

- When asked the "average % of inmates taking medications for M.H. issues", the responses by all jails ranged from 11% to 75% of inmates and the average per jail was 35%.
- When asked the "# of times in past year sought involuntary hospitalization for inmate" and the "# of times able to secure hospital bed", 6 of the 7 jails said they had sought involuntary hospitalization, of which—
  - ⇒ 2 jails secured a hospital bed all or most of the times they sought one (20 out of 20 for one jail and 7 out of 8 for the other).
  - ⇒ 2 jails secured a hospital bed half of the times they sought one (10 out of 20 for one jail and 12 out of 24 for the other).
  - ⇒ 2 jails had less success in securing a hospital bed (1 time out of 10 tries for one jail and 4 times out of 24 for the other jail).
  - ⇒ Overall, the 6 jails secured a hospital bed 50% of the time.

III. Underpinnings of Joint Plan of Action

A. National Perspectives and Evidence-Based Approaches

The Subcommittee on Criminal Justice of the New Freedom Commission on Mental Health described three major responses needed to address the needs of people with mental illness who are involved in the criminal justice system—diversion programs, institutional services, and re-entry transition programs.[20] DHHS and DOC will draw from these evidence-based approaches and programs in the implementation of their joint plan of action.

The Subcommittee identified two types of diversion programs for people with serious mental illness: *pre-booking* (before any criminal charges are filed) and *post-booking* (after charges are filed). Post-booking diversion includes court-based programs and jail-based programs. A 9-site study by the federal Substance Abuse and Mental Health Services Administration indicated that all of these diversion programs work equally well, depending on other community characteristics.

Diversion programs accomplish three things: *find* the people to be diverted, *arrange* an appropriate multi-system service plan, and *negotiate* an arrangement between the prosecutor, defense counsel, and judge for diversion services in lieu of incarceration. Those who are best able to accomplish these tasks are *boundary spanners*—people who are adept at operating across

systems and have credibility with multiple systems. Mounting a successful diversion program requires the following key components:

- *Coordinating* a comprehensive set of services at the community level—including integrated mental health care and substance abuse treatment, physical health, and social services—with a high level of cooperation among all involved agencies.
- *Liaisons*—to bridge barriers between the mental health and criminal justice systems and to manage interactions among corrections, mental health, and judicial staff—who have the trust and recognition of key players from each of the systems.
- *A strong leader* with good communication skills, who understands the systems involved and the informal networks needed to put the necessary pieces in place.
- *Early identification* of detainees with mental health needs who meet the diversion program's criteria. This is done through initial screening and evaluation that takes place in a crisis triage center, an arraignment court, or at the jail.
- *Case managers*, who have experience in both the mental health and criminal justice systems and who are culturally and racially similar to the clients they serve. This is one of the most important components of successful diversion.

With regard to institutional services, the Subcommittee on Criminal Justice pointed out that people with mental illness who are appropriately incarcerated have a constitutional right to "a modicum of treatment" for acute medical problems, including psychiatric problems. As described in *Table 1*, a 1980 court case (*Ruiz v. Estelle*) listed six criteria for constitutionally acceptable mental health services in jails and prisons, while a 1995 court case (*Madrid v. Gomez*) identified six additional criteria.

As described in *Table 2*, the Subcommittee on Criminal Justice organized correctional mental health care into three categories—*identification*, *treatment*, and *linkage* (including discharge planning). These categories are consistent with guidelines developed by a task force of the American Psychiatric Association and standards published by the National Commission on Correctional Health Care.

Short stays and the frequently unpredictable nature of discharges make transition planning from jails particularly challenging. The Subcommittee on Criminal Justice described the evidence-based APIC model (Assess, Plan, Identify, and Coordinate) for transition re-entry planning for both jails and prisons. This is summarized in *Table 3*.

Table 1
Constitutionally Acceptable Services in Jails and Prisons

Criteria Identified in *Ruiz v. Estelle*	**Criteria Identified in *Madrid v. Gome***
1. Systematic screening and evaluation.	1. A means for inmates to make their needs kno to medical staff.
2. Treatment that is more than seclusion or close supervision.	2. Staffing sufficient to allow individualized treatment.
3. Participation by trained mental health professionals.	3. Speedy access to services for inmates.
4. Accurate, complete, and confidential records.	4. A system of quality assurance.
5. Safeguards relating to the use of psychotropic medications.	5. Competent and well-trained staff.
6. A suicide prevention program.	6. A system to respond to emergencies and prevent suicides.

Table 2
Guidelines for Mental Health Services in Jails

Category of Services	**Types of Services**
Identification: • Screening • Referral • Evaluation	1. Mental health screening and determination of safety issues or custodial requirements should occur upon arrival at jail, including observation, identification of symptoms, and review/writing of treatment and medication records. 2. Screening should include standardized questions, written policies and procedures, and required actions with timeframes for those identified with mental illness. 3. A brief mental health assessment should be conducted within 72 hours for those identified with mental illness or immediately in the case of an emergency. Any further comprehensive diagnostic mental health exams should be conducted within 14 days of arrival and should include access to psychological services. 4. Mental health emergency services should be available on a 24-hour basis, and a psychiatrist should be on staff for diagnostic exams and medication prescriptions. 5. All health care and custodial staff should receive ongoing training in use of the referral process. 6. All inmates should receive an early explanation of the referral process.
Treatment	1. Because jail stays tend to be short, treatment should emphasize crisis intervention with medications and brief or supportive therapies and consumer education. 2. Jail-based mental health services should include: inpatient resources in the jail or in external hospital settings; 24-hour mental health and nursing coverage (including a staff psychiatrist); written treatment plans; medications and medical personnel; special observation capabilities; out-of-cell programs; and custodial staff trained in the recognition of mental disorders.
Linkage	All treatment services, including crisis intervention responses, should be related to the transition back to the community through discharge planning.

Table 3
APIC Model of Transition Re-Entry Planning

Components	Description
Assessment involves...	1. Cataloging inmate's psychosocial, medical, and behavioral needs/ strengths. 2. Gathering information from law enforcement, court, corrections, correctional health, and community providers to create fully informed transition plan. 3. Incorporating cultural formulation in transition plan to ensure culturally sensitive response. 4. Engaging inmate in assessing his/her own needs and ensuring that he/ she has access to and means to pay for services in community.
Planning involves...	1. Learning from inmate what has and has not worked during past transitions and seeking family input when relevant. 2. Addressing inmate's housing needs and arranging for benefits (e.g. MaineCare, SSI/SSDI, Veterans, food stamps, and TANF) for which inmate is eligible, while he/she is still incarcerated. 3. Involving criminal justice, mental health, and substance abuse systems in integrated treatment approach that focuses on critical period immediately following release and on long term needs, by ensuring that inmate: o Is on optimal medication regimen and has sufficient medication to last at least until follow-up appointment. o Has adequate clothing and resources needed to obtain adequate nutrition. o Has transportation from jail to his/her place of residence and from residence to appointments. o Has child care arrangements that allow appointments to be kept.
Identifying involves...	1. Naming in transition plan specific community referrals, based on underlying clinical diagnosis, cultural and demographic factors, financial arrangements, geographic location, and legal circumstances. 2. Providing provider—prior to release—with complete discharge summary, e.g. diagnosis, medications/dosages, legal status, and transition plan. 3. Ensuring that every person released from jail has photo ID, supporting conditions of release, and community corrections supervision that matches severity of his/her criminal behavior. Goal is to make sure that treatment and supportive services match person's level of disability, motivation for change, and availability of community resources. 4. Clarifying issues of confidentiality and information sharing. 5. Documenting transition plan in charts of both jail mental health service agency and the community provider.
Coordinating involves...	1. Confirming that person released from jail knows where, when, and with whom first follow up visit is scheduled and that person has adequate medication to last at least until that visit. 2. Explicitly communicating—to person being released, family, releasing jail, and community—responsibility for care of that person between time of release and first follow-up appointment. 3. Making sure person knows whom to call if it is necessary to change follow-up appointment. 4. Having mechanism in place to track people who do not keep first follow-up appointment.

B. Maine Perspectives and Ideas

During the summer of 2004, there were state-level discussions about areas of collaboration that would result in a more systematic and coordinated approach to providing mental health services to the mutual clients of DHHS and DOC. The receiver appointed by the court under the AMHI consent decree to operate Riverview Psychiatric Center (RPC) participated in these discussions. As described in *Attachment B*, opportunities for collaboration were identified in the areas of staff training; sharing clinical information between DOC facilities, county jails, and RPC; transition planning and services for mutual clients as they move from one facility to another and as they prepare to re-enter the community; and linking to community mental health services.

Also during the summer of 2004, DHHS and DOC, assisted by the Maine Sheriffs' Association, identified 6 priority issues relating to people with mental illness in Maine's county jails—diversion, discharge planning, hospitalization, medications, behavioral management vs. mental illness, and community provider issues. Six work groups met to address these issues during September and October 2004. DOC and DHHS gave the following instructions to the work groups:

- Examine the issue and recommend solutions for inclusion in the joint plan of action.
- Keep in mind the financial constraints facing the State.
- Take a realistic approach in moving toward improved system of care for persons with mental illness in Maine's prisons and jails.
- Build from what is currently going on that is positive.
- Be mindful of best practice models.

Table 4
Summary of Key Recommendations by 6 Work Groups

Recommendations relating to—	Number of Groups That Mentioned Recommendation	Number of Times Recommendation Was Mentioned
1. Standards/Protocols	6	9
2. Training	5	6
3. Facilities	5	5
4. Services for Inmates	4	10
5. Collaborative Process	4	7
6. Diversion	3	6
7. Liaisons in Jails	3	4
8. Community Hospitals	3	3
9. Finance/Administration	2	4
10. Measuring Effectiveness	2	3

Attachment C lists the members of the 6 work groups and *Attachment D* includes the recommendations of each work group. *Attachment E* is an analysis of the collective recommendations of the 6 work groups and *Table 4* is a summary of this analysis.

IV. Major Components of Joint Plan of Action

A. Who Are People with Mental Illness?

There is not a single population of people with mental illness who are the target of the joint plan of action. There are multiple target populations depending on the type of recommendation being made. For example, the target population of people who are most likely candidates for pre-booking diversion is very different than the target population of people who are incarcerated and most likely to need hospitalization. However, one thing is consistent across all of the target populations: many of the people have co-occurring mental health and substance abuse disorders.

Four of the 6 mental health/criminal justice work groups discussed and arrived at a description of the particular types of people with mental illness who present challenges and need services when they are arrested or incarcerated. Each was looking at the target population from a different perspective. For example, the Diversion Work Group discussed who should and should not be diverted; the Hospitalization Work Group defined who is appropriate for psychiatric hospitalization; the Behavioral Management vs. Mental Illness Work Group identified four categories of people based on their behavior and potential causes of their behavior; and the Community Provider Issues Work Group determined that the primary groups in the criminal justice system who need mental health services are people with persistent and serious mental illness and people with co-occurring mental health and substance abuse disorders.

DHHS and DOC agree with the following recommendations by the Diversion Work Group about who should and who should not be diverted:

- Diversion programs should focus on people whose crime or alleged crime is a result of their mental illness—not on those who have mental illness, but whose crime or alleged crime is not a result of their mental illness. Many who can benefit from diversion programs have co-occurring mental health and substance abuse addiction disorders.
- The ideal candidates for diversion are people with mental illness who have been accused or convicted of low-level or low-risk crimes or offenses that would be described as a public nuisance.
- A small number of people with mental illness have been accused or convicted of a crime that is violent (e.g. cases involving domestic violence). Extra care and consideration should be given when diverting them into the community, and diversion should be proposed only when the safety of the community can be reasonably assured. People accused of sexual assault should not be diverted.

The Hospitalization Work Group recommended that there should be a clear definition of those in the criminal justice system who are appropriate for referral to state and community psychiatric hospitals. DOC and DHHS agree with the following two groups identified as candidates for psychiatric hospitalization:

- People with major mental illness who are currently unstable in terms of potential injury to self or others may be candidates for somewhat longer-term hospitalization and stabilization through pharmacological intervention.
- People with an Axis II diagnosis who are extremely injurious or abusive to themselves or others may be appropriate for multiple shorter-term psychiatric admissions.

The Behavioral Management vs. Mental Illness Work Group categorized the population of people with mental illness in the criminal justice system, based on their behavior and potential causes of their behavior. DOC and DHHS agree with the 4 categories of people described by the work group:

1. *Axis I disorder/major mental illness*: People in this category are best served, when necessary, in a state psychiatric hospital where they can receive appropriate therapy and medications.
2. *Axis II disorder/personality disorders*: People in this category are the most challenging to the mental health and criminal justice systems. Included are people who have injured themselves or others repeatedly over many years. Their behavior is most likely connected to a significant history of trauma, psychosocial unrest, and mental illness. At any time, people in this category may meet criteria for hospitalization, but may not have an Axis I diagnosis.
3. *Acute stress reaction or mental health emergency*: While people in this category present a challenge in terms of resources and intervention, their needs can be addressed while they are in jail, provided that clinical consultation and crisis services are readily available.
4. *Disruptive behavior due to criminal manipulation*: People in this category seem to be managed best within DOC correctional facilities or the county jails.

The Community Provider Issues Work Group agreed that jail inmates who need mental health services are generally those who have a persistent and serious mental illness or who have a co-occurring mental health and substance abuse disorder. They determined that in assessing the need for services, a person's diagnosis and behavior, as well as functional status, should be considered. They cautioned against the tendency to dismiss a person's behavior when s/he is intoxicated, especially since intoxication increases the risk of suicidal behavior. DOC and DHHS agree with the points made by this work group.

B. Goals and Strategies

The overarching goal of the joint plan of action is to prevent people with mental illness from repeatedly and inappropriately cycling in and out of the criminal justice system. Working toward the following principal goals will move the State

of Maine closer to stopping the revolving door for people with mental illness:

Goal 1: Divert people with mental illness, when appropriate, from the criminal justice system in the first place.

Goal 2: Improve mental health services for people with mental illness who are involved in the criminal justice system.

Goal 3: Improve transition re-entry planning from prison or jail for people with mental illness.

Goal 4: Ensure that there are consistent, effective mental health services for the mutual clients of Riverview Psychiatric Center and DOC.

Goal 5: Foster mutual responsibility for meeting the needs of people with mental illness who are involved in the criminal justice system, while at the same time ensuring public and community safety.

In carrying out these goals, DOC and DHHS will use the following strategies, whenever appropriate and possible:

- Use evidence-based approaches and programs.
- Base decisions on today's fiscal realities, recognizing the need to consolidate and achieve efficiencies while improving services.
- Actively collaborate and work across jurisdictions, systems, and disciplines.
- Encourage family members, friends, and community-based organizations that are not providers to help address the needs of people with mental illness who are involved in the criminal justice system.
- Involve consumers and advocates in carrying out these goals.

C. Major Action Steps

Goal 1: Diversion

Divert people with mental illness, when appropriate, from the criminal justice system in the first place.

There is widespread national, state, and local support for diversion efforts. The President's New Freedom Commission recommended "widely adopting adult criminal justice and juvenile justice diversion...strategies to avoid unnecessary criminalization and extended incarceration of non-violent adults and juvenile offenders with mental illness."[21]

Action Step 1: DOC and DHHS will support and encourage the counties to build on diversion mechanisms that are currently being used, as well as to develop additional mechanisms. In performing the following tasks, the departments will consult with key stakeholders with an interest in diversion:

- Develop *statewide standards* to ensure that there are similar opportunities to participate in diversion programs throughout the State. Establish a short-term task force (including representatives of the District Attorneys, judges,

jails, DHHS, and local community support and crisis system providers) to develop standards.

- Use the upcoming DHHS assessment of the crisis services system to analyze whether and how crisis programs might provide *diversion screening* for inmates (especially pre-booking).
- Arrange for a team to visit each county to perform an *assessment* of available services and diversion possibilities, to offer recommendations, and—if needed and requested—to provide *technical assistance* about how to implement particular recommendations.
- Continue to support efforts relating to *court diversion.*
- Develop strategies for getting *bail to include requirements* for participation in behavioral health programs.
- Develop strategies for getting more *information for judges* about sentencing options and alternatives.
- Introduce *legislation* to amend Title 34-A, Section 1210-A of the Maine Revised Statutes to require counties to spend 50% of community corrections funding for diversion. See *Attachment F* for the existing law.

Goal 2: Mental Health Services

Improve mental health services for people with mental illness who are involved in the criminal justice system.

"Courts have interpreted the Eighth Amendment of the U.S. Constitution, which protects against cruel and unusual punishment, as requiring a modicum of treatment for acute medical problems—including psychiatric problems for jail and prison inmates."[22] The State of Maine cannot afford to provide comprehensive mental health services for inmates with mental illness in every single county jail, but it will make sure that basic services are available in every jail. The State also will develop regional mechanisms to provide necessary services for those who have more complex needs.

Action Step 2: Basic Services. DOC and DHHS will work with county jails to ensure that people with mental illness or co-occurring mental health and substance abuse disorders receive appropriate, basic behavioral health services, as follows:

- At the time of intake and booking, jail staff will use a *standardized screening tool* to identify possible mental illness or co-occurring mental health and substance abuse disorder.
- Inmates identified as having a possible mental illness or co-occurring disorder will receive *clinical evaluation and medication management services,* based on medical necessity criteria. Crisis management services will be available, as needed.
- Whenever possible, someone (preferably a nurse) will be designated as the *point person* to receive and provide information about medications.

- Whenever possible, *telemedicine* will be used.

Action Step 3: Addressing More Complex Needs. The county jails are currently not able to effectively address the needs of a relatively small number of high-risk, high profile people with mental illness who have an Axis II diagnosis. To help address their more complex needs, DOC and DHHS will take two actions:

- First, the departments will establish a *Forensic Treatment Team* comprised of behavioral health clinicians and correctional experts. The Team will address the more complex needs of the people in this group on an ongoing basis, whether they are in the community or in jail. The Team will have the capacity to mobilize very quickly in order to resolve crisis situations that occur either in the community or in jail.
- Second, the departments will work with a few county jails to create *specialized jail space and staffing* tailored to address the specific complex needs of this group of people.

Action Step 4: Purchasing Medications and Services. DHHS and DOC will work with the jails to encourage efficient purchases of medications and services. In particular, the departments will:

- Organize *bundle prescription purchasing* by jails, DOC, and the state psychiatric hospitals.
- Work with the jails to put out *collective bids for medical and psychiatric services.*

Action Step 5: Community Hospitals. DHHS and DOC will address issues of concern to community hospitals relating to emergency services, inpatient psychiatric care, and general medical care for people with mental illness who are involved in the criminal justice system. The departments will meet and consult with the Maine Hospital Association, the Maine Medical Association, and the Hospital and Crisis Services Initiative Group as they take the following steps:

- Develop strategies to address concerns about *medical clearance* in the emergency room.
- Develop strategies for *diverting inmates from the emergency room* when there are more appropriate solutions to crisis situations.
- Resolve *liability and security* concerns of community hospitals.
- Address the *availability of community hospital services* for inmates.

Goal 3: Transition Re-Entry Planning

Improve transition re-entry planning from jail or prison for people with mental illness.

"Inadequate transition planning puts people with mental illnesses who entered jail in a state of crisis back out on the streets in the midst of that same crisis. Good transition planning for...inmates with mental illnesses and co-occurring substance abuse disorders requires coordination of responsibility among jails, jail-based...treatment providers, and community-based treatment providers."[23]

Action Step 6: Re-Entry Planning. DOC and DHHS are committed to early and collaborative re-entry planning for inmates.

- DOC correctional facilities and county jails will:
  - ⇒ Begin *re-entry planning as soon as possible* after a person is booked.
  - ⇒ Follow the *APIC model*, described in *Table 3*, including making sure that inmates will be connected to and receive needed benefits and community services, including substance abuse treatment, in a timely manner.
- The departments will continue to support existing local collaborative planning efforts that focus on county jail inmates with mental illness or co-occurring disorders, and will facilitate similar efforts in counties where this is not yet happening. Local planning efforts will include:
  - ⇒ *Local Memoranda of Understanding* where they do not yet exist.
  - ⇒ *Local teams* including representatives of DHHS (mental health team leader and intensive case manager), the county jail, community mental health services providers, and others who have an impact on these inmates (e.g. representatives of the sheriff's office, local police, the District Attorney's Office, judges, probation and parole.)
  - ⇒ A *designated boundary spanner* to serve as the key "go to" person or liaison between the court, the District Attorney's Office, the jail, and community providers on behalf of inmates with mental illness or co-occurring disorders.
- The departments will create a short-term task force—comprised of DHHS mental health team leaders, DOC probation officers, jail staff, and representatives of community providers—to develop a *single re-entry planning document* that specifies who is responsible for re-entry planning before inmates are discharged and who is responsible for follow up after they have been discharged.

Goal 4: Mutual Responsibility

Foster mutual responsibility for meeting the needs of people with mental illness who are involved in the criminal justice system, while at the same time ensuring public and community safety.

"We have designed systems that make sense to bureaucrats, funders, agency administrators and service providers. We have not created systems that make sense from the perspective of people with multiple problems who need or are seeking our help."[24]

Action Step 7: Memorandum of Understanding. DOC and DHHS will enter into a memorandum of understanding (MOU) spelling out how they will collaborate on the implementation of the action steps in the Joint Plan of Action. Among other things, the MOU will:

- Describe how *clinical information* will be shared between DOC correctional facilities and DHHS psychiatric hospitals and between the jails and DHHS psychiatric hospitals.
- Specify *crisis services* and protocols for people with mental illness and co-occurring disorders who are involved in the criminal justice system.
- Specify *re-entry planning*, services, and protocols for people with mental illness and co-occurring disorders who are involved in the criminal justice system.
- Describe shared *training* opportunities.
- Spell out a joint effort to coordinate *information and research* regarding evidence-based approaches and practices.
- Indicate that designated DOC and DHHS representatives will meet with *jail administrators* at their monthly meetings, as a way of working together on a regular basis on the implementation of this plan of action.

Action Step 8: Joint Standards and Protocols. DHHS and DOC will develop and implement joint standards and protocols to guide planning for and treatment of people with mental illness and co-occurring disorders who are involved in the criminal justice system. In implementing this action step, the departments will make sure that the state level standards and protocols are flexible enough to allow for local strategies that are responsive to local issues. At the same time, the departments will make sure that the standards and protocols result in a consistent approach throughout the State. DOC and DHHS will consult with key stakeholders as they take the following steps:

- Establish parameters for *diversion programs*, in order to make sure that there is some consistency in county-based diversion efforts.
- Identify clear steps and assign responsibility to assure swift, effective action for *clients in crisis*.
- Develop uniform, clinically driven standards and protocols for the *services received in prison or jail* by people with mental illness or co-occurring

disorders, including screening and assessment, medications, and other services.

- Use the APIC model illustrated in *Table 3* to develop standards and protocols for *re-entry planning.*
- Work with the county jails to ensure that their *formulary* is consistent with the formulary used by DHHS psychiatric hospitals and DOC correctional facilities.
- Consult with Adult Protective Services and judges about how to streamline *guardianship* when there is a psychiatric emergency.
- Define the parameters of *confidentiality.*

Action Step 9: Training. DOC and DHHS will provide training to help professionals better meet the needs of people with mental illness in the criminal justice system.

- DHHS and DOC will collaborate with the Maine Criminal Justice Academy and NAMI-Maine to develop and deliver a *curriculum* that includes the following topics and target audiences:
  - ⇒ Training about crisis intervention, the identification and management of mental illness, co-occurring disorders, and safety and security for patrol officers, probation officers, prison and jail personnel, crisis workers, and psychiatric hospital security staff.
  - ⇒ Specialized training regarding mental health terminology, co-occurring substance abuse, the characteristics of Axis I and Axis II diagnoses, medications, risk reduction, crisis de-escalation, the role of the correctional officer, and other pertinent issues for correctional officers who work on the mental health unit at Maine State Prison.
  - ⇒ Specialized training for prison and jail personnel about mental health assessment at intake, especially regarding suicide risk and other forms of psychiatric acuity, and about medications.
  - ⇒ Training for judges about effective alternatives to incarceration for people with mental illness.
  - ⇒ Training about strategies for collaborative case management and collaborative resource utilization for people from both the mental health and criminal justice systems.
- DOC and DHHS will share *training resources* as follows:
  - ⇒ The departments will actively seek out training resources from national organizations.
  - ⇒ Each department will make relevant training initiatives and opportunities available to the staff of the other department.
  - ⇒ There will be cross training of DOC and DHHS staff about the clinical services provided by each department.

⇒ Training offered for DHHS psychiatric hospital clinical staff will be made available to DOC clinical staff and vice versa.

⇒ The DHHS psychiatric hospitals will invite DOC clinical staff to participate in the mental health educational grand rounds.

- DHHS and DOC will use *teleconferencing* for training and consultation activities whenever possible. The departments will provide training in the use of telemedicine and teleconferencing.

Action Step 10: Measuring Effectiveness. DOC and DHHS will design and implement an evaluation process to measure the effectiveness of interventions specified in these action steps. The initial focus will be on the *rate of recidivism* among people with mental illness who have been arrested.

Goal 5: Mutual Clients of Riverview and DOC

Ensure that there are consistent, effective mental health services for the mutual clients of Riverview Psychiatric Center and DOC.

During the summer of 2004, representatives of DHHS and DOC met with the receiver appointed by the court under the AMHI consent decree to operate Riverview Psychiatric Center (RPC) to determine how to ensure that there are consistent, effective mental health services for the mutual clients of Riverview and DOC.

Action Step 11: Mutual Clients of RPC and DOC. This action step is based on discussions among DHHS, DOC, and the receiver appointed to operate RPC about how to ensure that there are consistent, effective mental health services for the mutual clients of RPC and DOC. Riverview and DOC will enter into a *memorandum of agreement* that specifies how they will carry out the following tasks:

- RPC and DOC each will identify someone as the *point of contact*—with appropriate back-up personnel—whose responsibility is to facilitate the coordination of mental health services for mutual clients.
- DOC correctional officers and RPC security staff will receive *training* relating to safety and security involving people with significant mental health needs. Training offered for RPC clinical staff also will be made available to DOC clinical staff and vice versa. RPC will invite DOC clinical staff to participate in the monthly mental health educational grand rounds at RPC.
- RPC, DOC, and the jails will *share clinical information*, as appropriate, about their mutual clients.

  ⇒ There will be a monthly case conference for people with mental illness in DOC facilities and in the county jails, including a review of any substance abuse issues.

  ⇒ There will be a case conference for clinical debriefing following each critical event occurring in the prisons and jails.

⇒ Clinical staff from DOC and RPC will stay connected to mutual clients by participating in ongoing treatment planning at each facility through teleconferencing or on-site consultation.

⇒ RPC and DHHS clinical staff will provide mental health consultation to DOC facilities and county jails through teleconferencing or on-site visits.

- RPC and DOC will develop *protocols* for processes affecting their mutual clients, including:

  ⇒ The transition of people from RPC to DOC correctional facilities and from DOC correctional facilities to RPC.

  ⇒ The discharge planning and community re-entry process.

  ⇒ How the Forensic Treatment Team (described in Action Step 3) and RPC will work closely together to address the needs of people who have a history of institutionalization at DOC facilities and RPC.

- There will be *priority access* to RPC for inmates of DOC correctional facilities who meet RPC's admission criteria. There will be *priority return* to DOC correctional facilities for mutual clients who no longer meet medical necessity for hospitalization. RPC and DOC agree that they will define what constitutes "priority" in both situations.

D. Next Steps: Moving Toward Implementation

The next steps by DOC and DHHS will be to develop an implementation timeline, analyze the cost of implementing the action steps, present a resource reallocation plan for implementing the action steps, and finalize a memorandum of understanding to guide the implementation of the action steps.

Attachment A

Maine Public Law 2004, Chapter 711, Section A-23

Sec. A-23. Addressing mental illness in prisons and jails. No later than July 1, 2004, the Department of Corrections and the Department of Behavioral and Developmental Services shall develop a joint plan of action to address mental illness in the criminal justice community. In developing the plan the departments shall invite the Maine Sheriffs' Association to participate. The plan will be delivered to the Commission to Improve the Sentencing, Supervision, Management and Incarceration of Prisoners. No later than January 1, 2005, the Department of Corrections and the Department of Behavioral and Developmental Services shall present the plan to the joint standing committee of the Legislature having jurisdiction over criminal justice and public safety matters.

Attachment B

Opportunities for State-Level Collaboration

There are challenges to providing a consistent, effective mental health services to the mutual clients of the Department of Health and Human Services (DHHS) and the Department of Corrections (DOC) of DOC and DHHS. During the summer of 2004, DHHS and DOC explored how to overcome these challenges by identifying possible areas collaboration that would allow for a more systematic and coordinated approach. The receiver appointed by the court under the AMHI consent decree to operate Riverview Psychiatric Center (RPC) was part of these discussions. The following recommendations flowed from these state-level discussions.

To begin with, DHHS and DOC each should identify someone as the point of contact—with appropriate back-up personnel—whose responsibility is to facilitate the coordination of mental health services for mutual clients.

Second, DHHS and DOC should focus on staff training. DOC correctional officers and RPC security staff get training relating to safety and security involving people with significant mental health needs. DOC and RPC clinical staff are trained to provide treatment to the prisoners or patients in their care. However, neither correctional officers/security staff nor clinical staff have had specialized training in the management of inmates or patients who have acute psychiatric disorders or behavioral disorders attributable to a mental illness. They could benefit from additional training about approaches that have been found to be particularly effective with forensic populations. DHHS and DOC agree that:

- There should be training for correctional officers about mental health assessment at intake, especially regarding suicide risk, other forms of psychiatric acuity, and the role of substance abuse.
- There should be specialized training for correctional officers who work on the mental health unit at Maine State Prison regarding mental health terminology, co-occurring substance abuse, the characteristics of Axis I and Axis II diagnoses, medications, risk reduction, crisis de-escalation, the role of the correctional officer, etc.
- There should be cross training of DOC and DHHS staff about the clinical services provided by each department, including substance abuse services.
- Each department should make any training initiatives and opportunities available to the staff of the other department.
- Training offered for RPC clinical staff also should be made available to DOC clinical staff and vice versa.
- RPC should invite DOC clinical staff to participate in the monthly mental health educational grand rounds at RPC.

Third, DHHS and DOC should make sure that there are opportunities for RPC,

DOC, and the jails to share clinical information about their mutual clients. Some people with mental illness move back and forth between RPC and DOC facilities or county jails with some frequency. Until recently, there has been little coordination regarding their treatment and management strategies. DHHS and DOC agree that:

- There should be a monthly case conference for people with mental illness in DOC facilities and in the county jails, including a review of any substance abuse issues.
- There also should be a case conference for clinical debriefing following each critical event occurring in the prisons and jails.
- Clinical staff from DOC and RPC should stay connected to mutual clients by participating in ongoing treatment planning at each facility through teleconferencing or on-site consultation.
- RPC and DHHS clinical staff should provide mental health consultation to DOC facilities regarding complex psychiatric cases through teleconferencing or on-site visits. This consultation should include a review of any substance abuse issues.
- RPC and DHHS should develop the capacity to consult with the county jails to maximize local resources and potentially prevent unnecessary hospitalization among jail detainees. This consultation could be on-site or through telemedicine or telephone consultation to jails.

Fourth, DHHS and DOC should develop transition planning and service protocols regarding how they will plan for and provide services to adults with mental illness as they move from one facility or service to another. DHHS and DOC agree that protocols should specify how the following things will happen:

- The transition of people from RPC to DOC correctional facilities and from DOC correctional institutions to RPC.
- The transition of people from DOC correctional facilities to the community, including specific steps, including re-entry planning, which begins 6 months prior to release and which includes addressing any substance abuse issues.
- Identification of DOC and DHHS staff responsible for overseeing regional support/service teams to coordinate services, including substance abuse services, for high risk, high profile people with mental illness who are in the community, but have a history of institutionalization in DOC facilities and/or RPC.
- Coordination of—and attendance and sharing of information at—discharge planning meetings.

Fifth, DOC, DHHS, and the county jails should develop specific community linkage policies and protocols and training to help inmates in need of mental health and substance abuse services upon their return to the community. There should be cross training of community-based providers such as intensive case managers and probation officers.

Attachment C

Members of Six Work Groups

Diversion Work Group

Theresa Blanchura, Aroostook Mental Health Center
Dick Brown, Charlotte White Center
Captain Richard Clukey, Penobscot County
Sheriff Everett Flannery and Captain Richard Wurpel, Kennebec County
Nancy Ives and June Koegel, Volunteers of America
Cheryl LaBlond, MidCoast Mental Health Center
Ann LeBlanc and Debra Baeder, Director, State Forensic Service
Paul Ranucci, ACCESS-Diversion Team
Diana Scully, Adult MH Services, DHHS *facilitator*
Bill Tanner and Bill Bolduc, Community Correctional Alternatives
Wayne Theriault, Planning, DOC

Discharge Planning Work Group

Ed Dyminski, Region III, DHHS *facilitator*
Rebecca Chandler, Franklin County Health Network
Debra Henderlong, Region III, DHHS *facilitator*
Pam Holland, Tri-County Mental Health Services
Ellie Grover, Lincoln County
Michael Vitiello, York County
Lars Olsen, Correctional Programs, DOC
Tom Lynn, Community Health and Counseling Services

Hospitalization Work Group

Steve Addario, Sweetser
Debra Baeder, State Forensic Service
Anna Bragdon, Maine Medical Center
Steve Fisher
Joe Fitzpatrick, Behavioral Health Services, DOC *facilitator*
Jim Foss, Aroostook County
Ric Hanley, Spring Harbor
Tom Lynn, Community Health and Counseling Services
David Proffitt, Riverview Psychiatric Center
Rick Redmond, Acadia Hospital
Judy Tarr, Miles Health Care
Gordon Willis, Bangor Mental Health Institute

Medications Work Group

Rebecca Chandler, Franklin County Health Network
James Fine, M.D., Region II, DHHS
Tom McAdam, Kennebec Valley Mental Health Center
Kathy Plante, Department of Corrections
Mary Ellen Quinn, Community Health and Counseling Services
Sharon Sprague, Region III, DHHS *facilitator*
Bill Tanner, Community Correctional Alternatives
Jude Walsh, Governor's Office of Health Policy and Finance
Captain Richard Wurpel, Kennebec County

Behavioral Management vs. Mental Illness

Betty Carolin
Carol Carothers, NAMI-Maine
Joe Fitzpatrick, Behavioral Health Services, DOC *facilitator*
Sheriff Everett Flannery, Kennebec County
Ann LeBlanc and Debra Baeder, State Forensic Service
Karen Ludwig and Joyce Fortier Taplin, Sweetser
Greg Marley, Mid-Coast Mental Health Center
Phil Monaco, PenBay Medical Center
Ray Porter, Waldo County Jail
Terry Robertson
Corey Schwinn, Washington County Professional Associates
Marjorie Snyder, M.D., Bangor Mental Health Institute

Community Provider Issues

Geeta Balikrishna
Diana Scully, Adult MH Services, DHHS *facilitator*
Debra Henderlong, Region III, DHHS
Dick Brown, Charlotte White Center
Kim Lane, HealthReach Network
Mark Hedger, Community Health and Counseling Center
Kimberly Johnson, Office of Substance Abuse, DHHS
Jean Gallant, Employment Specialists of Maine
Amy Hocking, Aroostook Mental Health Center

Attachment D

Recommendations by Six Mental Health/Criminal Justice Work Groups

The Maine Department of Human Services and the Maine Department of Corrections, assisted by the Maine Sheriffs' Association, identified 6 priority issues relating to people with mental illness in Maine's county jails—diversion, discharge planning, hospitalization, medications, behavioral management vs. mental illness, and community provider issues. More than 40 people participated in work group meetings during September and October 2004. This attachment presents the recommendations developed by the work groups pursuant to the following instructions by the two departments:

- Examine the work group's particular issue and recommend solutions for inclusion in the joint plan of action.
- Keep in mind the financial constraints facing the State.
- Take a realistic approach in moving toward improved system of care for persons with mental illness in Maine's county jails.
- Build from what is currently going on that is positive.
- Be mindful of best practice models.

1. Diversion Work Group

Who Should Be Diverted? In developing their recommendations, the Diversion Work Group discussed who should be diverted and who should not be diverted.

- To the extent that the distinction can be made, diversion programs should focus on people whose crime or alleged crime is a result of their mental illness—not on those who have mental illness, but whose crime or alleged crime is not a result of their mental illness.
- Many who could benefit from diversion programs have co-occurring mental health and substance abuse addiction disorders.
- The ideal candidates for diversion are people with mental illness who have been accused or convicted of low-level or low-risk crimes or offenses that would be described as a public nuisance.
- A small number of people with mental illness have been accused or convicted of a crime that is violent (for example, cases involving domestic violence). Extra care and consideration should be given to diverting them into the community, and diversion should be proposed only when the safety of the community can be reasonably assured. [*Note*: Work Group members had extensive discussion about the diversion of people accused or convicted of domestic violence. Some felt that there should be a recommendation that people accused of domestic violence should never be diverted pre-booking. Others, expressing concern about carving out a special provision, felt that this general statement about people accused or convicted of a violent crime

would cover domestic violence situations.]

- People accused of sexual assault should never be diverted either pre- or post-booking.
- A small number of people with mental illness who have been accused or convicted of a crime engage in high levels of socially unacceptable behavior on a frequent basis. They are a challenge whether they are in a county jail, a prison, or the community.

Recommendations. The Diversion Work Group developed four multi-part recommendations.

Recommendation #1: Variety of Diversion Mechanisms. The State of Maine and the counties should support and build on diversion mechanisms that currently are being used and also should support the development of additional mechanisms. Diversion should be targeted to people who have committed or allegedly committed a crime as a result of their mental illness.

- *Pre-booking* is the ideal time for diversion. Patrol officers should be trained in how to make quick field observations and preliminary assessments with regard to mental health issues. They also should be encouraged and supported to make decisions to divert people with mental illness who have been accused of a crime to a behavioral health provider rather than to send them to jail. For pre-booking diversion to work, people should be required to comply with treatment with a reasonable expectation that, upon successful completion of the treatment, charges against them would be filed or dismissed altogether.

- There also are many opportunities for *post-booking* diversion:

  ⇒ If an initial assessment detects the presence of mental health issues, *bail* should include requirements to participate in mental health and/or substance abuse programs, as appropriate. Many people with mental illness accused or convicted of a crime are indigent and cannot make bail. When mental illness and indigence are both present, alternatives to cash bail need to be developed. Consideration should be given to waiving bail commissioner fees in such situations.

  ⇒ *Judges* should have more information about sentencing options and alternatives. Case managers—whose responsibilities towards a client should not cease upon the conviction of a crime—should make sure that judges are fully apprised of the offender's mental health status, as well as viable sentencing options that address the offender's mental heath and substance abuse issues.

  ⇒ *Mental health court,* which can speed up the adjudication process and ensure that the judge understands issues relating to mental illness, should play a role in diversion from jail. Some consumer groups are concerned that mental health court could have an effect on where people with mental illness are placed on waiting lists for services. Thus, it is

especially important for them to be included in discussions relating to this diversion mechanism.

⇒ Consideration should be given to the creative use of *furloughs* so inmates with mental illness may receive behavioral health services outside of jail.

⇒ Those already adjudicated who participate in diversion programs should be on *probation* that includes conditions for participating in mental health and/or substance abuse programs, as appropriate.

- DOC and DHHS should jointly develop and oversee a new *small secure community facility* for offenders with mental illness who are chronically and acutely engaging in socially unacceptable behavior, so that these individuals can be diverted from jail. Building on forensic Assertive Community Treatment (ACT) teams, the new facility should have a sufficient number of highly trained staff.

Recommendation #2: Training and Protocols. The State of Maine and the counties should increase their support for training and should develop crisis protocols. For example:

- Training about the identification of mental illness, the nature of co-occurring disorders, and the management of people with mental illness should be offered to law enforcement and corrections personnel both as part of their pre-service training and again later while on the job. More *patrol and probation officers* and *jail personnel* should receive Crisis Intervention Team (CIT) training to assess for mental illness and to refer those identified to behavioral health professionals.

- There should be training for *judges* about the possible effects of incarceration on a person with mental illness who has been accused or convicted of a crime. Judges need to have information about the full range of diversion and sentencing alternatives available to them.

- *Protocols* should be developed to clarify who is responsible for what when persons with mental illness who have been accused or convicted of a crime are in crisis. Protocols also should specify that when mental illness or substance abuse is identified, there should be an assessment to determine whether the offender has co-occurring disorders. Representatives of organizations responsible for particular aspects of the protocols—including law enforcement, corrections, emergency medical, and behavioral health organizations—should receive training and technical assistance regarding these protocols.

Recommendation #3: Funding and Performance. Diverting people with mental illness from the county jails saves money. The State of Maine and the counties should:

- *Reallocate existing funds* to help pay for services needed by those with mental illness who are in or involved with the county jails.

- *Measure the effectiveness* of diversion programs. Performance indicators might include jail days saved, the costs of psychotropic drugs used by inmates, time spent accompanying people in crisis, recidivism, completion of probation, use of crisis services, housing rates, participation in vocational activities, and employment status.

Recommendation #4: Statewide Parameters and Local Strategies. There should be both statewide diversion parameters and local diversion strategies. There should be a focus on each county's unique issues and responses, because what works in some places does not necessarily work in other places. At the same time, there should be similar opportunities to participate in diversion programs throughout the State. This is essential to ensure fairness for both offenders with mental illness, as well as for the victims of their crimes. Specifically:

- There should be a county-based *collaborative process* to support diversion programs:
  - ⇒ Representatives of the major systems—law enforcement, courts, corrections, courts, and mental health and substance abuse services — should be involved. The participants from county to county would vary, depending on the mix of resources. They might include representatives of the police, county jail, DA's Office, probation and parole, local DHHS personnel, and private community providers.
  - ⇒ Participants should meet at whatever intervals are needed to coordinate diversion efforts effectively (e.g. perhaps weekly in more populated areas and perhaps monthly in more rural areas.)

- DOC and DHHS should identify and arrange for a team to visit each county to perform an *assessment* of available services and critical players to determine, among other things, the level of coordination and collaboration among all concerned. The team should be prepared to provide recommendations about how the process can be improved and, if needed and requested, technical assistance about how to implement particular recommendations, including attention to integrated treatment for co-occurring disorders.

- DOC and DHHS should develop a *statewide memorandum of agreement* to guide the development and implementation of diversion mechanisms in Maine.

- There should be a *memorandum of agreement in each county*, signed by the participants in the collaborative process in that county. Each agreement should:
  - ⇒ Be consistent with the statewide parameters agreed upon DOC and DHHS;
  - ⇒ Describe the roles and responsibilities of each participating organization; and

⇒ Spell out the protocols that the organizations agree to follow.

2. Discharge Planning Work Group

Early Discharge Planning is Essential. The Discharge Planning Work Group agreed that discharge planning should begin on the day a person with mental illness is incarcerated. They also agreed that developing stability for the person upon discharge from jail is essential to a successful outcome for that person. The Work Group identified several issues that affect the transition of the person from jail back into the community, including the lack of community-based services (e.g. mental health providers, intensive case managers, transportation in rural areas, and housing options); difficulty in getting services set up while a person is incarcerated (in particular, SSI and MaineCare); no permanent home address for some; and very little family involvement.

Recommendations. The Discharge Planning Work Group identified three major recommendations.

Recommendation #1: Standardized Screening and Services. At the time of intake and booking, jail personnel should use a standardized screening tool to identify people with mental health and substance abuse issues. For those identified as having a mental illness or co-occurring mental health and substance abuse disorders, there should be a more in-depth assessment. More training (e.g. Crisis Intervention Team training) should be available to jail personnel. There should be statewide standards of care for incarcerated persons with mental illness or co-occurring mental health and substance abuse disorders. The roles of the various professionals providing services to these persons should be clearly defined.

Recommendation #2: Involvement of Intensive Case Manager (ICM). The role of the ICM should be redefined to allow for adequate outreach work within the jails. Funding should be shifted and, if needed, augmented to enable them to work in the jails. To ensure the successful transition of an incarcerated person back into the community, the ICM should:

- Begin discharge planning as soon as the person becomes incarcerated, in order to ensure that, upon leaving jail, the person will be connected to and receive needed community services (e.g. financial, housing, medical, vocational), as well as peer mentoring and/or other natural supports.
- Serve as a liaison or "boundary spanner" among the court, the District Attorney's Office, the jail, and community providers on behalf of the person.
- Ensure that any MaineCare and Social Security benefits for which the person is eligible will be available to him/her upon release from jail or as soon after release as possible.
- Involve family members in discharge planning.
- If applicable, encourage the judge to attach transitional housing to bail conditions.

- Upon discharge from jail, follow up with the person in the community for a specified period (e.g. 30 days).

Recommendation #3: Transitional Housing. There should be an analysis of the need for additional transitional housing resources for people with mental illness being released from jail and prisons.

3. Hospitalization Work Group

Who Should Be Hospitalized? The Hospitalization Work Group felt that there should be a clear definition of those in the criminal justice system who are appropriate for psychiatric hospitalization in a state and/or community hospital. The Work Group identified two groups who seem to be candidates for referral to psychiatric hospitalization at either the state or community hospital level:

- People with major mental illness who are currently unstable in terms of potential injury to self or others; and
- People with an Axis I diagnosis who are hurting themselves or others.

The purpose and duration of psychiatric hospitalization are quite different for those two groups. Persons with major mental illness may be candidates for longer-term hospitalization and potential stabilization through pharmacological intervention. Persons with an Axis I diagnosis who are extremely self-injurious or abusive, may be appropriate for multiple "short-term" psychiatric admissions.

Recommendations. The Hospitalization Work Group is making a number of recommendations.

Recommendation #1: Regional Forensic Treatment Teams. Regional Forensic Treatment Teams should be created to coordinate the care of the small number of high risk, high profile Axis II clients. Because persons with an Axis II diagnosis are involved in multiple systems (e.g. community resources, hospital resources, and criminal justice resources), it makes sense for them to be served by a team with representatives from these multiple systems. If regional forensic treatment teams effectively monitor this small number of high profile cases, interventions potentially could happen sooner and crisis situations and illness escalation possibly could be avoided.

Recommendation #2: Secure Residential Treatment Center. Community hospitals have significant liability concerns with high risk, high profile, Axis II patients in terms of their level of behavioral acting out and violence. The Work Group discussed the option of creating a secure community residential treatment center for this relatively small number of patients who are in need of more resources than the criminal justice system can provide to them and more security than the average psychiatric hospital can provide.

Recommendation #3: Crisis Intervention Training and Services. County jails need

increased training and services in the area of acute crisis management and stabilization of people in the process of psychiatric deterioration (especially given the absence of a secure community residential treatment program.) The training should target line staff who interact on a daily basis with people with major mental illness. Potential grant funding should be explored to support crisis intervention training and services at the county jail level.

Recommendation #4: Access to Services While in Jail. Community crisis providers are concerned about the challenge of providing services in a county jail system when MaineCare reimbursement is not applicable within a county jail setting. MaineCare rules should be reviewed to consider amendments allowing reimbursement for crisis intervention within county jails and correctional settings.

Recommendation #5: Emergency Rooms. A county jail's ability to medically stabilize and clear an individual for transfer to a hospital emergency room is quite variable and sometimes non-existent. Local emergency rooms are reluctant to accept these high-risk, potentially violent patients, particularly coming from county jail systems where the crisis intervention and medical clearance services are limited. There is a wide range of ability to respond to the challenge of medical clearance, which is necessary for transfers.

Recommendation #6: MOUs Regarding Psychiatric Hospital Beds. The Work Group recommends that memoranda of understanding (MOUs) should be developed between DOC and the state psychiatric hospitals, between county jails and the state psychiatric hospitals, and between county jails and community hospitals. The Maine Hospital Association could be asked to help develop MOUs between the county jails and community hospitals. The MOUs should include:

- A clear description of the types of inmates to be served.
- The communication and contact between the sending correctional facility and the receiving hospital. The purpose of ongoing contact should be to ensure that hospital staff and county jail/DOC staff stay in close communication with regard to the treatment for a shared client.
- The points of contact in each system. It should be very clear how transfers are to occur and what information and personnel need to be involved in transfers into or discharges from a state or community psychiatric facility.

Recommendation #7: Involuntary Medication. There was some disagreement in interpretations of the statute relating to the use of involuntary medication as a psychiatric intervention, especially at the state psychiatric hospital level. This issue lacks clarity and needs to be better understood.

Recommendation #8: Confidentiality. Open communication is critical among the different service providers. Given the historical struggles with confidentiality and particularly with the notion of HIPPA, the Work Group recommends legal exploration of the limits of confidentiality between the various systems.

Recommendation #9: Guardianship. There is misunderstanding and misinterpretation relating to the use of guardianship. The Work Group recommends discussions with DHHS regarding the potential to streamline the guardianship process in case of a psychiatric emergency.

Recommendation #10: Telemedicine. The Work Group recommends that consideration be given to using telemedicine in the county jails to address an ongoing need regarding psychiatric services to county jail prisoners.

Recommendation #11: Mental Health Court and Community Commitment. The Work Group discussed exploring the concept of a mental health court and the concept of outpatient community commitment laws. They pointed out that with the inadequacy of community services, these are difficult concepts to implement.

4. Medications Work Group

Recommendations. The Medications Work Group developed the following recommendations.

Recommendation #1: Prescription Purchasing. Bundle prescription purchasing by Riverview Psychiatric Center, Bangor Mental Health Institute, the Department of Corrections, and the jails. Also consider other possibilities, such as the State of Maine's employee health program. Representatives of DOC and the Governor's Office of Health Policy and Finance should meet with county jail administrators to collect some necessary information regarding what they are purchasing and for how much.

Recommendation #2: Out to Bid for Medical/Psychiatric Services. Consider putting the jails' medical and psychiatric services out to bid. Develop standards to strengthen medical capacity. Psychiatric services include assessment, triage, and on-going treatment. The cost of setting up the system and managing it should be part of the request for proposals. There could be one provider, or two or three with unified standards. Parameters might include the use of bubble cards and a 48-hour turn around for medications and data collection.

Recommendation #3: Standards and Procedures. A group with representatives of clinicians, nurses, and jail staff should develop standards and protocols relating to medications for inmates with mental illness. They should consider DOC standards as part of this process. The following standards and procedures should be considered:

- The choice of medication should be clinically driven. There should not an arbitrary change upon entrance to jail. People with mental illness should be able to maintain medications that are working well.
- Do not change medications for an inmate with mental illness until an assessment has been completed.
- Discharge inmates with mental illness with 2 weeks supply of medications.

- Have medical and psychiatric service providers discuss issues and work closely together.
- To ensure timely and accessible services, establish a standard of a 48-hour turn around time for diagnosis and prescriptions for medications. Begin counting the 48 hours immediately upon admission to jail.
- Develop prescribing standards (e.g. Benzodiazipine use and withdrawal management rather than abrupt cessation.)
- Intake standards and protocols should describe how to identify medications, to ascertain from whom the incarcerated person with mental illness is receiving community services, to get releases of information, and to identify who needs discharge planning. Intake standards and protocols should make it clear how mental health professionals need to relay information to the jails.
- Release standards and protocols should describe how to prescribe medications, to coordinate services, and to provide the medical/ medication history from the jail to community providers.
- There should be protocols for how to resolve differences of opinion between the person's community practitioner and the jail's Physician Assistant. If the advice by the person's community psychiatrist is not followed, the decision should be made after talking with the psychiatrist.

Recommendation #4: Formulary. To help ensure continuity of care, the same formulary should be used in the hospitals, correctional facilities, and the community.

Recommendation #5: Liaisons. There should be a point person/liaison within the jail to receive information from and provide information to community providers about medications. If possible, a nurse should serve this function, but in some rural jails this might be difficult.

Recommendation #6: Containment Center. Establish a containment center for inmates who do not require hospitalization, but need restraint and watching due to self-harming behavior.

Recommendation #7: Telemedicine. Use telemedicine, once relationships are established as a way to consult and maintain communication, consultation, and training.

Recommendation #8: Methadone. Work with the Office of Substance Abuse about the possibility of maintaining people on methadone while in jail.

Recommendation #9: Emergency Services. Develop the capacity of jails for the provision of emergency psychiatry services. Determine whether inmates could be diverted to a local practitioner or whether there could be a house call arrangement. Whenever possible, intervene before an inmate gets to the community hospital emergency room.

Recommendation #10: Case Management. DHHS staff could provide case conferencing to the jails. They should ensure that inmates receive MaineCare applications prior to discharge.

Recommendation #11: Cost-Sharing. Analyze the possibility of DOC cost sharing to assist the jails financially.

5. Behavioral Management vs. Mental Illness Work Group

Four Categories of People. The Behavioral Management vs. Mental Illness Work Group took on the challenge of trying to categorize the client population in ways that seemed descriptive with regard to their behavior and potential causes for the behavior. There was consensus that people seem to fall into four major categories: 1) Axis I/Major Mental Illness, 2) Axis II/Personality Disorders, 3) acute stress reaction with some degree of mental health history, and 4) disruptive behavior due to criminal manipulation.

The Work Group determined that the existing systems (DOC, county jails, and DHHS) seem to respond best to clients in the first and fourth categories. The people in the first category (Axis 1) are best served, when necessary, in a state psychiatric hospital where appropriate therapy and pharmacy can be applied. The people in the fourth category (criminal manipulation) seem to be best managed within correctional facilities and/or county jails.

The Work Group found that the high profile, high-risk people in the second category (Axis II) are most challenging to the existing systems. This category includes people who are extremely challenging due to their willingness to injure self or others repeatedly over a period of many years. The Work Group felt that the behavior of people in the second category is not purely manipulative, but is often connected to a significant history of trauma, psychosocial unrest and mental illness. At any time, people in this category may meet criteria for hospitalization, but this is not usually attributable to overt psychosis or uncontrolled major mental illness.

There were very strong opinions among Work Group members that the third category of people (those experiencing an acute stress reaction or mental health emergency) also present challenges in terms of resources and intervention, particularly at jail level.

Recommendations. The Work Group arrived at the following recommendations:

Recommendation #1: Diversion. The Work Group believes there is a need for diversion community resources, but they are concerned that there might not be adequate support for a major diversion effort. The Work Group recommends that an increase in community mental health resources in order to provide more community care and potentially divert mentally ill clients from the criminal justice system.

Recommendation #2: Training. There was consensus that there is a significant need for increased and improved training in the area of mental health and de-escalation techniques. This training would be very beneficial for security line staff and could help avert some crisis situations.

Recommendation #3: Guardianship. The existing guardianship process is quite challenging from the correctional and county jail perspective. There should be a review of the current statutes regarding guardianship in the case of psychiatric emergencies. There should be discussions with DHHS and advocacy groups to figure out how to have a more streamed-lined guardianship process in cases of psychiatric emergency.

Recommendation #4: Regional Support Teams. The Work Group recommends the creation of regional support teams comprised of community psychiatrists, DHHS mental health representatives, DOC, and county jail staff to plan and coordinate treatment services for the high-risk, high profile but small number of Axis II clients who are extremely challenging for the systems in the community and the state or county institutions.

Recommendation #5: Resources for People in Jail. The Work Group learned that community crisis intervention providers are concerned about their inability to bill MaineCare for mental health services provided within a correctional setting. The Work Group recommends that the State should increase funding and resources for mental health intervention and crisis management for inmates of the county jails. There should be a review of the current and potential reimbursement systems available to community providers when they provide services within a correctional setting (e.g. Maine Care, Medicaid, Medicare, Dirigo Health, etc).

Recommendation #6: Community Hospitals. The Work Group was concerned that community hospitals seem to be reluctant to work with inmates because of liability questions. There should be formal discussions with the Maine's community hospitals to consider their potential to be available to county jail inmates with mental illness and to explore their liability concerns.

Recommendation #7: Secure Facility. The Work Group recommends the establishment of a secure community residential facility to serve the small number of high profile, Axis II, high-risk clients who repeatedly find themselves involved with both the community and state institutional systems.

Recommendation #8: Pharmacological Intervention. During the discussion of psychiatric hospitalization for individuals in need of pharmacological intervention significant concerns were expressed about ready access to pharmacological intervention on behalf of patients. There are challenges within the system of psychiatric guardianship and the use of involuntary medication as a mental health intervention. The Work Group recommends that there should be a review of the current understanding and interpretation of the use of involuntary medications within the state psychiatric hospitals, as well as the potential to use involuntary pharmacological intervention in a correctional

setting.

6. Community Provider Issues Work Group

Which Inmates Need Mental Health Services? The Community Provider Issues Work Group agreed that jail inmates who need mental health services and supports are generally those who have a persistent and serious mental illness. In assessing the need for services and supports, a person's diagnosis and behavior, as well as functional status, should be considered.

The Work Group recognized that many inmates have co-occurring mental health and substance abuse disorders. They were concerned that there is a tendency to dismiss a person's behavior when s/he is intoxicated. Intoxication increases the risk of suicidal behavior; it should not be seen as a reason to dismiss other indicators of suicide.

The Work Group noted that if community-based mental health services were more readily and consistently available and accessible, it is likely that fewer people with mental illness would land in the county jails.

Recommendations. The Community Provider Issues Work developed the following recommendations:

Recommendation #1: County Coordinating Team. There should be a coordinating team in each county, which focuses on the behavioral health needs of county jail inmates with mental illness and substance abuse disorders. DHHS and DOC should provide guidance and support to these teams. Each team should—

- Be comprised of representatives of the regional DHHS office (e.g. Mental Health Team Leader and Intensive Case Manager), the county jail, community behavioral health providers delivering services to inmates, and others who have an impact on these inmates (e.g. representatives of the sheriff's office, local police, D.A.'s office, judges, probation and parole).
- Include someone who functions as a "boundary spanner."
- Meet regularly (e.g. perhaps weekly in areas with many inmates with mental illness and less frequently in areas with fewer inmates with mental illness.)
- Define the roles and responsibilities of each organization, as well as the relationships among the organizations, in relation to inmates with mental illness.
- Identify and resolve clinical issues affecting individual inmates with mental illness.
- Identify and resolve systemic and policy issues affecting inmates with mental illness.
- Examine how specific types of situations at the jails currently are dealt with, and develop protocols for how they ought to be dealt with in the future (e.g.

suicide attempts, co-occurring mental illness, and intoxication.)

- Develop and enter into a memorandum of agreement that articulates, at a minimum: the team's purpose and goals, the organizations represented on the team, and the roles and responsibilities of each member organization with respect to county jail inmates with mental illness.
- Review the national APIC Model, presented in *Table 3*, and adapt it to the local area.

Recommendation #2: Intensive Case Managers (ICMs). At present, the availability ICMs to county jails varies from county to county. In some jails, ICMs are actively involved with inmates with mental illness; in others, this is not the case. DHHS should—

- Assign an ICM to each county jail, who is actively involved in coordinating services and supports for inmates with mental illness and who serves as the point person for these inmates.
- Make sure the ICM is present at the county jail on a specific day or days each week.
- Clarify the role of the ICM in the county jail, and make sure there is consistency from one jail to the next.
- Consider the "boundary spanner" role for ICMs.

Recommendation #3: Funding. Maine has many mental health resources, but inadequate coordination among these resources. Because there is fragmentation, people with mental illness sometimes do not receive the services they need, even though these services often could be made available. To assure the most effective use of funds—

- County jails should use their funds for behavioral health services for clinical evaluations and medication monitoring, not for case management.
- DHHS should assign an active ICM to every county jail.
- Contracts should be in place for community providers to deliver clinical evaluation and medication management services at every county jail.
- DHHS should finalize putting in place the mechanisms necessary to release grant funds to pay for services for inmates with mental illness that would be covered by MaineCare if they were not in jail.

Recommendation #4. Evaluation. Both the effectiveness of the county coordinating team process and the impact of behavioral health services provided to inmates with mental illness should be evaluated. DOC, DHHS, and the county jails should work together to—

- Evaluate the county coordinating team process.
- Identify the outcomes to be measured, including those that show:
  - ⇒ Effects on the *jail system*, such as the number of people with mental

illness admitted to jail, the number of inmates who die or attempt suicide while in jail, and the number of former inmates with mental illness who return to jail; and

⇒ Effects on *individuals*, such as the number of inmates who received needed behavioral health services and the number former inmates who live in appropriate housing, receive public benefits (e.g. MaineCare, TANF, SSI/SSDI, food stamps, and veterans benefits), and continue to take their medication.

- Identify the variables that can and cannot be controlled, as well as the baseline information that needs to be gathered.
- Put a process in place for agreeing upon, collecting, and reporting on key data elements.

Attachment E

Analysis of Recommendations by Six Work Groups

Recommendations by 6 Work Groups	**Work Groups**					
	Diversion	Discharge Planning	Hospitali-zation	Medica-tions	Beh Mg't vs Mental Illness	Provider Issues
1. Standards/Protocols:						
a. Protocols about who is responsible for what when people with mental illness are in crisis.	x					
b. Statewide parameters for diversion programs.	x					
c. Standardized screening, assessment, and services in jail for people with mental illness and co-occurring disorders		x				
d. Streamline guardianship in cases of psychiatric emergencies			x		x	
e. Explore limits of confidentiality			x			
f. Jails, hospitals, and others use same formulary				x		
g. Uniform, clinically driven standards and protocols for medications for inmates				x		
h. Review APIC model						x
2. Training:						
a. Patrol officers, probation officers, and jail personnel— crisis training and training in identification and manage-ment of mental illness	x					
b. Judges—training about effect of incarceration on people with mental illness	x					
c. Jail personnel—crisis intervention training		x	x			
d. Use telemedicine to consult and provide training relating to medications				x		
e. Security line staff—training about mental health and de-escalation technique					x	

Recommendations by 6 Work Groups	**Work Groups**					
	Diversion	Discharge Planning	Hospitali-zation	Medica-tions	Beh Mg't vs Mental Illness	Provider Issues
3. Facilities:						
a. Small secure community facility	x					
b. Analysis of need for transitional housing		x				
c. Secure residential treatment center for high risk, high profile, Axis II patients			x		x	
d. Containment center for inmates who do not require hospitalization but need restraint and watching				x		
4. Services for Inmates:						
a. More crisis services and reimbursement			x			
b. Telemedicine to provide psychiatric services in jails			x			
c. Consider maintaining inmates on methadone				x		
d. Review reimbursement systems available to community providers					x	
e. Explore use of pharmaco-logical intervention			x		x	
a. Contracts with providers to deliver clinical evaluation and medication management						x
b. Jails—use funds for clinical evaluations and medication monitoring, not for case management					x	x
c. DHHS—release grant funds for services that would have been covered by MaineCare if people were not in jail						x
5. Collaborative Processes:						
a. Collaboration on diversion	x					
b. Memoranda of agreement	x		x			x
c. Regional forensic treatment teams for high-risk, high profile Axis II clients			x		x	
d. County coordinating team to focus on inmates with mental illness and co-occurring disorders						x

Recommendations by 6 Work Groups	**Work Groups**					
	Diversion	Discharge Planning	Hospitali-zation	Medica-tions	Beh Mg't vs Mental Illness	Provider Issues
6. Diversion:						
a. Support pre-booking diversion	x					
b. Support post-booking diversion	x					
c. Consider mental health court	x		x			
d. Reallocate funds available to jails to support diversion.	x					
e. Support diversion in general					x	
7. Liaisons in jails:						
a. Intensive case managers		x		x		x
b. Point person (e.g. nurse) to receive/ provide information about medications				x		
8. Community Hospitals						
a. Address concerns about medical clearance in ER			x			
b. Divert inmates from entering ER				x		
c. Formal discussions with community hospitals about liability concerns and availability for inmates					x	
9. Finance/Administration:						
a. Assist jails financially	x					
b. Bundle prescription purchasing by jails, DOC, and state psychiatric hospitals				x		
c. Put out to bid jails' medical and psychiatric services				x		
d. Increase funding for mental health intervention and crisis management for jail inmates				x		
10. Measure Effectiveness:						
a. Diversion programs	x					
b. County coordinating team process						x
c. Impact of behavioral health services on inmates						x

Attachment F

Title 34-A, Section 1210-A of the Maine Revised Statutes

§1210-A. Community corrections

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Community corrections" means the delivery of correctional services for juveniles or adults in the least restrictive manner that ensures the public safety by the county or for the county under contract with a public or private entity. "Community corrections" includes, but is not limited to, preventive or diversionary correctional programs, pretrial release or conditional release programs, alternative sentencing or housing programs, electronic monitoring, residential treatment and halfway house programs, community correctional centers and temporary release programs from a facility for the detention or confinement of persons convicted of crimes or adjudicated delinquents.

2. Establishment of County Jail Prisoner Support and Community Corrections Fund. The County Jail Prisoner Support and Community Corrections Fund is established for the purpose of providing state funding for a portion of the counties' costs of the support of prisoners detained or sentenced to county jails and for establishing and maintaining community corrections as defined in subsection 1.

3. Distribution. Beginning July 1, 1998 and annually thereafter, the department shall distribute the County Jail Prisoner Support and Community Corrections Fund to counties based on the percent distribution of actual funds reimbursed to counties pursuant to former section 1210 in fiscal year 1996-97...

4. Change in state funding of county jails. If a county experiences at least a 10% increase in the total annual jail operating budget or if a county issues a bond for the construction of a new jail or renovation of an existing jail, the county may file with the department a request for an increase in the amount of state funds the county receives for the support of prisoners. A county must file a request for an increase in the amount of state funds the county receives for the support of prisoners by February 15th for an increase experienced in the prior fiscal year. The department shall review the request and, if the county demonstrates to the department a need for the increase, the department shall distribute the approved amount to the county from the surcharges collected under subsection 9. All funds distributed under this subsection must be used only for the purpose of funding counties' costs of the support of prisoners detained or sentenced to county jails and for establishing and maintaining community corrections. The department shall forward the request and supporting documents to the joint standing committee of the Legislature having jurisdiction over corrections and criminal justice matters of a county's requested increase and any distributions made to counties under this subsection.

5. Community corrections program account. Each county treasurer shall place 20% of the funds received from the department pursuant to this section into a separate community corrections program account. A county may use funds placed in this account only for adult or juvenile community corrections as defined in subsection 1.

Before distributing to a county that county's entire distribution from the County Jail Prisoner Support and Community Corrections Fund, the department shall require that county to submit appropriate documentation verifying that the county expended 20% of its prior distribution for the purpose of community corrections as defined in subsection 1. If a county fails to submit appropriate documentation verifying that the

county expended 20% of its prior distribution for the purpose of community corrections, the department shall distribute to that county only 80% of its distribution from the County Jail Prisoner Support and Community Corrections Fund. The department shall distribute the 20% not distributed to that county to all other counties that submit appropriate documentation verifying compliance with the 20% expenditure requirement for the purpose of community corrections. The department shall distribute these funds to those qualifying counties in an amount equal to each county's percent distribution pursuant to subsection 3.

6. Report. Beginning January 15, 1999 and annually thereafter, each county shall submit a written report to the joint standing committee of the Legislature having jurisdiction over corrections and criminal justice matters. Reports must include descriptions of each county's community corrections programs and an accounting of expenditures for its community corrections.

7. Technical assistance. The commissioner shall provide technical assistance to counties and county advisory groups to aid them in the planning and development of community corrections.

8. Review. By July 1, 2001, the joint standing committee of the Legislature having jurisdiction over corrections and criminal justice matters shall review the County Jail Prisoner Support and Community Corrections Fund and its purpose and functions.

9. Surcharge imposed. In addition to the 14% surcharge collected pursuant to Title 4, section 1057, an additional 1% surcharge must be added to every fine, forfeiture or penalty imposed by any court in this State, which for the purposes of collection and collection procedures is considered a part of the fine, forfeiture or penalty. Except as provided in subsection 10, all funds collected pursuant to this subsection are nonlapsing and must be deposited monthly in the County Jail Prisoner Support and Community Corrections Fund that is administered by the department. Except as provided in subsection 10, all funds collected pursuant to this subsection must be distributed to counties that have experienced at least a 10% increase in their total annual jail operating budget or to counties that have issued bonds for the construction of a new jail or renovation of an existing jail and that meet all other requirements under subsection 4. Funds distributed to counties pursuant to this subsection must be used for the sole purpose of funding costs of the support of prisoners detained or sentenced to county jails and for establishing and maintaining community corrections.

10. Implementation. The first $23,658 collected under subsection 9 after the effective date of this subsection must be transferred to the Judicial Department to cover the costs of implementing the collection of surcharges.

Endnotes

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